STATE OF CALIFORNIA--HEALTH AND WELFARE AGENCY

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July 17, 1998

MEDI-CAL ELIGIBILITY PROCEDURES MANUAL LETTER NO.: 200

TO: All Holders of the Medi-Cal Eligibility Procedures Manual

Enclosed are revisions to Article 23, Medical Support Enforcement Program, of the Medi-Cal Eligibility Procedures Manual.

Procedure Revision	**Description**
Article 23	Revision of the Procedures for the Medical Support Enforcement Program due to federal and state legislation (Personal Responsibility and Work Opportunity Act of 1997, Balanced Budget Act of 1997, AB 1832, AB 573, and AB 1542) effective on January 1, 1998, and to be implemented no later than August 1, 1998.

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If you have any questions concerning a specific revision, please contact Ms. Elena Lara of my staff at (916) 657-0712.

Sincerely,

Original signed by

Angeline Mrva, Chief
Medi-Cal Eligibility Branch

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1. MEDI-CAL ONLY

The county must inform an applicant for or beneficiary of Medi-Cal only that, as a condition of eligibility, the applicant or beneficiary must:

- Assign to the State the applicant's or beneficiary's rights to any medical support and payments;
- Cooperate in obtaining medical support and payments;
- Cooperate in establishing paternity for a child born out of wedlock for whom aid is requested;
- Cooperate in identifying and locating the absent parent; and
- Provide information about possible entitlement to medical support and payments available through any third party.

Cooperation includes the following:

- Providing the name of the alleged or absent parent, along with other information, if known, such as address, Social Security number, telephone number, place of employment, school, or names and addresses of relatives or associates.
- Appearing at interviews, hearings, and legal proceedings if the applicant or recipient is provided with adequate notice of the interview and does not have good cause not to appear.
- If paternity is at issue, submitting to genetic tests, including tests of child, if necessary.
- Providing any additional information reasonably obtainable by the applicant or recipient necessary to establish paternity or to establish, modify, or enforce a child support order.
- A recipient or applicant shall not be required to sign a voluntary declaration as a condition of cooperation.

If the applicant or beneficiary is found ineligible for Medi-Cal because of the above, this will not affect the child(ren)'s Medi-Cal eligibility. The applicant can withdraw the application, claim good cause (Section 23E), close the case, or become an ineligible member of the Medi-Cal Family Budget Unit (MFBU), but the child(ren) is not denied, discontinued from Medi-Cal for noncooperation of applicant/caretaker relative. If applicant/ caretaker relative chooses not to cooperate, refer the child to the Family Support Division/District Attorney (FSD/DA) for medical support enforcement with whatever information was provided. Section 14008.7 was added to the Welfare and Institutions Code to set out the specific guidelines for noncooperation.

EXAMPLE: Mother with mutual child from present husband and one separate child from another man applies for Medi-Cal for family. She can exclude the separate child with absent parent from MFBU and is not mandated to cooperate with medical support enforcement for that child. She must cooperate ONLY if she is applying for Medi-Cal for the separate child and if she is legally responsible for the separate child. Then, if she does not cooperate, she is to be denied Medi-Cal, discontinued, or made an ineligible member of MFBU. Two children and husband may be granted Medi-Cal. if eligible.

2. VERIFICATION OF DOCUMENTS

The county welfare department is responsible for determining the identity of all applicants for Medi-Cal. For purposes of medical support referrals for health coverage or paternity establishment, the county may be guided by Sections 50167 and 50169(a) of the California Code of Regulations or Article 4W of the Medi-Cal Eligibility Procedures Manual.

As stated in Article 4W, the documents listed below should be used as a reference guide when interviewing Medi-Cal applicants and beneficiaries if the individual is without a California Drivers License or California Iidentification Card (ID) issued from the Department of Motor Vehicles:

1. I.D. that has a picture of the person is preferred
2. U.S. Citizenship or Alien Status Documents (passport)
3. School identification card
4. Birth Certificate
5. A Social Security card or document containing a Social Security number
6. Voter's Registration Card
7. Marriage record
8. Divorce Decree
9. Work Badge, Building Pass
10. Draft Card, Military I.D.
11. Adoption Record
12. Court Order for Name Change
13. Clinic, Doctor-Hospital-Admission Record
14. Church Membership or Baptism-Confirmation Record
15. Vaccination Record
16. Insurance Policy
17. Utility Bills
18. Two pieces of mail received at the applicant's-beneficiary's address
19. Any other documents providing identifying data such as physical description, photographs

NOTE: Not listed above, but which may be needed to prove that though there is an absent parent situation, no referral is necessary, are a death certificate of a deceased parent or a document which proves the absent parent is institutionalized.

3. **CalWORKs/Edwards**

A recipient of CalWORKs benefits who is discontinued from CalWORKs for refusal to cooperate in child support will NOT receive Edwards Medi-Cal. Under federal and state legislation, Applicants and Recipients of the CalWORKs and Medi-Cal programs must, as a condition of eligibility, assign child and medical support rights to the county and cooperate with the DA in establishing paternity and establishing, modifying, or enforcing a child/medical support order for the child(ren) for whom aid is requested. Under federal law, child support includes monetary support, health care, arrearage or reimbursement, and may include other costs such as fees, interest and penalties, income withholding, attorney's fees, and other relief.

When an Applicant or Recipient Parent or caretaker relative of a child for whom aid is sought refuses or fails to cooperate with the DA in paternity establishment or child/medical support enforcement, this individual remains a member of the Assistant Unit (AU), the AU cash grant is reduced by 25 percent, and this individual will be denied Medi-Cal. If otherwise eligible, the members of the AU are granted or continue to receive Medi-Cal benefits. The Notice of Action will need to state that the AU cash grant will be reduced and the custodial parent will be ineligible for Medi-Cal.

There will be no Edwards for these cases because the custodial parent will not be discontinued or denied CalWORKs. The AU will receive a cash grant. Can Medi-Cal benefits be denied by the CalWORKs county staff? Yes, because medical support is part of the definition of Child Support under federal law as defined above, and the county staff must deny or discontinue Medi-Cal if there is a determination of noncooperation by the FSD/DA and the cash grant is reduced by 25 percent.

Even though the CalWORKs eligibility worker (EW) is responsible for sending the case package of child support forms, the EW is responsible for ensuring that the medical support portions of these forms are filled out correctly for Medi-Cal. If needed, the counties can use the revised forms available in the DHS warehouse.

In child support enforcement actions, the DA may require the absent parent to pay child support payments which are in arrears; that is, the absent parent may also be liable for payments which were not paid or were skipped before the custodial parent applied for CalWORKs and Medi-Cal. In medical support, we start with the time of enforcement of coverage. We do not seek reimbursement for medical expenses up to the point of court-ordered medical support enforcement.

4. **MEDS PROCESS FOR RESTRICTION CODE TO DENY OR DISCONTINUE MEDI-CAL IN CALWORKS**

970 OR 971	Medi-Cal Ineligible CalWORKs recipient due to noncooperation.
980 or 981	Medi-Cal Ineligible CalWORKs recipient due to noncooperation overlaid with S/URS restriction.

