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Division Overview

Website: http://www.dhcs.ca.gov/services/Pages/CMS.aspx

The System of Care Division (SCD) of the California Department of Health Care Services (DHCS) is responsible for the administration and oversight of programs that focus on fragile children and adults with special health care needs. The Division focuses on high risk high cost populations including Children's Medical Services (CMS) programs and Adult Care Management programs.

- California Children's Services (CCS)
- High Risk Infant Follow-up Program (HRIF)
- Medical Therapy Program (MTP)
- Child Health and Disability Prevention (CHDP) Program
- Health Care Program for Children in Foster Care (HCPCFC)
- Newborn Hearing Screening Program (NHSP)
- Genetically Handicapped Person Program (GHPP)
- Coordinated Care Management I & II
- Real Choices Grant Program
- Disease Management Program

The mission of SCD is to assure the health of California's adults and children with special healthcare needs particularly children with special health care needs.

The SCD is organized as follows:

Information Technology Section (ITS)

The Information Technology Section is composed of two units and responsible for all aspects of information technology support for the Division and CMS Net, the Division's automated case management system.

- Information Technology Unit (ITU) - responsible for Division client, server and LAN/WAN support. This unit establishes network connectivity between county CCS offices and CMS Net application, located at the Office of

Technology Services (Otech) data center. ITU also performs IT needs assessments and procurements for the Division.

- Information Systems Unit (ISU) - responsible for change management activities to the CMS Net application. This unit has contract oversight of nine onsite consultants performing maintenance and operational tasks to the CMS Net application. ISU also manages the CMS Net Help Desk operation, supporting statewide users of the CMS Net application.

Program Support Section (PSS)

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

- Administration Unit – responsible for fiscal, personnel, contracting, purchasing, and business services for the Division. Staff in the unit evaluate and monitor the Division's budget and prepare a variety of fiscal and budgetary reports; 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 Division; develop and manage contracts and interagency agreements; process contract and county expenditure invoices; and maintain personnel and business services transactions for all Division 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 (PSU) – responsible for enrolling providers for the CCS, CHDP, and GHPP programs and acts as a liaison between Division programs, their providers, the Fiscal Intermediary and Contracts Oversight Division (formerly Medi-Cal Payment Systems Division), and the State fiscal intermediary. The PSU works with individual providers, hospitals, and CCS/GHPP Special Care Centers to assist in resolving 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.

Dependent County Operations Section (DCOS)

The Dependent County Operations Section (DCOS) is composed of two offices located in Sacramento, and Los Angeles. The section provides utilization review and management services for CCS-eligible clients residing in dependent counties (those with populations of less than 200,000). Utilization review and 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.

The Section's offices also have oversight responsibilities for local CCS program, including evaluating and monitoring county CCS program 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 DCOS 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 DCOS offices are responsible for coordinating and facilitating on-site reviews of dependent county programs including CHDP 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.

Independent County Operations Section (ICOS)

The Independent County Operations Section (ICOS) is composed of two offices located in Oakland, and Los Angeles. The section provides utilization review and management oversight of program for CCS-eligible clients residing in independent counties (those with populations of more than 200,000). Independent county utilization review and management services include, but are not limited to, financial, residential and medical eligibility authorizations for services, resolution of appeals, eligibility for Medical Therapy Unit services, and program consultation/technical assistance.

The ICOS offices also have oversight responsibilities for local CCS program, including evaluating and monitoring county CCS 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 ICOS consultant staff 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 ICOS offices are also responsible for coordinating and facilitating on-site reviews of local programs including Medical Therapy and CHDP Programs, hospitals, special care centers, neonatal and pediatric intensive care 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 (SPS)

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

The SPS also is responsible for implementation and monitoring of specialty programs under the purview of the Division such as the Health Care Program for Children in Foster Care and the Child Health and Disability Prevention (CHDP) Program. Staff 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 provides technical assistance for the CHDP providers on the audiometric testing of hearing and fulfills the DHCS 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 1,700 clients statewide with serious, often life threatening, genetic conditions (i.e., hemophilia, cystic fibrosis, sickle cell anemia).

Medical Policy Section (MPS)

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

- The MPS develops and implements medical program policy and regulations for all programs administered by the Division. Staff develop provider and

facility standards for CCS; develop medical policies 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 DHCS programs.

- The MPS provides statewide consultation expertise in the disciplines of medicine, nursing, social work, nutrition, dentistry, dental hygiene, health education, occupational therapy, and physical therapy and participates 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.

Waiver and Research Section (WARS)

The Waiver and Research Section is responsible for the development, implementation and monitoring of the 1115 Bridge to Reform Waiver (CCS Pilots). This section also is responsible for the maintenance of all databases in the Division collecting data to provide summary reports and data analysis as required. The section consists of two units: Research and Data Analysis Unit and Waiver Implementation Unit.

- Research and Data Analysis Unit

  This Unit coordinates the data collection and analysis for the CCS Waiver pilots and the entire Division, and provides the maintenance of databases including but not limited to correspondence with counties and provider databases, the PHI/PI database, the Division management information dashboard database, and others as needed. The unit is also responsible for research and program analysis functions of the pharmaceutical rebate program for CCS and GHPP.

- Waiver Implementation Unit

  This Unit is directly responsible for planning, organizing, implementing, developing, monitoring, analyzing, and evaluating the 1115 Demonstration Waiver functions for quantity, quality assurance, and efficiency. This unit ensures that the Program's laws, regulations, and/or policies are interpreted correctly to properly administer the 1115 Demonstration Waiver Program and its expansion to ensure effectiveness of the program statewide. It also acts as the liaison to, public and private organizations, institutions, agencies, and individuals regarding the 1115 Demonstration Waiver.

California Children's Services Overview

Website: http://www.dhcs.ca.gov/services/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 (DHCS). 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 Division provides medical case management and eligibility and benefits determination through its offices located in Sacramento, Oakland, 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 Division's offices in determining medical eligibility and service authorization. The Division's 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 182,000 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 Division 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 Division 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 DHCS 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 caseload; 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 maintenance of effort [MOE]).

B. The DHCS 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 DHCS will be asked to match.

D. Counties that submit authorized medical service claims for individual CCS clients to the state DHCS fiscal intermediary for payment prepare a "Report of Expenditure Invoice" and reimburse the Division for the county's share of diagnosis, treatment, and therapy services expenditures.

Funding for county CCS administrative and operational costs is based on an allocation of State General funds for each of the three CCS caseload payor categories (CCS, Healthy Families, and Medi-Cal) for the CCS Administrative Budget. Counties must prepare budgets and may not expend more General Funds than are allocated by caseload category. 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: http://www.dhcs.ca.gov/services/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, care coordination, 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).

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 (DHCS 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/chdp_manual.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 DHCS 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 DHCS 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 Division (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: http://www.dhcs.ca.gov/services/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 1,700 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. Effective July 1, 2009 Sections 125155.1, 125157, 125165, and 125166 of the Health and Safety Code were either added or amended to.

1. Change the annual GHPP enrollment fee methodology;
2. Implement a cost containment feature for GHPP clients to maintain employer-sponsored health care coverage; and
3. Implement payment of GHPP clients' employer-sponsored health insurance premiums.

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: http://www.dhcs.ca.gov/services/hcpcfc

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 Care Services (DHCS) through a Letter of Agreement with the California Department of Social Services (DSS) 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 DSS 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 DHCS 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). This section was amended in 2009 to mandate the implementation of the HCPCFC in each county.

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 Division (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 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: http://www.dhcs.ca.gov/services/nhsp

Program Description

The Newborn Hearing Screening Program (NHSP) has established a comprehensive coordinated system of early identification and provision of appropriate services for infants with hearing loss. The goal of NHSP is to identify newborns and infants with a hearing loss prior to three months of age and to implement audiology and early intervention services by six months of age. The program offers parents of all infants born in these 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.

Every general acute care hospital in California with licensed perinatal services must provide a hearing screening test for the identification of hearing loss to every newborn, in accordance with the requirements of the NHSP. A newborn hearing screening test cannot be performed without the written consent of the parent. A parent or guardian may object to the newborn screening test based on any belief and not just religious beliefs. If the parent/guardian refuses the hearing screening, a hospital shall have the parent/guardian sign a waiver form.

The NHSP utilizes three contracted Hearing Coordination Centers (HCCs) to assist hospitals in developing their screening programs, certify and monitor the screening programs, and track those infants who require further screening and intervention to assure that they are linked to appropriate services. Each of the three HCCs (Miller Children's Hospital, Loma Linda University, and John Muir Health System) has a geographic service area for which they are responsible. The certification process for hospitals and NICUs is conducted by the HCC assigned to the particular geographic service area in which the hospital is located.

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.

- Assembly Bill 2651 (Chapter 335, Statutes of 2006) extended the NHSP by requiring that all birthing hospitals participate in the program. In addition, as of January 1, 2008, all general acute care hospitals with licensed perinatal services must provide, rather than offer, a hearing screening test for the identification of hearing loss to every newborn.

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 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.

Pediatric Palliative Care Waiver Program

Partners for Children

Website: http://www.dhcs.ca.gov/services/ppc

Program Description

Partners for Children (PFC) is a waiver program designed to provide home and community-based palliative care services to eligible children who have life threatening or life-limiting, conditions. The PFC program aims to improve quality of life for children with life limiting or life threatening conditions, and their family members.

In accordance with AB 1745, the System of Care Division and the Medi-Cal program partnered with the Centers for Medicare and Medicaid Services to develop a pediatric palliative care waiver for the children of California. The goal of PFC is to promote the development of comprehensive Pediatric Palliative Care demonstration programs that allow for the provision of care coordination, expanded hospice-type services and curative care concurrently.

Participants in PFC are required to be under age 21, reside in a participating county, have full-scope, no share of cost Medi-Cal, meet CCS medical eligibility

criteria and not be enrolled in any other 1915c waiver. The waiver offers expanded funding to support a set of services that would not otherwise be covered by the State Medicaid (Medi-Cal) program. The waiver requires that: participants are offered a choice between waiver services and institutional care (Freedom of Choice); participants have a life-threatening medical condition (Level of Care); and that the program be cost neutral. PFC serves children who would, in the absence of this waiver and as a matter of medical necessity, be expected to require acute inpatient hospital services for at least 30 days during the year. Waiver participants can continue to receive medically necessary services already available as state plan services.

Services available in the PFC Program are provided by participating hospice and home health agencies. The services include care coordination, expressive therapies, family training, respite care, family counseling and pain and symptom management. County California Children Services Nurse Liaisons (CCSNL) are responsible for enrollment, service authorization, utilization management, and data reporting for children enrolled in PFC. The SCD is responsible for oversight of the administration and evaluation of PFC.

The Pediatric Palliative Care program is one of three ways to receive palliative care that are currently available to CCS or Medi-Cal clients under 21 years of age. A second option for all clients under 21 years of age, including those who do not meet the hospice eligibility requirement of 6 month life expectancy, and do not meet the waiver criteria, is to receive the palliative care services available through Medi-Cal which are outlined in CCS Numbered Letter 04-0207. Finally for children meeting hospice eligibility requirements, the third option is to enroll in hospice and receive 'curative' treatments concurrently with hospice care.

History and Legislative Authority

The Nick Snow Children's Hospice and Palliative Care Act of 2006/ Assembly Bill 1745 required the California Department of Health Care Services to submit a waiver to the federal government that allows children with life limiting or life threatening conditions to receive concurrent curative and palliative care.

References

- CCS N.L. 07-1109 (November 4, 2009) regarding "Policy Relating To CCS Nurse Liaison Position In Partners For Children (Pediatric Palliative Care Waiver Program)"
- CCS N.L. 08-1109 (November 18, 2009) regarding "Unique Aid Codes For Children Participating In The Pediatric Palliative Care Waiver"
- CCS NL 040207 Palliative Care Options for CCS Eligible Children and Codes Available for Authorization of Pediatric Palliative Care Services

- Medi-Cal Provider Manual, Hospice Care

Disease Management Pilot Program (DMPP) DM1

Program Description

The Disease Management Program (DMPP) tested the effectiveness of providing a disease management benefit.

The Disease Management Pilot Program, aka DM1 was a three year pilot program designed to improve health outcomes for SPDs with Chronic medical conditions in a cost-effective manner. Disease Management (DM1) was an opt-out program operating in several Los Angeles County zip codes and all of Alameda County. The Disease Management Pilot Program (DMPP) – HIV/AIDS (DM2) was a three year pilot program designed to improve health outcomes for SPDs with HIV/AIDS in a cost-effective manner.

DM serves beneficiaries with the following chronic diseases:

- Advanced atherosclerotic disease syndrome
- Congestive heart failure
- Diabetes
- Asthma
- Coronary artery disease
- Chronic obstructive pulmonary disease
- HIV/AIDS

The Disease Management Program was designed to provide eligible individuals with a range of services that enable them to remain in the least restrictive and most homelike environment while receiving the medical care necessary to protect their health and well-being. Services provided included those available under the state plan, and may include, but are not limited to, medication management, coordination with a primary care provider, use of evidence-based practice guidelines, supporting adherence to a plan of care, patient education, communication and collaboration among providers, and process and outcome measures. Coverage for those services was limited by the terms, conditions, and duration of the contract.

Eligibility for the Disease Management Program is limited to those persons who were eligible for the Medi-Cal program as Aged, Blind, or disabled persons and those persons over 21 years of age who are not enrolled in a Medi-Cal managed care plan, or eligible for the federal Medicare program, and who are determined by the department to be at risk of, or diagnosed with, select chronic diseases, including, but not limited to, advanced atherosclerotic disease syndromes,

congestive heart failure, and diabetes. Eligibility was based on the individual's medical diagnosis and other criteria, as specified in the contract.

History and Legislative Authority

The term of the DM1 program was February 1, 2007, August 1, 2007 through November 30, 2010. The term of the DM2 program was October 15, 2007 through May 15, 2011, February 1, 2009 through December 31, 2009.

The Department elected to implement pilot programs to test the disease management benefit through the administrative model, instead of through a waiver. The administrative model does not require CMS approval. The effectiveness of this benefit includes demonstration of the cost neutrality of the DM program. A disease management benefit shall include, but not be limited to, the use of evidence-based practice guidelines, supporting adherence to care plans, and providing patient education, monitoring, and healthy lifestyle changes.

Coordinated Care Management Program (CCMP) CCM1 and CCM2

Program Description

The goal of the CCMP is to maintain access to medically necessary and appropriate services, improve health outcomes, and provide care in a more cost effective manner for two populations enrolled in the Fee for Service (FFS) Medi-Cal Program who are not on Medicare: (1) Seniors and Persons with Disabilities (SPDs) who have chronic conditions, or who may be seriously ill and near the end of life; and (2) persons with chronic health condition(s) and Serious Mental Illnesses (SMIs). This demonstration project offers the State the opportunity to test targeted approaches for meeting the needs of high-end users of the medical system in a cost effective manner. Because of their multiple chronic conditions and complex care needs, SPDs with chronic conditions or terminal illnesses and persons with SMIs and chronic health conditions, account for a significant portion of Medi-Cal program expenditures. In order to ensure that the Medi-Cal program is cost effective, it is critical to address the high medical costs of these beneficiaries.

Most of Medi-Cal's SPDs with chronic conditions, including persons seriously ill or near end of life, and persons with SMIs with chronic health conditions, receive care through the FFS system. These people typically have two or more chronic health conditions, which may include substance abuse disorders, requiring multiple treatment modalities. End-of-life costs may be exorbitant in this population, due to the over-utilization of tertiary healthcare resources. Likewise, persons with SMIs compounded by chronic medical conditions are often unable to successfully manage their illnesses. As a result, uncoordinated care for these vulnerable individuals may result in inappropriate utilization of services, inadequate care, and needlessly high Medi-Cal Program costs.

Coordinated Care Management Program (CCMP) CCM1 – Seniors and Persons with Disabilities (SPD) is a three year pilot program designed to improve health outcomes for SPDs with chronic conditions or those near the end of life in a cost-effective manner incorporating lessons learned from the DM programs.

Coordinated Care Management Program (CCMP) CCM2 – Serious Mental Illness (SMI) is a three year, pilot program designed to improve health outcomes for SPDs with chronic conditions and Serious Mental Illness in a cost-effective manner.

History and Legislative Authority

The term of the CCM1 program is March 1, 2009 through December 31, 2012 March 31, 2012. The term of the CCM2 program is August, 20, 2009 through July 31, 2013, December 31, 2014.

The CCM Programs were authorized by the Budget Act of 2006-2007

Real Choice

Grant Description

California has pursued a vigorous statewide course of change transformation. The State is sponsoring several substantive initiatives addressing improved access to the long-term services and supports system, consumer choice in how and where they receive long-term care services, and consumer-centered, coordinated entry points into the long-term support system.

With a three-year Person-centered Hospital Discharge Planning grant, DHCS conducted a predictive modeling analysis of Medi-Cal paid claims data. Through this coordinated and structured predictive modeling tool, DHCS evaluates beneficiary utilization and operational costs to identify how the department can become even more effective.

History and Legislative Authority

This is a multi-year (2009 – 2012) Centers for Medicare and Medicaid (CMS) Real Choice Systems Change (RCSC) Grant dedicated to increasing consumer access to home and community-based long-term support services and diverting persons with disabilities and older adults from unnecessary institutionalization through development of California's long-term care infrastructure.

SECTION 2 – PLAN AND BUDGET SUBMISSION

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General Instructions

Submit one original and one copy 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. Programs will be notified on an annual basis on the submission due date for budgets.

Beginning with Fiscal Year (FY) 2006-07, CMS 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. Unless specified, counties should submit one package for all three CMS programs.

The following are required documents of the CMS plan and budget package for Fiscal Year (FY) 2011-12:

I. Checklist (see page 7)

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 9)

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. Name and contact information for the County/City Health Officer.

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 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 10 and 11)

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 9 - 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 CHDP programs are located;

2. The current organizational structures of the CHDP programs within the local agencies (Health and/or Social Services);

3. The integration of the CHDP and HCPCFC programs within the agency and county structure; and

4. Outline the accomplishments for the last fiscal year and any anticipated changes for the current fiscal year for CHDP programs.

B. Retain 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. Retain a copy of the CCS County Staffing Standards Profile (Section 6, page 94) 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. Submit Incumbent List (see pages 12 through 14) for CCS, CHDP, and HCPCFC programs using the same job titles as listed on the organizational chart and budget detail worksheet.

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 12 through 14).

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 8, page 8).

   e. If staff work in multiple programs, retain 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 CMS.

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 CMS.

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, 2010 for Fiscal Year (FY) 2010-11**

VI. Data Forms

A. CCS Caseload Summary Form (see Section 4, page 7).

B. CHDP Program Referral Data (see Section 4, pages 11-12).

VII. Memoranda of Understanding (MOU) and Interagency Agreements (IAA)

A. Submit a list of all current MOU and IAA

B. Submit all MOU and IAA that are new, renewed, or have been revised since the prior fiscal year.

1. Retain CHDP IAA with DSS biennially.
2. Retain Interdepartmental MOU for HCPCFC biennially.
3. Retain Memoranda of Understanding/Interagency Agreements List (Section 2, page 15).

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. CHDP 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

IX. Management of Equipment Purchased with State Funds

To ensure that each local program complies with the DHCS Asset Management policies, the following are now required to be submitted with the annual plan and budget. Detailed information and forms may be found in Section 7-106.

A. Contractor Equipment Purchased With DHCS Funds Form (DHCS 1203) **if applicable**.

B. Inventory/Disposition of DHCS-Funded Equipment Form (DHCS 1204) **if applicable**.

C. Property Survey Report Form (STD 152) **if applicable**.

Plan and Budget Required Documents Checklist

MODIFIED FY 2011-2012

County/City: _____ **Fiscal Year:**

	Document	Page Number
1.	**Checklist**	Yes
2.	**Agency Information Sheet**	Yes
3.	**Certification Statements**	
	A. Certification Statement (CHDP) – Original and one photocopy	Yes
	B. Certification Statement (CCS) – Original and one photocopy	Yes
4.	**Agency Description**	
	A. Brief Narrative	Yes, CHDP
	B. Organizational Charts for CCS, CHDP, and HCPCFC	Retain locally
	C. CCS Staffing Standards Profile	Retain locally
	D. Incumbent Lists for CCS, CHDP, and HCPCFC	Yes
	E. Civil Service Classification Statements – Include if newly established, proposed, or revised	Yes
	F. Duty Statements – Include if newly established, proposed, or revised	Yes
5.	**Implementation of Performance Measures** – Performance Measures for FY 20010--11 are due November 30, 200119.	**N/A**
6.	**Data Forms**	
	A. CCS Caseload Summary	Yes
	B. CHDP Program Referral Data	Yes
7.	**Memoranda of Understanding and Interagency Agreements List**	
	A. MOU/IAA List	Yes
	B. New, Renewed, or Revised MOU or IAA	Yes
	C. CHDP IAA with DSS biennially	Retain locally
	D. Interdepartmental MOU for HCPCFC biennially	Retain locally
8.	**Budgets**	
	A. CHDP Administrative Budget (No County/City Match)	
	1. Budget Summary	Yes

County/City: _____ **Fiscal Year:**

			Document	Page Number
		2.	Budget Worksheet	Yes
		3.	Budget Justification Narrative	Yes
	B.		CHDP Administrative Budget (County/City Match) - Optional	
		1.	Budget Worksheet	Yes
		2.	Budget Justification Narrative	Yes
		3.	Budget Justification Narrative	Yes
	C.		CHDP Foster Care Administrative Budget (County/City Match) - Optional	
		1.	Budget Summary	Yes
		2.	Budget Worksheet	Yes
		3.	Budget Justification Narrative	Yes
	D.		HCPCFC Administrative Budget	
		1.	Budget Summary	Yes
		2.	Budget Worksheet	Yes
		3.	Budget Justification Narrative	Yes
	E.		CCS Administrative Budget	
		1.	Budget Summary	Yes
		2.	Budget Worksheet	Yes
		3.	Budget Justification Narrative	Yes
		4.	Worksheet to Determine Healthy Families Funding Source	Yes
	G..		Other Forms	
		1.	County/City Capital Expenses Justification Form	Yes, only if applicable
		2.	County/City Other Expenses Justification Form	Yes, only if applicable
9.			**Management of Equipment Purchased with State Funds**	
		1.	Contractor Equipment Purchased with DHCS Funds Form (DHCS1203)	If applicable
		2.	Inventory/Disposition of DHCS Funded Equipment Form (DHCS1204)	If applicable
		3.	Property Survey Report Form (STD 152)	If applicable

Agency Information Sheet

County/City: **Fiscal Year:**

Official Agency

Name:		Address:	
Health Officer			

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:			
Phone:			
Fax:		E-Mail:	

Chief Probation Officer

Name:			
Phone:			
Fax:		E-Mail:	

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

County/City: _____ Fiscal Year:

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 DHCS 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:

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 DHCS 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 Care Services - Children's Medical Services

Incumbent List - California Children's Services

For FY 2011-12, 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:**

Job Title	Incumbent Name	FTE % on CCS Admin Budget	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 Care Services - Children's Medical Services

Incumbent List - Child Health and Disability Prevention Program

For FY 2011-12, 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:**

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 Care Services - Children's Medical Services

Incumbent List - Health Care Program for Children in Foster Care

For FY 2011-12, complete the table below for all personnel listed in the HCPCFC and CHDP 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:**

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 Care Services - Children's Medical Services

Memoranda of Understanding/Interagency Agreement List

List all current Memoranda of Understanding (MOU) and/or Interagency Agreements (IAA) 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 MOU and IAA that are new, have been renewed, or have been revised. For audit purposes, counties and cities should maintain current MOU and IAA on file.

County/City: _____ **Fiscal Year:**

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)

COUNTY_____ FISCAL YEAR_____

SECTION 3 – SCOPE OF WORK AND PERFORMANCE MEASURES

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COUNTY_____ FISCAL YEAR_____

Children's Medical Services (CMS) 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 CMS. The guiding principles used to complete this transition were the CMS 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 (HCPCFC) 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.

COUNTY_____ FISCAL YEAR_____

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 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 CMS. 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 Medical Therapy Unit, primary care, foster care resources and 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 CMS 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 CMS.

1. Expend funds according to allocations.

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 as appropriate and as requested by CMS.

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 Healthy 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 CMS.

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 CMS.

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. Participation in school reporting requirements.

CHDP Program Letter No.: 05-01 documents changes brought about by Assembly Bill 2855, 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.

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. Care Coordination/Utilization Review and Management, Tracking, and Quality Improvement in Public Health Services

A. Implement care coordination/utilization review and 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/utilization review and 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/utilization review and 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 assisting children receive quality medical, dental, and support services across all provider settings.

1. Develop measures to gauge quality of care coordination/utilization review and 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

COUNTY_____ FISCAL YEAR_____

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.

COUNTY_____ FISCAL YEAR_____

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 several 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 short term, incremental, intermediate, and/or precursors for the outcome measures. Performance measures 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.

COUNTY_____ FISCAL YEAR_____

Directions for Completing the Report of Performance Measures

Reporting on the CMS Performance Measures is a Scope of Work requirement.

The following outlines the annual reporting requirements of the Performance Measures. One original and one copy of the CMS Report of Performance Measures are sent to the local program's CMS Regional Administrative Consultant by November 30th.

I. CCS, CHDP, and HCPCFC programs under **joint** administrations submit a **single joint** performance report to CMS.

II. Performance Measures should be reported in the appropriate format identified for each performance measure. Include a short narrative description of the process used to define a percentage for the performance measure or to achieve the score presented.

III. Monitoring of the Performance Measures and their completion will be conducted on an annual basis.

IV. The Annual Report of the Performance Measures consist of the following required elements:

A. Report the Results of the Performance Measures using the report forms provided.

B. **Narrative:** The narrative should outline the methods that each program implemented for 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 correctly tracked). In addition, the narrative should include collaborative relationships with other departments, agencies and organizations, (e.g. meeting frequency, signed Memoranda of Understanding (MOU) and identified CHDP liaison). **The total narrative length is not to exceed three pages.**

C. Describe plans to enhance or change interventions and to monitor activities based on review of this data.

D. Describe plans to share the results of data collection with primary care providers, community and public health agencies.

E. Note any requests for additional information and provide the requested information/response to Regional Nurse Consultant and/or Administrative Analyst.

V. A. Performance Measures require the denominator to be divided by the numerator to determine the percentage. Once the percentage is determined, complete the Performance Measure Profile template located on pages 12 and 13. The P.M. Profile form ***must*** be submitted with the Performance Measures and Narrative.

COUNTY_____ **FISCAL YEAR**_____

B. Note that the reporting cycles for CCS and CHDP/HCPCFC differ. Correct information for the appropriate fiscal year should be recorded.

Performance Measure Profile

Performance Measure Number	2007-08		2008-09		2009-10		2010-11		2011-12	
CHDP	MC	N-MC	MC	N-MC	MC	N-MC	MC	N-MC	MC	N-MC
1										
2										
3										
4 Average for all three providers	BMI		BMI		BMI		BMI		BMI	
	Dental		Dental		Dental		Dental		Dental	
	Lead		Lead		Lead		Lead		Lead	
5										
6 (Optional)										
HCPCFC 1										
2	Health		Health		Health		Health		Health	
	Dental		Dental		Dental		Dental		Dental	

COUNTY_____ **FISCAL YEAR**_____

Performance Measure Profile – Continued

	2008-09		2009-10		2010-11		2011-12		2012-13	
CCS										
1										
2	MED		MED		MED		MED		MED	
	RES		RES		RES		RES		RES	
	FIN		FIN		FIN		FIN		FIN	
3 (A)										
3 (B)										
4	CCS		CCS		CCS		CCS		CCS	
	MTP		MTP		MTP		MTP		MTP	
5										

COUNTY_____ **FISCAL YEAR**_____

Performance Measure Profile - Example

Performance Measure Number	2007-08		2008-09		2009-10		2010-11		2011-12	
CHDP	MC	N-MC	MC	N-MC	MC	N-MC	MC	N-MC	MC	N-MC
1	51%	50%	75%	100%	95%	90%				
2	100%		100%		100%					
3	50%		75%		90%					
4 Average for all three providers	BMI	10%	BMI	31%	BMI	40%	BMI		BMI	
	Dental	8%	Dental	15%	Dental	30%	Dental		Dental	
	Lead	11%	Lead	20%	Lead	25%	Lead		Lead	
5	Hispanic Children 12-14 yrs of age 27% (>95th% Critical Prevalence		African American Children 5-8 yrs of age 30% (>95th% Critical Prevalence)		Hispanic Children 12-14 yrs of age 32% (>95th% Critical Prevalence					
6 (Optional)	55% of children referred for dental tx received care		75% of children referred for dental tx received care		N/A					
HCPCFC 1	75%		95%		90%					
2	Health	85%	Health	87%	Health	86%	Health		Health	
	Dental	60%	Dental	65%	Dental	97%	Dental		Dental	

COUNTY_____ **FISCAL YEAR**_____

Performance Measure Profile Example – Continued

	2008-09		2009-10		2010-11		2011-12		2012-13	
CCS 1	90%		92%							
2	MED	75%	MED	100%	MED		MED		MED	
	RES	100%	RES	90%	RES		RES		RES	
	FIN	100%	FIN	100%	FIN		FIN		FIN	
3 (A)	65%			100%						
3 (B)	75%			100%						
4	CCS	100%	CCS	90%	CCS		CCS		CCS	
	MTP	100%	MTP	95%	MTP		MTP		MTP	
5	50%		75%							

COUNTY_____ **FISCAL YEAR**_____

CHDP Performance Measure 1 - 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 care 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 that received follow-up care** (Numerator)	**Number of Children with Code 4 or 5** (Denominator)	**Percent that 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 PM160), actually received follow-up within 120 days of the receipt of the PM 160.			

COUNTY_____ **FISCAL YEAR**_____

CHDP Performance Measure 2 - 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 tracking system.

Reporting Form:

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

Number of New Providers Receiving Orientation (Numerator)	
Number of New Providers (Denominator)	
Percent of New Providers Oriented	

COUNTY_____ **FISCAL YEAR**_____

CHDP Performance Measure 3 - Provider Recertification

The percentage of CHDP providers (excludes newly enrolled providers within the past FY) who have a **completed** 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 system.

