STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF HEALTH SERVICES
714/7th P STREET
SACRAMENTO, CA 95814

April 28, 1987

TO: All County Welfare Directors
All County Administrative Officers

Letter: 87- 23

SUBJECT: MEDI-CAL FORMS -- NON-ENGLISH TRANSLATIONS

The Department of Health Services, Medi-Cal Eligibility Branch (MEB), is responsible for updating and maintaining approximately 130 Medi-Cal forms/publications. These forms/publications are used by county welfare departments for determining Medi-Cal eligibility and disseminating program information to beneficiaries and applicants.

The purpose of this letter is to determine how many forms are needed, for use by counties, in languages other than English and Spanish. California Government Code Sections stipulate in part that if 5 percent or more of the people served by any local office or facility of a state agency are non-English speaking then the state or local agency is responsible for producing non-English language materials.

MEB is asking all counties to complete the attached questionnaire so that we may determine future printing costs of the non-English language forms. Please note MEB will continue printing forms in Spanish.

Please complete and return the questionnaire by May 28, 1987 to:

Department of Health Services
Medi-Cal Eligibility Branch
714 P Street, Room 1676
Sacramento, CA 95814
Attn: Forms Coordinator

Thank you for your cooperation and if you have any questions, please feel free to contact our Forms Coordinator, Fahlda Nelson, at (916) 323-5439.

Sincerely,

Original signed by

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Attachment

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

Expiration Date: April 28, 1988

MEDI-CAL FORMS -- NON-ENGLISH TRANSLATIONS

QUESTIONNAIRE

County _____ Person Completing Form _____

Telephone # _____

1. Are you currently using any forms in languages other than English or Spanish that are not stocked by the DHS Warehouse?

YES |__| NO |__|

If yes, please list:

	FORM#/NAME	LANGUAGE	APPROXIMATE MONTHLY USAGE
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

2. Does your county welfare department serve a non-English (other than Spanish) speaking population of 5% or more?

YES |__| NO |__|

If yes, please list separately the non-English speaking primary language(s) of each group representing 5% or more of the population you serve.

1. _____

2. _____

3. _____

4. _____

5. _____

3. If you answered yes to question #2, please check the forms your county would use for the above listed groups and give the approximate monthly usage.

	FORM #/NAME		APPROXIMATE MONTHLY USAGE	LAUGUAGE
DHS	7026 - MEDI-CAL DENIAL/DISCONTINUANCE	|__|	_____	_____
MC	110 - MEDI-CAL CARD/POE LABEL REQUEST	|__|	_____	_____
MC	176 S - MEDI-CAL STATUS REPORT (Monthly)	|__|	_____	_____
MC	176 SQ - MEDI-CAL STATUS REPORT (Quarterly)	|__|	_____	_____
MC	210 - STATEMENT OF FACTS (Medi-Cal)	|__|	_____	_____
MC	210 A - SUPPLEMENT TO STATEMENT OF FACTS	|__|	_____	_____
MC	210 B - SUPPLEMENT TO STATEMENT OF FACTS	|__|	_____	_____
MC	215 - VOLUNTARY REQUEST FOR WITHDRAWAL OF APPLICATION	|__|	_____	_____
MC	215 A - BENEFICIARY WAIVER OF 10 DAY NOTIFICATION	|__|	_____	_____
MC	216 - RIGHTS OF PERSONS REQUESTING MEDI-CAL	|__|	_____	_____

C	217 - MEDI-CAL RESPONSIBILITY CHECKLIST	|__|	_____	_____
MC	218 - PRIVACY AND CONFIDENTIALITY NOTIFICATION	|__|	_____	_____
MC	223 - APPLICANT'S SUPPLEMENTAL STATEMENT OF FACTS FOR MEDI-CAL	|__|	_____	_____
MC	239 A - MEDI-CAL NOA DENIAL/ DISCONTINUANCE	|__|	_____	_____
MC	239 B-M - MEDI-CAL NOA APPROVAL FOR BENEFITS	|__|	_____	_____
MC	239 C-M - MEDI-CAL NOA CHANGE IN SHARE OF COST	|__|	_____	_____
MC	239 CR - MEDI-CAL NOA REDUCTION IN SHARE OF COST	|__|	_____	_____
MC	239 D - MEDI-CAL NOA APPLICATION FOR RETROACTIVE ELIGIBILITY	|__|	_____	_____
MC	239 E - MEDI-CAL NOA OVERPAYMENT	|__|	_____	_____
MC	239 F - MEDI-CAL SPECIAL TREATMENT PROGRAMS - NOA	|__|	_____	_____
MC	239 I - MEDI-CAL NOA DISCONTINUANCE OF BENEFITS STATUS REPORT NOT RECEIVED OR NOT COMPLETE	|__|	_____	_____
MC	239 R - MEDI-CAL NOA DECEASED	|__|	_____	_____
MC	239 U - MEDI-CAL NOA UTILIZATION OF PROPERTY	|__|	_____	_____
MC	239 W - MEDI-CAL NOA LIST PROPERTY FOR SALE PERSONS IN LTC	|__|	_____	_____
MC	239 X - MEDI-CAL NOA LIST PROPERTY FOR SALE PERSONS NOT IN LTC	|__|	_____	_____
MC	239 Y - MEDI-CAL NOA PROPERTY	|__|	_____	_____
MC	239 Z - MEDI-CAL NOA RESULT OF COUNTY REVIEW	|__|	_____	_____
MC	912 - BENEFIT CHOICE FORM	|__|	_____	_____