When reporting eligibility to MEDS for CalWORKs clients, it will be necessary to use a restriction code to identify the individual charged with noncooperation when the family's computed grant is subject to the new CalWORKs 25 percent reduction penalty. Since the law requires that the responsible individual be ineligible for Medi-Cal for the period of noncooperation, reporting of this code will change the client's Eligibility Status to "691" or "692":

691 = Health and welfare program other than Medi-Cal/CMSP Eligible Reported Timely.

692 = Health and welfare program other than Medi-Cal/CMSP Eligible Reported Retroactively.

This change will allow counties to continue to report the client as an eligible member of the CalWORKs case while the POS/MOPI health care eligibility message will say "NO RECORDED ELIGIBILITY FOR (MONTH/YEAR)." The anticipated implementation date for this MEDS change is August 1998. **(REMINDER: When 25 percent penalty restriction is removed, Medi-Cal benefits will be restored, and counties should report "000" or "001" in the restriction code to remove the noncooperation restriction.**

5. DEPARTMENT OF SOCIAL SERVICES (DSS) CHILD SUPPORT PROCEDURES

DSS child support procedures are to be found in the following:

- DSS Manual of Policy and Procedures (MPP) Sections 12-100 through 12-908 and 43-200 through 43-205;
- DSS Family Support Division (FSD) Letter No. 94-03, February 10, 1994 Title IV-D Child and Spousal Support Program Procedure Manual.

23D. PETITION TO THE COURT

The county must notify each applicant or beneficiary placed in the following aid codes that the California Child Support Enforcement (IV-D) Agencies must, by law, petition to the court to include health insurance coverage in support orders when a child receives Medi-Cal. Referral in aid codes cited below will be for children under 18 with an absent parent or when a child is born out of wedlock. **HOWEVER, NO UNDOCUMENTED CHILDREN UNLESS THE ABSENT PARENT IS A CITIZEN, NO PREGNANT WOMEN, AND NO CHILD IN A MINOR CONSENT CASE WILL BE REFERRED**. Also, referrals for infants will be made after the 60-day postpartum period. In a minor consent case, the child must be in a regular aid code before referral can be made. (For explanation of absent parent situations, please refer to MEPM Article 1-B.)

In situations where the applicant is filing for retroactive Medi-Cal only, no referral will be made. When the absent parent is incarcerated or institutionalized, no referral will be made, but obtain necessary verification and refer upon absent parent's release.

In situations where the absent parent is already providing health insurance, no referral is necessary unless paternity must be established, but all forms must be completed on other health coverage and kept in the file, and a copy of the DHS 6155 sent to DHS. Even though the child is covered by medical insurance, the child can be eligible if all Medi-Cal eligibility requirements are met, and the mother will have linkage based on the child. If the mother does not apply for the child or the child is ineligible for any reason, then the mother becomes ineligible for Medi-Cal because the child cannot be used to link the mother.

In on-going medical support cases, at redetermination or at any time, if there is any change in the case, it should be reported to the FSD/DA via Form CA 371. The FSD/DA should be advised of any changes in the case which involve a change in status such as discontinuance of eligibility, change in family composition, loss of health coverage, change in income, etcetera. If there are no changes in the case at redetermination, no report to the FSD/DA is necessary.

MEDI-CAL AID CODES

The following aid codes are the ones for which the Medi-Cal Eligibility Worker must refer the children with an absent parent.

3A	20	34	51	67	83
3C	24	37	60	72	
7A	27	47	64	82	

CalWORKs AID CODES

The following aid codes are the ones for which child support referrals, including medical support, should have already been made by the CalWORKs or Foster Care Intake Worker for CalWORKs or foster care cases.

3G	30	33	40	45
3H	32	35	42	

1. PREGNANT WOMEN

Medical support referrals will NOT be made on an unborn child until the end of the 60-day postpartum period of the mother. If the mother of the unborn has other eligible children in the MFBU, a medical support referral for these children will NOT be made until the end of the 60-day postpartum period of the pregnant caretaker parent. If a pregnant caretaker parent has other eligible children in the MFBU with a different absent parent than for the unborn, a medical support referral will NOT be made on the children of the absent or unmarried parent(s) until the end of the 60-day postpartum period of the pregnant caretaker parent.

When a woman with a child(ren) has applied for Medi-Cal but refuses to cooperate in medical support and does not claim good cause, she becomes ineligible for Medi-Cal and designated as an ineligible member of the MFBU. The woman's child(ren) may be eligible for Medi-Cal if otherwise eligible and she has not withdrawn the application or asked to close the case. If this caretaker parent then becomes pregnant and applies for Medi-Cal, she may be eligible until her 60-day postpartum period ends. A referral for the caretaker parent and the new child can be made at the completion of the 60-day postpartum period.

If a caretaker parent has a child(ren) and has cooperated with medical support requirements, but then becomes pregnant, the medical support referral process should not be interrupted. The pregnancy should be reported to the FSD/DA, but no referral on the new child should be made until the 60-day postpartum period ends. The rule in on-going medical support cases is if there is any change in the case, it should be reported to the FSD/DA via Form CA 371. The FSD/DA should be advised of any changes (e.g., discontinuance from CalWORKs, new Medi-Cal case).

An unmarried/absent parent may apply for Medi-Cal and medical support services for the caretaker parent at the hospital if the caretaker parent is unable to fill out an application. Under Title 22, CCR, Section 50143, if a person is unable to file an application for Medi-Cal, "(2) a person who knows of the applicant's need to apply" may file the application. An unmarried/absent parent would qualify under this definition.

2. OBRA REFERRALS

If the caretaker parent or mother is undocumented and her children are also undocumented, no medical support referral will be made. If the caretaker parent/mother is undocumented and the children are citizens, a medical support referral will be made. No undocumented children will be referred for either medical support enforcement or paternity establishment.

If the caretaker parent has both OBRA children and citizen children and requests that both be referred for medical support enforcement, the county will only make a referral on the citizen children. Medical support enforcement referrals will not be made on OBRA children.

3. **CONTINUING ELIGIBILITY**

Under this program, infants born to Medi-Cal eligible women are automatically "deemed eligible" for one year, provided they continue to live with their mother and the mother remains eligible for Medi-Cal, or would remain eligible if she were still pregnant. For purposes of medical support enforcement, the father/absent parent still has a legal responsibility for the health and welfare of his children and, at the end of the 60-day postpartum period, a medical support referral must be made.

4. **FOSTER CARE CHILDREN**

The CalWORKs or Foster Care Intake Workers will make child support referrals, including medical support for all foster care children. Medical support enforcement referrals will not be done by the county Medi-Cal Eligibility Worker on foster care children. Foster care children are automatically eligible for Medi-Cal after utilizing whatever other health coverage is available. This is clarified in Section 903 of the Welfare & Institutions Code, Liability for Costs of Support. This section prohibits any imposition of medical costs upon the natural parent(s) until the county has first exhausted any eligibility the child may have under private insurance coverage, standard or medically indigent Medi-Cal coverage, and the Robert W. Crown California Children's Services Act. If there are any costs over and above 100 percent of the average Medi-Cal payment that are not covered under any of the coverages listed, the county may choose to impose those costs.