Reporting Form:

Number of Completed Re-certifications (Numerator)	
Number of Active CHDP Providers (Denominator)	
Percent of CHDP Providers with Completed Re-certifications	

COUNTY_____ **FISCAL YEAR**_____

CHDP Performance Measure 4 - Desktop Review

The percentage of PM 160s reviewed for compliance with the CHDP Periodicity Schedule within the past fiscal year 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 percent of PM 160s that documentation is present for:

- Body Mass Index Percentile for ages **2 years and over**.
- The number of children referred to a dentist (**at 1 yr of age**).
- The number of children referred for a lead test (**minimum of 1 referral for age 2 and under**).

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

Denominator: The number of PM 160s reviewed per provider

Data Source: Local program tracking system

Reporting Form:

	BMI			**Dental**			**Lead**		
	Number of PM 160s reviewed (Denominator)			Number of PM 160s reviewed (Denominator)			Number of PM 160s reviewed (Denominator)		
Provider		w / BMI (Numerator)	% compliance		w/ dental (Numerator)	% compliance		w/ lead (Numerator)	% compliance
1.									
2.									
3.									
TOTAL*									
PACC**									

<u>TOTAL*</u> = Total Number of PM 160s in compliance from all three highest volume providers

<u>PAC</u> = Percent Average Compliance from all three highest volume providers**

COUNTY_____ FISCAL YEAR_____

CHDP Performance Measure 5 - 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 ≥ 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 (CDC), 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 % ≥ 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 ≥95th %)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.

COUNTY_____ FISCAL YEAR_____

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 *Please specify*:		
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)*		
Academic: Universities, Academic Institutions, Educators and Researchers Other (*Please specify):*		
Community Coalitions/Committees: Health Advisory Committee, Health Collaboratives/Coalitions Other (*Please specify):*		
Community Planning: City Planners, County Land Use Staff, Built Environment Groups		
Community Programs: Faith-based Groups. YMCA/YWCA, After School programs, Parks and Recreation programs, Child Care, University Cooperative Extension Other (*Please specify):*		
Healthcare: Managed Care Health Plans and Insurers, Hospitals, CCS Program/Special Care Centers, Medical Provider Groups, Medical Societies, Health Associations Other (*Please specify):*		
Policy Makers: County Board of Supervisors, City Councils, Community Planners, Legislators Other (*Please specify):*		
Projects or Funding Entities: First Five Commission, Public and Private Foundations/Endowments/Grants		

COUNTY_____ **FISCAL YEAR**_____

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

COUNTY_____ FISCAL YEAR_____

CHDP Performance Measure 6 - 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 or

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 tracking system.

COUNTY_____ FISCAL YEAR_____

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 include focused monitoring for presence of completed fields on the PM 160 for:

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

COUNTY_____ **FISCAL YEAR**_____

HCPCFC Performance Measure 1 - Care Coordination

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

Definition: This measure demonstrates effective care coordination in the HCPCFC program as evidenced by the percent of children who received follow-up care.

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 that received follow-up care within 120 days of receipt of the PM 160. (Numerator)	
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). (Denominator)	
Percent of children that received follow-up care within 120 days of receipt of the PM 160.	

*Data may be collected utilizing the PM 160, local county health contact form or electronic database used by the local program.

COUNTY_____ FISCAL YEAR_____

HCPCFC Performance Measure 2 - 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 With Exams (Numerator)	Number of Children (Denominator)	Percent of Children with Exams
Children in out-of-home placement supervised by Child Welfare Services or Probation Department with a preventive health exam 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 with a preventive dental exam according to the CHDP dental periodicity schedule documented in the Health and Education Passport.			

COUNTY_____ FISCAL YEAR_____

CCS Performance Measures

The degree to which local CCS programs provide effective utilization review and management to eligible CCS children; the local programs will evaluate and rate **each** of the five (5) components as individual indicators of program effectiveness.

The five components for review are:

1. Medical Home
2. Determination of CCS Eligibility
3. Special Care Center
4. Transition Planning
5. Family Participation

COUNTY_____ FISCAL YEAR_____

CCS Performance Measure 1 – 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 a physician who provides a medical home.

Numerator: The total number of children with a completed field with identification of a primary care physician and/or a physician that provides a medical home.

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

Data Source: Sample of 100 charts or 10% of caseload if caseload under 1,000.

Reporting Form:

Number of children with a primary care physician/ Medical Home **(Numerator)**	**Number of children in the local CCS program** **(Denominator)**	**Percentage of compliance**

* Note: If county percentage of compliance is under 80%, counties need to submit with the annual report a plan for how they will work to improve this result.

COUNTY_____ FISCAL YEAR_____

CCS Performance Measure 2 – 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 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 eligibility within 30 days of receipt of documentation needed to make the determination.

c. Financial eligibility within 30 days of receipt of documentation 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: 10% of the county CCS cases or 100 cases (which ever number is less).

COUNTY_____ FISCAL YEAR_____

Reporting Form:

MEDICAL ELIGIBILTY	Number of referrals determined medically eligible within 5 days (Numerator)		Number of new unduplicated referrals (Denominator)		Percentage of compliance
Medical eligibility determined within 5 days of receipt of all necessary documentation					
PROGRAM ELIGIBILITY	Number of cases determined eligible within 30 days of receipt of documentation needed to make the determination (Numerator)		Number of new unduplicated referrals (Denominator)		Percentage of compliance
Financial eligibility determined within 30 days	FSMC /HF	CCS only	FSMC /HF	CCS only	
Residential eligibility determined within 30 days					

COUNTY_____ FISCAL YEAR_____

CCS Performance Measure 3 (A & B) – Special Care Center

This Performance Measure is evaluated in two parts.

Part A: **Annual Team Report**

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

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

Denominator: Number of children enrolled in CCS whose condition as listed in categories defined in Numbered Letter 01-0108 requires CCS Special Care Center services and has received an authorization to a Special Care Center.

Data source: 10% of the county CCS cases authorized to SCC or 100 cases (which ever number is less).

Part B: **Referral of a Child to SCC**

Definition: This measure is based on the CCS requirement that certain CCS eligible medical conditions require a referral to a CCS Special Care Center for ongoing coordination of services.

Numerator: Number of children in CCS, with medical conditions in the categories as listed in Numbered Letter 01-0108 requiring a Special Care Center Authorization, who actually received an authorization for services.

Denominator: Number of children enrolled in CCS, with medical conditions, requiring Special Care Center Authorizations.

Data source: Counties shall identify and use four or five specific diagnosis categories (cardiac, pulmonary, etc) as listed in the Special Care Center Numbered Letter 01-0108 as it relates to the SCC(s) identified for your client population. The county shall identify one or more diagnostic codes and use the diagnosis codes indicated for the SCC categories selected for this PM.

COUNTY_____ FISCAL YEAR_____

Reporting Form - Part A:

Category selected (cardiac, pulmonary, etc.)	**Number of children with annual team report in client's medical records** (Numerator)	**Number of children with SCC authorization** (Denominator)	**Percentage of compliance**

Reporting Form - Part B:

Category selected (cardiac, pulmonary etc.)	**Number of children with authorization to SCC** (Numerator)	**Number of children with eligible medical conditions that require an authorization to a SCC** (Denominator)	**Diagnostic Code Chosen**	**Percentage of compliance**

*** Counties may select four (4) to five (5) specific medical conditions as outlined in the SCC NL to use as the basis for clients that should have a referral to a CCS SCC.**

COUNTY_____ FISCAL YEAR_____

CCS Performance Measure 4 – Transition Planning

Definition: Children, 14 years and older who are expected to have chronic health conditions that will extend past the twenty-first birthday will have documentation of a biannual review for long term transition planning to adulthood.

Numerator: Number of CCS charts for clients 14, 16, 18, or 20 years containing the presence of a Transition Planning Checklist completed by CCS program staff within the past 12 months for children aged 14 years and over whom requires long term transition planning.

Denominators:

a. Number of CCS charts reviewed of clients 14, 16, 18, and 20 years in (10% of children aged 14 and over) whose medical record indicates a condition that requires a transition plan.

b. Number of MTP charts reviewed of clients 14, 16, 18, and 20 years in (10% of children aged 14 and over) whose medical record indicates a condition that requires a transition plan.

Data Source: Chart Audit, Completion of Transition Planning Checklist.

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

COUNTY_____ **FISCAL YEAR**_____

Transition Planning Checklist

Transition Documentation	YES	NO	Comments
1. Client has an identified need for long-term transition planning.			
2. Transition planning noted in child's medical record.			
3. Transition planning noted in SCC reports.			
4. Vocational Rehab noted in child's reports.			
5. Adult provider discussed or identified for children 17 years of age or older.			
6. Transition planning noted in SELPA for those children that are in the MTP.			

* Note: Not all of the items in the Checklist will be applicable for each chart review.

Reporting Form:

Number of CCS charts reviewed	Number with transition planning	Percentage of compliance
Number of MTP charts reviewed	Number with transition planning	Percentage of compliance

COUNTY_____ **FISCAL YEAR**_____

CCS Performance Measure 5 – Family Participation

The degree to which the CCS program demonstrates family participation.

Definition: This measure is evaluated based on **each** of the following four (4) 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**	**Comments**
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 areas 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 members are participants of the CCS Special Care Center services provided to their child through family participation in SCC team meeting and/or transition planning.			
4. 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.			

COUNTY_____ FISCAL YEAR_____

Reporting Form:

Criteria	Performing (25% for each criteria)	Not Performing
1.		
2.		
3.		
4.		
Total	_____%	

SECTION 4 – DATA FORMS

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Caseload Determination (for each fiscal year requested) 5

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Child Health and Disability Prevention (CHDP) Program Referral Data Instructions 8

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CHDP FY 2008-2009 TARGET POPULATION ESTIMATE 13

CHDP FY 2009-2010 TARGET POPULATION ESTIMATE 13

CHDP FY 2010-2011 TARGET POPULATION ESTIMATE 13

CHDP FY 2011-2012 TARGET POPULATION ESTIMATE 18

HCPCFC AVERAGE ANNUAL CASELOAD* FY2011-2012 20

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.dhcs.ca.gov/services/chdp/Pages/BusinessObjects.aspx). For information on accessing the system, contact CMS 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 of 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 CMS.
    - *CHDP Target Population Estimate for Fiscal Years* 2008-09, 2009-10, and 2010-11.
- 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.cdss.ca.gov/research/PG299.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.

- HCPCFC Average Annual Caseload (see page 20).

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 2009-2010 will be calculated based on 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.dhcs.ca.gov/services/ccs/cmsnet/Pages/ThisComputes.aspx

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 Form (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 07-08 Actual Caseload	B % of Grand Total	08-09 Actual Caseload	% of Grand Total	09-10 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 09-10, the most recent year on the CHDP Program Referral Data is FY 08-09. 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 (see Section 5), describes the level and type of management information that will be compiled and shared between the departments (in Part IX. A).

   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 are 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 also have this information in their data reports 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 also have this information in their data reports 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 service 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 VII, 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 08-09**		**FY 09-10**		**FY 10-11**	
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 CARE SERVICES
CHILDREN'S MEDICAL SERVICES
CHILD HEALTH AND DISABILITY PREVENTION (CHDP) PROGRAM
TABLE 2-2
CHDP FY 2008-2009 TARGET POPULATION ESTIMATE

County	Medi-Cal Funded Under 21	Medi-Cal Funded Percent	State Funded Under 19	State Funded Percent	Total Children
ALAMEDA	95,739	71.4%	38,411	28.6%	134,149
ALPINE	91	69.8%	39	30.2%	130
AMADOR	1,594	62.8%	944	37.2%	2,538
BUTTE	22,598	71.3%	9,102	28.7%	31,700
CALAVERAS	2,327	59.8%	1,562	40.2%	3,889
COLUSA	2,491	62.9%	1,468	37.1%	3,959
CONTRA COSTA	56,749	68.1%	26,591	31.9%	83,340
DEL NORTE	3,679	74.1%	1,286	25.9%	4,965
EL DORADO	7,237	58.4%	5,145	41.6%	12,382
FRESNO	151,288	72.5%	57,487	27.5%	208,775
GLENN	3,638	62.8%	2,159	37.2%	5,797
HUMBOLDT	12,114	66.6%	6,072	33.4%	18,186
IMPERIAL	23,773	64.9%	12,876	35.1%	36,649
INYO	1,419	67.9%	671	32.1%	2,090
KERN	116,042	70.1%	49,542	29.9%	165,584
KINGS	17,828	63.0%	10,484	37.0%	28,312
LAKE	6,617	64.8%	3,602	35.2%	10,219
LASSEN	2,521	67.4%	1,220	32.6%	3,741
LOS ANGELES	1,146,306	69.2%	510,237	30.8%	1,656,543
MADERA	20,903	69.7%	9,088	30.3%	29,991
MARIN	7,234	64.7%	3,947	35.3%	11,181
MARIPOSA	1,148	61.5%	719	38.5%	1,867
MENDOCINO	10,063	70.6%	4,183	29.4%	14,246
MERCED	40,568	67.7%	19,366	32.3%	59,934
MODOC	969	70.2%	411	29.8%	1,380
MONO	668	54.7%	553	45.3%	1,221
MONTEREY	40,442	63.7%	23,061	36.3%	63,503
NAPA	6,324	60.0%	4,221	40.0%	10,545
NEVADA	3,834	56.1%	2,998	43.9%	6,832
ORANGE	194,030	62.2%	118,042	37.8%	312,072
PLACER	11,034	57.8%	8,044	42.2%	19,078
PLUMAS	1,126	63.1%	658	36.9%	1,784
RIVERSIDE	167,571	61.2%	106,026	38.8%	273,597
SACRAMENTO	143,459	69.9%	61,723	30.1%	205,182
SAN BENITO	4,443	61.4%	2,796	38.6%	7,239
SAN BERNARDINO	208,729	65.0%	112,161	35.0%	320,890
SAN DIEGO	182,511	60.3%	120,335	39.7%	302,846
SAN FRANCISCO	40,404	70.8%	16,649	29.2%	57,053
SAN JOAQUIN	78,953	68.1%	36,903	31.9%	115,856

SAN LUIS OBISPO	13,897	63.5%	7,973	36.5%	21,870
SAN MATEO	28,912	67.1%	14,166	32.9%	43,078
SANTA BARBARA	37,046	69.0%	16,646	31.0%	53,692
SANTA CLARA	103,412	72.5%	39,198	27.5%	142,610
SANTA CRUZ	18,643	69.1%	8,346	30.9%	26,989
SHASTA	16,370	66.9%	8,092	33.1%	24,462
SIERRA	202	63.9%	114	36.1%	316
SISKIYOU	4,463	70.5%	1,868	29.5%	6,331
SOLANO	29,514	67.3%	14,373	32.7%	43,887
SONOMA	23,991	63.2%	13,961	36.8%	37,952
STANISLAUS	60,848	66.4%	30,733	33.6%	91,581
SUTTER	9,902	66.4%	5,010	33.6%	14,912
TEHAMA	7,109	70.5%	2,976	29.5%	10,085
TRINITY	1,250	68.9%	563	31.1%	1,813
TULARE	82,123	72.0%	31,979	28.0%	114,102
TUOLUMNE	3,184	63.7%	1,817	36.3%	5,001
VENTURA	57,287	67.2%	27,929	32.8%	85,216
YOLO	13,765	59.8%	9,267	40.2%	23,032
YUBA	9,611	64.4%	5,319	35.6%	14,930
CITY OF BERKELEY	7,143	71.3%	2,881	28.7%	10,025
CITY OF LONG BEACH	59,537	69.6%	26,027	30.4%	85,564
CITY OF PASADENA	17,750	69.6%	7,760	30.4%	25,510
TOTAL	**3,444,424**	**67.4%**	**1,667,777**	**32.6%**	**5,112,200**

Data Sources:

1. Estimated Population Age 0-18 derived from State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail , 2000-2050, 2007, (Year 2007.txt), 2007.

2. Percent of Persons Between 100-200% FPL derived from Census of Population and Housing 2000 [California]: Summary File 3, *P88. Ratio of Income in 1999 to Poverty Level*, 2000.

3. Medi-Cal Funded Target Population Under 21 derived from State of California, Department of Health Care Services,

CALIFORNIA DEPARTMENT OF HEALTH SERVICE
CHILDREN MEDICAL SERVICES
CHILD HEALTH AND DISABILITY PREVENTION (CHDP) PROGRAM
TABLE 2-2
FY 2009-2010 TARGET POPULATION ESTIMATE

County	Medi-Cal Funded Under 21	Medi-Cal Funded Percent	State Funded Under 19	State Funded Percent	Total Children
ALAMEDA	95,803	71.5%	38,204	28.5%	134,008
ALPINE	91	68.5%	42	31.5%	133
AMADOR	1,594	62.5%	954	37.5%	2,548
BUTTE	22,598	71.1%	9,190	28.9%	31,788
CALAVERAS	2,327	59.8%	1,566	40.2%	3,893
COLUSA	2,491	63.1%	1,457	36.9%	3,948
CONTRA COSTA	56,749	68.2%	26,423	31.8%	83,172
DEL NORTE	3,679	73.6%	1,316	26.4%	4,995
EL DORADO	7,237	58.3%	5,166	41.7%	12,403
FRESNO	151,288	72.5%	57,262	27.5%	208,550
GLENN	3,638	62.7%	2,160	37.3%	5,798
HUMBOLDT	12,114	66.4%	6,123	33.6%	18,237
IMPERIAL	23,773	65.1%	12,754	34.9%	36,527
INYO	1,419	67.5%	683	32.5%	2,102
KERN	116,042	70.3%	48,947	29.7%	164,989
KINGS	17,828	63.3%	10,336	36.7%	28,164
LAKE	6,617	64.8%	3,593	35.2%	10,210
LASSEN	2,521	67.1%	1,238	32.9%	3,759
LOS ANGELES	1,146,646	69.2%	511,010	30.8%	1,657,656
MADERA	20,903	70.1%	8,924	29.9%	29,827
MARIN	7,234	64.4%	3,996	35.6%	11,230
MARIPOSA	1,148	61.0%	735	39.0%	1,883
MENDOCINO	10,063	70.7%	4,178	29.3%	14,241
MERCED	40,568	68.0%	19,059	32.0%	59,627
MODOC	969	69.4%	427	30.6%	1,396
MONO	668	54.5%	558	45.5%	1,226
MONTEREY	40,442	63.9%	22,857	36.1%	63,299
NAPA	6,324	60.0%	4,209	40.0%	10,533
NEVADA	3,834	55.9%	3,020	44.1%	6,854
ORANGE	194,030	62.2%	117,923	37.8%	311,953
PLACER	11,034	58.3%	7,907	41.7%	18,941
PLUMAS	1,126	62.5%	675	37.5%	1,801
RIVERSIDE	167,571	61.8%	103,542	38.2%	271,113
SACRAMENTO	143,459	70.4%	60,395	29.6%	203,854
SAN BENITO	4,443	61.4%	2,796	38.6%	7,239
SAN BERNARDINO	208,729	65.1%	111,956	34.9%	320,685
SAN DIEGO	182,511	60.3%	119,915	39.7%	302,426
SAN FRANCISCO	40,404	71.3%	16,248	28.7%	56,652
SAN JOAQUIN	78,953	68.6%	36,203	31.4%	115,156

SAN LUIS OBISPO	13,897	63.2%	8,086	36.8%	21,983
SAN MATEO	28,912	67.1%	14,167	32.9%	43,079
SANTA BARBARA	37,046	69.1%	16,590	30.9%	53,636
SANTA CLARA	103,412	72.5%	39,139	27.5%	142,551
SANTA CRUZ	18,643	69.0%	8,376	31.0%	27,019
SHASTA	16,370	67.1%	8,041	32.9%	24,411
SIERRA	202	62.8%	120	37.2%	322
SISKIYOU	4,463	70.0%	1,910	30.0%	6,373
SOLANO	29,514	67.3%	14,372	32.7%	43,886
SONOMA	23,991	63.2%	13,996	36.8%	37,987
STANISLAUS	60,848	66.7%	30,442	33.3%	91,290
SUTTER	9,902	66.6%	4,955	33.4%	14,857
TEHAMA	7,109	70.5%	2,979	29.5%	10,088
TRINITY	1,250	68.3%	579	31.7%	1,829
TULARE	82,123	72.3%	31,475	27.7%	113,598
TUOLUMNE	3,184	63.4%	1,841	36.6%	5,025
VENTURA	57,287	67.1%	28,151	32.9%	85,438
YOLO	13,765	60.4%	9,037	39.6%	22,802
YUBA	9,611	64.6%	5,261	35.4%	14,872
CITY OF BERKELEY	7,117	71.5%	2,838	28.5%	9,955
CITY OF LONG BEACH	58,097	69.2%	25,891	30.8%	83,989
CITY OF PASADENA	17,469	69.2%	7,785	30.8%	25,254
TOTAL	**3,443,080**	**67.5%**	**1,659,979**	**32.5%**	**5,103,059**

Data Sources:

1. Estimated Population Age 0-18 derived from State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail , 2000-2050, 2009, (Year 2009.txt), 2007.

2. Percent of Persons Between 100-200% FPL derived from Census of Population and Housing 2000 [California]: Summary File 3, *P88. Ratio of Income in 1999 to Poverty Level*, 2000.

3. Medi-Cal Funded Target Population Under 21 derived from State of California, Department of Health Care Services,
Medical Assistance Program Statistical Report Calendar Year 2006, *Table 17, Persons Certified Eligible by County, Sex, Age, July 2006*, 2007.

4. Medi-Cal Funded Births 100-200% derived from State of California, Department of Health Care Services, Medi-Cal Funded Deliveries Calendar Year 2005 , *Table 2005-13Deliveries to Medi-Cal Beneficiaries, By Beneficiary County and Ethnicity, Calendar Year 2005.*

5. County/City Population derived from California Statistical Abstract, *Table B-4 Totap Population California Counties and Cities,2008*, 2009.

CALIFORNIA DEPARTMENT OF HEALTH SERVICE
CHILDREN MEDICAL SERVICES
CHILD HEALTH AND DISABILITY PREVENTION (CHDP) PROGRAM
TABLE 2-2
FY 2010-2011 TARGET POPULATION ESTIMATE

Target Population Estimates will not be available for 2010-2011. Please use the FY 2009-2010 Target Population Estimates.

CALIFORNIA DEPARTMENT OF HEALTH SERVICE
CHILDREN MEDICAL SERVICES
CHILD HEALTH AND DISABILITY PREVENTION (CHDP) PROGRAM
TABLE 2-2
FY 2011-2012 TARGET POPULATION ESTIMATE

County	Medi-Cal Funded Under 21	Medi-Cal Funded Percent	State Funded Under 19	State Funded Percent	Total Children
ALAMEDA	95,803	71.5%	38,158	28.5%	133,961
ALPINE	91	68.5%	42	31.5%	133
AMADOR	1,594	62.5%	954	37.5%	2,548
BUTTE	22,598	71.1%	9,190	28.9%	31,788
CALAVERAS	2,327	59.8%	1,566	40.2%	3,893
COLUSA	2,491	63.1%	1,457	36.9%	3,948
CONTRA COSTA	56,749	68.2%	26,423	31.8%	83,172
DEL NORTE	3,679	73.6%	1,316	26.4%	4,995
EL DORADO	7,237	58.3%	5,166	41.7%	12,403
FRESNO	151,288	72.5%	57,262	27.5%	208,550
GLENN	3,638	62.7%	2,160	37.3%	5,798
HUMBOLDT	12,114	66.4%	6,123	33.6%	18,237
IMPERIAL	23,773	65.1%	12,754	34.9%	36,527
INYO	1,419	67.5%	683	32.5%	2,102
KERN	116,042	70.3%	48,947	29.7%	164,989
KINGS	17,828	63.3%	10,336	36.7%	28,164
LAKE	6,617	64.8%	3,593	35.2%	10,210
LASSEN	2,521	67.1%	1,238	32.9%	3,759
LOS ANGELES	1,146,646	69.8%	494,999	30.2%	1,641,645
MADERA	20,903	70.1%	8,924	29.9%	29,827
MARIN	7,234	64.4%	3,996	35.6%	11,230
MARIPOSA	1,148	61.0%	735	39.0%	1,883
MENDOCINO	10,063	70.7%	4,178	29.3%	14,241
MERCED	40,568	68.0%	19,059	32.0%	59,627
MODOC	969	69.4%	427	30.6%	1,396
MONO	668	54.5%	558	45.5%	1,226
MONTEREY	40,442	63.9%	22,857	36.1%	63,299
NAPA	6,324	60.0%	4,209	40.0%	10,533
NEVADA	3,834	55.9%	3,020	44.1%	6,854
ORANGE	194,030	62.2%	117,923	37.8%	311,953
PLACER	11,034	58.3%	7,907	41.7%	18,941
PLUMAS	1,126	62.5%	675	37.5%	1,801
RIVERSIDE	167,571	61.8%	103,542	38.2%	271,113
SACRAMENTO	143,459	70.4%	60,395	29.6%	203,854
SAN BENITO	4,443	61.4%	2,796	38.6%	7,239
SAN BERNARDINO	208,729	65.1%	111,956	34.9%	320,685
SAN DIEGO	182,511	60.3%	119,915	39.7%	302,426
SAN FRANCISCO	40,404	71.3%	16,248	28.7%	56,652
SAN JOAQUIN	78,953	68.6%	36,203	31.4%	115,156
SAN LUIS OBISPO	13,897	63.2%	8,086	36.8%	21,983
SAN MATEO	28,912	67.1%	14,167	32.9%	43,079

SANTA BARBARA	37,046	69.1%	16,590	30.9%	53,636
SANTA CLARA	103,412	72.5%	39,139	27.5%	142,551
SANTA CRUZ	18,643	69.0%	8,376	31.0%	27,019
SHASTA	16,370	67.1%	8,041	32.9%	24,411
SIERRA	202	62.8%	120	37.2%	322
SISKIYOU	4,463	70.0%	1,910	30.0%	6,373
SOLANO	29,514	67.3%	14,372	32.7%	43,886
SONOMA	23,991	63.2%	13,996	36.8%	37,987
STANISLAUS	60,848	66.7%	30,442	33.3%	91,290
SUTTER	9,902	66.6%	4,955	33.4%	14,857
TEHAMA	7,109	70.5%	2,979	29.5%	10,088
TRINITY	1,250	68.3%	579	31.7%	1,829
TULARE	82,123	72.3%	31,475	27.7%	113,598
TUOLUMNE	3,184	63.4%	1,841	36.6%	5,025
VENTURA	57,287	67.1%	28,151	32.9%	85,438
YOLO	13,765	60.4%	9,037	39.6%	22,802
YUBA	9,611	64.6%	5,261	35.4%	14,872
CITY OF BERKELEY	7,117	71.5%	2,838	28.5%	9,955
CIRY OF LONG BEACH	58,097	69.2%	25,891	30.8%	83,989
CITY OF PASADENA	17,469	69.2%	7,785	30.8%	25,254
TOTAL	**3,443,080**	**67.7%**	**1,643,920**	**32.3%**	**5,087,000**

Data Sources:

1. Estimated Population Age 0-18 derived from State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail , 2000-2050, 2009, (Year 2011.txt), 2007.

2. Percent of Persons Between 100-200% FPL derived from Census of Population and Housing 2000 [California]: Summary File 3,

P88. Ratio of Income in 1999 to Poverty Level, 2000.

3. Medi-Cal Funded Target Population Under 21 derived from State of California, Department of Health Care Services,

Medical Assistance Program Statistical Report Calendar Year 2006, *Table 17, Persons Certified Eligible by County, Sex, Age, July 2006*, 2007.

4. Medi-Cal Funded Births 100-200% derived from State of California, Department of Health Care Services, Medi-Cal Funded Deliveries Calendar Year 2005 ,

Table 2005-13Deliveries to Medi-Cal Beneficiaries, By Beneficiary County and Ethnicity, Calendar Year 2005.

5. County/City Population derived from California Statistical Abstract, *Table B-4 Totap Population California Counties and Cities,2008*, 2009.

HCPCFC AVERAGE ANNUAL CASELOAD*
FISCAL YEAR 2011-2012

County/City Program	May 2011 Caseload	County/City Program	May 2011 Caseload
Alameda	1,138	Placer	211
Alpine	2	Plumas	54
Amador	33	Riverside	3,198
Berkeley	75	Sacramento	2,743
Butte	564	San Benito	44
Calaveras	63	San Bernardino	2,680
Colusa	25	San Diego	2,890
Contra Costa	709	San Francisco	931
Del Norte	68	San Joaquin	918
El Dorado	232	San Luis Obispo	275
Fresno	1,833	San Mateo	206
Glenn	76	Santa Barbara	461
Humboldt	189	Santa Clara	824
Imperial	205	Santa Cruz	187
Inyo	10	Shasta	480
Kern	1,670	Sierra	6
Kings	200	Siskiyou	92
Lake	109	Solano	263
Lassen	44	Sonoma	386
Los Angeles	15,863	Stanislaus	497
Madera	192	Sutter	127
Marin	63	Tehama	146
Mariposa	19	Trinity	44
Mendocino	183	Tulare	703
Merced	598	Tuolumne	69
Modoc	6	Ventura	529
Mono	10	Yolo	211
Monterey	210	Yuba	83
Napa	108		
Nevada	70		
Orange	2,032	TOTAL	45,857

*** Caseload Data Source: California Department of Social Services, May 2011**

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

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General Instructions

Please complete the Memoranda of Understanding (MOU)/Inter/Intra-Agency Agreements (IAA) listing to summarize all of 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 CMS, 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 CMS 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 9 - 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 two plan model and the Geographic Managed Care (GMC) counties must have a **current** negotiated MOU in place with each of the Medi-Cal Managed Care Plans in their jurisdiction.

Local CHDP programs in counties with County Organized Health Systems (COHS) 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, or 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	• 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.	• 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	• 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.	• 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	• 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.	• Provide plans with CCS provider applications to expedite the paneling or approval of specialty and primary care network providers. • Coordinate with CMS 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	• 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.	• 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	• 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.	• 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	• 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.	• 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	• 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.	• 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 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

Louis Rico
Chief, Systems of Care Division — Date

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

County/City: Effective Dates:

Service	CCS Program Responsibilities	CMS and Dependent County CCS Program Responsibilities
Liaison	• 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.	• CMS 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.
	• 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.	• CMS staff, one representative from Regional Office and designated dependent county representative(s).
Provider Training	• Collaborate with plan to assist in the development of CCS related policies and procedures as needed by health plan and CCS.	• Regional Office and dependent county CCS program (joint)
	• Collaborate with health plan to provide multiple initial training opportunities that will give providers an understanding of the CCS program and eligibility requirements.	• Regional Office and dependent county CCS program (joint)
	• 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.	• Regional Office
	• Support ongoing training opportunities as needed.	• Regional Office and dependent county CCS program (joint)
CCS Provider Network	• Provide plans with CCS provider applications to expedite the paneling or approval of specialty and primary care network providers.	• Dependent county CCS program
	• Coordinate with the State office to assure identification of local CCS provider network to health plan.	• Dependent county CCS program
	• Coordinate with plan to refer to an appropriate CCS-paneled specialty provider to complete diagnostic services and treatment as needed.	• Regional Office and dependent county CCS program (joint)

County/City: Effective Dates:

Service	CCS Program Responsibilities	CMS and Dependent County CCS Program Responsibilities
Case Identification and Referral	• Provide technical assistance to plans for the development of plan policies, procedures, and protocols for making referrals to the program including necessary medical documentation.	• Regional Office
	• Determine medical eligibility within five working days of receiving adequate medical documentation of the suspicion of a CCS-eligible condition.	• Regional Office
	• Ensure that provider, designated plan personnel, and subscriber family are informed of either program eligibility or denial upon eligibility determination.	• Regional Office and dependent county CCS program (joint), as per CCS Case Management Procedure manual
	• Provide medical consultation as appropriate during the time period from referral to medical eligibility determination.	• Regional Office
	• 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.	• Regional Office
	• 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.	• CMS
Case Management/Tracking and Follow-Up	• 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.	• Regional Office and dependent county CCS program (joint)
	• 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.	• Regional Office and dependent county CCS program (joint)
	• Develop systems that will result in transmission of medical reports of services provided by CCS-authorized providers to the appropriate plan primary care providers.	• Regional Office

County/City: Effective Dates:

Service	CCS Program Responsibilities	CMS and Dependent County CCS Program Responsibilities
Quality Assurance and Monitoring	• Conduct, jointly with the plans, regular reviews of policies and procedures related to this agreement.	• CMS and designated dependent county representative (joint) with CMS as lead
	• Participate, at a minimum, in quarterly meetings with the plans to update policies and procedures as appropriate	• CMS and designated dependent county representative (joint) with CMS as lead.
	• Review and update protocol on an annual basis in conjunction with the health plan.	• CMS and designated dependent county representative (joint) with CMS as lead.
	• Develop work plan in conjunction with the plans that will monitor the effectiveness of the MOU and the plan/CCS interface.	• CMS and designated dependent county representative (joint) with CMS as lead.
Problem Resolution	• 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.	• Regional Office
	• Assign appropriate CCS program/liaison staff to participate in, at 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.	• Regional Office will refer to CMS, Program Standards, and Quality Assurance Section if issue cannot be resolved.
	• Refer issue to CMS Regional Office if problem cannot be resolved locally.	• Regional Office will refer to CMS, 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 _____

Louis Rico
Chief, Systems of Care Division _____ 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 Care 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.

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,*

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

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

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 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.

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

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

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 local CHDP Program will make all possible attempts to assure an adequate number of dental providers are available to meet local 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. (*A "Good Faith Effort" 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.*

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*.

County/City: _____ Effective Dates: _____ to _____

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*:

   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. *At a minimum, a quarterly newsletter focusing on the aforementioned information from "1"and "2" is 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 Care Services and Social Services.

1. Children's Medical Services (CMS) /CHDP Program Letters and Information Notices - Health Care Services.

2. All County Letters - Social Services.

3. Joint Letters - Health Care Services and Social Services

4. CMS /CCS Numbered Letters pertaining to the CHDP Program - Health Care 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

In providing these services, the PHN administratively coordinates the health care needs of children in foster care, including their developmental, dental and mental health needs. The PHN supports adherence to the health assessment periodicity schedule specified in the CHDP Health Assessment Guidelines, ensures that identified health needs are monitored, and supports continuity of health care services. The PHN/Social Worker updates the CWS/CMS Health and Education Passport, including prescribed medications, and shares medical information where appropriate. The PHN consults with physicians and other medical and non-medical professionals regarding the health and well being of children in foster care and in coordinating appropriate medical treatment.

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) include the following:

County/City: Effective Dates:

Service Provided	Local CHDP Responsibilities Foster Care PHN	Local Child Welfare Service Agency Responsibilities Social Worker/Probation Officer
Location	• PHN will be located in the CWS agency with accessibility to all team members	• 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	• PHN will be supervised by supervising PHN in the local CHDP Program with input from CWS agency staff.	• CWS agency/Supervising Probation Officer will provide input to the supervising PHN.
Accessing Resources	• 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.	• 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	• 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.	• 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	• 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 provider s, school nurses and others about the health care needs of children in foster care.	• 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	• PHN will provide program consultation to DSS/ 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.	• 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	• 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.	• 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	• 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.	• 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

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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, (excluding HCPCFC and CHDP Foster Care Match Budgets)
4. Indirect Expenses, and
5. Other Expenses (excluding HCPCFC and CHDP Foster Care Match Budgets)

(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	5,110	
	$ 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. Staff should be budgeted at actual salary step for filled positions and at mid-step in the salary range for vacant positions.

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 and or Deputy 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. A budget justification narrative must accompany each budget worksheet and budget summary, and must justify budget line items, e.g.:

1. The basis or formula used to determine travel costs, space rental, etc.,

2. Increases/decreases in FTE and enhanced/non-enhanced 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

L. CMS Budget Revisions are no longer required. Due to the current capped allocation methodology, budgets may not exceed the initial allocation. Local Match budgets are also capped at the amount of federal matching funds requested to augment local funds based upon a local program's initial request and will not be increased.

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. **CHDP 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 CHDP 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

CCS Administrative Budget – represents a county request for CCS program funding for utilization review and management and administrative costs. 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 utilization review and 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. FTE on the duty statement must match FTE 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 "County/City 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 non-enhanced in accordance with Federal Financial Participation (FFP) Guidelines (See Section 8).

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 and or the CHDP Deputy 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 utilization review and 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. (See K.1 on page 3 and space rental on page 12.)

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 8.)

2. Miscellaneous office supplies such as pens, pencils, paper, staplers, etc.

E. Furniture

1. Costs of small office furniture and small office machines which do not meet the definitions of "capital expenses" equipment below.

2. Costs of modular office furniture work stations.

3. 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 FTE?

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. Written approval by CMS must accompany the county/city quarterly administrative invoice for this expenditure. See County/City Capital Expenses Justification Form, page 14.

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, invoicing, and disposing equipment purchased with State funds are found in Section 7 – 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 (A-87 plan. 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". See VI on pages 39-40 and IV on pages 51-52.)

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 CMS.

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 7 of this manual for claiming instructions.)

Sample Budget Justification Narrative

Children's Medical Services
Gold County
Budget Narrative
Fiscal Year 2011-2012

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 Utilization Review and Management 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 @$.505 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:	$293,064	
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:	0	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:	$259,707	

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 year's 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:	$ 52,721	
BUDGET GRAND TOTAL	**$2,623,226**	

California Department of Health Care Services

Children's Medical Services

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.

California Department of Health Care Services

Children's Medical Services

County/City Other Expenses Justification Form

County/City: _____

Contact Person: _____

Date: _____

Telephone Number: _____

List all the subcontractor/consultant agreement claimed under "Other Expenses" and the price. Describe the services to be performed and how the CMS program(s) will benefit. Be specific but concise.

_____

_____

_____

_____

_____

_____

_____

_____

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 (Tile 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 FTE 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 MCP)
  - 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 MCP 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 MCP, 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 MCP)

  - 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 MCP 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 MCP)

  - 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 MCP 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 MCP, 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 FTE of PHN for Provider Orientation and Training
- total FTE of HP for Provider Orientation and Training
- established ratio
  - 1:5
  - one (1) ANC to every five (5) FTE of PHN and HP

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

Administration and Information Technology (AIT)

Basis of Formula

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

- total FTE of ANC for Informing/Linking, Care Coordination, and Provider Orientation and Training
- total FTE of Supervision (SUPV)
- total FTE of Administration and Information Technology (AIT)
- established ratio
  - 1:6
  - one (1) Clerical Support (CS) FTE to every six (6) FTE 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 2008 – 2009
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 FTE 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 FTE of ANC	=	FTE 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 FTE of HP	=	FTE 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 MCP)	–	screens via M-C MCP
=	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 FTE of PHN	=	FTE of PHN

Health Professional (HP)

	Total annual number of screens performed		screens
–	Total screens reported through M-C MCP	–	screens via M-C MCP
=	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 FTE of HP	=	FTE of HP

Ancillary (ANC)

	Total annual number of screens performed		screens
–	Total screens reported through M-C MCP	–	screens via M-C MCP
=	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 FTE of ANC	=	FTE 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 FTE of PHN	=	FTE 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 FTE of HP	=	FTE of HP

Ancillary (ANC)

	Total FTE of PHN		FTE of PHNs
+	Total FTE of HP	+	FTE of HPs
=	Total FTE of PHN and HP	=	FTE of PHNs and HPs
÷	Established ratio of ANC to PHN and HP		÷ 5
=	Annual FTE of ANC	=	FTE 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.

FTE	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 = FTE of HP

PROGRAM MANAGEMENT

Supervision (SUPV)

	Total FTE of PHN		FTE of PHN
+	Total FTE of HP	+	FTE of HP
+	Total FTE of ANC	+	FTE of ANC
=	Total FTE of PHN, HP, and ANC	=	FTE of PHN, HP, and ANC
÷	Established ratio of SUPV to PHN, HP, and ANC		÷ 10
=	Annual FTE of SUPV	=	FTE of SUPV

Administration and Information Technology (AIT)

	Total FTE of PHN		FTE of PHN
+	Total FTE of HP	+	FTE of HP
+	Total FTE of ANC	+	FTE of ANC
=	Total FTE of PHN, HP, and ANC	=	FTE of PHN, HP, and ANC
x	Percentage of AIT for oversight, guidance, direction, and technical support of all other staff, excluding SUPV		× 10%
=	Annual FTE of AIT	=	FTE of AIT

PROGRAM SUPPORT

Clerical Support (CS)

	Total FTE of PHN		FTE of PHN
+	Total FTE of HP	+	FTE of HP
+	Total FTE of ANC	+	FTE of ANC
+	Total FTE of SUPV	+	FTE of SUPV
+	Total FTE of AIT	+	FTE of AIT
=	Total FTE of PHN, HP, ANC, SUPV and AIT	=	FTE
÷	Established ratio of CS to PHN, HP, ANC, SUPV, and AIT		÷ 6
=	Annual FTE of CS	=	FTE of CS

CHDP EPSDT
FISCAL YEAR 2009 - 2010
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
FTE 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	
FTE 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	
FTE 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 FTE	**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 (PHN) 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
FTE 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	
FTE 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	
FTE 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 FTE	**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 2011-2012 (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 annually by CMS.

Complete the County/City Name and Budget Fiscal Year. See sample on pages 43 and 44.

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.

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."

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.

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 non-enhanced time for personnel claimed in the two budgets must be the same.

5A. Percentage of FTE/Non-enhanced 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 non-enhanced Medi-Cal funding for each position. See FFP Information in Section 8.
- 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 "Non-enhanced."
- 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 Non-enhanced 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 Non-enhanced 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 (See IV, page 10.)

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/city 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 FTE 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 non-enhanced.
- 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 Non-enhanced, 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 2011-2012
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**	**Non-enhanced 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 2011-2012
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**	**Non-enhanced 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 (Signature) Date Prepared Phone Number E-mail Address

CHDP Director or Deputy Director (Signature) Date Phone Number E-mail Address

SAMPLE

CHDP Administrative Budget Worksheet for FY 2011-2012
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**	**Non-enhanced 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.Publich 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 Technician – 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			$1000		$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 2011-2012
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**	**Non-enhanced 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	5/1/08	916-555-1212	jsmith@golden.ca.us
Prepared By (Signature)	Date Prepared	Phone Number	Email Address
Dr. Jane Doe	5/1/08	916-555-1212	jdoe@golden.ca.us
CHDP Director or Deputy Director (Signature)	Date	Phone Number	Email Address

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 48).

- 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 by CMS.

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. Non-enhanced Funds

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

   - Multiply the Non-enhanced, Column 5, "Budget Grand Total" amount by 50 percent, and enter the amount in the "Source of Funds" section, Non-enhanced 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 Allocation letter by CMS.

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

CHDP Administrative Budget Summary for FY 2011-2012
No County/City Match
County/City Name: _____

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)**	**Non-enhanced 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	4	5
Source of Funds	**Total Funds**	**Total CHDP Budget**	**Total Medi-Cal Budget**	**Enhanced State/Federal**	**Non-enhanced State/Federal**
State General Funds					
Medi-Cal Funds:					
State					
Federal (Title XIX)					

Prepared By (Signature) | 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

SAMPLE

CHDP Administrative Budget Summary for FY 2011-2012
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)**	**Non-enhanced 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**	**Non-enhanced 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

John Smith	05/01/08	916-555-1212	jsmith@golden.ca.us
Prepared By (Signature)	Date Prepared	Phone Number	Email Address

Dr. Jane Doe	5/01/08	916-555-1122	jdoe@golden.ca.us
CHDP Director or Deputy Director (Signature)	Date	Phone Number	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 55 and 56).

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.)

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 non-enhanced time for personnel claimed in the two budgets must be the same.

3A. Percentage of FTE/Non-enhanced

- Enter in Column 3A, the percentage of the FTE in Column 1A for eligible non-enhanced 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, Non-enhanced.

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 Non-enhanced 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 Non-enhanced (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 (See page 10.)

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/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 FTE or from the budgeted amounts as described above.

- Enter the calculated amounts of "External Indirect Expenses" 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 non-enhanced.
- 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 Non-enhanced, 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 2011-2012
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/City/Federal (25/75)**	**% or FTE**	**Non-enhanced 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 %) %							
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 2011-2012
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 (Signature) | Date Prepared | Phone Number | Email Address

CHPD Director or Deputy Director (Signature) | Date | Phone Number | Email Address

SAMPLE

CHDP Administrative Budget Worksheet for FY 2011-2012
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/City/Federal (25/75)**	**% or FTE**	**Non-enhanced County/City/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 2011-2012
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	May 1, 2011	916-555-1212	Jsmith@golden.ca.us
Prepared By (Signature)	Date Prepared	Phone Number	Email Address
Dr. Jane Doe	May 1, 2011	916-555-1122	Jdoe@golden.ca.us
CHPD Director or Deputy Director (Signature)	Date	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. Non-enhanced Funds

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

- Multiply the Non-enhanced, Column 3, "Budget Grand Total" amount by 50 percent, and enter the amount in the "Source of Funds" section, Non-enhanced column, on the Federal Funds line.

C. Total Funds

- Total Funds will equal the Enhanced plus the Non-enhanced County/City Funds for the County/City Funds line and the Enhanced plus the Non-enhanced 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

CHDP Administrative Budget Summary for FY 2011-2012
County/City Match
County/City Name: _____

Column	1	2	3
Category/Line Item	**Total Budget (2 + 3)**	**Enhanced County/City /Federal (25/75)**	**Non-enhanced 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)**	**Non-enhanced County/City/Federal (50/50)**
County/City Funds			
Federal Funds (Title XIX)			

Prepared By (Signature)	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

CHDP Administrative Budget Summary for FY 2011-2012
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)**	**Non-enhanced 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/City/Federal (25/75)**	**Non-enhanced County/City /Federal (50/50)**
County/City Funds	$24,312	$8,530	$15,782
Federal Funds (Title XIX)	$41,370	$25,588	$15,782

John Smith	05/01/2011	916-555-1212	jsmith@golden.ca.us
Prepared By (Signature)	Date Prepared	Phone Number	Email Address
Dr. Jane Doe	05/01/2011	916-555-1122	jdoe@golden.ca.us
CHDP Director or Deputy Director (Signature)	Date	Phone Number	Email Address

CHDP 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 PHN(s) and SPHN(s) who meet the federal definition of Skilled Professional Medical Personnel (SPMP) and clerical staff providing direct support to the PHN(s) who meet the federal definition of SPMP. (See section 8.) 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.)

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 CHDP Foster Care County/City Match Budget the proportions of enhanced and non-enhanced time for personnel claimed in the two budgets must be the same.

3A. Percentage of FTE/Non-enhanced

- Enter in Column 3A, the percentage of the FTE in Column 1A for eligible non-enhanced 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, Non-enhanced.

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 PHN and SPHN 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 Non-enhanced 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

External Indirect Expenses cannot be claimed on this budget.

Internal – 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 non-enhanced.
- 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.

CHDP Foster Care Administrative Budget Fiscal Year 2011-2012
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**	**Non-enhanced 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.								
II. Total Capital Expenses								
IV. Indirect Expenses								
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 (Signature) Date Prepared Phone Number Email Address

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

CHDP Foster Care Administrative Budget Fiscal Year 2011-2012
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**	**Non-enhanced 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								
1. Internal (Specify %)	%			$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	May 1, 2009	916-555-1122	Jsmith@golden.ca.us
Prepared By (Signature)	Date Prepared	Phone Number	Email Address

Dr. Jane Doe	May 1, 2009	915-555-1122	Jdoe@golden.ca.us
CHDP Director or Deputy Director (Signature)	Date	Phone Number	Email Address

CHDP 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 CHDP Foster Care Administrative Budget County/City Match Worksheet to the CHDP 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. Non-enhanced Funds

- Multiply the Non-enhanced Budget Grand Total amount in Column 3 by 50 percent. Enter this amount on the County/City Funds line, Non-enhanced 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, Non-enhanced 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 Non-enhanced State Funds for the State Funds line and the Enhanced plus the Non-enhanced 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.

CHDP Foster Care Administrative Budget Summary Fiscal Year 2011-2012
County-City Match
County/Title XIX Federal Funds
County/City Name:

Column	1	2	3
Category/Line Item	**Total Budget (2 + 3)**	**Enhanced County/City/Federal (25/75)**	**Non-enhanced 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)**	**Non-enhanced 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 (Signature)	Date Prepared	Phone Number	Email Address
CHDP Director or Deputy Director (Signature)	Date	Phone Number	Email Address

SAMPLE

CHDP Foster Care Administrative Budget Summary Fiscal Year 2011-2012
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)**	**Non-enhanced 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)**	**Non-enhanced 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.)

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Prepared By (Signature)	Date Prepared	Phone Number	Email Address
Dr. Jane Doe	05/01/11	916-555-1122	jdoe@golden.ca.us
CHDP Director or Deputy Director (Signature)	Date	Phone Number	Email Address

HCPCFC 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 HCPCFC.

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 7).

D. Program administrative oversight for the HCPCFC PHNs is provided by the local CHDP program. PHN(s) funded by the HCPCFC 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 HCPCFC Administrative budgets should reflect the total Public Health Nurse (PHN), Supervising PHN (SPHN), and clerical 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 PHN(s) and SPHN(s) who meet the federal definition of Skilled Professional Medical Personnel (SPMP), and for clerical staff who directly support and are supervised by the SPMP. (See Section 8).

2. Operating Expenses to support the PHN and SPHN are limited to travel and training. Space and computer access are provided by the child welfare agency.

3. Internal Indirect Expenses are all non-enhanced. External Indirect Expenses are not allowed on the HCPCFC Budget (see page 74).

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 CHDP Foster Care Administrative Budget (see page 65). A statement identifying the source of local funds is required (e.g. county child welfare, probation, grant, etc).

II. Staffing Guidelines

A. PHN(s) 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. PHN(s) 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, PHN(s) 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. PHN 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 serve as consultants 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. PHN(s) working in the HCPCFC require professional nursing supervision. The HCPCFC established ratio is one (1) SPHN FTE to every ten (10) FTE of PHN, 1:10.

E. Clerical personnel must be supervised by SPMP.

HCPCFC 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 x 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.)

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.

3A. Percentage of FTE/Non-enhanced (50/50)

- Enter in Column 3A, the portion of annualized FTE to be spent on eligible non-enhanced 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, Non-enhanced.

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 8.

IV. Capital Expenses

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

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

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

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.

NOTE: These dollar amounts are not to exceed the amounts allocated annually by CMS.

HCPCFC Administrative Budget Worksheet for FY 2011-2012

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**	**Non-enhanced 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.							
II. Total Capital Expenses							
IV. Indirect Expenses							
1. Internal (Specify %) %							
2.							
IV. Total Indirect Expenses							
V. Other Expenses							
1.							
2.							
V. Total Other Expenses							
Budget Grand Total							

Prepared By (Signature) Date Prepared Phone Number Email Address

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

HCPCFC Administrative Budget Worksheet for FY 2011-2012

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**	**Non-enhanced 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.							
II. Total Capital Expenses							
IV. Indirect Expenses							
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	May 1, 2011	916-555-1122	Jsmith@golden.ca.us
Prepared By (Signature)	Date Prepared	Phone Number	Email Address
Dr. Jane Doe	May 1, 2011	916-555-1122	Jdoe@golden.ca.us
CHDP Director or Deputy Director (Signature)	Date	Phone Number	Email Address

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. Non-enhanced Funds

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

- Multiply the Non-enhanced, Column 3, "Budget Grand Total" amount by 50 percent, and enter the amount in the "Source of Funds" section, Non-enhanced 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 Non-enhanced State Funds for the State Funds line and the Enhanced plus the Non-enhanced 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

HCPCFC Administrative Budget Summary for FY 2011-2012

County/City Name: _____

Column	1	2	3
Category/Line Item	**Total Budget (2 + 3)**	**Enhanced State/Federal (25/75)**	**Non-enhanced 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)**	**Non-enhanced State/Federal (50/50)**
State Funds			
Federal Funds (Title XIX)			
Budget Grand Total			

Prepared By (Signature)	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

SAMPLE

HCPCFC Administrative Budget Summary for FY 2011-2012

County/City Name: Golden

Column	1	2	3
Category/Line Item	**Total Budget (2 + 3)**	**Enhanced State/Federal (25/75)**	**Non-enhanced 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)**	**Non-enhanced 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, 2009	916-555-1212	jsmith@golden.ca.us
Prepared By (Signature)	Date Prepared	Phone Number	Email Address
Dr. Jane Doe	May 1, 2009	916-555-1122	jdoe@golden.ca.us
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 utilization review and 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 utilization review and 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 8).

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 utilization review and 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 utilization review and 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 utilization review and management of Medi-Cal beneficiaries.

4. Reimburse the county quarterly based upon submission of the invoice for actual administrative expenditures not to exceed the amount of the allocation.

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 utilization review and 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 Utilization Review and Management, Other Health Care Professionals, Ancillary Support, and Clerical and Claims Support.

NOTE: It is recognized that in some counties, 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 CCS County Staffing Standards Profile

1. CCS Independent Counties

a. Utilizing total county caseload, determine the total FTE needed according to the CCS County Staffing Standards Profile.

b. Counties may elect to utilize the Independent County tab of the Staffing Standards Calculator which produces a caseload specific Total FTE based upon the CCS County Staffing Standards Profile.

c. Medi-Cal Managed Care liaison positions are not included in the 1:400 nurse ratio in the Staffing Standards Profile Calculator. If your county has Medi-Cal Managed Care, you may add up to a 1.0 FTE nurse liaison position to your budget. The total FTE, up to a maximum, **should be based upon the number of Medi-Cal Managed Care Plans** and **volume of liaison duties required in your county**.

d. The grand total FTEs identified via the CCS County Staffing Standards Profile/Calculator, before the addition of the Medi-Cal Managed Care Nurse Liaison position, if eligible, represents the maximum FTE that can be submitted on the CCS Administrative budget.

e. To determine the number of non-ratio based staff (Administrator, Information Technology Support, Parent Liaison, Physician and Chief Therapist) 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 ÷ 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 x .50 = .30). (The Staffing Standards Calculator also produces this calculation.)

2. CCS Dependent Counties

a. Small Dependent counties (generally with caseloads under 190) will develop their administrative budgets by applying a baseline staffing level and integrating estimated costs in accordance with the following :

i. Integrate a baseline budget allocation for staffing. The baseline staffing level in a small county CCS program will include:

- 1.0 FTE Nurse
- 0.5 FTE Eligibility Worker
- 0.25 FTE Clerical support
- 0.25 FTE Administrator

ii. Budgets developed within the staffing baseline are not required to follow CCS Staffing Standards (because of small caseloads).

b. Budgets for dependent counties with larger caseloads that will exceed the dependent county staffing baseline above should be developed as follows:

i. Utilizing total county caseload, determine Total FTE needed, based upon CCS Staffing Standards with the following exclusions/modifications:

1. Physician and Other Health Care Professionals are excluded position for all Dependent Counties.

2. Case Management Technician, Chief Therapist, and Therapist (OT/PT) are only available to Level III Dependent Counties.

3. Fiscal Personnel is limited to CCS Dependent Counties who elect to review and correct the Paid Claims Data Reports.

ii. Counties may elect to utilize the appropriate Dependent County tab (Below Level 3, Level 3 no MTU or Level 3 with MTU) of the Staffing Standards Calculator which produces a caseload specific Total FTE based upon the CCS County Staffing Standards Profile and the exclusions/modifications listed above.

iii. To determine the number of non-ratio based staff (Administrator, Information Technology Support, Parent Liaison, Physician and Chief Therapist) required to implement the CCS county program responsibilities in an Dependent 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 ÷ 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 x .50 = .30). (The Staffing Standards Calculator also produces this calculation.)

d. Determination of the percentage of time required for intensive utilization review and 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 x 15 percent = 45.

Divide 45 by 80, which equals .56 or 56 percent FTE PHN staff (45 ÷ 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) utilization review and 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 Utilization Review and Management

a. Staff in this section are physicians, registered nurses, physical therapists, and occupational therapists who are responsible for day-to-day CCS medical utilization review and management 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 Utilization Review and Management services. Please refer to Section 8 for the federal definition of a "skilled medical professional."

c. Utilization Review and Management 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 Utilization Review and Management role includes the proactive medical utilization review and management 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 utilization review and 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 utilization review and 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, Utilization Review and Management 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 Utilization Review and Management** of selected cases is required to ensure optimal coordination of medical services. Children in need of Utilization Review and Management 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 intensive utilization review and management cases. Intensive Utilization Review and Management 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 Utilization Review and Management 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: FTE 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 is 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 8 of this manual: audiologist, speech therapist, nutritionist, social worker and dental consultant.

b. The number of FTE for these positions for a county is based on county need and caseload. These positions are not mandatory, but are highly recommended for administrative Medical Utilization Review and Management. 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 Utilization Review and 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 Fiscal Support

a. This category includes CCS County clerical staff working under direct supervision of Administrative or Medical Utilization Review and 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 utilization review and 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 utilization review and management services must time study appropriately for that portion of time spent in those activities.

e. Staff who provide support for provider relations, billing/fiscal technical assistance, maintenance of fiscal data, review of MR 940/910 reports, preparation and submission of corrections to CMS, and development of quarterly expenditure reports.

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 2008-09 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.dhcs.ca.gov/services/ccs/cmsnet/Documents/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 pending 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.

Pending cases represent the work required on non-open cases referred to CCS and are cases for which CCS eligibility determination has not been completed. The pending 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 pending cases by:

    a. An average count of pending cases assigned a temporary number if the county CCS Program is using CMS Net, or

    b. An average count of pending 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 pending 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 pending 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 pending 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 pending 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 Caseload	B % of Grand Total
	MEDI-CAL		
1	Average of Total Open (Active) Medi-Cal Children	372	48%
2	Pending 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	Pending 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	Pending 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	50000+ (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	calculated by using 1 staff to 6000 caseload													
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	13.5
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	calculated by using 1 staff to 4000 caseload													
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)	calculated by using 1 staff to 6000 caseload																
Nurse [D, E]	calculated by using 1 staff to 400 caseload																
Other Health Care Professionals																	
Other Health Care Professionals [F]	calculated by using 1 staff to 4500 caseload																
Ancillary Support																	
Case Management Technician	calculated by using 1 staff to 400 caseload																
Program Eligibility Technician	calculated by using 1 staff to 800 caseload																
Clerical and Claims Support																	
Clerical Personnel	calculated by using 1 staff to 1100 caseload																
Fiscal Personnel	calculated by using 1 staff to 1500 caseload																
Supervision																	
Global Supervision (For all positions listed above)	calculated by using 1 supervisor to 10 FTE staff																

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. 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 and volume of liaison duties in each county as outlined in Section 5.
E. The positions are recommended but not required. These include Audiologist, Speech Therapist, Nutritionist, Social Worker, and Dental Consultant.

Caseload	
Active Caseload:	1583
Pending Caseload:	77
Total Caseload:	1660

← Enter Active Caseload

(Independent County)

SAMPLE

	Caseload Range	0-499	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	Los Angeles
Program Administration	Administrator	0.00	0.5	1	**1**	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	Admin Asst Personnel	0.00	0	0	**0**	0.5	0.8	1.1	1.4	1.7	2	2.3	2.6	2.9	3.2	3.5	3.8	4.7	26.5
	Information Technology Support	0.00	0.25	0.5	**1**	1	1	1	1.5	1.5	1.5	1.5	2	2	2	2	2.5	2.5	13.5
	Parent Liaison	0.00	0.5	0.5	**0.75**	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	Subtotal	0.000	1.25	2	**2.75**	3.5	3.8	4.1	4.9	5.2	5.5	5.8	6.6	6.9	7.2	7.5	8.3	9.2	42
Medical Case Management	Physician	0.00	0.5	0.5	**0.5**	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Chief Therapist	0.00	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)	0.00	0.00	0.00	**0.30**	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Nurse	0.00	0.00	0.00	**4.20**	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Subtotal	0.000	0.6000	0.7000	**5.200**	0.2000	0.2000	0.2000	0.2000	0.2000	0.2000	0.2000	0.2000	0.2000	0.2000	0.2000	0.2000	0.2000	0.2000
Other Health Care Prof	Other Health Care Professionals	0.00	0.00	0.00	**0.40**	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Ancillary Support	Case Mgmt Technician	0.00	0.00	0.00	**4.20**	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Program Eligibility Technician	0.00	0.00	0.00	**2.10**	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Subtotal	0.000	0.000	0.000	**6.30**	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Clerical & Claims Support	Clerical Personnel	0.00	0.00	0.00	**1.55**	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Fiscal Personnel	0.00	0.00	0.00	**1.15**	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Subtotal	0.000	0	0	**2.7**	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Total (without Supervision)		0.000	1.850	2.700	**17.35**	3.700	4.000	4.300	5.100	5.400	5.700	6.000	6.800	7.100	7.400	7.700	8.500	9.400	42.200
Supervision (No specified on Staffing Data Profile)	Global Supervision *(1:10 FTE Ratio for all positions listed above)*	0.00	0.20	0.30	**1.75**	0.40	0.40	0.45	0.55	0.55	0.60	0.60	0.70	0.75	0.75	0.80	0.85	0.95	4.25
GRAND TOTAL FTE *(with supervision)*		0.000	2.050	3.000	**19.10**	4.100	4.400	4.775	5.655	5.955	6.300	6.600	7.500	7.855	8.150	8.500	9.355	10.355	46.45

SAMPLE

Caseload	
Active Caseload:	145
Pending Caseload:	19
Total Caseload:	**164**

← Enter Active Caseload

(Dependent County: Not Level 3)

	Caseload Range	0-499	500-1000	1001-1500	1501-3000
Program Administration	Administrator	0.16	0.5	1	1
	Admin Asst Personnel	0.00	0	0	0
	Information Technology Support	0.08	0.25	0.5	1
	Parent Liaison	0.16	0.5	0.5	0.75
	Subtotal	**0.41**	1.25	2	2.75
Medical Case Management	Physician	0.00	0	0	0
	Chief Therapist	0.00	0	0	0
	Therapist (OT/PT)	0.00	0	0	0
	Nurse	0.45	0.00	0.00	0.00
	Subtotal	**0.45**	0.0000	0.0000	0.0000
Other Health Care Prof	Other Health Care Professionals	0.00	0.00	0.00	0.00
Ancillary Support	Case Mgmt Technician	0.00	0.00	0.00	0.00
	Program Eligibility Technician	0.25	0.00	0.00	0.00
	Subtotal	**0.25**	0.00	0.00	0.00
Clerical & Claims Support	Clerical Personnel	0.15	0.00	0.00	0.00
	Fiscal Personnel	0.15	0.00	0.00	0.00
	Subtotal	**0.30**	0	0	0
Sub-Total (without Supervision)		**1.41**	1.250	2.00	2.75
Supervision (Not specified on Staffing Slide Profile)	Global Supervision *(1:10 FTE Ratio for all positions listed above)*	0.14	0.15	0.20	0.30
GRAND TOTAL FTE *(with supervision)*		**1.60**	1.400	2.20	3.05

If Grand Total FTE is less than 2.0 -- Use Baseline Staffing
(See Budget Instructions)

Caseload	
Active Caseload:	538
Pending Caseload:	71
Total Caseload:	**609**

Enter Active Caseload

(Dependent County: Level 3 without MTU)

SAMPLE

	Caseload Range	0-499	500-1000	1001-1500	1501-3000
Program Administration	Administrator		0.5		
	Admin Asst Personnel		0		
	Information Technology Support		0.25		
	Parent Liaison		0.5		
	Subtotal		**1.25**		
Medical Case Management	Physician		0		
	Chief Therapist		0		
	Therapist (OT/PT)		0		
	Nurse		1.55		
	Subtotal		**1.550**		
Other Health Care Prof	Other Health Care Professionals		0.00		
Ancillary Support	Case Mgmt Technician		1.55		
	Program Eligibility Technician		0.80		
	Subtotal		**2.35**		
Clerical & Claims Support	Clerical Personnel		0.60		
	Fiscal Personnel		0.45		
	Subtotal		**1.05**		
Sub-Total (without Supervision)			**6.200**		
Supervision (Not specified on Staffing Stds Profile)	Global Supervision *(1:10 FTE Ratio for all positions listed above)*		0.65		
GRAND TOTAL FTE *(with supervision)*			**6.850**		

If Grand Total FTE is less than 2.0 -- Use Baseline Staffing

(See Budget Instructions)

Caseload	
Active Caseload:	876
Pending Caseload:	115
Total Caseload:	**991**

Enter Active Caseload

(Dependent County: Level 3 with MTU)

SAMPLE

	Caseload Range	0-499	500-1000	1001-1500	1501-3000
Program Administration	Administrator		0.5		
	Admin Asst Personnel		0		
	Information Technology Support		0.25		
	Parent Liaison		0.5		
	Subtotal		**1.25**		
Medical Case Management	Physician		0		
	Chief Therapist		0.1		
	Therapist (OT/PT)		0.125		
	Nurse		2.50		
	Subtotal		**2.725**		
Other Health Care Prof	Other Health Care Professionals		0.00		
Ancillary Support	Case Mgmt Technician		2.50		
	Program Eligibility Technician		1.25		
	Subtotal		**3.75**		
Clerical & Claims Support	Clerical Personnel		0.95		
	Fiscal Personnel		0.70		
	Subtotal		**1.65**		
Sub-Total (without Supervision)			**9.375**		
Supervision (Not specified on Staffing Stds Profile)	Global Supervision *(1:10 FTE Ratio for all positions listed above)*		0.95		
GRAND TOTAL FTE *(with supervision)*			**10.325**		

If Grand Total FTE is less than 2.0 -- Use Baseline Staffing

(See Budget Instructions)

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 89)

I. Personnel Expenses

List each funded position as a separate line item under the appropriate subcategory (Administration, Medical Utilization Review and 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 non-enhanced 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		
Pending Cases Medi-Cal		
TOTAL MEDI-CAL		
NON MEDI-CAL		
Healthy Families		
Average of Total Open (Active) HF Children		
Pending Cases HF		
Total Healthy Families		
Straight CCS		
Average of Total Open (Active) Straight CCS Children		
Pending Cases Straight CCS		
Total Straight CCS		
TOTAL NON MEDI-CAL		
GRAND TOTAL		

CCS Administrative Budget Worksheet for FY 2011-2012

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 Non-enhanced 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 Administrative Budget Worksheet for FY 2011-2012

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**	**% FTE**	**% FTE**	**Medi-Cal Non-enhanced State/Federal (50/50)**
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											
II. 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 (Signature) | Date Prepared | Phone Number | Email Address

CCS Administrator (Signature) | Date Signed | Phone Number | Email Address

CCS CASELOAD	Actual Caseload	Percent of Grand Total
MEDI-CAL		
Average of Total Open (Active) Medi-Cal Children	542	58%
Pending Cases Medi-Cal	108	12%
TOTAL MEDI-CAL	650	70%
NON MEDI-CAL		
Healthy Families		
Average of Total Open (Active) HF Children	18	2%
Pending Cases HF	5	1%
Total Healthy Families	23	3%
Straight CCS		
Average of Total Open (Active) Straight CCS Children	214	23%
Pending 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 2011-2012

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 Non-enhanced 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

CCS Administrative Budget Worksheet FY 2011-2012

County Name: Golden

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 Non-enhanced 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	May 1, 2011	916-555-2222	Jsmith@golden.ca.us
Prepared By (Signature)	Date Prepared	Phone Number	Email Address
Dr. Jane Doe	May 2, 2011	916-555-1111	Jdoe@golden.ca.us
CCS Administrator (Signature)	Date Signed	Phone Number	Email Address

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 103 for the CCS Administrative Budget Summary Form and page 104 for a completed sample.

B. Source of Funds – State General Funds

C. Source of Funds – State General Funds

Administration of the county CCS programs is funded by the State General Fund (GF), county funds and federal funds. Each county is allocated discrete GF dollars for funding the CCS county program administration according to the three separate CCS caseload populations comprised of CCS-only, CCS-Healthy Families subscribers, and CCS-Medi-Cal beneficiaries. The total funds budgeted may not exceed the funds allocated annually by CMS.

- CCS-only funding is shared equally (50/50) by the county and State.
- The CCS-Healthy Families funding is shared 17.5% county, 17.5% State, and 65% federal.
- CCS-Medi-Cal funding is split between State GF and federal funds; the county does not contribute.

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

- Enter the allocated state general fund amount for Straight CCS in Column 2 "Non-Medi-Cal County/State/HF Co/State/Federal" in the State funds line. Enter the same amount in Column 2 in the County funds line. The total Straight CCS funds may not exceed the funds allocated annually in the CCS allocation letter sent out by CMS.
- Enter the allocated state general fund amount for CCS Healthy Families in Column 2 "Non-Medi-Cal County/State/HF Co/State/Federal" in the State funds line. The total CCS Healthy Families funds may not exceed the funds allocated annually in the CCS allocation letter sent out by CMS.

Instructions for completing the Healthy Families Worksheet

- Complete the "Worksheet to Determine Funding Sources for Administrative Costs related to Healthy Families".
- • The Worksheet (see page ____ assists counties in completing Column 2 in the "Source of Funds" Section on the CCS Administrative Budget Summary.
- Caseload Percentages
- Line 1(a): enter the Total Non Medi-Cal Caseload from the Caseload Box on the Budget Summary.
- 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).**
- 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
- Line 4(a): enter the Budget Grand Total for Non Medi-Cal (from the Budget Summary, Column 2).
- 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).**
- 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**).
- 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
- 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)**.
- 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).**

- 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).**

- 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).**

- 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 Non-enhanced, Column 5, "Budget Grand Total" amount by 50 percent, and enter the amount in the "Source of Funds" section, Non-enhanced 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		**(a)**			**(b)**
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))					#DIV/0!
Enter the Total 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))					#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))		#DIV/0!			
State (Line 5(a) x 50%)	**(Transfer to Budget Summary, Column 2)**			→	#DIV/0!
County (subtract Line 6(b) from Line 5(a))	**(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)		#DIV/0!			
State/County (35%) (multiply Total Healthy Families Dollars, line 8, column (a) by 35%)		#DIV/0!			
State (multiply line 9, column (a) by 50%)	**(Transfer to Budget Summary, Column 2)**			→	#DIV/0!
County (subtract line 10(b) from line 9(a)	**(Transfer to Budget Summary, Column 2)**			→	#DIV/0!
Federal Title XXI (65%) (multiply Total Healthy Families Dollars, line 8, column (a) by 65%)	**(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		
Pending Cases Medi-Cal		
TOTAL MEDI-CAL		
NON MEDI-CAL		
Healthy Families		
Average of Total Open (Active) HF Children		
Pending Cases HF		
Total Healthy Families		
Straight CCS		
Average of Total Open (Active) Straight CCS Children		
Pending Cases Straight CCS		
Total Straight CCS		
TOTAL NON MEDI-CAL		
GRAND TOTAL		

CCS Administrative Budget Summary for FY 2011-2012

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)**	**Non-enhanced 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)**	**Non-enhanced 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 (Signature) 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%
Pending Cases Medi-Cal	108	12%
TOTAL MEDI-CAL	650	70%
NON MEDI-CAL		
Healthy Families		
Average of Total Open (Active) HF Children	18	2%
Pending Cases HF	5	1%
Total Healthy Families	23	3%
Straight CCS		
Average of Total Open (Active) Straight CCS Children	214	23%
Pending 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 2011-2012

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)**	**Non-enhanced 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)**	**Non-enhanced 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	May 1, 2011	916-555-2222	Jsmith@golden.ca.us
Prepared By (Signature)	Date Prepared	Phone Number	Email Address
Dr. Jane Doe	May 1, 2011	916-555-1111	Jdoe@golden.ca.us
CCS Administrator (Signature)	Date	Phone Number	Email Address

CMS Budget Revision General Information

I. Policies for CMS Budget Revisions

CMS BUDGET REVISIONS ARE NO LONGER REQUIRED. Due to the capped allocation methodology, budgets may not exceed the initial allocation. Local Match budgets are also capped at the amount of matching federal funds requested to augment local funds based upon a local program's initial request.

SECTION 7 – EXPENDITURE CLAIMS AND PROPERTY MANAGEMENT

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CHDP Quarterly Administrative Expenditure – Supplemental (Part B) (No County/City Match) . 22

HCPCFC Quarterly Administrative Expenditure Invoice Instructions 29

CHDP Foster Care Administrative Expenditure Invoice Instructions 34

CCS Quarterly Administrative Expenditure Invoice Instructions 39

CCS Quarterly Administrative Expenditure Invoice Instructions – Supplemental (Part A) 52

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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 8, Federal Financial Participation).

IV. Tools for using time study information to allocate personnel services and benefits expenses are included in Section 8, FFP. These include time study policies, instructions for completion of the time study, time study function code definitions, and examples of activities for CMS programs.

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.

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. All quarterly invoices are paid on a cash basis. Therefore, it is important to submit invoices timely.

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. Although the due date for the third quarter invoice is May 31, it is important to submit this invoice by the middle of May in order to allow sufficient time to process it out of the current year funds.

D. Fourth quarter invoice (time period of April 1 through June 30) is due by August 31.

E. Supplemental invoices for Child Health and Disability Prevention (CHDP) Administrative invoices; CHDP Foster Care invoices; Diagnostic, Treatment, and Therapy invoices; Healthy Families invoices; and CCS Administrative 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. Please note supplemental invoices are paid on a cash basis and will be deducted from the current fiscal year allocation.**

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 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

Enter the date for which the quarter ends, using the chart below:

Quarter	Time Period of Quarter	Quarter End Date
1	July 1, 20xx – September 30, 20xx	September 30, 20xx
2	October 1, 20xx – December 31, 20xx	December 31, 20xx
3	January 1, 20xx+1 – March 31, 20xx+1	March 31, 20xx+1
4	April 1, 20xx+1 – June 30, 20xx+1	June 30, 20xx+1

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, e-mail address and telephone number with the area code.

B. Signatures of authorized officials certifying the accuracy of the expenditures reported. **Signatures must be original signatures, signature stamps are not acceptable.**

C. Date invoice 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.

http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx

Starting with the 2009 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) 2010-11 expenditures which will be reported to DOF for the FY 2011-12 Realignment Caseload Growth calculations, **the cut-off for receiving the diagnosis, treatment, and therapy expenditure reports will be December 31, 2011**. The FY 2010-11 county expenditures reported after that date will not be reported to DOF. CMS 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
Program Support Section – Administration Unit
P.O. Box 997413 MS 8104
Sacramento, CA 95899-7413

CHDP Quarterly Administrative Expenditure Initial Invoice Instructions (No County/City Match)

CHDP 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.

County/City

1) Enter the name of the county or city for which this invoice applies.

Quarter Ending

2) Enter the date for which the quarter ends, using the chart below:

Quarter	Time Period of Quarter	Quarter End Date
1	July 1, 20xx – September 30, 20xx	September 30, 20xx
2	October 1, 20xx – December 31, 20xx	December 31, 20xx
3	January 1, 20xx+1 – March 31, 20xx+1	March 31, 20xx+1
4	April 1, 20xx+1 – June 30, 20xx+1	June 30, 20xx+1

Fiscal Year

3) Enter the fiscal year (FY) for which this invoice applies.

Category / Line Item

Total Personnel Expenses

4) 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.

5) 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.

6) 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.

7) 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.

Total Operating Expenses

8) Enter in Column 1 on this line, the total of all operating expenses.

9) 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.

10) 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.

11) 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 8).

Total Capital Expenses

12) Enter in Column 1, the total of all capital expenses. The definitions of equipment and prerequisites for reimbursement are found in Section 7, Page 114.

13) 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.

14) 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.

15) Enter the Capital Expenses amount from Column 3 into Column 5, non-enhanced.

Total Indirect Expenses

16) Enter in Column 1, the total of all Indirect Expenses.

17) 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.

18) 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.

19) Enter the indirect expenses amount from Column 3 in Column 5, non-enhanced.

Total Other Expenses

20) Enter the total of all other expenses on this line in Column 1.

21) 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.

22) 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.

23) Enter the amount claimed for Other Expenses from Column 3 into Column 5, non-enhanced.

Expenditure Grand Total

24) 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.

Source of Funds

State Funds

25) 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.

Medi-Cal Funds

The Medi-Cal Funds under the Source of Funds are calculated beginning with Column 4, Enhanced State/Federal (25/75) and Column 5, Non-Enhanced State/Federal (50/50).

26) Enhanced State/Federal (25/75)

    a. 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.

    b. 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.

27) Non-Enhanced State/Federal (50/50)

    a. 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.

    b. 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.

28) Total Medi-Cal Funds

a. Enter in Column 3 on the State Funds line the total of Column 4 and Column 5, State Funds.

b. Enter in Column 3 on the Federal Funds (Title XIX) line the total of Column 4 and Column 5, Federal Funds (Title XIX).

29) Total Funds

a. 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.

b. 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.

c. Add Columns 4 and 5 together for the Federal Funds (Title XIX) 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.

Certification

30) Provide the contact name, e-mail address and telephone number, with the area code, of the county/city staff person who is responsible for processing the invoice form.

31) 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.

32) Print or type the name and title of the official who signed the invoice.

Submission

33) Submit all invoices with original signatures. **Signature stamps are not acceptable.** Additional copies are not necessary.

34) All invoices and supporting documentation that justifies the expenditures should be submitted to:

California Department of Health Care Services
Children's Medical Services
Program Support Section – Administration Unit
P.O. Box 997413 MS 8104
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.

Quarter	Due Date
1st	November 30, 20xx
2nd	February 28, 20xx+1
3rd	May 31, 20xx+1
4th	August 31, 20xx+1

Supplemental invoices shall be submitted no later than December 31st after the end of the fiscal year.

Example: FY 2011-2012 ends June 30, 2012. Supplemental invoices for FY 2011-2012 are due no later than December 31, 2012.

State of California - Health & Human Services Agency

Department of Health Care Services - Children's Medical Services

COUNTY/CITY: **QUARTER ENDING:**

MONTH/DAY/YEAR

CHDP QUARTERLY ADMINISTRATIVE EXPENDITURE INITIAL INVOICE
(No County / City Match)
FISCAL YEAR_____

CATEGORY/LINE ITEM	TOTAL EXPENDITURES	TOTAL CHDP ***Non Medi-Cal***	TOTAL MEDI-CAL	ENHANCED STATE/FEDERAL (25/75)	NON-ENHANCED STATE/FEDERAL (50/50)
COLUMN	*1 = 2 + 3*	*2*	*3 = 4 + 5*	*4*	*5*
I. TOTAL PERSONNEL EXPENSES	**0**		0		
II. TOTAL OPERATING EXPENSES	**0**		0		
III. TOTAL CAPITAL EXPENSES	**0**		0		
IV. TOTAL INDIRECT EXPENSES	**0**		0		
V. TOTAL OTHER EXPENSES	**0**		0		
EXPENDITURES GRAND TOTAL	**0**	**0**	**0**	**0**	**0**

SOURCE OF FUNDS	TOTAL FUNDS	TOTAL CHDP	TOTAL MEDI-CAL	ENHANCED STATE/FEDERAL (25/75)	NON-ENHANCED STATE/FEDERAL (50/50)
COLUMN	*1*	*2*	*3*	*4*	*5*
STATE GENERAL FUNDS	0	0			
MEDI-CAL FUNDS:					
STATE FUNDS	0		0	0	O
FEDERAL FUNDS (TITLE XIX)	0		0	0	O
EXPENDITURES GRAND TOTAL	**0**	**0**	**0**	**0**	**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 E-mail Address Date Area Code / Telephone No.

CHDP Director/Deputy Director (Signature) Date Type or Print Name of Signer

Revised June 2011

CHDP Quarterly Administrative Expenditure Initial Invoice (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.**

County/City

1) Enter the name of the county or city for which this invoice applies.

Quarter Ending

2) Enter the date for which the quarter ends, using the chart below:

Quarter	Time Period of Quarter	Quarter End Date
1	July 1, 20xx – September 30, 20xx	September 30, 20xx
2	October 1, 20xx – December 31, 20xx	December 31, 20xx
3	January 1, 20xx+1 – March 31, 20xx+1	March 31, 20xx+1
4	April 1, 20xx+1 – June 30, 20xx+1	June 30, 20xx+1

Fiscal Year

3) Enter the fiscal year (FY) for which this invoice applies.

Category / Line Item

Total Personnel Expenses

4) 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.

5) 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.

Total Operating Expenses

6) Enter in Column 1, the total of all operating expenses.

7) 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 8).

Total Capital Expenses

8) 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 7, Page 114.

Total Indirect Expenses

9) Enter the total Indirect Expenses on this line in Column 1 and Column 3.

Total Other Expenses

10) Enter the total other expenses on this line in Column 1 and Column 3.

Expenditure Grand Total

11) 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.

Source of Funds

County/City Funds

12) County/city expenditures must meet the federal fund (Title XIX) 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.

Federal Funds (Title XIX)

13) 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.

14) 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.

15) Total Funds

- Add Columns 2 and 3 together for the Federal Funds (Title XIX) line and enter the total in Column 1, Total Funds.

Certification

16) Provide the contact name, e-mail address and telephone number, with the area code, of the county/city staff person who is responsible for processing the invoice form.

17) 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.

18) Print or type the name and title of the official who signed the invoice.

Submission

19) Submit all invoices with original signatures. **Signature stamps are not acceptable.** Additional copies are not necessary.

20) All invoices and supporting documentation that justifies the expenditures should be submitted to:

California Department of Health Care Services
Children's Medical Services
Program Support Section – Administration Unit
P.O. Box 997413 MS 8104
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.

Quarter	Due Date
1st	November 30, 20xx
2nd	February 28, 20xx+1
3rd	May 31, 20xx+1
4th	August 31, 20xx+1

Supplemental invoices shall be submitted no later than December 31st after the end of the fiscal year.

Example: FY 2011-2012 ends June 30, 2012. Supplemental Invoices for FY 2011-2012 are due no later than December 31, 2012.

State of California - Health & Human Services Agency

Department of Health Care Services - Children's Medical Services

COUNTY/CITY: **QUARTER ENDING:**

MONTH/DAY/YEAR

CHDP QUARTERLY ADMINISTRATIVE EXPENDITURE INITIAL INVOICE
(County / City Match)
FISCAL YEAR_____

CATEGORY/LINE ITEM	TOTAL EXPENDITURES	ENHANCED STATE/FEDERAL (25/75)	NON-ENHANCED STATE/FEDERAL (50/50)
COLUMN	*1 = 2 + 3*	*2*	*3*
I. TOTAL PERSONNEL EXPENSES	0		
II. TOTAL OPERATING EXPENSES	0		
III. TOTAL CAPITAL EXPENSES	0		
IV. TOTAL INDIRECT EXPENSES	0		
V. TOTAL OTHER EXPENSES	0		
EXPENDITURES GRAND TOTAL	**0**	**0**	**0**

SOURCE OF FUNDS	TOTAL FUNDS	ENHANCED COUNTY/FEDERAL (25/75)	NON-ENHANCED COUNTY/FEDERAL (50/50)
COLUMN	*1 = 2 + 3*	*2*	*3*
COUNTY/CITY MATCH	0	0	0
FEDERAL FUNDS (TITLE XIX)	0	0	0
EXPENDITURES GRAND TOTAL	**0**	**0**	**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 E-mail Address Date Area Code / Telephone No.

CHDP Director/Deputy Director (Signature) Date Type or Print Name of Signer

Revised June 2011

CHDP Quarterly Administrative Expenditure Supplemental Invoice Parts A and B Instructions

No County/City Match

A supplemental invoice identifies the differences between the expenditures and funding amounts previously submitted on the Initial Invoice and the expenditures and funding amounts that are currently true, correct, and accurately reflect the actual spending pattern for a particular quarter. Supplemental invoices for the Child Health and Disability Prevention (CHDP) administrative expenditures are prepared on an as needed basis during the fiscal year.

A supplemental invoice is comprised of the following two parts:

- **Supplemental Invoice – Part A, Approved Invoice Plus Changes** – represents the Initial Invoice that has been approved by Children's Medical Services (CMS) and any changes that update the information previously reported on the Initial Invoice.

  Example: The Initial Invoice showed an expenditure of $1,500 for Total Operating Expense in Quarter One. Several months after the Initial Invoice was approved by CMS for reimbursement, the county found a supply order for $500 that was paid in Quarter One.

  In order to be reimbursed for the $500 supply order, the county shall submit a Supplemental Invoice – Part A for Quarter One that shows $2,000 ($1,500 + $500) for Total Operating Expense.

- **Supplemental Invoice – Part B, Amounts of Changes** – represents the differences between the Initial Invoice and the Supplemental Invoice – Part A.

  Example: After the Supplemental Invoice – Part A has been completed the county shall then complete Supplemental Invoice – Part B for Quarter One. To do this, the county shall subtract the $1,500 Total Operating Expense which was reported on the Initial Invoice from the Total Operating Expense costs of $2,000 that was reported on the Supplemental Invoice – Part A. The difference of $500 shall be reported for Total Operating Expenses on the Supplemental Invoice – Part B.

In summary, the Supplemental Invoice – Part A represents the desired total expenditures. The Supplemental Invoice – Part B represents the dollar amount of change (increase or decrease) to the approved total expenditures.

Separate instructions are prepared for the Supplemental Invoice – Part A, Approved Invoice Plus Changes and Supplemental Invoice – Part B, Amounts of Changes.

CHDP Quarterly Administrative Expenditure – Supplemental (Part A)

(No County/City Match)

Approved Invoice Plus Changes

Instructions for Completion

The following are instructions for the completion of the Supplemental Invoice – Part A, Approved Invoice Plus Changes for the Child Health and Disability Prevention (CHDP) Quarterly Administrative Expenditure Invoice.

Please use whole numbers when preparing the supplemental invoices.

County/City

1) Enter the name of the county or city for which this invoice applies.

Supplemental No.

2) Enter the number in the sequence of supplemental invoices submitted to CMS. Example: 01, 02, etc.

Quarter Ending

3) Enter the date for which the quarter ends, using the chart below:

Quarter	Time Period of Quarter	Quarter End Date
1	July 1, 20xx – September 30, 20xx	September 30, 20xx
2	October 1, 20xx – December 31, 20xx	December 31, 20xx
3	January 1, 20xx+1 – March 31, 20xx+1	March 31, 20xx+1
4	April 1, 20xx+1 – June 30, 20xx+1	June 30, 20xx+1

Fiscal Year

4) Enter the fiscal year (FY) for which this invoice applies.

Category / Line Item

Column B – Total Expenditures

5) Enter the amounts of Total Expenditures that were previously approved on the Initial Invoice for each category/line item listed in Column A and any changes that update these amounts.

6) Enter the Grand Total by adding all entries in Column B.

For each category/line item, the amounts entered in Column B must equal the sum of respective amounts in Columns C and D.

Column C – Total CHDP Non-Medi-Cal

7) Enter the amount of Total CHDP Non-Medi-Cal expenditures charged during the quarter to each category/line item listed in Column A.

The amount of Total CHDP Non-Medi-Cal expenditures is derived by multiplying the Total Expenditures identified in Column B by the percentage of the non-Medi-Cal share from the approved CHDP No County/City Administrative Budget.

8) Enter the Grand Total by adding all entries in Column C.

Column D – Total Medi-Cal

9) Enter the amount of Total Medi-Cal expenditures charged during the quarter to each category/line item listed in Column A.

The amount of Total Medi-Cal expenditures is derived by subtracting the amount of Total CHDP Non-Medi-Cal expenditures in Column C from the amount of Total Expenditures in Column B for each category/line item.

10) Enter the Grand Total 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.

Also, the Grand Total in Column D must equal the difference after subtracting the Grand Total in Column C from the Grand Total in Column B.

Column E – Enhanced State/Federal (25/75)

11) Enter the amount of Enhanced Medi-Cal funding charged during the quarter to Total Personnel Expenses.

The amount of Enhanced Medi-Cal funding for Total Personnel Expenses is calculated using time study percentages and other applicable documents that are based on program activities eligible for enhanced Medi-Cal funding.

12) Enter the amount of Enhanced Medi-Cal funding charged during the quarter to Total Operating Expenses.

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.

The amount of Enhanced Medi-Cal funding for Total Operating Expenses may only be claimed in accordance with the travel and training costs that were approved in the CHDP No County/City Administrative Budget.

13) Enter the Grand Total by adding all entries in Column E.

Column F – Non-Enhanced State/Federal (50/50)

14) Enter the amounts of Non-Enhanced Medi-Cal funding charged during the quarter to Total Personnel Expenses and Total Operating Expenses.

    The amount of Non-Enhanced Medi-Cal funding is derived by subtracting the amount of Enhanced Medi-Cal funding in Column E from the amount of Total Medi-Cal expenditures in Column D for Total Personnel Expenses and Total Operating Expenses, respectively.

15) Enter the amounts of Non-Enhanced Medi-Cal funding charged during the quarter to Total Capital Expenses, Total Indirect Expenses, and Total Other Expenses from Column D.

16) Enter the Grand Total by adding all entries in Column F.

    The Grand Total in Column F must equal the difference after subtracting the Grand Total in Column E from the Grand Total in Column D.

Source of Funds

Column H – Total Funds

17) Enter the Grand Total amount from Column I – Total CHDP Non-Medi-Cal for State General Funds.

18) Enter the amount from Column J – Total Medi-Cal for Medi-Cal Funds: State Funds.

19) Enter the amount from Column J – Total Medi-Cal for Medi-Cal Funds: Federal Funds (Title XIX).

20) Enter the Grand Total by adding all entries in Column H.

    The entry for the Grand Total must equal the Grand Total amount in Column B – Total Expenditures in Category/Line Item.

Column I – Total CHDP Non-Medi-Cal

21) Enter the Grand Total amount from Column C –Total CHDP Non-Medi-Cal in Category/Line Item for State General Funds.

22) Enter the Grand Total by adding all entries in Column I.

    The entry for the Grand Total must equal the Grand Total amount in Column C – Total CHDP Non-Medi-Cal in Category/Line Item.

Column J – Total Medi-Cal

23) Enter the amount for Total Medi-Cal for Medi-Cal Funds: State Funds.

The amount for Total Medi-Cal for Medi-Cal Funds: State Funds is calculated by adding the amounts in Column K – Enhanced State/Federal (25/75) and Column L – Non-Enhanced State/Federal (50/50).

24) Enter the amount for Total Medi-Cal for Medi-Cal Funds: Federal Funds (Title XIX).

The amount for Total Medi-Cal for Medi-Cal Funds: Federal Funds (Title XIX) is calculated by adding the amounts in Column K – Enhanced State/Federal (25/75) and Column L – Non-Enhanced State/Federal (50/50).

25) Enter the Grand Total by adding all entries in Column J.

For each source of funds, the amounts entered in Column J must equal the sum of respective amounts in Columns K and L.

Also, the Grand Total in Column J must equal the difference after subtracting the Grant Total in Column I from the Grand Total in Column H.

Additionally, the entry for the Grand Total in Column J must equal the Grand Total amount in Column D – Total Medi-Cal in Category/Line Item.

Column K – Enhanced State/Federal (25/75)

26) Enter the amount for Medi-Cal Funds: State Funds by multiplying the Grand Total amount in Column E – Enhanced State/Federal (25/75) by 25 percent.

27) Enter the amount for Medi-Cal Funds: Federal Funds (Title XIX) by multiplying the Grand Total amount in Column E – Enhanced State/Federal (25/75) by 75 percent.

28) Enter the Grand Total by adding all entries in Column K.

The entry for the Grand Total must equal the Grand Total amount in Column E – Enhanced State/Federal (25/75) in Category/Line Item.

Column L – Non-Enhanced State/Federal (50/50)

29) Enter the amount for Medi-Cal Funds: State Funds by multiplying the Grand Total amount in Column F – Non-Enhanced State/Federal (50/50) by 50 percent.

30) Enter the amount for Medi-Cal Funds: Federal Funds (Title XIX) by multiplying the Grand Total amount in Column F – Non-Enhanced State/Federal (50/50) by 50 percent.

31) Enter the Grand Total by adding all entries in Column L.

The entry for the Grand Total must equal the Grand Total amount in Column F – Non-Enhanced State/Federal (50/50) in Category/Line Item.

Certification

32) Type or print the name of the person who prepared the supplemental invoices.

All questions concerning the supplemental invoices will be addressed to the name of the person identified here.

33) Enter the e-mail address of the person preparing the invoices.

34) Enter the date the supplemental invoices were prepared.

35) Enter the telephone number, including the area code, for the person preparing the invoices.

36) Affix the signature of the CHDP Director, CHDP Deputy Director, or an official who is authorized to sign the CHDP Quarterly Administrative Expenditure Invoices and Supplemental Invoices – Parts A and B.

Original signatures are required. **Signature stamps are not acceptable.**

37) Enter the date that the signature was affixed.

38) Type or print the name of the authorized official.

Submission

39) Submit the Supplemental Invoice (Part A) and any supporting documentation to justify expenditures to the following:

Department of Health Care Services
Children's Medical Services
Program Support Section – Administration Unit
P.O. Box 997413 MS 8104
Sacramento, CA 95899-7413

Supplemental Invoice (Parts A) shall be submitted **no later than December 31st** after the end of the fiscal year.

Example: FY 2011-12 ends June 30, 2012. Supplemental Invoices (Part A) for FY 2011-12 are due no later than December 31, 2012.

State of California - Health & Human Services Agency

Department of Health Care Services - Children's Medical Services

COUNTY/CITY: **SUPPLEMENTAL NO.:** **QUARTER ENDING:**

MONTH/DAY/YEAR

CHDP QUARTERLY ADMINISTRATIVE EXPENDITURE INVOICE
(No County / City Match)

FISCAL YEAR _____

SUPPLEMENTAL INVOICE - PART A

CATEGORY/LINE ITEM	TOTAL EXPENDITURES	TOTAL CHDP Non-MEDI-CAL	TOTAL MEDI-CAL	ENHANCED STATE/FEDERAL (25/75)	NON-ENHANCED STATE/FEDERAL (50/50)
a	*b = c + d*	*c*	*d = b - c*	*e*	*f = d - e*
I. TOTAL PERSONNEL EXPENSES					
II. TOTAL OPERATING EXPENSES					
III. TOTAL CAPITAL EXPENSES					
IV. TOTAL INDIRECT EXPENSES					
V. TOTAL OTHER EXPENSES					
EXPENDITURES GRAND TOTAL	**0**	**0**	**0**	**0**	**0**

SOURCE OF FUNDS	TOTAL FUNDS	TOTAL CHDP Non MEDI-CAL	TOTAL MEDI-CAL	ENHANCED STATE/FEDERAL (25/75)	NON-ENHANCED STATE/FEDERAL (50/50)
g	*h = i + j*	*i*	*j = h - i*	*k*	*l = j - k*
STATE GENERAL FUNDS	0	0			
MEDI-CAL FUNDS:					
STATE FUNDS	0		0	0	0
FEDERAL FUNDS (TITLE XIX)	0		0	0	0
EXPENDITURES GRAND TOTAL	**0**	**0**	**0**	**0**	**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/Contact Person E-mail Address Date Area Code/ Telephone Number

CHDP Director/Deputy Director (Signature) Date Type or Print Name of Signer

Revised June 2011

CHDP Quarterly Administrative Expenditure – Supplemental (Part B)

(No County / City Match)

Amounts of Changes

Instructions for Completion

The following are instructions for the completion of the Supplemental Invoice – Part B, Amounts of Changes for the Child Health and Disability Prevention (CHDP) Quarterly Administrative Expenditure Invoice.

Please use whole numbers when preparing the supplemental invoices.

County/City

1) Enter the name of the county or city for which this invoice applies.

Supplemental No.

2) Enter the number in the sequence of supplemental invoices submitted to CMS. Example: 01, 02, etc.

Quarter Ending

3) Enter the date for which the quarter ends, using the chart below:

Quarter	Time Period of Quarter	Quarter End Date
1	July 1, 20xx – September 30, 20xx	September 30, 20xx
2	October 1, 20xx – December 31, 20xx	December 31, 20xx
3	January 1, 20xx+1 – March 31, 20xx+1	March 31, 20xx+1
4	April 1, 20xx+1 – June 30, 20xx+1	June 30, 20xx+1

Fiscal Year

4) Enter the fiscal year (FY) for which this invoice applies.

Category / Line Item

Column B – Total Expenditures

5) Enter the amount of change for each category/line item listed in Column A.

The amount of change is calculated by subtracting the Total Expenditures amount that was previously reported on the Initial Invoice for each category/line item listed in Column A from the corresponding Total Expenditures amount reported on the Supplemental Invoice – Part A.

6) Enter the Grand Total by adding all entries in Column B.

For each category/line item, the amounts entered in Column B must equal the sum of respective amounts in Columns C and D.

Column C – Total CHDP Non-Medi-Cal

7) Enter the amount of change for each category/line item listed in Column A.

The amount of change is calculated by subtracting the Total CHDP Non-Medi-Cal expenditure that was previously reported on the Initial Invoice for each category/line item listed in Column A from the corresponding Total CHDP Non-Medi-Cal expenditure amount reported on the Supplemental Invoice – Part A.

8) Enter the Grand Total by adding all entries in Column C.

Column D – Total Medi-Cal

9) Enter the amount of change for each category/line item listed in Column A.

The amount of change is calculated by subtracting the Total Medi-Cal expenditure that was previously reported on the Initial Invoice for each category/line item listed in Column A from the corresponding Total Medi-Cal expenditure amount reported on the Supplemental Invoice – Part A.

10) Enter the Grand Total 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.

Also, the Grand Total in Column D must equal the difference after subtracting the Grand Total in Column C from the Grand Total in Column B.

Column E – Enhanced State/Federal (25/75)

11) Enter the amount of change for Total Personnel Expenses.

The amount of change is calculated by subtracting the Total Personnel Expenses amount that was previously reported on the Initial Invoice from the corresponding Total Personnel Expenses amount reported on the Supplemental Invoice – Part A.

12) Enter the amount of change for Total Operating Expenses.

The amount of change is calculated by subtracting the Total Operating Expenses amount that was previously reported on the Initial Invoice from the corresponding Total Operating Expenses amount reported on the Supplemental Invoice – Part A.

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.

The amount of Enhanced Medi-Cal funding for Total Operating Expenses may only be claimed in accordance with the travel and training costs that were approved in the CHDP No County/City Administrative Budget.

13) Enter the Grand Total by adding all entries in Column E.

Column F – Non-Enhanced State/Federal (50/50)

14) Enter the amounts of change for each category/line item listed in Column A.

The amounts of change are calculated by subtracting the category/line item amounts that were previously reported on the Initial Invoice from the corresponding category/line item amounts reported on the Supplemental Invoice – Part A.

15) Enter the amounts of change for Total Capital Expenses, Total Indirect Expenses, and Total Other Expenses.

The amounts of change are calculated by subtracting the Total Capital, Indirect, and Other Expenses amounts that were previously reported on the Initial Invoice from the corresponding Total Capital, Indirect, and Other Expenses amounts reported on the Supplemental Invoice – Part A.

16) Enter the Grand Total by adding all entries in Column F.

The Grand Total in Column F must equal the difference after subtracting the Grand Total in Column E from the Grand Total in Column D.

Source of Funds

Column H – Total Funds

17) Enter the Grand Total amount from Column I – Total CHDP Non-Medi-Cal for State General Funds.

18) Enter the amount from Column J – Total Medi-Cal for Medi-Cal Funds: State Funds.

19) Enter the amount from Column J – Total Medi-Cal for Medi-Cal Funds: Federal Funds (Title XIX).

20) Enter the Grand Total by adding all entries in Column H.

The entry for the Grand Total must equal the Grand Total amount in Column B – Total Expenditures in Category/Line Item.

Column I – Total CHDP Non-Medi-Cal

21) Enter the Grand Total amount from Column C –Total CHDP Non-Medi-Cal in Category/Line Item for State General Funds.

22) Enter the Grand Total by adding all entries in Column I.

The entry for the Grand Total must equal the Grand Total amount in Column C – Total CHDP Non-Medi-Cal in Category/Line Item.

Column J – Total Medi-Cal

23) Enter the amount for Total Medi-Cal for Medi-Cal Funds: State Funds.

The amount for Total Medi-Cal for Medi-Cal Funds: State Funds is calculated by adding the amounts in Column K – Enhanced State/Federal (25/75) and Column L – Non-Enhanced State/Federal (50/50).

Also, the amount of change must equal the result from multiplying the Grand Total amount in Column E – Enhanced State/Federal (25/75) by 25 percent.

24) Enter the amount for Total Medi-Cal for Medi-Cal Funds: Federal Funds (Title XIX).

The amount for Total Medi-Cal for Medi-Cal Funds: Federal Funds (Title XIX) is calculated by adding the amounts in Column K – Enhanced State/Federal (25/75) and Column L – Non-Enhanced State/Federal (50/50).

Also, the amount of change must equal the result from multiplying the Grand Total amount in Column E – Enhanced State/Federal (50/50) by 50 percent.

25) Enter the Grand Total by adding all entries in Column J.

For each source of funds, the amounts entered in Column J must equal the sum of respective amounts in Columns K and L.

Also, the Grand Total in Column J must equal the difference after subtracting the Grand Total in Column I from the Grand Total in Column H.

Additionally, the entry for the Grand Total in Column J must equal the Grand Total amount in Column D – Total Medi-Cal in Category/Line Item.

Column K – Enhanced State/Federal (25/75)

26) Enter the amount of change for Medi-Cal Funds: State Funds.

The amount of change is calculated by subtracting the Medi-Cal Funds: State Funds amount that was previously reported on the Initial Invoice from the corresponding Medi-Cal Funds: State Funs amount reported on the Supplemental Invoice – Part A.

Also, the amount of change must equal the result from multiplying the Grand Total amount in Column E – Enhanced State/Federal (25/75) by 25 percent.

27) Enter the amount of change for Medi-Cal Funds: Federal Funds (Title XIX).

The amount of change is calculated by subtracting the Medi-Cal Funds: Federal Funds (Title XIX) amount that was previously reported on the Initial Invoice from the corresponding Medi-Cal Funds: Federal Funds (Title XIX) amount reported on the Supplemental Invoice – Part A.

Also, the amount of change must equal the result from multiplying the Grand Total amount in Column E – Enhanced State/Federal (25/75) by 75 percent.

28) Enter the Grand Total by adding all entries in Column K.

The entry for the Grand Total must equal the Grand Total amount in Column E – Enhanced State/Federal (25/75) in Category/Line Item.

Column L – Non-Enhanced State/Federal (50/50)

29) Enter the amount of change for Medi-Cal Funds: State Funds.

The amount of change is calculated by subtracting the Medi-Cal Funds: State Funds amount that was previously reported on the Initial Invoice from the corresponding Medi-Cal Funds: State Funds amount reported on the Supplemental Invoice – Part A.

Also, the amount of change must equal the result from multiplying the Grand Total amount in Column F – Non-Enhanced State/Federal (50/50) by 50 percent.

30) Enter the amount of change for Medi-Cal Funds: Federal Funds (Title XIX)

The amount of change is calculated by subtracting the Medi-Cal Funds: Federal Funds (Title XIX) amount that was previously reported on the Initial Invoice from the corresponding Medi-Cal Funds: Federal Funds (Title XIX) amount reported on the Supplemental Invoice – Part A.

Also, the amount of change must equal the result from multiplying the Grand Total amount in Column F – Non-Enhanced State/Federal (50/50) by 50 percent.

31) Enter the Grand Total by adding all entries in Column L.

The entry for the Grand Total must equal the Grand Total amount in Column F – Non-Enhanced State/Federal (50/50) in Category/Line Item.

Also, the entry for Grand Total must equal the difference from subtracting the Grand Total amount in Column K from the Grand Total amount in Column J.

Certification

32) Type or print the name of the person who prepared the supplemental invoices.

All questions concerning the supplemental invoices will be addressed to the name of the person identified here.

33) Enter the e-mail address of the person preparing the invoices.

34) Enter the date the supplemental invoices were prepared.

35) Enter the telephone number, including the area code, for the person preparing the invoices or contact person.

36) Affix the signature of the CHDP Director, CHDP Deputy Director, or an official who is authorized to sign the CHDP Quarterly Administrative Expenditure Invoices and Supplemental Invoices – Parts A and B.

Original signatures are required. **Signature stamps are not accepted**.

37) Enter the date that the signature was affixed.

38) Type or print the name of the authorized official.

Submission

39) Submit the Supplemental Invoice (Part B) and any supporting documentation to justify expenditures to the following:

Department of Health Care Services
Children's Medical Services
Program Support Section – Administration Unit
P.O. Box 997413 MS 8104
Sacramento, CA 95899-7413

Supplemental Invoice (Part B) shall be submitted **no later than December 31st** after the end of the fiscal year.

Example: FY 2011-12 ends June 30, 2012. Supplemental Invoices (Parts A and B) for FY 2011-12 are due no later than December 31, 2012.

State of California - Health & Human Services Agency

Department of Health Care Services - Children's Medical Services

COUNTY/CITY: **SUPPLEMENTAL NO.:** **QUARTER ENDING:**

MONTH/DAY/YEAR

CHDP QUARTERLY ADMINISTRATIVE EXPENDITURE INVOICE
(No County / City Match)
FISCAL YEAR _____

SUPPLEMENTAL INVOICE - PART B

CATEGORY/LINE ITEM	TOTAL EXPENDITURES	TOTAL CHDP Non MEDI-CAL	TOTAL MEDI-CAL	ENHANCED STATE/FEDERAL (25/75)	NON ENHANCED STATE/FEDERAL (50/50)
a	*b = c + d*	*c*	*d = b - c*	*e*	*f = d - e*
I. TOTAL PERSONNEL EXPENSES					
II. TOTAL OPERATING EXPENSES					
III. TOTAL CAPITAL EXPENSES					
IV. TOTAL INDIRECT EXPENSES					
V. TOTAL OTHER EXPENSES					
EXPENDITURES GRAND TOTAL	**0**	**0**	**0**	**0**	**0**

SOURCE OF FUNDS	TOTAL FUNDS	TOTAL CHDP Non MEDI-CAL	TOTAL MEDI-CAL	ENHANCED STATE/FEDERAL (25/75)	NON ENHANCED STATE/FEDERAL (50/50)
g	*h = i + j*	*i*	*j = h - i*	*k*	*l = j - k*
STATE GENERAL FUNDS	0	0			
MEDI-CAL FUNDS:					
STATE FUNDS	0		0	0	0
FEDERAL FUNDS (TITLE XIX)	0		0	0	0
EXPENDITURES GRAND TOTAL	**0**	**0**	**0**	**0**	**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/Contact Person E-mail Address Date Area Code/ Telephone Number

CHDP Director/Deputy Director (Signature) Date Type or Print Name of Signer

RevisedJune 2011

HCPCFC Quarterly Administrative Expenditure Invoice Instructions

In order to receive reimbursement for Health Care Program for Children in Foster Care (HCPCFC) expenditures, the Quarterly HCPCFC Administrative Expenditure Invoice must be prepared in accordance with the following instructions. The HCPCFC Quarterly Administrative Expenditure invoice form is found in Section 7, page 33.

The HCPCFC 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 HCPCFC 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 7, page 2.

County/City

1) Enter the name of the county or city for which this invoice applies.

Quarter Ending

2) Enter the date for which the quarter ends, using the chart below:

Quarter	Time Period of Quarter	Quarter End Date
1	July 1, 20xx – September 30, 20xx	September 30, 20xx
2	October 1, 20xx – December 31, 20xx	December 31, 20xx
3	January 1, 20xx+1 – March 31, 20xx+1	March 31, 20xx+1
4	April 1, 20xx+1 – June 30, 20xx+1	June 30, 20xx+1

Fiscal Year

3) Enter the fiscal year (FY) for which this invoice applies.

Category / Line Item

Total Personnel Expenses

4) Column 1 is the total expenditures 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.

5) Enter the total amount of State and federal funds at the enhanced percentage in Column 2.

6) 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.

Total Operating Expenses

7) The total amount of state and federal funds for the quarter are in Column 1.

8) Enter the total amount of enhanced travel and training expenses in Column 2.

9) 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 8).

Total Capital Expenses

- Total Capital Expenses are not allowed on the HCPCFC Administrative Budget.

Total Indirect Expenses

Indirect expenses are non-enhanced; they may not be claimed at the enhanced rate.

10) Enter the total of internal indirect expenses for the quarter in Columns 1 and 3.

11) The Total Invoiced amount in Column 1 should be the same as the amount in Column 3.

Total Other Expenses

- Total Other Expenses are not allowed on the HCPCFC Administrative Budget.

Expenditure Grand Total

12) Expenditure Grand Total is 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.

Source of Funds

State Funds

13) The Total State General Funds in Column 1 is the sum of the amounts in Columns 2 and 3.

Federal Funds (Title XIX)

14) The Total Federal Funds (Title XIX) is the sum of the amounts in Columns 2 and 3.

Enhanced State/Federal (25/75)

15) Multiply the Expenditure Grand Total line of Column 2, by 25 percent. Enter this amount in the State Funds line of Column 2.

16) 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.

Non-Enhanced State/Federal (50/50)

17) Multiply the Expenditure Grand Total line of Column 3 by 50 percent. Enter this amount in the State Funds line of Column 3.

18) 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.

Expenditure Grand Total

19) Enter in Column 1 the total of Column 2 and Column 3, in the County/City Funds line.

20) 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.

Certification

21) Enter the name, e-mail address, and telephone number with the area code of the staff person responsible for preparing the HCPCFC Quarterly Administrative Expenditure invoice form.

22) Type or print the name of the authorized official.

23) Enter the date that the signature was affixed.

24) Type or print the name of the CHDP Director or Deputy Director that has signed the expenditure invoice.

Submission

25) Submit the invoice with original signature. **Signature stamps are not acceptable.** No additional copies are required.

26) Submit the quarterly invoice and any supporting documentation to justify expenditures to the following:

California Department of Health Care Services
Children's Medical Services
Program Support Section – Administration Unit
P.O. Box 997413 MS 8104
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.

Quarter	Due Date
1st	November 30, 20xx
2nd	February 28, 20xx+1
3rd	May 31, 20xx+1
4th	August 31, 20xx+1

All invoices shall be submitted no later than September 30th after the end of the fiscal year.

Example: FY 2011-2012 ends June 30, 2012. All invoices for FY 2011-2012 are due no later than September 30, 2012.

State of California – Health and Human Services Agency

Department of Health Care Services – Children's Medical Services

COUNTY/CITY:

QUARTER ENDING:

MONTH/DAY/YEAR

HCPCFC Quarterly Administrative Expenditure Invoice
Fiscal Year _____

Category/Line Item	Total Invoiced	Enhanced State/Federal (25/75)	Non-Enhanced State/Federal (50/50)
Column	*1 = 2 + 3*	*2*	*3*
I. Total Personnel Expenses	0		
II. Total Operating Expenses	0		
III. Total Capital Expenses			
IV. Total Indirect Expenses	0		
V. Total Other Expenses			
Expenditures Grand Total	0	0	0

Source of Funds	Total Funds Invoiced	Enhanced State/Federal (25/75)	Non-Enhanced State/Federal (50/50)
Column	*1 = 2 + 3*	*2*	*3*
State Funds	0	0	0
Federal Funds (Title XIX)	0	0	0
Expenditures Grand Total	0	0	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 | E-Mail Address | Date / Area Code /Telephone No.

CHDP Director or Deputy Director (Signature) | Date | Print or Type Name of Signer

Revised June 2011

CHDP Foster Care Administrative Expenditure Invoice Instructions

In order to receive reimbursement for Child Health and Disability Prevent (CHDP) Foster Care expenditures, 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 7, page 38.

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 Submission sections of the invoice form. Local county and city CHDP 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 7, page 2.

The CHDP Foster Care Administrative Budget (County/City Match) is an optional budget to fund public health nurse (PHN) and supervising public health nurse (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.

County/City

1) Enter the name of the county or city for which this invoice applies.

Quarter Ending

2) Enter the date for which the quarter ends, using the chart below:

Quarter	Time Period of Quarter	Quarter End Date
1	July 1, 20xx – September 30, 20xx	September 30, 20xx
2	October 1, 20xx – December 31, 20xx	December 31, 20xx
3	January 1, 20xx+1 – March 31, 20xx+1	March 31, 20xx+1
4	April 1, 20xx+1 – June 30, 20xx+1	June 30, 20xx+1

Fiscal Year

3) Enter the fiscal year (FY) for which this invoice applies.

Category / Line Item

Total Personnel Expenses

4) Column 1 is the amount of total personnel expenses 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.

5) Enter the total amount of county/city and federal funds at the enhanced percentage in Column 2.

6) 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.

Total Operating Expenses

7) Column 1 is the total amount of operating expenses for the quarter.

8) Enter the total amount of enhanced operating expenses in Column 2.

9) 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 8).

Total Capital Expenses

- Total Capital Expenses are not allowed on this budget.

Total Indirect Expenses

- External Indirect Expenses are not allowed on this budget.

10) Enter the total amount of indirect expenses for the quarter on this line in Column 3.

Total Other Expenses

- Total Other Expenses are not allowed on this budget.

Expenditures Grand Total

11) Column 1 Expenditures Grand Total is the sum total of the Total Personnel Expenses, Operating Expenses, and Indirect Expenses.

Source of Funds

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.

Federal Funds (Title XIX)

12) 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.

13) 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.

14) Total Funds

Add Columns 2 and 3 together for the Federal Funds (Title XIX) line and enter the total in Column 1, Total Funds.

Certification

15) Type or print the name of the staff person responsible for preparing the Foster Care Administrative Expenditure invoice form.

16) Enter the e-mail address of the person preparing the invoice form.

17) Enter the date the invoice was prepared.

18) Enter the telephone number including the area code of the person preparing the invoice.

19) 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.

20) Type or print the name and title of the CHDP Director or Deputy Director that is signing the invoice.

Submission

21) **Submit all invoices with original signatures. Signature stamps are not acceptable.** Additional copies are not necessary.

22) All invoices and supporting documentation that justifies the expenditures should be submitted to:

California Department of Health Care Services
Children's Medical Services
Program Support Section – Administration Unit
P.O. Box 997413 MS 8104
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.

Quarter	Due Date
1st	November 30, 20xx
2nd	February 28, 20xx+1
3rd	May 31, 20xx+1
4th	August 31, 20xx+1

Supplemental invoices shall be submitted no later than December 31st after the end of the fiscal year.

Example: FY 2011-12 ends June 30, 2012. Supplemental Invoices for FY 2011-12 are due no later than December 31, 2012.

State of California – Health and Human Services Agency

Department of Health Care Services – Children's Medical Services

COUNTY/CITY:

QUARTER ENDING:

MONTH/DAY/YEAR

CHDP Foster Care Quarterly Administrative Expenditure Invoice
Fiscal Year _____

Category/Line Item	Total Invoiced	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
Column	*1 = 2 + 3*	*2*	*3*
I. Total Personnel Expenses	0		
II. Total Operating Expenses	0		
III. Total Capital Expenses			
IV. Total Indirect Expenses	0		
V. Total Other Expenses			
Expenditures Grand Total	0	0	0

Source of Funds	Total Funds Invoiced	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
Column	*1 = 2 + 3*	*2*	*3*
County-City Funds	0	0	0
Federal Funds (Title XIX)	0	0	0
Expenditures Grand Total	0	0	0

Source County-City 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 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 | E-Mail Address | Date / Area Code /Telephone Number

CHDP Director or Deputy Director (Signature) | Date | Print or Type Name of Signer

Revised June 2011

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 2011-12 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.dhcs.ca.gov/services/ccs/Pages/default.aspx

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 Children's Medical Services (CMS) for reimbursement. This means that no other invoice had been previously submitted to CMS for this particular quarter.

The following are instructions for the completion of the CCS Program Administrative Expenditure Invoice – Initial, which are prepared on a quarterly basis.

County

1) Enter the name of the county for which this invoice applies.

Quarter Ending

2) Enter the date for which the quarter ends, using the chart below:

Quarter	Time Period of Quarter	Quarter End Date
1	July 1, 20xx – September 30, 20xx	September 30, 20xx
2	October 1, 20xx – December 31, 20xx	December 31, 20xx
3	January 1, 20xx+1 – March 31, 20xx+1	March 31, 20xx+1
4	April 1, 20xx+1 – June 30, 20xx+1	June 30, 20xx+1

Fiscal Year

3) Enter the state fiscal year (FY) for which this invoice applies.

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 Total Medi-Cal Cases.

Non-Medi-Cal Cases: Healthy Families

6) 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.

7) Enter Total Healthy Families Cases.

Non-Medi-Cal Cases: Straight CCS

8) 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.

9) Enter Total Straight CCS Cases.

Total Non-Medi-Cal Cases

10) Enter Total Non-Medi-Cal Cases by adding Total HF Cases and Total Straight CCS Cases.

Total Caseload

11) Enter Total Caseload by adding Total Medi-Cal Cases and Total Non-Medi-Cal Cases.

Column C – Percent of Grand Total

Medi-Cal Percentages

12) 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.

13) 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

14) 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.

15) 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

16) 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.

17) 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

18) 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

19) 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

20) Enter the name of the county for which this invoice applies.

Quarter Ending

21) Enter the date for which the quarter ends, using the chart below:

Quarter	Time Period of Quarter	Quarter End Date
1	July 1, 20xx – September 30, 20xx	September 30, 20xx
2	October 1, 20xx – December 31, 20xx	December 31, 20xx
3	January 1, 20xx+1 – March 31, 20xx+1	March 31, 20xx+1
4	April 1, 20xx+1 – June 30, 20xx+1	June 30, 20xx+1

Fiscal Year

22) Enter the state fiscal year (FY) for which this invoice applies.

Column C – Total Expenditures

23) Enter the total of all expenditures charged during the quarter to each category/line item listed in Column B.

24) 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

25) Enter the amount of Non-Medi-Cal expenditures charged during the quarter to each category/line item listed in Column B in Columns E and F.

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:

+	Total Other Expenses
-	All M&T Expenditures
=	Remaining Balance
x	Total Non-Medi-Cal Cases Percent
=	Share of Total Other Expenses for Total Non-Medi-Cal Cases
+	M&T Expenditures for Non-Medi-Cal Clients
=	Amount of Total Other Expenses for Total Non-Medi-Cal Cases

26) 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

27) 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.

28) Enter the Total Expenditures for Straight CCS by adding all entries in Column E.

Column F – Healthy Families (HF)

29) 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.

30) Enter the Total Expenditures for HF by adding all entries in Column F.

Column G – Total Medi-Cal

31) 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 <u>must be identified directly</u> 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 <u>all</u> 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:

+	Total Other Expenses
-	All M&T Expenditures
=	Remaining Balance
x	Total Medi-Cal Cases Percent
=	Share of Total Other Expenses for Total Medi-Cal Cases
+	M&T Expenditures for Medi-Cal Clients
=	Amount of Total Other Expenses for Total Medi-Cal Cases

32) 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 State/Federal (25/75)

33) 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 State/Federal (50/50)

34) 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 and Transportation (M&T)

35) 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

36) 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.

37) Enter Total Source of Funds by adding all entries in Column M.

Column N – Healthy Families

38) 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.

39) Enter Total Source of Funds by adding all entries in Column N.

Column L – Total Non-Medi-Cal

40) Enter Total Non-Medi-Cal amounts by adding the amounts in Columns M and N for each funding source listed in Column J.

41) 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

42) 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.

43) Enter Total Source of Funds by adding all entries in Column P.

Column Q – Medi-Cal Non-Enhanced

44) 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.

45) Enter Total Source of Funds by adding all entries in Column Q.

Column O – Total Medi-Cal

46) Enter Total Medi-Cal amounts by adding the amounts in Columns P and Q for each funding source listed in Column J.

47) 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

48) Enter the amounts for Medi-Cal State and federal funds (Title XIX) from Column O to Column K.

49) Enter the amounts for HF State, County, and federal funds (Title XXI) from Column N to Column K.

50) Enter the amounts for straight CCS State and County funds from Column M to Column K.

Total Source of Funds

51) 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

52) Affix the signature of an official who is authorized to sign CCS Administrative Expenditure Invoices. **Original signature is required. Signature stamps are not acceptable.**

53) Type or print the name of the authorized official.

54) Enter the date that the signature was affixed.

55) Type or print the name of the contact person for the expenditure invoice.

56) Enter the e-mail address and telephone number with the area code for the contact person.

Submission

57) Submit the invoice with original signature. **Signature stamps are not acceptable.** No additional copies are required.

58) Submit the quarterly invoice and any supporting documentation to justify expenditures to the following:

California Department of Health Care Services
Children's Medical Services
Program Support Section – Administration Unit
P.O. Box 997413 MS 8104
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.

Quarter	Due Date
1st	November 30, 20xx
2nd	February 28, 20xx+1
3rd	May 31, 20xx+1
4th	August 31, 20xx+1

Supplemental invoices shall be submitted **no later than December 31st** after the end of the fiscal year.

Example: FY 2011-12 ends June 30, 2012. Supplemental Invoices for FY 2011-12 are due no later than December 31, 2012.

State of California - Health and Human Resources Agency

Department of Health Care Services - Children's Medical Services

COUNTY:

QUARTER ENDING:

MONTH/DAY/YEAR

CCS ADMINISTRATIVE EXPENDITURE INVOICE - INITIAL

FISCAL YEAR _____

CCS CASELOAD	ACTUAL CASELOAD	PERCENT OF GRAND TOTAL
A	*B*	*C*
MEDI-CAL CASES		
Average Total Cases of Open (Active) Medi-Cal Children		
TOTAL MEDI-CAL CASES		
NON-MEDI-CAL CASES		
HEALTHY FAMILIES (HF)		
Average Total Cases of Open (Active) HF Children		
TOTAL HEALTHY FAMILIES CASES		
STRAIGHT CCS		
Average Total Cases of Open (Active) Straight CCS Children		
TOTAL STRAIGHT CCS CASES		
TOTAL NON-MEDI-CAL CASES		
TOTAL CASELOAD		

Page 1 of 2

Revised June 2011

State of California - Health and Human Resources Agency

Department of Health Care Services - Children's Medical Services

COUNTY:

QUARTER ENDING:

MONTH/DAY/YEAR

CCS ADMINISTRATIVE EXPENDITURE INVOICE - INITIAL
FISCAL YEAR _____

	CATEGORY/LINE ITEM	TOTAL EXPENDITURES	NON-MED-CAL			MEDI-CAL		
			TOTAL NON-MEDI-CAL	STRAIGHT CCS State/County (50/50)	HEALTHY FAMILIES Fed/State/Co (65/17.5/17.5)	TOTAL MEDI-CAL	ENHANCED State/Federal (25/75)	NON-ENHANCED State/Federal (50/50)
A	*B*	*C=D+G*	*D=E+F*	*E*	*F*	*G=H+I*	*H*	*I*
I.	Total Personnel Expenses	0	0			0		
II.	Total Operating Expenses	0	0			0		
III.	Total Capital Expenses	0	0			0		
IV.	Total Indirect Expenses	0	0			0		
V.	Total Other Expenses	0	0			0		
	TOTAL EXPENDITURES	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	Maintenance & Transportation	$ -	$ -	$ -	$ -	$ -		

	SOURCE OF FUNDS							
	J	*K=L+O*	*L*	*M*	*N*	*O=P+Q*	*P*	*Q*
MEDI-CAL								
	State Funds	0				0	0	0
	Federal Funds (Title XIX)	0				0	0	0
HEALTHY FAMILIES								
	State Funds	0	0		0			
	County Funds	0	0		0			
	Federal Funds (Title XXI)	0	0		0			
STRAIGHT CCS								
	State Funds	0	0	0				
	County Funds	0	0	0				
TOTAL SOURCE OF FUNDS		0	0	0	0	0	0	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 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.

Prepared By | E-mail Address | Date | Area Code / Telephone Number

Signature of Authorized Official | Date | Print or Type Name of Signer | Title

Revised June 2011

Page 2 of 2

CCS Quarterly Administrative Expenditure Invoice Instructions – Supplemental (Part 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 Children's Medical Services (CMS), 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 first quarter. Several months after the Initial Invoice was submitted to CMS for reimbursement, the county found a supply order for $1,000 that was paid in the first quarter.

  In order to be reimbursed for the $1,000 supply order, the county must now complete Supplemental (Part A) Invoice for the first 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 first 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.

County

1) Enter the name of the county for which this invoice applies.

Supplemental No.

2) Enter the number in the sequence of supplemental invoices submitted to CMS. Example: 01, 02, etc.

This number must be the same on pages 1 and 2 of the Supplemental (Part A) Invoice.

Quarter Ending

3) Enter the date for which the quarter ends, using the chart below:

Quarter	Time Period of Quarter	Quarter End Date
1	July 1, 20xx – September 30, 20xx	September 30, 20xx
2	October 1, 20xx – December 31, 20xx	December 31, 20xx
3	January 1, 20xx+1 – March 31, 20xx+1	March 31, 20xx+1
4	April 1, 20xx+1 – June 30, 20xx+1	June 30, 20xx+1

These dates must be the same on pages 1 and 2 of the Supplemental (Part A) Invoice.

Fiscal Year

4) Enter the state fiscal year (FY) for which this invoice applies.

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 2011-12 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.dhcs.ca.gov/services/ccs/Pages/default.aspx

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 Total Medi-Cal Cases.

Non-Medi-Cal Cases: Healthy Families (HF)

7) Enter the Average Total Cases of Open (Active) HF Children that was previously reported on the Initial Invoice and any changes to this figure.

8) Enter Total Healthy Families Cases.

Non-Medi-Cal Cases: Straight CCS

9) 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.

10) Enter Total Straight CCS Cases.

Total Non-Medi-Cal Cases

11) Enter Total Non-Medi-Cal Cases by adding Total HF Cases and Total Straight CCS Cases.

Total Caseload

12) Enter Total Caseload by adding Total Medi-Cal Cases and Total Non-Medi-Cal Cases.

Column C – Percent of Grand Total

Medi-Cal Percentages

13) 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.

14) 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

15) 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.

16) 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

17) 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.

18) 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

19) 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

20) 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

The entries for County, Supplemental No., Quarter Ending, and Fiscal Year must be the same on pages 1 and 2 of the Supplemental (Part A) Invoice.

County

21) Enter the name of the county for which this invoice applies.

Supplemental No.

22) Enter the number in the sequence of supplemental invoices submitted to CMS. Example: 01, 02, etc.

This number must be the same on pages 1 and 2 of the Supplemental (Part A) Invoice.

Quarter Ending

23) Enter the date for which the quarter ends, using the chart below:

Quarter	Time Period of Quarter	Quarter End Date
1	July 1, 20xx – September 30, 20xx	September 30, 20xx
2	October 1, 20xx – December 31, 20xx	December 31, 20xx
3	January 1, 20xx+1 – March 31, 20xx+1	March 31, 20xx+1
4	April 1, 20xx+1 – June 30, 20xx+1	June 30, 20xx+1

Fiscal Year

24) Enter the state fiscal year (FY) for which this invoice applies.

Column C – Total Expenditures

25) Enter the amounts of Total Expenditures that were previously reported on the Initial Invoice and any changes to these amounts.

26) 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

27) 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:

+	Total Other Expenses (amounts previously reported and any changes)
-	All M&T Expenditures (amounts previously reported and any changes)
=	Remaining Balance (amounts previously reported and any changes)
x	Total Non-Medi-Cal Cases Percent (from Supplemental (Part A) Invoice)
=	Correct Share of Total Other Expenses for Total Non-Medi-Cal Cases
+	Correct M&T Expenditures for Non-Medi-Cal Clients
=	Correct Amount of Total Other Expenses for Total Non-Medi-Cal Cases

28) 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

29) Enter the amounts of straight CCS expenditures that were previously reported on the Initial Invoice and any changes to these amounts.

30) Enter the total expenditures for straight CCS by adding all entries in Column E.

Column F – Healthy Families (HF)

31) Enter the amounts of HF expenditures that were previously reported on the Initial Invoice and any changes to these amounts.

32) Enter the total expenditures for HF by adding all entries in Column F.

Column G – Total Medi-Cal

33) 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:

+	Total Other Expenses (amounts previously reported and any changes)
-	All M&T Expenditures (amounts previously reported and any changes)
=	Remaining Balance (amounts previously reported and any changes)
x	Total Medi-Cal Cases Percent (from Supplemental (Part A) Invoice)
=	Correct Share of Total Other Expenses for Total Medi-Cal Cases
+	Correct M&T Expenditures for Medi-Cal Clients
=	Correct Amount of Total Other Expenses for Total Medi-Cal Cases

34) 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

35) 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

36) 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 and Transportation (M&T)

37) 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

38) 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

39) 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

40) Enter Total Non-Medi-Cal amounts by adding the amounts in Columns M and N for each funding source listed in Column J.

41) 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

42) 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

43) 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

44) Enter Total Medi-Cal amounts by adding the amounts in Columns P and Q for each funding source listed in Column J.

45) 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

46) Enter the amounts for Medi-Cal State and federal funds (Title XIX) from Column O to Column K.

47) Enter the amounts for HF State, county, and federal funds (Title XXI) from Column N to Column K.

48) Enter the amounts for straight CCS State and county funds from Column M to Column K.

Total Source of Funds

49) 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

50) 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**.

51) Type or print the name of the authorized official.

52) Enter the date that the signature was affixed.

53) Type or print the name of the contact person for the expenditure invoice.

54) Enter the e-mail address and telephone number with the area code for the contact person.

Submission

55) 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.

56) 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
Program Support Section – Administration Unit
P.O. Box 997413 MS 8104
Sacramento, CA 95899-7413

Supplemental invoices shall be submitted no later than December 31st after the end of the fiscal year.

Example: FY 2011-12 ends June 30, 2012. Supplemental Invoices for FY 2011-12 are due no later than December 31, 2012.

State of California - Health and Human Resources Agency

Department of Health Care Services - Children's Medical Services

COUNTY: **SUPPLEMENTAL NO.:** **QUARTER ENDING:**

MONTH/DAY/YEAR

CCS ADMINISTRATIVE EXPENDITURE INVOICE - SUPPLEMENTAL (PART A)

FISCAL YEAR _____

CCS CASELOAD	CORRECT CASELOAD	PERCENT OF GRAND TOTAL
A	*B*	*C*
MEDI-CAL CASES		
Average Total Cases of Open (Active) Medi-Cal Children		
TOTAL MEDI-CAL CASES		
NON-MEDI-CAL CASES		
HEALTHY FAMILIES (HF)		
Average Total Cases of Open (Active) HF Children		
TOTAL HEALTHY FAMILIES CASES		
STRAIGHT CCS		
Average Total Cases of Open (Active) Straight CCS Children		
TOTAL STRAIGHT CCS CASES		
TOTAL NON-MEDI-CAL CASES		
TOTAL CASELOAD		

Revised June 2011

State of California - Health and Human Resources Agency

Department of Health Care Services - Children's Medical Services

COUNTY: **SUPPLEMENTAL NO.:** **QUARTER ENDING:**

MONTH/DAY/YEAR

CCS ADMINISTRATIVE EXPENDITURE INVOICE - SUPPLEMENTAL (PART A)

FISCAL YEAR _____

	CATEGORY/LINE ITEM	TOTAL EXPENDITURES	NON-MED-CAL			MEDI-CAL		
			TOTAL NON-MEDI-CAL	STRAIGHT CCS State/County (50/50)	HEALTHY FAMILIES Fed/State/Co (65/17.5/17.5)	TOTAL MEDI-CAL	ENHANCED State/Federal (25/75)	NON-ENHANCED State/Federal (50/50)
A	*B*	*C=D+G*	*D=E+F*	*E*	*F*	*G=H+I*	*H*	*I*
I.	Total Personnel Expenses	0	0			0		
II.	Total Operating Expenses	0	0			0		
III.	Total Capital Expenses	0	0			0		
IV.	Total Indirect Expenses	0	0			0		
V.	Total Other Expenses	0	0			0		
	TOTAL EXPENDITURES	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	Maintenance & Transportation	$ -	$ -	$ -	$ -	$ -		-

	SOURCE OF FUNDS							
	J	*K=L+O*	*L*	*M*	*N*	*O=P+Q*	*P*	*Q*
MEDI-CAL								
	State Funds	0				0	0	0
	Federal Funds (Title XIX)	0				0	0	0
HEALTHY FAMILIES								
	State Funds	0	0		0			
	County Funds	0	0		0			
	Federal Funds (Title XXI)	0	0		0			
STRAIGHT CCS								
	State Funds	0	0	0				
	County Funds	0	0	0				
TOTAL SOURCE OF FUNDS		**0**	**0**	**0**	**0**	**0**	**0**	**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 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.

Prepared By E-mail Address Date Area Code / Telephone Number

Signature of Authorized Official Date Print or Type Name of Signer Title

Revised June 2011

Page 2 of 2

State of California - Health and Human Resources Agency

Department of Health Care Services - Children's Medical Services

COUNTY: ANY COUNTY, CALIFORNIA **SUPPLEMENTAL NO.: 01** **QUARTER ENDING: SEPTEMBER 30, 2011**

MONTH/DAY/YEAR

CCS ADMINISTRATIVE EXPENDITURE INVOICE - SUPPLEMENTAL (PART A)

FISCAL YEAR 2011 / 2012

CCS CASELOAD	CORRECT CASELOAD	PERCENT OF GRAND TOTAL
A	*B*	*C*
MEDI-CAL CASES		
Average Total Cases of Open (Active) Medi-Cal Children	2,133	58.94%
TOTAL MEDI-CAL CASES	2,133	58.94%
NON-MEDI-CAL CASES		
HEALTHY FAMILIES (HF)		
Average Total Cases of Open (Active) HF Children	323	8.93%
TOTAL HEALTHY FAMILIES CASES	323	8.94%
STRAIGHT CCS		
Average Total Cases of Open (Active) Straight CCS Children	1,163	32.14%
TOTAL STRAIGHT CCS CASES	1,163	32.14%
TOTAL NON-MEDI-CAL CASES	1,486	41.06%
TOTAL CASELOAD	3,619	100.00%

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Revised June 2011

State of California - Health and Human Resources Agency

Department of Health Care Services - Children's Medical Services

COUNTY: ANY COUNTY, CALIFORNIA **SUPPLEMENTAL NO.: 01** **QUARTER ENDING: SEPTEMBER 30, 2011**
MONTH/DAY/YEAR

CCS ADMINISTRATIVE EXPENDITURE INVOICE - SUPPLEMENTAL (PART A)

FISCAL YEAR 2011/2012

	CATEGORY/LINE ITEM	TOTAL EXPENDITURES	NON-MED-CAL			MEDI-CAL		
			TOTAL NON-MEDI-CAL	STRAIGHT CCS State/County (50/50)	HEALTHY FAMILIES Fed/State/Co (65/17.5/17.5)	TOTAL MEDI-CAL	ENHANCED State/Federal (25/75)	NON-ENHANCED State/Federal (50/50)
A	*B*	*C=D+G*	*D=E+F*	*E*	*F*	*G=H+I*	*H*	*I*
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	-	-	-	-	-		-
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 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 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.

JANE DOE	Jane.Doe@anycounty.california.com	11/30/2011	(000) 123-45678
Prepared By	E-mail Address	Date	Area Code / Telephone Number
John Smith	11/30/2011 JOHN SMITH	CCS ADMINISTRATOR	
Signature of Authorized Official	Date Print or Type Name of Signer	Title	

Revised June 2011

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CCS Quarterly Administrative Expenditure Invoice Instructions – Supplemental (Part 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 2011-12 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.dhcs.ca.gov/services/ccs/Pages/default.aspx

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 CMS, 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 first quarter. Several months after the Initial Invoice was submitted to CMS for reimbursement, the county found a supply order for $1,000 that was paid in the first quarter.

  In order to be reimbursed for the $1,000 supply order, the county must now complete Supplemental (Part A) Invoice for the first 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 first 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.

County

1) Enter the name of the county for which this invoice applies.

Supplemental No.

2) Enter the number in the sequence of supplemental invoices submitted to CMS. Example: 01, 02, etc.

This number must be the same on pages 1 and 2 of the Supplemental (Part B) Invoice.

Quarter Ending

3) Enter the dates of the quarter for which the invoice applies.

Quarter	Time Period of Quarter	Quarter End Date
1	July 1, 20xx – September 30, 20xx	September 30, 20xx
2	October 1, 20xx – December 31, 20xx	December 31, 20xx
3	January 1, 20xx+1 – March 31, 20xx+1	March 31, 20xx+1
4	April 1, 20xx+1 – June 30, 20xx+1	June 30, 20xx+1

These dates must be the same on pages 1 and 2 of the Supplemental (Part B) Invoice.

Fiscal Year

4) Enter the state fiscal year (FY) for which this invoice applies.

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 Total Medi-Cal Cases.

Non-Medi-Cal Cases: HF

7) 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.

8) Enter Total Healthy Families Cases.

Non-Medi-Cal Cases: Straight CCS

9) 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.

10) Enter Total Straight CCS Cases.

Total Non-Medi-Cal Cases

11) Enter Total Non-Medi-Cal Cases by adding Total HF Cases and Total Straight CCS Cases.

Total Caseload

12) 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

13) 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.

14) Enter the percentage for Total Medi-Cal Cases.

Non-Medi-Cal Percentages: HF

15) 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.

16) Enter the percentage for Total HF Cases.

Non-Medi-Cal Percentages: Straight CCS

17) 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.

18) Enter the percentage for Total Straight CCS Cases.

Total Non-Medi-Cal Cases Percentage

19) 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

20) 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

21) Enter the name of the county for which this invoice applies.

Supplemental No.

22) Enter the number in the sequence of supplemental invoices submitted to CMS. Example: 01, 02, etc.

This number must be the same on pages 1 and 2 of the Supplemental (Part B) Invoice.

Quarter Ending

23) Enter the date for which the quarter ends, using the chart below:

Quarter	Time Period of Quarter	Quarter End Date
1	July 1, 20xx – September 30, 20xx	September 30, 20xx
2	October 1, 20xx – December 31, 20xx	December 31, 20xx
3	January 1, 20xx+1 – March 31, 20xx+1	March 31, 20xx+1
4	April 1, 20xx+1 – June 30, 20xx+1	June 30, 20xx+1

These dates must be the same on pages 1 and 2 of the Supplemental (Part B) Invoice.

Fiscal Year

24) Enter the state fiscal year (FY) for which this invoice applies.

Column C – Total Expenditures

25) 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.

26) 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

27) 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.

28) 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

29) 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.

30) 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)

31) 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.

32) 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

33) 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.

34) 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

35) 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.

36) 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

37) 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.

38) 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)

39) 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

40) 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.

41) Enter the Total Source of Funds by adding all entries in Column M.

Column N – Healthy Families (HF)

42) 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.

43) Enter the Total Source of Funds by adding all entries in Column N.

Column L – Total Non-Medi-Cal

44) Enter Total Non-Medi-Cal amounts by adding the amounts in Columns M and N for each funding source listed in Column J.

45) 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

46) 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.

47) Enter the Total Source of Funds by adding all entries in Column P.

Column Q – Medi-Cal Non-Enhanced

48) 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.

49) Enter the Total Source of Funds by adding all entries in Column Q.

Column O – Total Medi-Cal

50) Enter Total Medi-Cal amounts by adding the amounts in Columns P and Q for each funding source listed in Column J.

51) 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

52) Enter the amounts for Medi-Cal state and federal funds (Title XIX) from Column O to Column K.

53) Enter the amounts for HF State, county, and federal funds (Title XXI) from Column N to Column K.

54) Enter the amounts for straight CCS state and county funds from Column M to Column K.

Total Source of Funds

55) 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

56) 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**.

57) Type or print the name of the authorized official.

58) Enter the date that the signature was affixed.

59) Type or print the name of the contact person for the expenditure invoice.

60) Enter the e-mail address and telephone number, with the area code, for the contact person.

Submission

61) 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.

62) 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
Program Support Section – Administration Unit
P.O. Box 997413 MS 8104
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 2011-12 ends June 30, 2012. Supplemental Invoices (Parts A and B) for FY 2011-12 are due no later than December 31, 2012.

State of California - Health and Human Resources Agency

Department of Health Care Services - Children's Medical Services

COUNTY: **SUPPLEMENTAL NO.:** **QUARTER ENDING**

MONTH/DAY/YEAR

CCS ADMINISTRATIVE EXPENDITURE INVOICE - SUPPLEMENTAL (PART B)

FISCAL YEAR _____

CCS CASELOAD	DIFFERENCE IN CASELOAD	PERCENT OF GRAND TOTAL
A	*B*	*C*
MEDI-CAL CASES		
Average Total Cases of Open (Active) Medi-Cal Children		
TOTAL MEDI-CAL CASES		
NON-MEDI-CAL CASES		
HEALTHY FAMILIES (HF)		
Average Total Cases of Open (Active) HF Children		
TOTAL HEALTHY FAMILIES CASES		
STRAIGHT CCS		
Average Total Cases of Open (Active) Straight CCS Children		
TOTAL STRAIGHT CCS CASES		
TOTAL NON-MEDI-CAL CASES		
TOTAL CASELOAD		

Page 1 of 2

State of California - Health and Human Resources Agency

Department of Health Care Services - Children's Medical Services

COUNTY: **SUPPLEMENTAL NO.:** **QUARTER ENDING:**

MONTH/DAY/YEAR

CCS ADMINISTRATIVE EXPENDITURE INVOICE - SUPPLEMENTAL (PART B)

FISCAL YEAR _____

	CATEGORY/LINE ITEM	TOTAL EXPENDITURES	NON-MED-CAL			MEDI-CAL		
			TOTAL NON-MEDI-CAL	STRAIGHT CCS State/County (50/50)	HEALTHY FAMILIES Fed/State/Co (65/17.5/17.5)	TOTAL MEDI-CAL	ENHANCED State/Federal (25/75)	NON-ENHANCED State/Federal (50/50)
A	*B*	*C=D+G*	*D=E+F*	*E*	*F*	*G=H+I*	*H*	*I*
I.	Total Personnel Expenses	0	0			0		
II.	Total Operating Expenses	0	0			0		
III.	Total Capital Expenses	0	0			0		
IV.	Total Indirect Expenses	0	0			0		
V.	Total Other Expenses	0	0			0		
	TOTAL EXPENDITURES	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	Maintenance & Transportation	0	0	0	0	0		0

	SOURCE OF FUNDS							
	J	*K=L+O*	*L*	*M*	*N*	*O=P+Q*	*P*	*Q*
MEDI-CAL								
	State Funds	0				0	0	0
	Federal Funds (Title XIX)	0				0	0	0
HEALTHY FAMILIES								
	State Funds	0	0		0			
	County Funds	0	0		0			
	Federal Funds (Title XXI)	0	0		0			
STRAIGHT CCS								
	State Funds	0	0	0				
	County Funds	0	0	0				
TOTAL SOURCE OF FUNDS		**0**	**0**	**0**	**0**	**0**	**0**	**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 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.

Prepared By E-mail Address Date Area Code / Telephone Number

Signature of Authorized Official Date Print or Type Name of Signer Title

Revised June 2011

Page 2 of 2

State of California - Health and Human Resources Agency

Department of Health Care Services - Children's Medical Services

COUNTY: ANY COUNTY, CALIFORNIA **SUPPLEMENTAL NO.: 01** **QUARTER ENDING: SEPTEMBER 30, 2011**

MONTH/DAY/YEAR

CCS ADMINISTRATIVE EXPENDITURE INVOICE - SUPPLEMENTAL (PART B)

FISCAL YEAR 2011/2012

CCS CASELOAD	DIFFERENCE IN CASELOAD	PERCENT OF GRAND TOTAL
A	*B*	*C*
MEDI-CAL CASES		
Average Total Cases of Open (Active) Medi-Cal Children		
TOTAL MEDI-CAL CASES		
NON-MEDI-CAL CASES		
HEALTHY FAMILIES (HF)		
Average Total Cases of Open (Active) HF Children	1,163	24.75%
TOTAL HEALTHY FAMILIES CASES	1,163	32.19%
STRAIGHT CCS		
Average Total Cases of Open (Active) Straight CCS Children	-1,163	-24.75%
TOTAL STRAIGHT CCS CASES	-1,163	-32.16%
TOTAL NON-MEDI-CAL CASES	0	0.00%
TOTAL CASELOAD		

Page 1 of 2

Revised June 2011

State of California - Health and Human Resources Agency

Department of Health Care Services - Children's Medical Services

COUNTY: ANY COUNTY, CALIFORNIA **SUPPLEMENTAL NO.: 01** **QUARTER ENDING: SEPTEMBER 30, 2011**
MONTH/DAY/YEAR

CCS ADMINISTRATIVE EXPENDITURE INVOICE - SUPPLEMENTAL (PART B)

FISCAL YEAR 2011 / 2012

	CATEGORY/LINE ITEM	TOTAL EXPENDITURES	NON-MED-CAL			MEDI-CAL		
			TOTAL NON-MEDI-CAL	STRAIGHT CCS State/County (50/50)	HEALTHY FAMILIES Fed/State/Co (65/17.5/17.5)	TOTAL MEDI-CAL	ENHANCED State/Federal (25/75)	NON-ENHANCED State/Federal (50/50)
A	*B*	*C=D+G*	*D=E+F*	*E*	*F*	*G=H+I*	*H*	*I*
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**	**0**	**0**
	Maintenance & Transportation	0	0	-755	755	0		0

	SOURCE OF FUNDS							
	J	*K=L+O*	*L*	*M*	*N*	*O=P+Q*	*P*	*Q*
MEDI-CAL								
	State Funds	0				0	0	0
	Federal Funds (Title XIX)	0				0	0	0
HEALTHY FAMILIES								
	State Funds	17,052	17,052		17,052			
	County Funds	17,052	17,052		17,052			
	Federal Funds (Title XXI)	63,337	63,337		63,337			
STRAIGHT CCS								
	State Funds	-48,721	-48,721	-48,721				
	County Funds	-48,721	-48,721	-48,721				
TOTAL SOURCE OF FUNDS		**0**	**0**	**-97,442**	**97,442**	**0**	**0**	**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 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.

JANE DOE	JANE.DOE@ANYCOUNTY.CALIFORNIA.COM	11/30/2011	(000) 123-4567
Prepared By	E-mail Address	Date	Area Code / Telephone Number
John Smith	11/30/2011 JOHN SMITH	CCS ADMINISTRATOR	
Signature of Authorized Official	Date Print or Type Name of Signer	Title	

Revised June 2011

Page 2 of 2

CCS Diagnostic, Treatment, and Therapy Quarterly Expenditure Reporting

Part I. Summary Report of Diagnostic and Treatment Expenditures

Instructions

1) Open the Excel file and go to the worksheet tab labeled 'Part I Dx Trtmnt' (yellow tab if you have Microsoft Excel 2003).

County

2) Enter the name of the county for which this invoice applies.

Quarter Ending

3) Enter the dates of the quarter for which the invoice applies.

Quarter	Time Period of Quarter	Quarter End Date
1	July 1, 20xx – September 30, 20xx	September 30, 20xx
2	October 1, 20xx – December 31, 20xx	December 31, 20xx
3	January 1, 20xx+1 – March 31, 20xx+1	March 31, 20xx+1
4	April 1, 20xx+1 – June 30, 20xx+1	June 30, 20xx+1

These dates must be the same on pages 1 and 2 of the Supplemental (Part B) Invoice.

Fiscal Year

4) Enter the state fiscal year (FY) for which this invoice applies.

Diagnostic Expenditures

5) Enter on line **1.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.)**

6) Enter on line **1.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 Children's Medical Services (CMS) or the transition to the fiscal intermediary (FI) provider payment processing occurred within the last 18 months of the quarter being claimed.)*

7) Enter on line **1.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**.

8) Enter on line **1.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.)

9) Lines **1.e** and **1. f** are formula driven and will calculate based on the data entered in the lines a, b, c, and d.

10) Enter on line **1.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.)***

Treatment Expenditures

11) Enter on line **2.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.)**

12) Enter on line **2.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.** (See CCS HF Expenditures Form for aid codes 9K/OC, 9K/9H, 9U/OC, 9U/9H in Section 7, Page 107.)

13) Enter on line **2.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.)*

14) Enter on line **2.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**.

15) Enter on line **2.e** the amount of **Miscellaneous Revenue** the county received during the quarter. (This includes returned warrants and provider refunds, enter amount as a positive.)

16) Lines **2.f** and **2.g** are formula driven and will calculate based on the data entered in the lines a, b, c, d, and e.

17) Enter on line **2.h** 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 if the county has prior approval and has coordinated with state personnel the correct amount.)***

Subtotals Diagnostic and Treatment Expenditures

18) Lines **3.a** and **3.b** are formula driven and will calculate from the data entered in the lines above. Line **3.a** represents the total reportable expenditures, and line **3.b** represents a gross total which is used in determining the amount of reimbursement due to the state or due to the county.

Total County Share 50 Percent Net Diagnostic & Treatment Expenditures

19) 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.*

Assessment Fees

20) Enter in field **5.a** the amount of the year to date outstanding assessment fees and enter in field **5.b** the amount collected for the quarter.

Enrollment Fees

21) Enter in field **6.a** the amount of the year to date outstanding enrollment fees and enter in field **6.b** the amount collected for the quarter.

Total Fees Collected

- This line calculates from the entries in lines 5 and 6.

Gross Diagnostic and Treatment Expenditures, and Fees Collected

- This line will calculate from the data in the fields **'3.b.'** and **'7**'.

50 Percent of Gross Diagnostic and Treatment and Fees Collected

- This field will calculate from the field on line 8.

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.