Does your county welfare department serve a non-English (other than Spanish) speaking population of less than 5%?

YES |__| NO |__|

If yes, please list the non-English speaking language(s) of each group.

1. _____

2. _____

3. _____

4. _____

5. _____

Please check the forms your county would order for the above listed groups and give the approximate monthly usage.

	FORM #/NAME		APPROXIMATE MONTHLY USAGE	LANGUAGE
HS	7026 - MEDI-CAL DENIAL/DISCONTINUANCE	|__|	_____	_____
MC	110 - MEDI-CAL CARD/POE LABEL REQUEST	|__|	_____	_____
MC	176 S - MEDI-CAL STATUS REPORT (Monthly)	|__|	_____	_____
MC	176 SQ - MEDI-CAL STATUS REPORT (Quarterly)	|__|	_____	_____
MC	210 - STATEMENT OF FACTS (Medi-Cal)	|__|	_____	_____
MC	210 A - SUPPLEMENT TO STATEMENT OF FACTS	|__|	_____	_____
MC	210 B - SUPPLEMENT TO STATEMENT OF FACTS	|__|	_____	_____
MC	215 - VOLUNTARY REQUEST FOR WITHDRAWAL OF APPLICATION	|__|	_____	_____
MC	215 A - BENEFICIARY WAIVER OF 10 DAY NOTIFICATION	|__|	_____	_____
MC	216 - RIGHTS OF PERSONS REQUESTING MEDI-CAL	|__|	_____	_____

C	217 - MEDI-CAL RESPONSIBILITY CHECKLIST	|__|	_____	_____
MC	218 - PRIVACY AND CONFIDENTIALITY NOTIFICATION	|__|	_____	_____
MC	223 - APPLICANT'S SUPPLEMENTAL STATEMENT OF FACTS FOR MEDI-CAL	|__|	_____	_____
MC	239 A - MEDI-CAL NOA DENIAL/ DISCONTINUANCE	|__|	_____	_____
MC	239 B-M - MEDI-CAL NOA APPROVAL FOR BENEFITS	|__|	_____	_____
MC	239 C-M - MEDI-CAL NOA CHANGE IN SHARE OF COST	|__|	_____	_____
MC	239 CR - MEDI-CAL NOA REDUCTION IN SHARE OF COST	|__|	_____	_____
MC	239 D - MEDI-CAL NOA APPLICATION FOR RETROACTIVE ELIGIBILITY	|__|	_____	_____
MC	239 E - MEDI-CAL NOA OVERPAYMENT	|__|	_____	_____
MC	239 F - MEDI-CAL SPECIAL TREATMENT PROGRAMS - NOA	|__|	_____	_____
MC	239 I - MEDI-CAL NOA DISCONTINUANCE OF BENEFITS STATUS REPORT NOT RECEIVED OR NOT COMPLETE	|__|	_____	_____
MC	239 R - MEDI-CAL NOA DECEASED	|__|	_____	_____
MC	239 U - MEDI-CAL NOA UTILIZATION OF PROPERTY	|__|	_____	_____
MC	239 W - MEDI-CAL NOA LIST PROPERTY FOR SALE PERSONS IN LTC	|__|	_____	_____
MC	239 X - MEDI-CAL NOA LIST PROPERTY FOR SALE PERSONS NOT IN LTC	|__|	_____	_____
MC	239 Y - MEDI-CAL NOA PROPERTY	|__|	_____	_____
MC	239 Z - MEDI-CAL NOA RESULT OF COUNTY REVIEW	|__|	_____	_____
C	912 - BENEFIT CHOICE FORM	|__|	_____	_____

5. Are there Medi-Cal forms other than those listed in questions 3 and 4, your county would use if they were translated?

YES |__| NO |__|

Please list:

	FORM#/NAME	LANGUAGE	APPROXIMATE MONTHLY USAGE
1.			
2.			
3.			
4.			
5.			

6. Comments: