

DEPARTMENT OF HEALTH SERVICES

714/744 P STREET
SACRAMENTO, CA 95814

January 7, 1985

Letter No. 85-3

TO: All County Welfare Directors
All County Administrative Officers

STATE CORRECTIVE ACTION INITIATIVE MEDI-CAL STUFFER

RE: ALL COUNTY WELFARE DIRECTORS (ACWD) LETTERS NO. 83-81 AND 84-56

The Department of Health Services (DHS) has issued a series of letters dealing with Quality Control (QC) and Corrective Action initiatives. ACWD Letter No. 83-81 requested your evaluation of the Medi-Cal stuffer (Attachment A) which was sent to beneficiaries with their January 1984 Medi-Cal card, and ACWD Letter No. 84-56 discussed the results of those county evaluations. This letter is to request your participation in a controlled study of the effectiveness of the same Medi-Cal stuffer which is to be sent again with the March 1985 Medi-Cal cards. The stuffer will be sent to all cash assistance recipients except for those receiving SSI/SSP (aid codes 10, 20, and 60) and to all Medi-Cal only beneficiaries.

In order to ensure a more accurate evaluation of the stuffer, we request that you gather control data in February 1985, as well as test data in March 1985. We have attached a survey form for the February control month (Attachment B) and a survey form for the March test month (Attachment C) which should be used to report your findings.

Several counties have previously indicated that they would like to conduct surveys such as this in one district or unit only. This would be acceptable as long as the district/unit is representative of the Medi-Cal population/caseload.

Each eligibility worker selected to complete the survey must do so for both the February control month and the March test month. Please tally each case surveyed in the appropriate spaces in sections one, two and three. The reverse of the survey forms may be used for additional comments.

Please consolidate the data on the consolidation forms (Attachments D and E), and return by April 15, 1985 to:

Corrective Action Unit
Eligibility Branch
714 P Street, Room 1692
Sacramento, CA 95814
Attention: Marie Leonard

We wish to express our appreciation to all counties which responded to our first survey, and to those counties which will be responding to this second survey.

If you or your staff have any questions, please contact the Corrective Action Unit analyst assigned to your county. Thank you for your assistance.

Sincerely,

Original signed by

Doris Z. Soderberg, Chief
Medi-Cal Eligibility Branch

Attachments

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

db806ml

WARNING

State law and regulation require you to tell your county welfare department:

- Any time you have an increase or decrease in income.
- Any time someone moves into or out of your home.
- Any time you or your dependents begin to receive health insurance coverage.
- Any other changes which might affect your eligibility for assistance.

AFDC recipients must report changes within five (5) days.

Medi-Cal beneficiaries must report changes within ten (10) days.

The State now uses computer systems to match welfare and Medi-Cal records with regular Social Security payments, unemployment insurance benefits, disability insurance benefits and wage records.

**AVOID THE RISK OF LEGAL ACTION AGAINST YOU!
REPORT CHANGES WHEN THEY HAPPEN.**

AVISO

La ley del estado y regulaciones exige que Ud. le informe al departamento de bienestar del condado:

- Cuando Ud. reciba un aumento o disminución de sus ingresos.
- Cuando alguien venga a vivir con Ud. o se mude de su casa.
- Cuando Ud. o sus dependientes comiencen a recibir otra cobertura de salud.
- Cualquiere cambio que pueda afectar su elegibilidad para asistencia pública.

Los recipientes de Ayuda a Familias con Niños Necesitados (AFDC) deben informar los cambios dentro de (5) días.

Los beneficiarios de Medi-Cal deben informar los cambios dentro de (10) días.

El estado usa sistemas de computadoras para aparear los archivos de asistencia pública y de Medi-Cal con los pagos del Seguro Social, beneficios por desempleo, pagos por incapacidad y archivos de salarios.

**¡EVITE EL RIESGO DE ACCIÓN LEGAL CONTRA USTED!
INFORME LOS CAMBIOS CUANDO OCURRAN.**

CONTROL MONTH: FEBRUARY 1985

County: _____

District Office: _____

Eligibility Worker: _____

Average Monthly Caseload: _____

Number of Status Reports Mailed for February 1985: _____

Please tally in all three sections for each case:

CLIENT CONTACTS	Section 1 CLIENT CONTACTS					Section 2 CLIENT ACTION			Section 3 COUNTY ACTION			
	ABD/MN	AFDC/MN	OTHER MN/MI	AFDC CASH	NO CHANGE	TIMELY CHANGE	UNTIMELY CHANGE	INCREASE SOC	DECREASE SOC	INELIGIBLE	NO CHANGE	
NO CONTACT												
TELEPHONE												
STATUS REPORT												
OTHER WRITTEN												
OFFICE VISIT												

COMMENTS:

TEST MONTH: MARCH 1985

County: _____

District Office: _____

Eligibility Worker: _____

Average Monthly Caseload: _____

Number of Status Reports mailed for March 1985: _____

Please tally in all three sections for each case:

	Section 1 CLIENT CONTACTS				Section 2 CLIENT ACTION			Section 3 COUNTRY ACTION			
	ABD/MN	AFDC/MN	OTHER MN/MI	AFDC CASH	NO CHANGE	TIMELY CHANGE	UNTIMELY CHANGE	INCREASE SOC	DECREASE SOC	INELIGIBLE	NO CHANGE
CLIENT CONTACTS											
NO CONTACT											
TELEPHONE											
STATUS REPORT											
OTHER WORKER											
OFFICE VISIT											

COMMENTS: _____

CONTROL MONTH: FEBRUARY 1985

Consolidation Form

Name of County: _____

Return to:

Contact person: _____

Corrective Action Unit
Eligibility Branch
714 F Street, Room 1692
Sacramento, CA 95814

Number of participating Eligibility workers: _____

Total average monthly caseload of all participating Eligibility workers: _____

Total status reports mailed for participating Eligibility workers: _____

Please tally in all three sections for each case:

	Section 1 CLIENT CONTACTS					Section 2 CLIENT ACTION			Section 3 COUNTRY ACTION		NO INELIGIBLE CHANGE
	CLIENT CONTACTS	ABD/MN	AFDC/MN	OTHER MN/MI	AFDC CASH	NO CHANGE	TIMELY CHANGE	UNTIMELY CHANGE	INCREASE SOC	DECREASE SOC	
NO CONTACT											
TELEPHONE											
STATUS REPORT											
OTHER WRITTEN											
OFFICE VISIT											

COMMENTS:

EVALUATION OF MEDICAL WARNING NOTICE STUFFER

Attachment E

TEST MONTH: MARCH 1985

Consolidation Form

Name of County: _____

Return to:

Contact person: _____

Corrective Action Unit
Eligibility Branch
714 P Street, Room 1692
Sacramento, CA 95814

Number of participating Eligibility Workers: _____

Total average monthly caseload of all participating Eligibility Workers: _____

Total status reports mailed for participating Eligibility Workers: _____

Please tally in all three sections for each case:

	Section 1 CLIENT CONTACTS				Section 2 CLIENT ACTION			Section 3 COUNTY ACTION			
	AND/MN	AFDC/MN	OTHER MN/MI	AFDC CASH	NO CHANGE	TIMELY CHANGE	UNTIMELY CHANGE	INCREASE SOC	DECREASE SOC	NEGLIGIBLE	NO CHANGE
CLIENT CONTACTS											
NO CONTACT											
TELEPHONE											
STATUS REPORT											
OTHER WRITTEN											
OFFICE VISIT											

COMMENTS: _____