COUNTY: **QUARTER ENDING:** _____
MONTH/DAY/YEAR

CCS DIAGNOSTIC AND TREATMENT QUARTERLY EXPENDITURE REPORTING

FISCAL YEAR:_____

(Per H&S Code, Sections 123800-123995 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&SC 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 ***(Aid Code 9K Only)*** _____

* 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&SC 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 **$0**

(amount reportable as actual County share of expenditures)

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.

CCS Diagnostic, Treatment, and Therapy Quarterly Expenditure Reporting

Part II. Summary Report of Therapy Expenditures

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 Care Services, Children's Medical Services (CMS) and California Department of Education (CDE), Special Education Division.

Instructions

1) Open the Excel file and go to the worksheet tab labeled 'Part II Therapy" (orange tab if you have Microsoft Excel 2003).

County

2) Enter the name of the county for which this invoice applies.

Quarter Ending

3) Enter the dates of the quarter for which the invoice applies.

Quarter	Time Period of Quarter	Quarter End Date
1	July 1, 20xx – September 30, 20xx	September 30, 20xx
2	October 1, 20xx – December 31, 20xx	December 31, 20xx
3	January 1, 20xx+1 – March 31, 20xx+1	March 31, 20xx+1
4	April 1, 20xx+1 – June 30, 20xx+1	June 30, 20xx+1

Fiscal Year

4) Enter the state fiscal year (FY) for which this invoice applies.

MTP Caseload

Non-Medi-Cal

5) Enter the number of cases that qualify as non-Medi-Cal.

Medi-Cal

6) Enter the number of cases that qualify as Medi-Cal.

Total

7) 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)

Name

8) 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.

Classification

9) Enter the appropriate civil service classification for each staff person.

Monthly Salary

10) Enter the monthly salary for each staff person listed.

Full Time Equivalent (FTE) Percent

11) 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.

Expenditures Paid for Quarter

12) 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.

Total, Personal Services

13) Enter the total for personal services by adding all entries in Column 5. Expenditures Paid for Quarter.

Staff Benefits

14) Enter the staff benefits percentage paid by the county for county employed therapy staff.

15) 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.

Travel Costs

16) 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.

Internal Indirect Costs

17) Enter the percentage paid by the county for internal indirect costs.

18) 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.

Total County Employed MTU Staff

19) 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.

20) Enter the State share due county by multiplying the total from Line 10a by 50 percent.

Section II. Contract Therapists

Name

21) Enter the name of each therapist contracted by the county to provide direct patient care in the MTU during the reporting period.

Job Title

22) Enter the job title of each therapist contracted by the county for the reporting quarter.

Hourly Rate

23) Enter the hourly rate paid by the county for each contract therapist.

Number of Hours Worked

24) Enter the number of hours, or fractions thereof, that each contract therapist worked during the reporting quarter.

Expenditures Paid for Quarter

25) 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.

Total Contract Therapists

26) Enter the total for contract therapists by adding all entries in Column 5. Expenditures Paid for Quarter.

27) 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.

Name

28) Enter the name of each county employed therapist allocated by the State who performs SELPA/LEA/IEP functions during the reporting period.

Classification

29) Enter the appropriate civil service classification for each staff person.

Monthly Salary

30) Enter the monthly salary for each staff person listed.

FTE Percent

31) Enter, in decimals, the percent of time that each staff person worked in the therapy program.

Expenditures Paid for Quarter

32) 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.

Total, Personal Services

33) Enter the total for personal services by adding all entries in Column 5. Expenditures Paid for Quarter.

Staff Benefits

34) Enter the staff benefits percentage paid by the county for county employed therapy staff performing SELPA/LEA/IEP functions.

35) 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.

Travel Costs

36) 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.

Internal Indirect Costs

37) Enter the percentage paid by the county for internal indirect costs.

38) 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.

Total County Staff For SELPA/LEA/IEP Functions

39) 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.

40) 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 percent.

Section IV. MTU Expenditures (Detail Document Required)

MTU Supply and Equipment Costs

41) Enter the total of MTU Supply and Equipment Costs from the MTU Expenditures – Detail Document.

MTU Conference Costs

42) Enter the total of MTU Conference Costs from the MTU Expenditures – Detail Document.

Training/Education

43) Enter the total of Training/Education from the MTU Expenditures – Detail Document.

Miscellaneous MTU Costs

44) Enter the total of Miscellaneous MTU Costs from the MTU Expenditures – Detail Document.

Total MTU Expenditures

45) 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

46) 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.

47) Enter the total State share due county by multiplying the total from Line a. by 50 percent.

Section VI. Fiscal Intermediary (FI) Paid Claims

48) 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.

49) 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

50) 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

51) 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

52) Enter the amount from Section III., Line 10.b. State Share Due County (100%).

Section X. Total, Therapy Expenditures

53) 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. FI 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

CMS 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.

54) Enter the amount of MTU claims billed to Medi-Cal or COHS for the reporting quarter.

55) 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 CMS.

Section IV. MTU Expenditures

56) Open the Excel file and go to the worksheet tab labeled "Detail MTU Expenditures" (purple tab if you have Microsoft Excel 2003).

County

57) Enter the name of the county for which this invoice applies.

Quarter Ending

58) Enter the dates of the quarter for which the invoice applies.

Quarter	Time Period of Quarter	Quarter End Date
1	July 1, 20xx – September 30, 20xx	September 30, 20xx
2	October 1, 20xx – December 31, 20xx	December 31, 20xx
3	January 1, 20xx+1 – March 31, 20xx+1	March 31, 20xx+1
4	April 1, 20xx+1 – June 30, 20xx+1	June 30, 20xx+1

These dates must be the same on pages 1 and 2 of the Supplemental (Part B) Invoice.

Fiscal Year

59) Enter the state fiscal year (FY) for which this invoice applies.

MTU Supply and Equipment Costs

Item

60) List each individual supply or equipment item that is purchased.

Description

61) Provide a brief, concise description or explanation of the each item. **Be specific**.

Quantity

62) Enter the number of each item that is purchased.

Unit Cost

63) Enter the unit cost of each individual item. Unit cost must correlate to the unit of issue.

Cost Extension

64) Enter the total cost of each item by multiplying the quantity by the unit cost.

Unit of Issue

65) 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

66) Explain the purpose, provide the reason(s), and/or justify the need for each item.

Authority

67) 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

68) Enter the total for MTU supply and equipment costs by adding all entries in the Cost Extension column.

MTU Conference Costs

Item

69) List each individual conference cost that is incurred.

Description

70) Provide a brief, concise description or explanation of the each cost. **Be specific**.

Cost

71) Enter the cost of each item.

Purpose

72) Explain the purpose, provide the reason(s), and justify the need for each item.

Authority

73) 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

74) Enter the total for MTU conference costs by adding all entries in the Cost column.

Training/Education

Name

75) Enter the name of the county employed staff person registered for training/education.

Course Name and Description

76) Enter the name of the training/education course and provide a brief, concise description of the class, seminar, etc.

Cost

77) 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

78) Enter the number of days that the staff person will be attending the training/education.

Course Date(s)

79) Provide the dates of the scheduled training/education course.

Authority

80) 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

81) Enter the total for all training/education by adding all the entries in the Cost column.

Miscellaneous MTU Costs

Item

82) List each miscellaneous item that is purchased.

Description

83) Provide a brief, concise description or explanation of the each item. **Be specific**.

Quantity

84) Enter the number of each item that is purchased.

Unit Cost

85) Enter the unit cost of each miscellaneous item. Unit cost must correlate to the unit of issue.

Cost Extension

86) Enter the total cost of each item by multiplying the quantity by the unit cost.

Unit of Issue

87) Enter how each item is produced for sale (box, roll, kit, package, each, etc.). Unit of issue must correlate to the unit cost.

Purpose

88) Explain the purpose, provide the reason(s), and justify the need for each item.

Authority

89) 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

90) Enter the total for miscellaneous MTU costs by adding all entries in the Cost Extension column.

Total MTU Expenditures

91) 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.

COUNTY: _____ **QUARTER ENDING:** _____
MONTH/DAY/YEAR

CCS QUARTERLY REPORT OF THERAPY EXPENDITURES
MEDICAL THERAPY PROGRAM
PART II. SUMMARY REPORT OF THERAPY EXPENDITURES
FISCAL YEAR_____

MTP Caseload	
Non-Medi-Cal	
Medi-Cal	
Total	0

Per Health and Safety Code Sections 123800-123995

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 Sate Children's Medical Services. 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%) -

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. FI 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 2010

COUNTY: **QUARTER ENDING:**

MONTH/DAY/YEAR

CCS QUARTERLY REPORT OF THERAPY EXPENDITURES
MEDICAL THERAPY PROGRAM
PART II. SUMMARY REPORT OF THERAPY EXPENDITURES

FISCAL YEAR_____

ADDITIONAL STAFF PERSONS PAGE

Per Health and Safety Code Sections 123800-123995

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

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 Sate Children's Medical Services . On a separate attachment, please notate any costs that are not reimbursed by the State.

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

Revised June 2011

COUNTY: **QUARTER ENDING:**
MONTH/DAY/YEAR

CCS QUARTERLY REPORT OF THERAPY EXPENDITURES
MEDICAL THERAPY PROGRAM
PART II. SUMMARY REPORT OF THERAPY EXPENDITURES
FISCAL YEAR: _____

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 $ -

Revised June 2011

CCS Claims for Reimbursement Cover Page Instructions

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 below.

Instructions

1) Open the Excel file and go to the worksheet tab labeled: "Claim for Reimb' (green tab if you have Microsoft Excel 2003).

County

2) Enter the name of the county for which this invoice applies.

Quarter Ending

3) Enter the dates of the quarter for which the invoice applies.

Quarter	Time Period of Quarter	Quarter End Date
1	July 1, 20xx – September 30, 20xx	September 30, 20xx
2	October 1, 20xx – December 31, 20xx	December 31, 20xx
3	January 1, 20xx+1 – March 31, 20xx+1	March 31, 20xx+1
4	April 1, 20xx+1 – June 30, 20xx+1	June 30, 20xx+1

Fiscal Year

4) Enter the state fiscal year (FY) for which this invoice applies.

Certification

5) Provide the contact name, e-mail address and telephone number with area code of the county staff who is responsible for processing the invoice form.

6) 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.

7) Print or type the name and the title of the official who signed the invoice.

Submission

8) **Submit all invoices with original signatures**. Signature stamps are not acceptable. Additional copies are not necessary.

9) 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
Program Support Section – Administration Unit
P.O. Box 997413 MS 8104
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.

Quarter	Due Date
1st	November 30, 20xx
2nd	February 28, 20xx+1
3rd	May 31, 20xx+1
4th	August 31, 20xx+1

Supplemental invoices shall be submitted **no later than December 31st** after the end of the fiscal year.

Example: FY 2011-12 ends June 30, 2012. Supplemental Invoices for FY 2011-12 are due no later than December 31, 2012.

State of California - Health and Human Resources Agency | Department of Health Care Services - Children's Medical Services

COUNTY: **QUARTER ENDING:**

MONTH/DAY/YEAR

CCS DIAGNOSTIC/TREATMENT/THERAPY QUARTERLY EXPENDITURE REPORTING

FISCAL YEAR: _____

(EXPENDITURES INCURRED 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 DIAGNOSTIC AND TREATMENT EXPENDITURE REPORTING, 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 - (*amount from Line 1. f.*)	$0	
	1.a. County Share (50% of line 1. above or adjusted for relief)		$0
2.	TREATMENT - (*amount from Line 2. f.*)	$0	
	2.a. County Share (50% of line 2. above or adjusted for relief)		$0
3.	Subtotal COUNTY SHARE Diagnostic & Treatment (line 1.a.+ line 2.a.) ***positive amount = amount due State, negative (-) amount = amount due County***		$0
4.	TOTAL Fees Collected	$0	
	4.a. County Share (50% of line 4. above)		$0
5.	**TOTAL PART I (line 3. + line 4.a.)** ***positive amount = amount due State, negative (-) amount = amount due County***		$0

PART II **MEDICAL THERAPY PROGRAM** **(amounts are from CCS QUARTERLY REPORT OF EXPENDITURES, PART II)**

6.	Total County Share (*amount from Section VII or Section VIII*)	$0
7.	Total 100% Reimbursable to County *(from Section IX, as applicable)*	$0
8.	Total Medi-Cal /COHS due State *(amount from Section XI)*	-
9.	**TOTAL PART II (sum of lines 6, 7, & 8)**	$0

PART III **TOTAL CLAIM FOR REIMBURSEMENT**

10.	**TOTAL OF PART I and PART II (Line 5 + Line 9)**	$0
11.	**AMOUNT DUE COUNTY**	$0
	or	
12.	**AMOUNT DUE STATE**	$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 | E-Mail Address | Date | Area Code/Telephone Number

Authorized Signature | Date | Print or Type Name and Title of Signer

Revised June 2011

CCS Bone Marrow Invoice Instructions

Information pertaining to CCS Bone Marrow can be found in Numbered Letter 01-0185.

CCS Healthy Families (HF) Quarterly Report of Expenditures Instructions

Instructions

1) Open the Excel file CCS HF Invoice.

County

2) Enter the name of the county for which this invoice applies.

Quarter Ending

3) Enter the dates of the quarter for which the invoice applies.

Quarter	Time Period of Quarter	Quarter End Date
1	July 1, 20xx – September 30, 20xx	September 30, 20xx
2	October 1, 20xx – December 31, 20xx	December 31, 20xx
3	January 1, 20xx+1 – March 31, 20xx+1	March 31, 20xx+1
4	April 1, 20xx+1 – June 30, 20xx+1	June 30, 20xx+1

Fiscal Year

4) Enter the state fiscal year (FY) for which this invoice applies.

Healthy Families Treatment

5) Enter on line **1.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.)**

6) Enter on line **1.b the sum of the three MR-O-163(M) Monthly CCS Financial Reports,** CCS HF FUNDED TOTALS, **(Aid Codes 9K/OC, 9K/9H, 9U/OC, 9U/9H)**, Net Paid Amount. **(If the amount is negative, enter as a negative.)**

7) Enter on line **1.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**.

8) Enter the amount of county paid HF treatment expenditures on line **1.d** (this includes county paid dental, also). ***(Pre-approval by CMS must be attached or on file in the CMS Administration Unit***).

9) Line **1.e** will calculate the total HF Treatment expenditures.

Healthy Families Therapy

Healthy Families 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.

10) Enter on line **2.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.)**

11) Enter on line **2.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**.

12) Enter on line **2.c** the amount of County Paid HF Therapy expenditures (***pre-approval by CMS must be attached or on file in the CMS Administration Unit***).

13) Line **2.d** calculates the total HF Therapy expenditures.

Total Healthy Families Expenditures

14) Formula will calculate from the entries made in HF Treatment and HF Therapy. This amount is rounded to the nearest dollar.

Funding Sources

15) The funding sources for **4.a** Total HF expenditures and adjustments; **4.b** Total County Paid; and **4.c** Total HF Expenditure Funding Sources are formula driven.

Amount Due

16) Amount due is formula driven and calculates the **Amount due State or Amount due County**.

Certification

17) Provide the contact name, e-mail address and telephone number with area code of the county staff who is responsible for processing the invoice form.

18) 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.

19) Print or type the name and the title of the official who signed the invoice.

Submission

20) **Submit all invoices with original signatures**. Signature stamps are not acceptable. Additional copies are not necessary.

21) 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
Program Support Section – Administration Unit
P.O. Box 997413 MS 8104
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.

Quarter	Due Date
1st	November 30, 20xx
2nd	February 28, 20xx+1
3rd	May 31, 20xx+1
4th	August 31, 20xx+1

Supplemental invoices shall be submitted **no later than December 31st** after the end of the fiscal year.

Example: FY 2011-12 ends June 30, 2012. Supplemental Invoices for FY 2011-12 are due no later than December 31, 2012.

State of California - Health and Human Resources Agency

Department of Health Care Services - Children's Medical Services

COUNTY: **QUARTER ENDING** _____
MONTH/DAY/YEAR

CCS HEALTHY FAMILIES (HF) QUARTERLY REPORT OF EXPENDITURES

FISCAL YEAR: _____

(Per H&S Code, Sections 123800-123995 and related legislation)

1. HF TREATMENT

a. MR-0-940 $ _____

b. MR-0-163 (M) Delta Dental Report _____
[Aid Codes 9K/OC, 9K/9H, 9U/OC, 9U/9H]

* c. Treatment Adjustments *(fiscal intermediary related, MR-0-940 only)* _____

d. County Paid HF Treatment _____

e. Total HF Treatment (a. + b. + c. + d.) **$0**

* ***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.) **$0**

* ***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)*** **$0**

4. FUNDING SOURCES	**Federal Title XXI**	**State**	**County**
a. Total MR-0-940 and Adjustments	$0	$0	$0
b. Total County Paid	$0	$0	$0
c. Total HF Expenditure Funding Sources	$0	$0	$0

5. AMOUNT DUE (formula will calculate) :

Amount due STATE **$0**

or

Amount due COUNTY **$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 | E-Mail Address | Date | Area Code/Telephone No.

Authorized Signature | Title | Date

Revised June 2011

CCS PEDIATRIC PALLIATIVE CARE INVOICE INSTRUCTIONS

The following are instructions for the completion of the California Children's Services (CCS) Pediatric Palliative Care (PPC) invoice. The PPC invoice is prepared on a quarterly basis.

County

1) Enter the name of the county for which this invoice applies.

Quarter Ending

2) Enter the date for which the quarter ends using the chart below.

Quarter	Time Period of Quarter	Quarter End Date
1	July 1, 20xx – September 30, 20xx	September 30, 20xx
2	October 1, 20xx – December 31, 20xx	December 31, 20xx
3	January 1, 20xx+1 – March 31, 20xx+1	March 31, 20xx+1
4	April 1, 20xx+1 – June 30, 20xx+1	June 30, 20xx+1

Quarterly invoices shall be submitted no later than 60 days after the end of each quarter.

Fiscal Year

3) Enter the State fiscal year (FY) for which this invoice applies.

Expenditures

Column A – Category

4) The PPC invoice has three categories of expenditures, which are:

- Personnel Expenses,
- Operating Expenses, and
- Indirect Costs

Total Category Expenditures is comprised of all categories of expenditures.

Column B – Total Expenditures

5) Enter the total of all expenditures charged during the quarter to each category listed in Column A.

6) Enter the amount for Total Category Expenditures by adding all entries in Column B.

For each category, the amounts entered in Column B must equal the total of respective amounts in Columns C and D.

Column C – Medi-Cal Enhanced Funds State/Federal (25/75)

7) Enter the amount of Medi-Cal enhanced expenditures charged during the quarter to Personnel Expenses and Operating Expenses.

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 that directly support and are supervised by the SPMP.

The amount of expenditures allowed for Operating Expenses is only training and travel costs for SPMP.

Medi-Cal enhanced does not allow expenditures for indirect costs.

8) Enter the amount for Total Category Expenditures by adding all entries in Column C.

Column D – Medi-Cal Non-Enhanced Funds State/Federal (50/50)

9) Enter the amount of Medi-Cal non-enhanced expenditures charged during the quarter to each category listed in Column A.

The amount of expenditures charged to each category 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, shall be charged at the non-enhanced rate.

The amount of Medi-Cal non-enhanced expenditures for each category listed in Column A is determined by subtracting the entries in Column C from the corresponding entries in Column B.

10) Enter the amount for Total Category Expenditures by adding all entries in Column D.

Source of Funds

The columns for Sources of Funds need to be completed in reverse order. First, complete Column H – Medi-Cal Non-Enhanced. Second, complete Column G – Medi-Cal Enhanced Funds. And lastly, complete Column F – Total Funds.

Column E – Sources of Funds

11) The PPC Program has two sources of funds, which are:

- State General Funds; and
- Federal Funds, e.g., Medi-Cal Title XIX.

Total Sources of Funds is comprised of all sources of funds.

Column H – Medi-Cal Non-Enhanced Funds

12) Enter the amounts 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.

The amount of State funds is determined by multiplying the Total Category Expenditures in Column D by 50 percent.

The amount of Federal Funds (Title XIX) is determined by multiplying the Total Category Expenditures in Column D by 50 percent.

13) Enter Total Sources of Funds by adding all entries in Column H.

Column G – Medi-Cal Enhanced Funds

14) Enter the amounts 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.

The amount of State funds is determined by multiplying the Total Category Expenditures in Column C by 25 percent.

The amount of Federal Funds (Title XIX) is determined by multiplying the Total Category Expenditures in Column C by 75 percent.

15) Enter Total Sources of Funds by adding all entries in Column G.

Column F – Total Funds

16) Enter the amounts for Total Funds by adding the respective amounts in Columns G and H for each funding source listed in Column E.

17) Enter the amount for Total Sources of Funds by adding all entries in Column F.

For each source of funds, the amounts entered in Column F must equal the total of respective amounts in Columns G and H.

Certification

18) Type or print the name of the contact person.

19) Enter the e-mail address of the contact person.

20) Enter the date the invoice was prepared by the contact person.

21) Enter the telephone number with the area code of the contact person.

22) Affix the signature of the CCS Administrator or an official who is authorized to sign in place of the CCS Administrator. **Original signature is required. Signature stamps are not acceptable**.

23) Type or print the name of the authorized official.

24) Enter the date that the authorized official signed the invoice.

Submission

25) Submit the invoice that has the original signature. **Signature stamps are not acceptable**. No additional copies are required.

26) Submit the quarterly invoice and any supporting documentation to justify expenditures to the following:

California Department of Health Care Services
Children's Medical Services
Program Support Section – Administration Unit
P.O. Box 997413 MS 8104
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.

Quarter	Due Date
1st	November 30, 20xx
2nd	February 28, 20xx+1
3rd	May 31, 20xx+1
4th	August 31, 20xx+1

Supplemental invoices shall be submitted **no later than December 31st** after the end of the fiscal year.

Example: FY 2011-12 ends June 30, 2012. Supplemental Invoices for FY 2011-12 are due no later than December 31, 2012.

State of California - Health and Human Resources Agency

Department of Health Care Services - Children's Medical Services

COUNTY: **QUARTER ENDING:**

MONTH/DAY/YEAR

CCS PEDIATRIC PALLIATIVE CARE QUARTERLY INVOICE
FISCAL YEAR _____

CATEGORY	TOTAL EXPENDITURES	Enhanced Funds State/Federal (25/75)	Non-Enhanced Funds State/Federal (50/50)
A	*B = C + D*	*C*	*D*
Personnel Expenses	0		
Operating Expenses	0		
Indirect Costs	0		
EXPENDITURES GRAND TOTAL	0	0	0

SOURCE OF FUNDS	TOTAL FUNDING	Enhanced Funds State/Federal (25/75)	Non-Enhanced Funds State/Federal (50/50)
E	*F = G + H*	*G*	*H*
State Funds	0	0	0
Federal Funds (Title XIX)	0	0	0
EXPENDITURES GRAND TOTAL	0	0	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 | E-Mail Address | Date | Area Code/Telehone Number

CCS Administrator (Signature) | Date | Print or Type Name of Signer

Revised June 2011

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).

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 CMS regional office a list of all new equipment purchased on the "Contractor Equipment Purchased with DHCS Funds" form (DHCS 1203). This form can be found at:

http://www.dhcs.ca.gov/publications/forms/pdf/dhcs1203.pdf

The regional office will forward the DHCS 1203 to the CMS'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 DHCS 1203.

E. Invoices for budgeted equipment purchases are to be submitted with their quarterly invoice only after the equipment is received.

II. County/City Required Annual Inventory and Final Disposition

The county/city shall submit an annual inventory of State-purchased equipment on the form entitled "Inventory/Disposition of DHCS-Funded Equipment" (DHCS 1204). The form can be found at:

http://www.DHCS.ca.gov/publications/forms/pdf/dhcs1204.pdf

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.

Final disposition of all equipment shall be in accordance with instructions from the State and reported on the Property Survey Report (STD 152).

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.

III. 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 DHCS 1203 received from the county/city, CMS 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 CMS Regional Administrative Consultant to dispose of equipment, or CMS Administrative Consultant notifies the county/city in writing that certain equipment is scheduled for disposition.

2. CMS 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.documents.dgs.ca.gov/osp/pdf/std152.pdf

Contractor Equipment Purchased With DHCS Funds Form (DHCS 1203)

State of California—Health and Human Services Agency

Department of Health Care Services

Exhibit _____

CONTRACTOR EQUIPMENT PURCHASED WITH DHCS FUNDS

Current Contract Number: _____

Date Current Contract Expires: _____

Previous Contract Number (if applicable): _____

DHCS Program Name: _____

Contractor's Name: _____

DHCS Program Contract Manager: _____

_____

DHCS Program Address: _____

Contractor's Complete Address: _____

_____

_____

DHCS Program Contract Manager's Telephone Number: _____

Contractor's Contact Person: _____

Date of this Report: _____

Contact's Telephone Number: _____

(THIS IS NOT A BUDGET FORM)

STATE/DHCS PROPERTY TAG (If motor vehicle, list license number.)	QUANTITY	ITEM DESCRIPTION 1. Include manufacturer's name, model number, type, size, and/or capacity. 2. If motor vehicle, list year, make, model number, type of vehicle (van, sedan, pick-up, etc.) 3. If van, include passenger capacity.	UNIT COST PER ITEM (Before Tax)	DHCS PURCHASE ORDER (STD 65) NUMBER	DATE PURCHASED	MAJOR/MINOR EQUIPMENT SERIAL NUMBER (If motor vehicle, list VIN number.)	*OPTIONAL* *PROGRAM USE ONLY*
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				

DHCS 1203 (12/07)

Instructions for DHCS 1203 Form

(PLEASE READ CAREFULLY)

The information on this form will be used by the Department of Health Care Services (DHCS) Asset Management (AM) to tag contract equipment and/or property (see definitions A and B) which is purchased with DHCS funds and is used to conduct state business under this contract. After the Standard Agreement has been approved and each time state/ DHCS equipment and/or property has been received, the DHCS Program Contract Manager is responsible for obtaining the information from the Contractor and submitting this form to DHCS AM. The DHCS Program Contract Manager is responsible for ensuring the information is complete and accurate. (See *Health Administrative Manual (HAM),* Section 2-1060 and Section 9-2310.)

Upon receipt of this form from the DHCS Program Contract Manager, AM will fill in the first column with the assigned state/ DHCS property tag, if applicable, for each item (see definitions A and B). AM will return the original form to the DHCS Program Contract Manager, along with the appropriate property tags. The DHCS Program Contract Manager will then forward the property tags and the original form to the Contractor and retain one copy until the termination of this contract. The Contractor should place property tags in plain sight and, to the extent possible, on the item's front left-hand corner. The manufacturer's brand name and model number are not to be covered by the property tags.

If the item was shipped via the DHCS warehouse and was issued a state/ DHCS property tag by warehouse staff, fill in the assigned property tag. If the item was shipped directly to the Contractor, leave the first column blank.

Provide the quantity, description, purchase date, base unit cost, and serial number (if applicable) for each item of:

A. Major Equipment:

Tangible item having a base unit cost of $5,000 or more and a life expectancy of one (1) year or more.

Intangible item having a base unit cost of $5,000 or more and a life expectancy of one (1) year or more (e.g., software, video).

These items are issued green numbered state/ DHCS property tags.

B. Minor Equipment/Property: Specific tangible items with a life expectancy of one (1) year or more that have a base unit cost less than $5,000. **These items are issued green unnumbered "BLANK" state/ DHCS property tags** with the exception of the following, which are issued numbered tags: Personal Digital Assistant (PDA), PDA/cell phone combination (Blackberries), laptops, desktop personal computers, LAN servers, routers, and switches. NOTE: It is DHCS policy not to tag modular furniture. (See your Federal rules, if applicable.)

Provide the DHCS Purchase Order (STD 65) number if the items were purchased by DHCS.

If a vehicle is being reported, provide the Vehicle Identification Number (VIN) and the vehicle license number to DHCS Vehicle Services. (See HAM, Section 2-10050.)

If all items being reported do not fit on one form, make copies and write the number of pages being sent in the upper right-hand corner (e.g., "Page 1 of 3.") The DHCS Program Contract Manager should retain one copy and send the original to: Department of Health Care Services, Asset Management, MS 1405, P.O. Box 997413, 1501 Capitol Avenue, Sacramento, CA 95899-7413.

Property tags that have been lost or destroyed must be replaced. Replacement property tags can be obtained by contacting AM at (916) 650-0150.

Use the version on the DHCS Intranet forms site. The DHCS 1203 consists of one page for completion and one page with information and instructions.

Inventory/Disposition of DHCS-Funded Equipment Form (DHCS 1204)

State of California—Health and Human Services Agency

Department of Health Care Services

Exhibit _____

INVENTORY/DISPOSITION OF DHCS-FUNDED EQUIPMENT

Current Contract Number: _____

Previous Contract Number (if applicable): _____

Contractor's Name: _____

_____

Contractor's Complete Address: _____

_____

Contractor's Contact Person: _____

Contact's Telephone Number: _____

Date Current Contract Expires: _____

DHCS Program Name: _____

DHCS Program Contract Manager: _____

DHCS Program Address: _____

_____

DHCS Program Contract Manager's Telephone Number: _____

Date of this Report: _____

(THIS IS NOT A BUDGET FORM)

STATE/ DHCS PROPERTY TAG (If motor vehicle, list license number.)	QUANTITY	ITEM DESCRIPTION 1. Include manufacturer's name, model number, type, size, and/or capacity. 2. If motor vehicle, list year, make, model number, type of vehicle (van, sedan, pick-up, etc.) 3. If van, include passenger capacity.	UNIT COST PER ITEM (Before Tax)	DHCS ASSET MGMT. USE ONLY DHCS Document (DISPOSAL) Number	ORIGINAL PURCHASE DATE	MAJOR/MINOR EQUIPMENT SERIAL NUMBER (If motor vehicle, list VIN number.)	*OPTIONAL— PROGRAM USE ONLY*
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				

DHCS 1204 (12/07)

Instructions for DHCS 1204 Form

(PLEASE READ CAREFULLY)

The information on this form will be used by the Department of Health Care Services (DHCS) Asset Management (AM) to; (a) conduct an inventory of DHCS equipment and/or property (see definitions A and B) in the possession of the Contractor and/or Subcontractors, and (b) dispose of these same items. Report all items, regardless of the items' ages, per number 1 below, purchased with DHCS funds and used to conduct state business under this contract. (See *Health Administrative Manual (HAM),* Section 2-1060 and Section 9-2310.)