5. **ADULT CHILDREN**

"Adult children" are individuals in Medi-Cal between the ages of 14 to 18 years of age who are not living in the home of a parent or caretaker relative and who do not have a parent, caretaker relative, or legal guardian handling any of their financial affairs or 18 to 21, not living in the home and who do not have a parent, caretaker relative or legal guardian handling any of their financial affairs (Sec. 50014). The parents do not claim the children as dependents in order to receive a tax credit or deduction for state or federal income tax purposes. Children 16 and over are eligible for CalWORKs and cash-based CalWORKs-Medically Needy Only Medi-Cal because they are not dependent children. However, under 42 Code of Federal Regulations (CFR) 435.222, the State of California may provide Medi-Cal benefits to individuals under age 21 who would be eligible for cash-based Medi-Cal but do not qualify as dependent children. These "adult children" **WILL NOT BE REFERRED** for Medical Support Enforcement. Aid Codes 82 and 83 will be reinstated to the referral list because medically indigent children who are not "adult children" will be referred.

Under Medi-Cal regulations, individuals under 21 years of age (not disabled or blind) and living in the home of a caretaker relative are considered children and are eligible for Medi-Cal.

Under new Medi-Cal regulations if a married individual under the age of 21(not disabled or blind) is living in the home of his/her parents, regardless of whether or not he/she is claimed as a tax dependent, this individual is considered a child for budget purposes and financial responsibility.

If the applicant is an unmarried minor parent (14-18 years of age with a child), who is living on his/her own and does not want to cooperate with medical support , do not deny or discontinue him/her for noncooperation, but do refer the child for medical support enforcement.

If the applicant is an unmarried minor parent (14-18 years of age with a child) and is living with a

parent or caretaker relative, do not deny or discontinue the parent for noncooperation, but refer the child. If the parent or caretaker relative is using the linkage with minor for Medi-Cal benefits, then the parent or caretaker relative must cooperate with medical support enforcement or be discontinued or denied Medi-Cal benefits.

If a mother is under 21 but over 18, and living on her own, she must cooperate because an individual 18 years of age or older is considered an adult under the Family Code.

Disabled Adult Children under the Pickle program are at least 18 years of age or older. They will not be referred for medical support enforcement. Referrals are for those under 18.

Disabled children who have been placed in an institution through a guardianship are not to be referred for medical support enforcement.

6. TRANSITIONAL MEDI-CAL OR FOUR-MONTH CONTINUING MEDI-CAL

No transitional Medi-Cal cases are to be referred. This includes children in aid codes 39, 54, and 59. These families were initially on CalWORKs and lost their cash grant due to increased earnings, increased hours of employment, or increased allocation of child/spousal support payments. Transitional Medi-Cal or Four-Month Continuing Medi-Cal is provided to these families as an aid in helping them become self-sufficient. If they apply for Medi-Cal Only at the end of their transition period, they should be treated as a new case and a referral should be made.

7. DECEASED ABSENT PARENT

No medical support enforcement referral will be initiated for deceased absent parents. However, sufficient substantiation of the fact that the absent parent is deceased is required.

8. CALIFORNIA ALTERNATIVE ASSISTANCE PROGRAM

This program allows individuals who qualify for Aid to Families with Dependent Children, Family Group (CAAP-AFDC [FG]) or Aid to Families with Dependent Children, Unemployed Parent Group (CAAP-AFDC[U]) to decline the federal cash grant and instead receive child care assistance and Medi-Cal.

9. VOLUNTARY DECLARATION OF PATERNITY

Upon application for Medi-Cal, unmarried parents shall be informed of the availability of the Declaration of Paternity, and given the option of signing the CS 909 in order to establish paternity. A copy of the brochure which explains the voluntary paternity program (PUB 244 (1/97 Revision)), the Information Sheet (CS 910), and the Declaration of Paternity (CS 909) shall be given to the applicants. Completion of the form is **not mandatory** for Medi-Cal eligibility. If the form is not signed, the case will be referred to the Family Support Division/District Attorney (FSD/DA) for paternity establishment. Medi-Cal eligibility **should not be denied or delayed** if the voluntary declaration is not signed at this time. However, cooperation with and information regarding the children's father

Appropriate copies of the completed Declaration along with the CA 2.1Q should be sent to the FSD/DA, who will forward the Declaration to the State Office of Vital Records. If there are any questions regarding legal issues that are not answered by the brochure or information sheet, refer the case to the FSD/DA. You may inform the parents that the signed Declaration may be rescinded by either parent by filing a rescission with the State Office of Vital Records within 60 days of execution or by a judicial proceeding.

MINOR PARENTS: When either parent is a minor, the Declaration of Paternity does not establish paternity until 60 days after both minor parents are emancipated or 60 days after the eighteenth birthday of both minors, whichever occurs first.

REFERRAL TO FSD/DA: If the Declaration of Paternity is signed by both parents, DO NOT REFER to the FSD/DA for paternity establishment. The signed Declaration should be sent with other documentation and a note on the CA 371 that the Declaration has been signed and is attached. The Declaration of Paternity will have the same force and effect of law as a judgment rendered by a court.

EXAMPLES:

1. Woman with three children declares father is deceased and provides birth certificate for children, death certificate for father, and marriage certificate.

   a. Marriage occurred after birth of children and father's name is not on birth certificates. **Question:** Do we do paternity referral? **Response:** Yes. Children born out of wedlock.

   b. Marriage occurred after birth of children and father's name is on birth certificates. **Question:** Do we do paternity referral? **Response:** Yes. Mother may declare he is rightful father and that is why he is on birth certificates, but birth certificate alone does not establish paternity.

   c. Marriage occurred before birth of all children and father's name is not on birth certificates. **Question:** Do we do paternity referral? **Response:** No. Children were not born out of wedlock. Presumption is deceased person is father.

   d. Marriage occurred before birth of children and father's name is on birth certificate. **Question:** Do we refer since we have a death certificate? Must the FSD/DA validate the death for us? **Response:** No referral. He is not absent; he's deceased.

   e. Same as Number d, but woman claims that at least one of the children has a father other than the man named on the death certificate. **Question:** Would a referral be sent on this new man even though we have a death certificate on the father? **Response:** Refer if there is no name on birth certificate, but use your best judgment since children were not born out of wedlock.

   f. Death of husband occurred over nine months before the birth of child(ren), and woman claims he is father. Question: Would referral be made on child(ren)? Response: Yes, child(ren) was born out of wedlock.

2. Woman with one child applies and is granted benefits. Prior to completing the approval action, she calls the EW and advises that she has moved to County A. EW completes the disposition and processes for an intercounty transfer (ICT) to County A. **Question:** Case

should be referred for medical support if she had stayed in County B, but since she is in County A physically, are we required to send the medical support referral to County B FSD/DA as part of the regulations even knowing that they will be closing because of the

change in county address? **Response:** In this case, make sure County A is aware of need for medical support referral in County A in the ICT documents. Since case will be in County A, County A must make the referral.

3. Woman with two children applies and is granted benefits for one month only. Case requires cooperation with medical support. **Question:** At point that benefits are approved and cooperation with medical support referral is okay, do we send the medical support referral to the FSD/DA knowing that the case is closed and that they will do nothing with it. Seems to be a workload that is unnecessary. **Response:** If woman requests child and medical support, then refer. If a woman requests medical support enforcement and is willing to request child support enforcement services also, she may be referred to FSD/DA. If woman wants medical support enforcement services only, she can only receive this service if she is continuing on Medi-Cal. However, since there is no retro enforcement, do not refer unless she specifically wants medical support and child support enforcement services.

4. Woman with two children is working and has health insurance available through her employer. Question: Will the FSD/DA pursue medical support from the mother/custodial parent (CP)? Response: No. Federal regulations require the FSD/DA to pursue medical support from the absent parent/noncustodial parent, not the CP. Although the court has discretion to order the CP to provide health coverage for the dependent children, the FSD/DA is not required to enforce it.

23E. GOOD CAUSE FOR NONCOOPERATION

The applicant or beneficiary may claim good cause for noncooperation in establishing paternity, medical support payments, or identifying third party liability if he/she feels there is a risk of emotional or physical harm to himself/herself or a child(ren) if a referral is made for medical support enforcement. The county must determine if the applicant or beneficiary, in fact, has good cause for failure to cooperate with medical support requirements. (No provision exists for a finding of good cause when the applicant or beneficiary refuses to assign to the State his/her rights to medical support, payments, care, and services.) If the county determines that good cause does not exist (Form CA 51), then the applicant or beneficiary should be given an opportunity to withdraw the application, close the case, or be designated as an ineligible member of the Medi-Cal Family Budget Unit (MFBU) (California Code of Regulations, Title 22, Sections 50155 and 50379).

If good cause is claimed, Medi-Cal is granted pending the good cause determination if the applicants are otherwise eligible. Once good cause is established, it continues unless the mother/caretaker parent rescinds the claim for good cause and is able to cooperate with medical support enforcement. Review at redetermination to determine if circumstances have changed. It is not necessary to process another claim for good cause.

The CA 51 Good Cause Claim for Noncooperation form calls for statistical reporting.

1. COOPERATION

The Family Support Division/District Attorney's (FSD/DA) office shall have staff available in person or by telephone at every county welfare office and shall interview each applicant to obtain information necessary to establish paternity, and establish, modify, or enforce a support order. The FSD/DA shall make the determination of noncooperation, and, in making this finding, it shall take into consideration:

- The age of the child for whom support is sought;
- The circumstances surrounding conception of the child;
- The age or mental capacity of the parent or caretaker of the child for whom aid is being sought; and
- The time that has elapsed since the parent or caretaker last had contact with the alleged father or absent parent.

Cooperation is defined as including:

- The name of the alleged parent or absent parent, and other information about that person if known, including the names and addresses of relatives or associates;
- Submitting to genetic tests, including tests of the child;
- Address;
- Social Security number;
- Telephone number or numbers;
- Place of employment or school;
- Appearing at interviews and court hearings.

The caretaker parent has the right to refuse to cooperate in medical support enforcement for himself/herself and for the child(ren). If this occurs, the caretaker parent is denied or discontinued from Medi-Cal, but the child(ren) may be granted Medi-Cal or continues to receive Medi-Cal, if otherwise eligible, and the caretaker parent does not withdraw the child(ren)'s application. The county would refer the child(ren) for medical support services. Assignment of right is an automatic process

of Medi-Cal eligibility. (Welfare and Institutions Code, Section 14008.6.) The caretaker parent can withdraw the application or close the case if he/she does not want a medical support referral on the child(ren).

- When an applicant/custodial parent does not agree to assign their rights to medical support or establish paternity and does not claim good cause, deny Medi-Cal to the custodial parent and refer the children for medical support enforcement.

- When an applicant/custodial parent agrees to assign their rights and signs the Medi-Cal application, but does not wish to cooperate with the FSD/DA in paternity establishment or identification of medical support and does not claim/have good cause, deny Medi-Cal to the custodial parent and refer the children for medical support enforcement.

- When an applicant/custodial parent agrees to assign their rights, signs the application and agrees to cooperate in paternity establishment and identification of medical support, refer the case to the FSD/DA for medical support enforcement.

- When an applicant/custodial parent agrees to assign their rights and signs the Medi-Cal application but states that he/she has good cause not to cooperate, do not refer the case to the DA until good cause determination can be made, or you may indicate on the CA 371 that good cause has been claimed. The FSD/DA will not begin any action on the case until the good cause determination has been made. Information from the FSD/DA can be requested in making the determination of good cause, but the county welfare department no longer needs to request an independent evaluation of the good cause claim from the DA. If the good cause claim is denied, the case will be referred to the FSD/DA for medical support enforcement. If the good cause claim is valid, the applicant or recipient should be referred to appropriate community, legal, medical, and support services.

- Cooperation determinations will be done by the FSD/DA. Medi-Cal county staff must work with the FSD/DA in determining procedures for accomplishing a cooperation determination. The county will not discontinue any applicant/custodial parent until it receives a statement/document from the FSD/DA which specifies the circumstances of the individual's failure or refusal to cooperate in medical support enforcement. The county shall then review and verify the evidence that the applicant/custodial parent failed or refused to cooperate without good cause. If this is correct, the county must discontinue the individual from Medi-Cal benefits and refer the children for medical support enforcement.

- If the applicant/recipient comes back two months later and agrees to cooperate, do not reinstate applicant/recipient back on Medi-Cal until he/she cooperates with the FSD/DA and brings back a letter of cooperation. Later, if he/she comes in and wants to cooperate and makes an appointment with the FSD/DA's office and the appointment is not until the following month, the applicant/recipient will receive retroactive Medi-Cal for the month in which he/she first made the appointment if it is documented by the FSD/DA in the letter of cooperation.

2. **GOOD CAUSE**

Good Cause shall be determined by the county welfare department. Suspension of child support services will occur as long as good cause exists, and Medi-Cal will not be discontinued or denied until the Good Cause determination has been made. If the applicant/beneficiary did not cooperate without good cause, Medi-Cal will be discontinued or denied to the custodial parent, but not the children unless the application is withdrawn.

GOOD CAUSE DETERMINATION REQUIREMENTS - Good Cause may be determined if the following conditions exist:

- Efforts to establish paternity or establish, modify or enforce a support obligation would increase risk of physical, sexual, or emotional harm to the child for whom support is being sought.

- Efforts to establish paternity or establish, modify, or enforce a support obligation would increase the risk of abuse to the parent or caretaker with whom the child is living.

- The child for whom support is sought was conceived as a result of incest or rape. A conviction for incest or rape is not necessary for this paragraph to apply.

- Legal proceedings for the adoption of the child are pending.

- The applicant/beneficiary is being assisted to resolve the issue of whether to keep or relinquish a child for adoption.

- The applicant/beneficiary is cooperating in good faith but is not able to identify or assist in locating the alleged father or absent parent.

- Any other reason that would make efforts to establish paternity or establish, modify, or enforce a support obligation contrary to the best interests of the child.

EVIDENCE TO SUPPORT GOOD CAUSE CLAIM

- Police, governmental agency, or court records, documentation from a domestic violence program, or a legal, clerical, medical, mental health, or other professional from whom the applicant or recipient has sought assistance in dealing with abuse, physical evidence of abuse, or any other evidence that supports the claim of good cause.

- Statements under penalty of perjury from individuals, including the applicant/beneficiary with knowledge of the circumstances surrounding the good cause claim.

- Birth certificates or medical, mental health, rape crisis, domestic violence program, or law enforcement records that indicate that the child was conceived as the result of incest or rape.

- Court documents or other records that indicate legal proceedings for adoption are pending.

- A written statement from a public or licensed private adoption agency that the applicant/beneficiary is being assisted by the agency to resolve the issue of whether to keep the child or relinquish the child for adoption.

3. **NOTICES OF ACTION**

Good cause in medical support is the process by which someone can make a claim that he/she has good cause for not cooperating in medical support enforcement. The claim is documented by filing a CA 51. The Notices of Action (NOA) for good cause are to be used to inform the caretaker parent whether his/her claim has been approved or denied. An applicant may claim good cause if he/she feels that there is a risk of emotional or physical harm to himself/herself or a child(ren) if a referral is made for medical support enforcement. The county will request documentation from the caretaker

parent to support the claim of good cause. This information will be sent to the FSD/FSD/DA with the CA 51, and the FSD/DA will investigate further and make a recommendation on the claim. The claim is then returned to the county for a final recommendation of approval or denial of good cause. The applicant is informed of this decision through the NOAs for Good Cause.

(For Notices of Action for Approval or Denial of Good Cause Claims, see Section 23H.)

23F. REFERRAL PROCESS

DHS has adopted the Department of Social Services' (DSS') child support procedures, including the forms and referral process, for the Medi-Cal program. The county welfare department shall refer Medi-Cal Only absent parent cases to the Family Support Division/District Attorney (FSD/DA) for applicable support enforcement services. The county welfare department will also make referrals for paternity establishment services to the FSD/DA when there is a child born out of wedlock. These services will be provided without application or application fee.

All new applicants for Medi-Cal in the appropriate aid codes will be referred **within two days** of the Medi-Cal eligibility determination for medical support enforcement services. No referral is to be made until a Medi-Cal determination is approved. Existing cases will be referred at the time of redetermination. These redeterminations will be face-to-face for proper notification and forms completion by the beneficiary. The county welfare department will inform Aid to Families with Dependent Children (AFDC) recipients of changes related to medical support enforcement. Whenever the county becomes aware that an on-going case is an absent parent situation or there is a child born out of wedlock, a medical support referral should be made. Do not wait for redetermination if there is a change in the case.

Please notify the applicant or beneficiary if he or she receives direct payment for medical support for services which were paid for by Medi-Cal. Payments made in this situation should be forwarded to DHS. If payments are not forwarded to DHS, the Department's Third Party Liability Branch will pursue reimbursement from him or her. (Further information can be found in Section 23M.)

Each applicant for Medi-Cal with an absent parent or a child born out of wedlock will be advised of child support services available through the FSD/DA. If a Medi-Cal applicant indicates all child support services are wanted, the case should be handled in the same manner as a non-aid case, except that medical support is assigned to the State. All current child support collected on behalf of Medi-Cal only families must be paid to the family in accordance with the State's non-AFDC policy.

1. FORMS REFERRAL

For application and referral of Medi-Cal cases to the IV-D agencies, the county shall use the following forms:

- **MC 219 (Cover Sheet) (7/96) and MC 210 (11/96)** - Applicant is advised of rights regarding medical support enforcement referrals and third party liability. A copy is given to applicant; the original is placed in file. If the applicant refuses to sign and cooperate, then a notice of action denying Medi-Cal is sent to applicant.

- **Health Insurance Questionnaire (DHS 6155, 10/90 or later)** - Applicant fills out form if there is other health coverage available through the absent parent. County sends a copy both to DHS Third Party Liability Branch and to the FSD/DA.

- **Child/Spousal and Medical Support Notice and Agreement (CA 2.1 Notice and Agreement (12/89))** - Applicant reviews and signs the agreement. If this form is not signed and good cause is claimed, a CA 51 (Child Support - Good Cause Claim for Noncooperation) must be completed and sent to the FSD/DA with evidence of good cause. If form is signed, then medical support process begins and all documents are sent to FSD/DA via CA 371.

- **Child Support Questionnaire (CA 2.1 Q Support Questionnaire (8/96))** - Applicant fills out form, and original is sent to the FSD/DA within two days. The FSD/DA may set up interview with applicant if form is not complete.

- **Child Support - Good Cause Claim for Noncooperation (CA 51 (3/93))** - If applicant claims good cause for failure to cooperate with medical support enforcement requirements, applicant must fill out the form and send the original with evidence of good cause to the FSD/DA. The FSD/DA will return it to the county with a recommendation. The county will make a final decision and, if good cause is denied, the county will give the applicant an opportunity to withdraw the application, close the case, or be designated as an ineligible member of the MFBU. The county will send a copy of the CA 51 to the FSD/DA with the final determination.

- **Child Support Enforcement Program Notice (CS 196 (5/95))** - A copy shall be given to all applicants who claim Medi-Cal for children with absent parent. This is an information notice which explains child and medical support enforcement program, services available, and rights of applicant.

- **Referral to District Attorney (CA 371 (3/93))** - This is a cover sheet to transmit absent parent information to FSD/DA (one form for each absent parent). The county sends a CA 371 to the FSD/DA with originals of CA 2.1 Questionnaire, CA 51 when good cause is claimed (with evidence), and DHS 6155. This form is used to convey any information regarding the status of the case back and forth between the county and the FSD/DA.

- **Medical Insurance Form (DHS 6110 10/91)** - Applicant fills out this form if there is other health coverage available through the absent parent. The FSD/DA sends the form to DHS Third Party Liability Branch. DHS will then send a copy to county welfare department.

- **Attestation Statement (CS 870)** - The FSD/DA will use the CS 870 to give the applicant an opportunity to attest (swear), under penalty of perjury, that he or she has provided all available information regarding the absent parent. A determination of noncooperation cannot be made without giving the applicant the opportunity to complete this form.

- **Establishing Paternity for You and Your Child (PUB 244 (1/97 Revision))** - An eight-panel brochure that explains what paternity is and how a mother, father, and child will benefit from having paternity established. The brochure can be used in conjunction with the Declaration of Paternity or may be used to provide general information about the program without the Declaration of Paternity.

- **How a Declaration Can Help You and Your New Baby (CS 910 1/97)** - A one-page informational sheet for unmarried parents that provides a brief summary of the paternity declaration process. Parents should be given this form along with the Declaration of Paternity. This is a two-sided form with the English version on one side and the Spanish version on the reverse.

