CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

DATE: October 31, 2025

TO: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY WELFARE ADMINISTRATIVE OFFICERS
ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIAISONS
ALL COUNTY HEALTH EXECUTIVES
ALL COUNTY MENTAL HEALTH DIRECTORS
ALL COUNTY MEDS LIAISONS

Letter No.:25-20

SUBJECT: RESUMPTION OF ASSET VERIFICATION PROGRAM OPERATIONS DUE TO ASSET LIMIT REINSTATEMENT
(References: All County Welfare Directors Letter (ACWDL) 25-14, 25-09, 23-29, 22-33, 22-13E, 22-12, 21-24, 21-23, 21-12, 19-17E, 17-37, 17-26E, and Medi-Cal Eligibility Division Information Letter (MEDIL) I 22-49, I 21-42, I 21-03, I 17-05)

Purpose

The purpose of this All County Welfare Directors Letter (ACWDL) is to inform counties that Asset Verification Program (AVP) operations will resume due to the reinstatement of asset limits for all Long-Term Care (LTC) and non-LTC Aged, Blind, and Disabled (ABD) applicants, members, and their responsible relatives (RRs) effective January 1, 2026. This ACWDL consolidates previous DHCS guidance on AVP and reminds counties of actions to be taken when determining eligibility for Non-MAGI Medi-Cal cases requiring an asset test at application, change in circumstance (CIC), and annual renewal.

Authority

Federal law (42 United States Code Section 1396w [Section 1940 of the Federal Social Security Act]) requires California's Medicaid program, Medi-Cal, to maintain an electronic AVP to detect unreported assets for applicants, members, and their RRs. Welfare & Institutions Code (WIC) Section 14013.5 outlines the requirements of California's AVP.

Background

DHCS conducted a test pilot program from January 2017 through March 2017. As outlined in MEDIL I 17-05 and ACWDL 17-37, the pilot aimed to assess a new AVP and its ability to identify undisclosed assets that may exceed property reserve limits. The success of the pilot program resulted in a phased rollout, beginning with monthly AVP reports for LTC annual redeterminations, and gradually increasing scope to include reports for all ABD annual redeterminations. This expansion occurred alongside report automation and request functionality programming in the Medi-Cal Eligibility Data System (MEDS) and the Statewide Automated Welfare System (SAWS) allowing County Eligibility Workers (CEWs) to order AVP for applications, CIC, and RR requests.

In 2021, several health measures were consolidated in Assembly Bill (AB) 133 as part of the Health Omnibus Bill of 2021-2022. AB 133 added section 14005.62 to the Welfare and Institutions Code (WIC), which established a two-phased approach to eliminating the asset limits for Non-MAGI Medi-Cal programs:

- Phase I: Increased the asset limits to $130,000 person and $65,000 for each additional household member (up to a maximum of 10 people) effective July 1, 2022.
- Phase II: Eliminated the asset limits for all Non-MAGI programs, effective January 1, 2024.
    - In accordance with ACWDL 23-29, AVP is used only to determine whether ABD applicants or members seeking coverage for LTC transferred assets for less than fair market value during the federally-mandated five-year lookback period. ***Starting with applications and renewals dated on or after January 1, 2026, CEWs must resume normal business processes as outlined in this ACWDL.***

The 2025-2026 Health Omnibus Bill, AB 116, amends section 14005.62 of the Welfare and Institutions Code (WIC) to remove the subdivision which had eliminated the asset limits for all Non-MAGI programs, and reenacts sections of the WIC to reinstate the consideration of resources, including property and other assets, when making Medi-Cal eligibility determinations, no sooner than January 1, 2026. An asset test will be required for all impacted Non-MAGI programs, including the Medicare Savings Programs (MSP) and LTC programs, at application, CIC, and annual renewal. The Pickle, Disabled Adult Child (DAC), and Disabled Widow/er (DW) programs are under separate federal waiver authority and are currently exempt from the new requirements.

Changes to AVP Review Requirements at Application, and Change in Circumstance, and Annual Renewal Effective January 1, 2026

Effective January 1, 2026, the asset limit will be reinstated and set to $130,000 for one person and $65,000 for each additional person (up to 10 maximum). CEWs must follow the modified asset verification review requirements at application, CIC, and annual renewal below.