The DHCS Program Contract Manager is responsible for obtaining information from the Contractor for this form. The DHCS Program Contract Manager is responsible for the accuracy and completeness of the information and for submitting it to AM.

Inventory: List all DHCS tagged equipment and/or property on this form and submit it within 30 days prior to the three-year anniversary of the contract's effective date, if applicable. **The inventory should be based on previously submitted** DHCS **1203s**, "Contractor Equipment Purchased with DHCS Funds." AM will contact the DHCS Program Contract Manager if there are any discrepancies.

Disposal: *(Definition: Trade in, sell, junk, salvage, donate, or transfer; also, items lost, stolen, or destroyed (as by fire).)* The DHCS 1204 should be completed, along with a "Property Survey Report" (STD. 152) or a "Property Transfer Report" (STD. 158), whenever items need to be disposed of; (a) during the term of this contract and (b) 30 calendar days before the termination of this contract. After receipt of this form, the AM will contact the DHCS Program Contract Manager to arrange for the appropriate disposal/transfer of the items.

List the state/ DHCS property tag, quantity, description, purchase date, base unit cost, and serial number (if applicable) for each item of;

A. Major Equipment: (These items were issued green numbered state/ DHCS property tags.)

Tangible item having a base unit cost of $5,000 or more and a life expectancy of one (1) year or more.

Intangible item having a base unit cost of $5,000 or more and a life expectancy of one (1) year or more (e.g., software, video.)

B. Minor Equipment/Property:

Specific tangible items with a life expectancy of one (1) year or more that have a base unit cost less than $5,000. The minor equipment and/or property items were issued green unnumbered "BLANK" state/ DHCS property tags with the exception of the following, which are issued numbered tags: Personal Digital Assistant (PDA), PDA/cell phone combination (Blackberries), laptops, desktop personal computers, LAN servers, routers, and switches.

If a vehicle is being reported, provide the Vehicle Identification Number (VIN) and the vehicle license number to DHCS Vehicle Services. (See HAM, Section 2-10050.)

If all items being reported do not fit on one page, make copies and write the number of pages being sent in the upper right-hand corner (e.g. "Page 1 of 3.")

The DHCS Program Contract Manager should retain one copy and send the original to: Department of Health Care Services, Asset Management, MS 1405, P.O. Box 997413, 1501 Capitol Avenue, Sacramento, CA 95899-7413.

Use the version on the DHCS Intranet forms site. The DHCS 1204 consists of one page for completion and one page with information and instructions.

For more information on completing this form, call AM at (916) 650-0150.

Property Survey Report Form (STD 152)

Print Clear

STATE OF CALIFORNIA
PROPERTY SURVEY REPORT
STD. 152 (REV. 9-2002c)

Record as of disposition data (lost, stolen or destroyed property--record as of the date such determination was made).

RETURN TO:

REPORTING DEPARTMENT/AGENCY	ATTENTION	DOCUMENT NUMBER
RETURN ADDRESS	IMS CODE	DATE
CITY	ZIP CODE	REPLACEMENTS: SEE PURCHASE ESTIMATE NUMBER

Authority is requested to dispose of the following State property:

FUND OWNED BY	CONTACT PERSON	TELEPHONE NUMBER

ATTACHED

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

***DISPOSITION CODE**
1. TRADE-IN
2. SALE (INCLUDING JUNK SALE)
3. JUNK - VALUELESS
4. LOST**
5. STOLEN**
6. DESTROYED (AS BY FIRE, ETC.)**
7. TO BE SALVAGED
8. PROPERTY REUTILIZATION--GENERAL SERVICES, SURPLUS PROPERTY

} DEPARTMENT OF GENERAL SERVICES REVIEW NOT REQUIRED

**IF LOST, STOLEN OR DESTROYED, REFER TO SAM SECTION 6542 FOR INSTRUCTIONS.

EXPLANATION--REASONS FOR PROPOSED DISPOSITION OF EACH ITEM

APPROVED BY PROPERTY SURVEY BOARD

(A minimum of two signatures is required)

The above statements regarding state property are true and correct; culpable negligence (check appropriate box)

☐ *was* ☐ *was not*

involved in loss, theft, or damage; the disposition proposed is best for the public interest.

SIGNATURE	DATE SIGNED
1.	
2.	
3.	

CERTIFICATION OF DISPOSITION

The above described property was disposed of as follows: (specify if no consideration was received)

MANNER OF DISPOSAL

DISPOSAL DATE

SIGNATURE *(Officer Supervising Disposal of the Property)*

TITLE

REVIEWED BY DEPT. OF GENERAL SERVICES

FOR DGS REVIEW, SEND TO: Department of General Services
State Agency for Surplus Property

NORTH
1700 National Drive
Sacramento, CA 95834

SOUTH
701 Barning Tree Road
Fullerton, CA 92833

FOR DISPOSITION OF VEHICLES AND MOBILE EQUIPMENT, SEND TO:

Department of General Services
Office of Fleet Administration
602 Q Street
Sacramento, CA 95814

SIGNATURE

DATE SIGNED

(DO NOT USE HALF SHEETS OR STAPLES)

152PRT.FRP

Equipment Identification Tag Transmittal Letter and Form CMSB-A-2

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 (DHCS 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 Staff Name)
Administrative Consultant
Children's Medical Services

State of California - Health and Human Services
Department of Health Care Services

Systems of Care
Children's Medical Services

CMSB A-2
ANNUAL INVENTORY OF STATE FURNISHED EQUIPMENT

County/City Name:

Date of Report:

Complete Address:

CMS Administrative Consultant:

Consultant's Address:

Program Name:

Consultant's Telephone No.:

Program Contract Telephone No.:

Program Contract E-Mail Address:

DHCS PROPERTY CONTROL USE ONLY STATE ID TAG NO.	Quantity	Description 1. Include Manufacturer's name, model no./(type, size, and/or capacity. 2. If motor vehicle, list year, make model no., type of vehicle (van, sedan, truck, etc.) 3. If Van, include passenger capacity.	Base Cost Per Unit	DHCS Order or Document No.	Date Received	Serial No. (If Motor Vehicle, list VIN No.)
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			

Revised: March 2008
CMSB A-2 (7/01)

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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 local program's time studies are designed to support FFP claiming in a uniform system that allows for the time study to be used by staff working in various CMS programs.

3. Tools for FFP timekeeping including a sample time study form are located at the end of this section.

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 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.

Local programs have the responsibility to determine whether their staff meet the qualifications. The program job classification and duty statements must stipulate that the job requires staff from one of the classifications listed below. The program duty statement for the SPMP must reflect both SPMP and non-SPMP activities and also 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 CMS 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 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 who:

   a). must be immediately responsible for the work performed by the clerical staff, and must directly supervise (immediate first-level supervision) the supporting staff reflected on the organization chart and the performance of the supporting staff's work, and

   b). is responsible for preparing, conducting, and signing the directly supporting staff's performance appraisal as the immediate first-level supervisor, and

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 non-SPMP 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 CMS in this section.

2. Be completed at the same time either during the first, middle, or last month of each calendar quarter for the fiscal year unless 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.

_____

_____

_____

(Attach a copy of any certificates or documentation describing your training, and a C.V. if available.)

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.

_____

_____

(Attach a copy of any certificates or course completion notices you received and a C.V. if available.)

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 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 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 physician groups, 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 physician groups, 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/EPSDT 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 Children's Medical Services, 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 B:
Program C:

Program D:
Program E:
Program F:

Monthly Summary of FFP Time Study Information

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

Allocated Functions

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

Program A

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

Program B

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

Program C

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

Program D

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

Program E

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

Program F

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

FFP Time-Study Calculations

Monthly Summary of Hours by Program

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

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

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

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

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

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

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

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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 or referrals to active cases was found to be as follows: range - 0.49 to 1.23; mean - 0.58; median - 0.61; and mode - 0.50, 0.71. These figures suggest that, when the extremes are excluded, the ratio is fairly consistent for most of the counties and active cases can be used in this iteration of the standards as proxy for the caseload. However, in subsequent iterations, caseload, as defined above, is to be used in developing staffing profiles.

C. Staffing Profiles

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

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

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

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

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

The profiles are presented in Figure 3 (see page 10-11). 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)

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

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

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

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

d. No meaningful pattern.

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

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

I. Background

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

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

II. Program Activities- Staffing Factors and Methodology

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

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

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

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

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

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

CMS 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 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

[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."

treatment services for persons in families with higher incomes if the estimated cost of care to the family in one year is expected to exceed 20 percent of the family's adjusted gross income.

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

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

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

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

123872. Repayment agreement for treatment services

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

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

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

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

(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.

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.

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

7573. Special education and related services

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

whose employment standards are covered by the Education Code and implementing regulations.

7575. Occupational therapy and physical therapy

(a)

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

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

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

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

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

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

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

(5) Relevant medical records.

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

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

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

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

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

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

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

Insurance Code (Re: Healthy Families)

"CCS Carve-out related to HF Health Benefits"

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

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

"CCS Carve-out related to HF Dental Benefits"

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

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

"CCS Carve-out related to HF Vision Benefits"

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

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

"CCS County Expenditure Exemption"

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

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

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

14093. Purpose

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

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

(a) The director shall enter into contracts with managed care plans under this chapter and Chapter 8 (commencing with Section 14200), including, but not limited to, health maintenance organizations, prepaid health plans, and primary

care case management plans; counties, primary care providers, independent practice associations, private foundations, children's hospitals, community health centers, rural health centers, community clinics, and university medical center systems, or other entities for the provision of medical benefits to all persons who are eligible to receive medical benefits under publicly supported programs. The director may also amend existing Medi-Cal managed care contracts to include the provision of medical benefits to persons who are eligible to receive medical benefits under publicly supported programs. Contracts may be on an exclusive or nonexclusive basis.

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

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

(d)

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

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

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

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

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

(g) Any managed care contract which will affect 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 non-paneled 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. Federal regulations governing States' provision of EPSDT:

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

g. 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 Local 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 pre-enrollment 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 screenings and evaluation services may be provided at the frequency provided 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. Inter-county service contracts

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

124065. State reimbursement

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

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

124070. State reimbursement

Counties shall be reimbursed for the amount required by the county to carry out its community child health and disability prevention program in accordance with the approved community child health and disability prevention plan. Claims for state reimbursement shall be made in a manner as the director shall provide. Each claims 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.

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 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.

(d) The governing board of a school district may exempt any pupil from the exclusion described in subdivision (c) 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 be used in extraordinary circumstances, including, but not limited to, family situations of great dysfunction or disruption, including substance abuse by parents or guardians, child abuse, or child neglect.

(e) 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 of 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.

(f) 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 screenings 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 re-adoption 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 re-adoption of those regulations shall be exempt from review by the Office of Administrative Law. The initial emergency regulations and one re-adoption 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 pre-enrollment 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 pre-enrollment 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 pre-enrolled 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 pre-enrolled for the Medi-Cal program pursuant to this section.

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

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

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

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

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

Legislation, Regulations, and Guidelines for the HCPCFC

a. Enabling legislation of the HCPCFC.

Reference: Welfare and Institutions Code; Section 16501.3.

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

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

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

b. Social Services Statutes

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

c. Social Services Regulations

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

d. Medi-Cal Regulations

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

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

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

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

3. Joint Letters - Health Services and Social Services

4. CHDP Program Health Assessment Guidelines - Health Services

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

Reference: Health and Safety Code, Section 100925

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

Reference: Health and Safety Code, Section 100950.

g. Federal regulations governing States' provision of EPSDT:

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

h. Federal statutes applying to the EPSDT program:

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

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

Selected State Laws Relating to the HCPCFC

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

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

Welfare and Institutions Code Section

16501.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(k)

(1)

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

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

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

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

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

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

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

16501.3.

(a) The State 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 identify, respond to, and enhance the physical, mental, dental, and developmental well-being of children in the child welfare system.

(b) 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 shall include, but need not be limited to, the following:

(1) Documenting that each child in foster care receives initial and follow up health screenings that meet reasonable standards of medical practice.

(2) 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 necessary for the child.

(3) 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.

(4) 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.

(e)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: http://www.cdss.ca.gov/cdssweb/entres/forms/English/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:
http://www.dhcs.ca.gov/formsandpubs/forms/Forms/ChildMedSvcForms/dhcs4073.pdf

CHDP Referral (PM 357)

State of California—Health and Human Services Agency

Department of Health Services

CHDP REFERRAL

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

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

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

5. ☐ Requested additional information, but no services.

Requested Medical Services (Health Assessment)			Requested Dental Services		
6. Services ☐ Yes ☐ No	7. Transportation ☐ Yes ☐ No	8. Scheduling ☐ Yes ☐ No	9. Services ☐ Yes ☐ No	10. Transportation ☐ Yes ☐ No	11. Scheduling ☐ Yes ☐ No

12. ☐ New application 13. ☐ Redetermination 14. ☐ Self-referral 15. ☐ CALWORKs

16. ☐ Foster care 17. ☐ Medi-Cal only 18. ☐ Share-of-cost

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

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

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

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

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

Comments:

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

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

12-1204.34

PM 357 (6/99) Required Form

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

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

Case name (last) (first) (middle)

Contact attempt with responsible person:

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

Comments:

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

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

Comments:

EPSDT worker signature | Date

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

Contact attempt with responsible person:

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

Comments:

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

Comments:

CHDP Health Professional Signature | Date

PM 357 (6/99) Required Form

INSTRUCTIONS FOR COMPLETING PART A

ITEM

1–4 Self-explanatory.

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

6 Check yes or no as appropriate.

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

9 Check yes or no as appropriate.

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

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

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

15–17 Check the one applicable box.

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

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

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

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

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

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

35–37 Self-explanatory.

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

12.1204.35.a

PM 357 (6/99) Required Form

CHDP Referral for SAWS Automated Template

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

SAWS CHDP REFERRAL

Date:

CASE INFORMATION

CASE LAST NAME FIRST M APP CO AID CODE CASE NUMBER

29 84

RESIDENCE ADDRESS HOME TELEPHONE:
MESSAGE PHONE:

MAILING ADDRESS:

CASE STATUS PRIMARY LANGUAGE

DATE ELIGIBILITY DETERMINED:

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

OTHER CIRCUMSTANCES: _____

PARENT/CARETAKER

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

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

OTHER PERSON IN HOME:

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

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

REQUESTED ADDITIONAL INFORMATION BUT NO SERVICES? Y/N

FAMILY DOCTOR:

FAMILY DENTIST:

FORM PM 357 Revision Date: March, 1999

CHDP Referral for Welfare Case Data System Counties

PM 357
DEL 4/87

BD50120--5Z

COUNTY OF ALAMEDA
WELFARE CASE DATA SYSTEM
CHDP REFERRAL FORM

CDS286

CODE 4 SW EW WH6H

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

PAYEE -

PHONE NUMBER-

LANGUAGE-

OAKLAND CA 94603-1602

CASE REFERRED FOR- MEDICAL AND DENTAL WITH SCHEDULING/TRANSPORTATION

ELIGIBLE PERSONS IN CASE REFERRED

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

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

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

COMMENTS:

FINAL RESULT:
☐ CONTACT MADE
☐ NO CONTACT MADE

'ART 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.

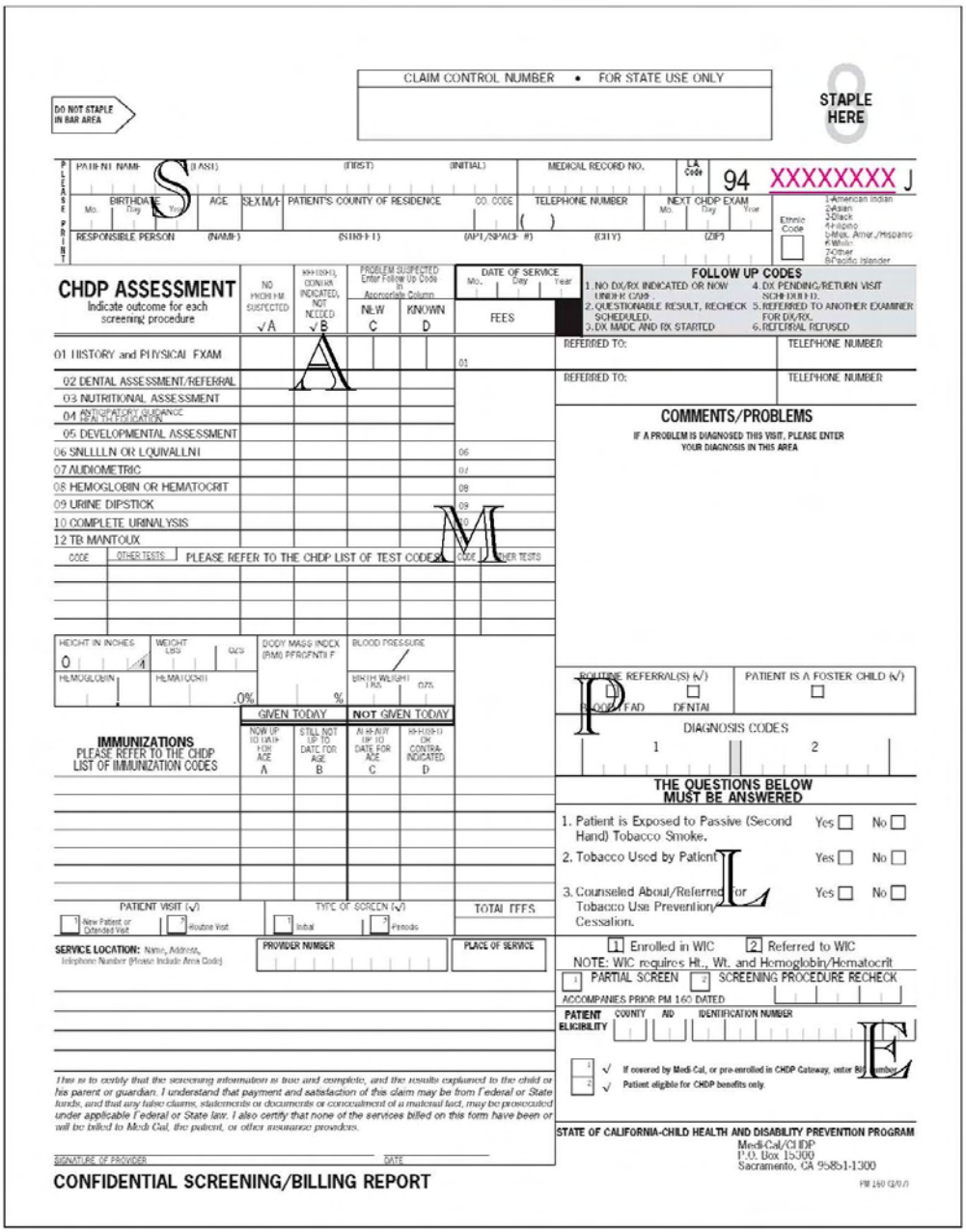
Online Version:
http://www.dhcs.ca.gov/formsandpubs/forms/Forms/ChildMedSvcForms/pm161.pdf

Confidential Screening/Billing Report – Standard (PM 160)

To access the most current version of the PM 161 form, please click on the link listed below.

Online Version:

http://files.medi-cal.ca.gov/pubsdoco/publications/Masters-Other/CHDP/Forms/confPM160_c01.pdf



CLAIM CONTROL NUMBER • FOR STATE USE ONLY

DO NOT STAPLE IN BAR AREA

STAPLE HERE

PATIENT NAME (LAST) (FIRST) (INITIAL) | MEDICAL RECORD NO. | LA Code 94 XXXXXXXX J

BIRTHDATE | AGE | SEX M/F | PATIENT'S COUNTY OF RESIDENCE | CO. CODE | TELEPHONE NUMBER | NEXT CHDP EXAM

RESPONSIBLE PERSON (NAME) (STREET) (APT/SPACE #) (CITY) (ZIP)

Ethnic Code: 1-American Indian 2-Asian 3-Black 4-Filipino 5-Mex. Amer./Hispanic 6-White 7-Other 8-Pacific Islander

CHDP ASSESSMENT
Indicate outcome for each screening procedure

	NO PROBLEM SUSPECTED √A	PROBLEM, CONDITION INDICATED, NOT NEEDED √B	PROBLEM SUSPECTED Enter Follow Up Code in Appropriate Column NEW C	KNOWN D	FEES
01 HISTORY and PHYSICAL EXAM					01
02 DENTAL ASSESSMENT/REFERRAL					
03 NUTRITIONAL ASSESSMENT					
04 ANTICIPATORY GUIDANCE HEALTH EDUCATION					
05 DEVELOPMENTAL ASSESSMENT					
06 SINGLELEN OR EQUIVALENT					06
07 AUDIOMETRIC					07
08 HEMOGLOBIN OR HEMATOCRIT					08
09 URINE DIPSTICK					09
10 COMPLETE URINALYSIS					10
12 TB MANTOUX					

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

DATE OF SERVICE Mo. Day Year

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

REFERRED TO: | TELEPHONE NUMBER
REFERRED TO: | TELEPHONE NUMBER

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

HEIGHT IN INCHES | WEIGHT LBS OZS | BODY MASS INDEX (BMI) PERCENTILE | BLOOD PRESSURE
HEMOGLOBIN | HEMATOCRIT .0% % | BIRTH WEIGHT LBS OZS

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

DIAGNOSIS CODES 1 2

IMMUNIZATIONS
PLEASE REFER TO THE CHDP LIST OF IMMUNIZATION CODES

	GIVEN TODAY: NOW UP TO DATE FOR AGE A	GIVEN TODAY: STILL NOT UP TO DATE FOR AGE B	NOT GIVEN TODAY: AT 48-MO UP TO DATE FOR AGE C	NOT GIVEN TODAY: 48-MO OR CONTRA-INDICATED D

PATIENT VISIT (√): 1 New Patient or Extended Visit, 2 Routine Visit | TYPE OF SCREEN (√): 1 Initial, 2 Periodic | TOTAL FEES

THE QUESTIONS BELOW MUST BE ANSWERED
1. Patient is Exposed to Passive (Second Hand) Tobacco Smoke. Yes ☐ No ☐
2. Tobacco Used by Patient Yes ☐ No ☐
3. Counseled About/Referred for Tobacco Use Prevention/Cessation. Yes ☐ No ☐

SERVICE LOCATION: Name, Address, Telephone Number (Please Include Area Code) | PROVIDER NUMBER | PLACE OF SERVICE

1 Enrolled in WIC 2 Referred to WIC
NOTE: WIC requires Ht., Wt. and Hemoglobin/Hematocrit
1 PARTIAL SCREEN 2 SCREENING PROCEDURE RECHECK
ACCOMPANIES PRIOR PM 160 DATED

PATIENT ELIGIBILITY: COUNTY AID IDENTIFICATION NUMBER
1 √ If covered by Medi-Cal, or pre-enrolled in CHDP Gateway, enter BIC number
2 √ Patient eligible for CHDP benefits only.

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

SIGNATURE OF PROVIDER DATE

STATE OF CALIFORNIA-CHILD HEALTH AND DISABILITY PREVENTION PROGRAM
Medi-Cal/CHDP
P.O. Box 15300
Sacramento, CA 95851-1300

CONFIDENTIAL SCREENING/BILLING REPORT

PM 160 (2/01)

Listed below are Place of Service (POS) Codes and Corresponding Descriptions to be used when Billing CHDP services

POS Code	Description
11	Office (any location other than Place of Service code 22 or 71)
22	Outpatient Hospital
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other

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
Department of Health Care Services
MS 8100
1515 K Street, Suite 400
Sacramento, CA 95814

(916) 327-1400

PM 160
06/07

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

To access the most current version of the PM 161 form, please click on the link listed below.

Online Version:

http://files.medi-cal.ca.gov/pubsdoco/publications/Masters-Other/CHDP/Forms/confPM160info_c01.pdf

DO NOT STAPLE IN BAR AREA

CLAIM CONTROL NUMBER • FOR STATE USE ONLY

STAPLE HERE

PLEASE PRINT

PATIENT NAME (LAST) (FIRST) (INITIAL) | MEDICAL RECORD NO. | LA. Code

BIRTHDATE Mo. Day Year | AGE | SEX M/F | PATIENT'S COUNTY OF RESIDENCE | CO. CODE | TELEPHONE NUMBER ( ) | NEXT CHDP EXAM Mo. Day Year

RESPONSIBLE PERSON (NAME) (STREET) (APT/SPACE #) (CITY) (ZIP)

Ethnic Code: 1-American Indian, 2-Asian, 3-Black, 4-Filipino, 5-Mex. Amer./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: NEW C	KNOWN D	FEES
01 HISTORY and PHYSICAL EXAM					01
02 DENTAL ASSESSMENT/REFERRAL					
03 NUTRITIONAL ASSESSMENT					
04 ANTICIPATORY GUIDANCE HEALTH EDUCATION					
05 DEVELOPMENTAL ASSESSMENT					
06 SNELLEN OR EQUIVALENT					06
07 AUDIOMETRIC					07
08 HEMOGLOBIN OR HEMATOCRIT					08
09 URINE DIPSTICK					09
10 COMPLETE URINALYSIS					10
12 TB MANTOUX					

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

DATE OF SERVICE Mo. Day Year

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

REFERRED TO: | TELEPHONE NUMBER

REFERRED TO: | TELEPHONE NUMBER

COMMENTS/PROBLEMS

IF A PROBLEM IS DIAGNOSED THIS VISIT, PLEASE ENTER YOUR DIAGNOSIS IN THIS AREA

HEIGHT IN INCHES 0 4 | WEIGHT LBS OZS | BODY MASS INDEX (BMI) PERCENTILE | BLOOD PRESSURE

HEMOGLOBIN | HEMATOCRIT .0% | BIRTH WEIGHT LBS OZS | %

INFORMATION ONLY REPORTING

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

DIAGNOSIS CODES 1 2

IMMUNIZATIONS
PLEASE REFER TO THE CHDP LIST OF IMMUNIZATION CODES

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

THE QUESTIONS BELOW MUST BE ANSWERED

1. Patient is Exposed to Passive (Second Hand) Tobacco Smoke. Yes ☐ No ☐
2. Tobacco Used by Patient Yes ☐ No ☐
3. Counseled About/Referred For Tobacco Use Prevention/ Cessation. Yes ☐ No ☐

PATIENT VISIT (✓): 1 New Patient or Extended Visit, 2 Routine Visit | TYPE OF SCREEN (✓): 1 Initial, 2 Periodic | TOTAL FEES

SERVICE LOCATION: Name, Address, Telephone Number (Please Include Area Code) | HEALTH PLAN CODE/PROVIDER NUMBER | PLACE OF SERVICE

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

CONFIDENTIAL SCREENING/BILLING REPORT

PM 160 INFORMATION ONLY (03/07)

Listed below are Place of Service (POS) Codes and Corresponding Descriptions to be used when Billing CHDP services

POS Code	Description
11	Office (any location other than Place of Service code 22 or 71)
22	Outpatient Hospital
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other

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
Department of Health Care Services
MS 8100
1515 K Street, Suite 400
Sacramento, CA 95814

(916) 327-1400

PM 160 Information Only
06/07

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

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

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

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

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

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

   Please check box if you want:

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

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

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

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

Temp 602B CHDP/FP Questionnaire Revision Date March 1999

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: http://www.dhcs.ca.gov/formsandpubs/forms/Forms/mc 219.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/Publications/Applications/HF_FullApp_en.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: http://www.dhcs.ca.gov/formsandpubs/forms/Forms/mc13.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: http://www.cdss.ca.gov/cdssweb/entres/forms/English/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: http://www.dhcs.ca.gov/services/medi-cal/Documents/PDF_Medi-Cal%20Applications/English/English%20Application.pdf

SECTION 10 – APPENDIX

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The Essential Services of Public Health and Ten Essential Public Health Services to Promote Child Health in America[1]

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.

8. Assure a competent public health and personal health care workforce.

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[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.

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.rrnetwork.org > Enter > Our Research > Select Subject

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 > Bulletin and Reports Tab > Reports and Periodicals > Demographic Reports > 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://dq.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://www.dhcs.ca.gov/services/chdp/Pages/BusinessObjects.aspx (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: http://www.adp.ca.gov/prevention/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 > Select Subject

Notes: This website includes the online query system (Ask CHIS) 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: http://www.cdph.ca.gov/programs/CHS/Pages/default.aspx > Organization > Health Information and Research

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 A - Z > Criminal Justice Statistics Center > Select Desired Table

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.dhcs.ca.gov/dataandstats/statistics/Pages/MCSSHomePage.aspx > Statistical Publications > Medi-Cal 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.dhcs.ca.gov/dataandstats/statistics/Pages/MCSSHomePage.aspx. > Statistical Publications > Medi-Cal Funded Deliveries > Select Desired Year > 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 Desired Report

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 > Public and Gov. Services Tab > 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: http://www.whitehouse.gov/omb/circulars/a087/a87_2004.pdf

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
CDPH ..... California Department of Public Health
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 Services; 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
DHCS ..... Department of Health Care Services
DHCS 4073 ..... CHDP Pre-Enrollment Application
DHCS 4504 ..... CHDP Report of Distribution
DSS ..... Department of Social Services
E 47 ..... Enhancement 47
EDC ..... Expected Date of Confinement

EDS .....Electronic Data Systems (DHCS'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
ITS.....Information Technology Section
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
M/C..... 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
PDS ..... Program Development 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
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 ..... Southern California Regional Office
SELPA ..... Special Education Local Planning Area
SFRO ..... San Francisco Regional Office

SOC.....Systems of Care
SOC……Share of Cost
SOW..... Scope of Work
SCP ..... Substitute Care Provider
SPHN.....Supervising Public Health Nurse
SPMP ..... Skilled Professional Medical Personnel
SPS ..... Statewide Programs Section
SRO..... 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	2. Check one	3. School year
County School District School Code	Public school district Private school	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

Page 1 of 2

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.

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