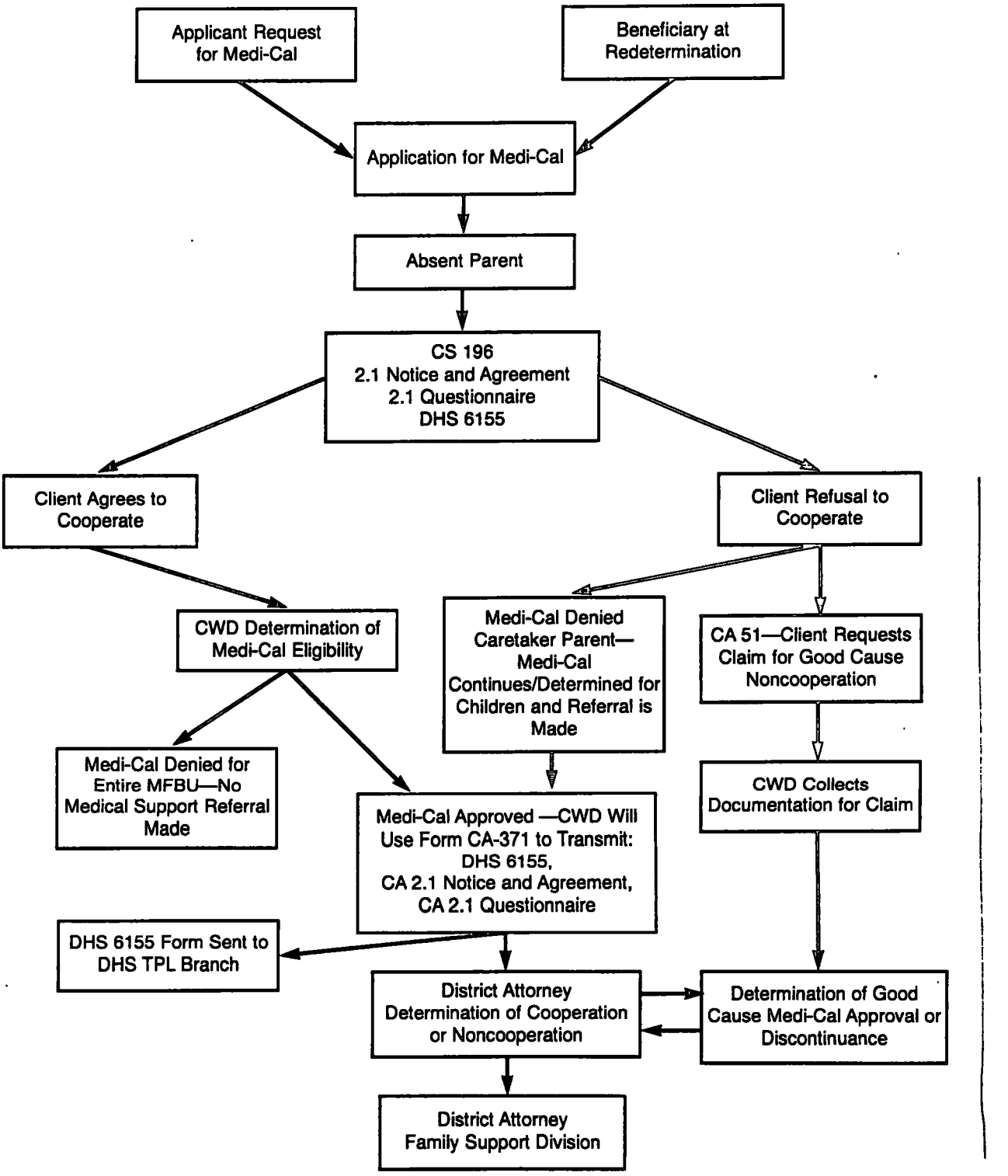
- **Declaration of Paternity (CS 909 1/97)** - A four-part carbonized (NCR) form that when completed, witnessed and officially filed is an acknowledgment of paternity. This form has a blue informational coversheet which contains the heading, **IMPORTANT NOTICE TO UNMARRIED PARENTS**, and an explanation of the purpose of the form. The second page contains instructions for completing and distributing the form. The original is sent to the State Office of Vital Records. The third copy of the Declaration is sent to the local FSD/DA. Copies 1 and 2 are given to the parents. A photocopy may be made for the case file.

NOTE: The county must ask the applicant or beneficiary to state whether he or she wants child support, medical support, or both, and must indicate services requested on the CA 2.1 Questionnaire and on the CA 371. The CA 371 will be used by the county and FSD to communicate subsequent changes or additional information on the case. **THE COUNTY MUST EMPHASIZE TO THE APPLICANT OR BENEFICIARY THAT, FOR RECEIPT OF MEDI-CAL ONLY, CHILD SUPPORT SERVICES ARE AVAILABLE BUT NOT MANDATORY, AND THAT REFUSAL OF CHILD SUPPORT SERVICES WILL NOT AFFECT MEDI-CAL ELIGIBILITY (CS 196 AND CA 2.1).**

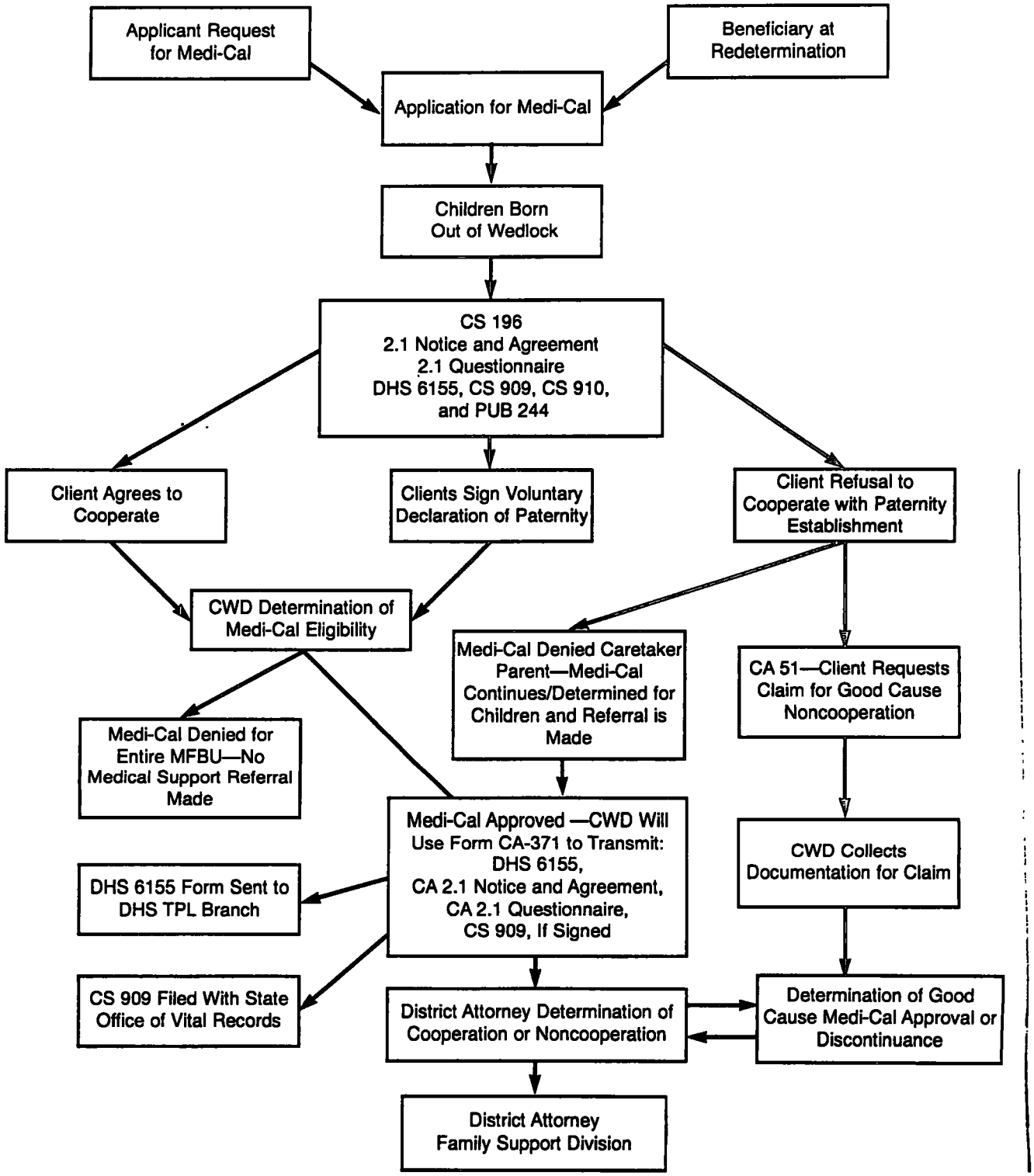
NOTE: Voluntary Paternity Establishment: Send signed Declaration to the State Office of Vital Records. Send copy of Declaration with a CA 371 that it is attached and has been signed.

(The above forms are available in the DHS warehouse, except the for the Voluntary Paternity Declaration forms, which are available through the DSS warehouse. Copies of the forms are shown in Section 23J.)

FORMS REFERRAL CHART—ABSENT PARENT



FORMS REFERRAL CHART—PATERNITY ESTABLISHMENT



23G. HEALTH INSURANCE ASSIGNMENTS, COST SHARING AND MEDI-CAL COPAYMENTS

As a condition of eligibility for Medi-Cal, a beneficiary must assign to the State his or her rights, and the rights of any other Medi-Cal eligible for whom he or she can legally make an assignment, to medical support, health insurance payments, or other third party payments for medical care. This assignment is completed automatically as part of the application process.

The Medi-Cal beneficiary must cooperate with the county and Department of Health Services in obtaining medical support or payments, and cooperate in identifying and providing information to assist medical providers and the State in pursuing third parties who may be liable to pay for medical care and services. Identification of a Medi-Cal beneficiary's other health coverage enables the State to cost avoid medical services and/or to recover from insurance funds previously paid to a provider.

1. HEALTH INSURANCE COST-SHARING

In addition to Medi-Cal, a Medi-Cal beneficiary may also have private health insurance. The private health insurance plan may require a deductible, copayment, and/or coinsurance amount. (A medical support custodial parent is not liable for these charges).

Following are definitions of deductibles, copayments, and coinsurance:

Deductibles

A deductible is the expense that must be incurred by an insured or otherwise covered individual before an insurer will assume any liability for all or part of the remaining cost of covered services. Deductibles are generally fixed dollar amounts and are usually tied to some reference period over which they may be incurred, e.g., $100 per calendar year, benefit period, or spell of illness.

Copayments

A copayment is a type of cost sharing whereby an insured or covered person pays a specified flat amount per service (e.g., $5 per prescription; $10 per office visit). Copayment is incurred at the time the service is received.

Coinsurance

Coinsurance is a cost-sharing requirement under a health insurance policy which provides that the insured will assume a percentage of the costs of covered services. The policy provides that the insurer will reimburse a specified percentage (usually 80 percent) of all or certain services above any deductible. The percent paid may be applied only to a "reasonable" charge. The insured is then liable for the remaining percentage of covered costs and may be liable for charges above those deemed reasonable, until the maximum amount stipulated under the insurance policy is reached.

2. LIABILITY FOR INSURANCE COST SHARING

A provider may not require the beneficiary to pay insurance copayments, deductibles, coinsurance or charges above those deemed reasonable if the provider takes the Beneficiary Identification Card (BIC) and uses it to obtain proof of eligibility through the Automated Eligibility Verification System (AEVS) or bills Medi-Cal.

According to State law, when a provider elects to verify Medi-Cal eligibility using a BIC, a photocopy of a paper identification card or a paper card label, the provider has obtained proof of eligibility and has agreed to accept the patient as a Medi-Cal patient and be bound by the rules and regulations of the Medi-Cal program. And having obtained eligibility verification, the provider must not bill the recipient for all or part of the charge of a Medi-Cal covered service except to collect the Medi-Cal copayment or Share of Cost. Providers must not bill recipients for private insurance cost-sharing amounts such as deductibles, coinsurance or copayments.

Under Federal law (42 U.S.C. Sec. 1396A(25)) health insurance belonging to a Medi-Cal recipient in a child or medical support enforcement case is used as follows:

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

In instances where the other health coverage is an HMO, the provider may not seek reimbursement nor attempt to obtain payment for the cost of those covered health care services from the Medi-Cal eligible which are included in the Medi-Cal program's scope of benefits. Medical support beneficiaries are not liable for any copayments or deductibles. (CCR, Title 22, Sec. 51002(a); W&I Code Sec. 14019.4.)

23I. OTHER HEALTH COVERAGE OBTAINED THROUGH MEDICAL SUPPORT ENFORCEMENT

This section provides an overview for the Family Support Division/District Attorney's (FSD/DA) offices in the processing of the DHS 6110 Medical Insurance Form. Item 1-e, Transmittal Letter, and Item 2, County Welfare Department Action, and Item 3-a, Notification, however, describe the county welfare department's role in this process.

1. FSD/DA REPORTING HEALTH INSURANCE COVERAGE

a. Reporting

The availability of health insurance in Medi-Cal eligible family support cases must be reported to Department of Health Services' (DHS) Third Party Liability Branch, Health Insurance Section (HIS). The method used by the FSD/DA's offices to report the availability of health insurance is the DHS 6110 Medical Insurance Form. As part of any court order and family support determination, the parents, employer of the absent parent, other third party providing health insurance to the absent parent, or FSD/DA's office will complete a DHS 6110 form. The DHS 6110 identifies the availability of medical insurance coverage for the dependent child(ren) on public assistance or for whom Medi-Cal is being sought.

b. Procedures

The FSD/DA will:

1. Secure a completed DHS 6110 form for any action against the absent parent in a public assistance case or enforcement proceeding;

2. Ensure the DHS 6110 form is properly completed; and

3. Forward the completed form to DHS for processing.

c. Monitoring, Verifying and Enforcing

The FSD/DA will establish a monitoring system that will ensure that the DHS 6110 forms are completed and returned from the parents, employers, or other third parties who are requested to provide the health insurance information. In addition, verifying the health insurance information will ensure that all dependent children reported to DHS are eligible for coverage under the absent parent's health plan. This information is then used to cost avoid the health insurance benefits or collect from insurance carriers medical payments made by the Medi-Cal program. The FSD/DA must take appropriate action to ensure the responsible parent's obligation to obtain or maintain health insurance for the child(ren) is upheld.

d. Notifying Custodial Parents

The FSD/DA, in all child support and medical support cases, is required to provide the custodial parent with the absent parent's health insurance information.

e. **Transmittal Letter**

After DHS uses the health insurance information provided on the DHS 6110 form to update HIS and MEDS, a transmittal letter and the DHS 6110 form is sent to the appropriate county welfare department for inclusion in the beneficiary's case file.

2. **COUNTY WELFARE DEPARTMENT ACTION**

When the DHS 6110 form and transmittal letter are received from DHS, each county welfare department will take the following actions:

a. Place the DHS 6110 form in the beneficiary's case file.

b. Change the OHC designator in the case file to correspond with the OHC indicator code on MEDS. There is no need to update MEDS because DHS assumes responsibility for updating MEDS in all medical support cases.

c. If the custodial parent of the beneficiary contacts the county to question the health insurance coverage for the dependent child(ren) specified in the Automated Eligibility Verification System (AEVS), explain that the coverage is being provided by the absent parent under court order for child support, and instruct the beneficiary to use the insurance coverage before using Medi-Cal if it is an HMO. If not an HMO, instruct the beneficiary to use the Beneficiary Identification Card (BIC), and Medi-Cal will bill the other health coverage.

3. **LAPSES IN HEALTH COVERAGE**

a. **Notification**

The FSD/DA requests employers of absent parents, county welfare departments, and/or other groups offering health insurance coverage to notify the FSD/DA if there has been a lapse in insurance coverage. In turn, the DHS Health Insurance Section is responsible for ensuring that all FSD/DA's are informed quarterly of any lapses or changes in absent parent health insurance coverage. The FSD/DA will be paid an incentive fee of $50 for each case where the absent parent's health insurance coverage has lapsed and is re-obtained. The re-obtained health insurance should be reported on the DHS 6110 form along with a note on the top of the form stating "**RE-OBTAINED**."

b. **Enforcement**

The FSD/DA will take appropriate action, civil or criminal, to enforce the obligation to obtain health insurance when there has been a lapse in insurance coverage or failure by the responsible parent to obtain insurance as ordered by the court.

4. UTILIZATION OF HEALTH COVERAGE

a. Post Payment Recovery/Pay and Chase

Under Federal Law (42 U.S.C. Section 1396a(25)) health insurance belonging to a Medi-Cal beneficiary in a child or medical support enforcement case is used by the following method, also referred to as "pay and chase":

The provider of service will bill Medi-Cal. Medi-Cal will pay the provider of service. Thereafter, Medi-Cal will seek reimbursement from the other health coverage.

(NOTE: NO CUSTODIAL PARENT AND NO CHILD WHO HAVE AGREED TO COOPERATE WITH MEDICAL SUPPORT ENFORCEMENT ARE TO BE CHARGED A CO-PAYMENT OR DEDUCTIBLE FROM A HEALTH INSURANCE PROVIDER. MEDI-CAL WILL PAY THE CO-PAYMENT AND/OR DEDUCTIBLE (See Article 23G-1 and G-2).)

b. Cost Avoidance

When the other health insurance is a Prepaid Health Plan (PHP) or a Health Maintenance Organization (HMO), however, the dependent must utilize the plan's facilities for regular medical care. Out of area services or emergency care for such dependents are billed to the PHP/HMO. Again, no custodial parent is to pay co-payments and/or deductibles in these instances.

5. DISTRICT ATTORNEY HEALTH INSURANCE INCENTIVE

a. Policy

Effective October 1, 1993, the California Department of Social Services (CDSS) began paying the FSD/DAs an incentive of $50/case for reporting health insurance coverage obtained as a result of enforcement activities for dependent children. Health insurance includes any third party insurance policy that provides coverage or benefits payable for:

Scope Code	Service Type	Services Covered
O	Outpatient	Hospital outpatient (e.g., lab work or physical therapy)
I	Inpatient	Hospital stays
M	Medical	Medical doctor visits
P	Prescriptions	Prescription drugs
L	Long-term care	Long-term care (e.g., nursing home) or coverage for a specific illness (e.g., cancer)
D	Dental	Dental coverage
V	Vision	Vision care

(NOTE: Health insurance does not include insurance coverage for automobile insurance, indemnity policies or periodic benefits for disability, hospitalization or income protection, coverage limited to a specific circumstance (e.g., accidental injury or dismemberment), Medicare, or Medi-Cal capitated health care plans and initiatives. For a more comprehensive list, please refer to the Medi-Cal Eligibility Manual, Article 15A.)

b. **Reporting Process**

DHS will use the obtained health insurance coverage information reported by the FSD/DA on the Medical Insurance Form (DHS 6110) and provide CDSS with a quarterly county-by-county listing of the number of health insurance carriers which have been added to their computer system. The county-by-county list will be used by CDSS to pay health insurance incentives to the FSD/DAs for the health insurance carrier information reported to DHS and provided to Aid to Families with Dependent Children, Foster Care, and Medically Needy Only custodial parents.

CDSS will pay these incentives to FSD/DAs on a quarterly basis. If the health insurance coverage information provided by the FSD/DA was previously known by DHS, the duplicate health insurance carrier information will not be counted, and the DHS 6110 form will be destroyed by DHS.

DHS will, however, return to the initiating county the DHS 6110 forms that are rejected because they cannot be entered into the Health Insurance System (HIS). The rejected documents will be returned weekly with a cover letter explaining the rejection reason. (See Section 23J-15 for a copy of the rejection letter.)

The causes for rejection include:

- No MEDS record found: Eligibility has not, as yet, been established on MEDS. The county welfare department must establish Medi-Cal eligibility before re-submission of the DHS 6110.
- Medi-Cal eligibility not established: The record was found on MEDS, but not eligible for Medi-Cal. Re-submit the DHS 6110 only after the county welfare department has determined the case to be eligible for Medi-Cal.
- Incomplete/Illegible form: The DHS 6110 was incomplete or illegible. Re-submit the DHS 6110 after completing or rewriting the items highlighted on the form.
- Other: Non-Codeable Insurance: Insurance could not be coded into the DHS HIS for other reasons (i.e., out of country carrier, initial report of an HMO with a termination date prior to submission, life insurance, etc.)

For additional information on DA Health Insurance Incentives, see FSD/DA Letter No. 93-24 (November 5, 1993.)