I: Application and Change in Circumstance

Weekly Batch Process/AVP Requests Submitted by CEWs

Each week, CEWs will submit AVP requests for applications, reported and unreported CIC[1], and RR searches in the MEDS[2] or the SAWS by 5pm PT each Friday. For RRs who are not applying for coverage and are not known to MEDS, CEWs must submit requests through a manual process by 5pm PT each Wednesday. DHCS will distribute updated instructions on submitting non-applying RR requests to counties via CWDA following the publication of this ACWDL.

Submitted requests, including non-applying RRs, are compiled by DHCS on Friday evening and are sent to LexisNexis for processing on Monday morning. Requests in this batch cycle are processed at a volume of about 6,000 per week.

<u>Request Rejections</u>
Requests that could not be sent to LexisNexis due to an invalid SSN or address will be returned to CEWs the following week for revision and resubmission. If CEWs do not receive a rejection email, then it indicates that there were no rejections for that week.

For successful AVP requests, LexisNexis returns the response file to DHCS within 12-14 calendar days. DHCS will distribute the response file to CalSAWS 1-3 business days later.

Below is a visualization of the weekly batch process and timeline:

Batch Process	Target Population(s)	AVP Requests Submitted By	Timeline		
Weekly	Applications, Change in Circumstance, and Responsible Relative Searches	CEWs via MEDS or SAWS by 5pm PT each Friday ***(manual)***	Request file picked up and submitted by vendor each Monday	Response file received by DHCS within 12-14 calendar days	Response file received by CEWs via SAWS 1-3 business days later

[1] Counties shall not send out a Medi-Cal Request for Information form (MC 355) requesting asset information for reported changes unrelated to assets.
[2] ACWDL 21-24 and MEDIL I 21-42 provide guidance on how to submit AVP requests in MEDS with expectations for appropriate use.

Reminders and Useful Tips for Submitting AVP Requests

Constraints

- AVP cannot be ordered in SAWS or MEDS for individuals with no SSN, pseudo SSN, or SSN that has not yet been verified in MEDS. For ABD applicants and RRs with no SSN or pseudo SSN, CEWs must request administrative verification of all assets.
- Determine whether RRs not known to MEDS are applying for benefits. If applying, wait for the SSN to be verified in MEDS before requesting AVP electronically. If not applying, utilize the manual process.

Lookback Period

- Both MEDS and SAWS have lookback indicator functionality, allowing CEWs to differentiate between LTC and non-LTC AVP requests. Marking the LTC indicator in either system will result in a request for asset information with a 60-month lookback period, while marking the non-LTC indicator will result in a 90-day lookback period.
- The lookback period is calculated based on the date the request is submitted to the vendor, not when it is submitted in MEDS or SAWS.

Request Tracking

- There is no mechanism to prevent the request of asset verification inquiries for non-ABD individuals.
- Improperly submitted requests will result in additional costs to DHCS and unnecessary response data returning to the county. Therefore, CEWs must carefully track AVP request submissions and remain mindful of the demographics subject to AVP reporting requirements.

Fair Credit Reporting Act (FCRA)

- Consumer information obtained via the asset verification reports is protected under the provisions of the Fair Credit Reporting Act (FCRA). The presence of an AVP response will subject the case to the FCRA requirements as set forth in ACWDL 21-23.

Data Longevity

- All data received from the AVP reports are valid for 90 days. CEWs must consider attested values and the timeliness of AVP response when adjudicating eligibility. Please refer to the section "Use of Self-Attestation and Reasonable Compatibility for Non-MAGI Eligibility Determinations" and "Determining Counts," below, for more information.

II: Annual Renewal

Monthly Batch Process/Requests Submitted by DHCS

After MEDS renewal, DHCS compiles AVP requests for all ABD LTC and Non-LTC Medi-Cal members with an upcoming annual renewal. Annual renewal requests are submitted two months prior to their redetermination date in MEDS (for example, members with a redetermination due in June 2026 will have their AVP requests submitted in April 2026).

LexisNexis picks up the request file between the 1st and 5th of each month and returns the response file to DHCS within 12-14 calendar days. DHCS will distribute the response file to CalSAWS 1-3 business days later.

Below is a visualization of the monthly batch process and timeline:

Batch Process	Target Population(s)	AVP Requests Submitted By	Timeline		
Monthly	Annual Renewals	DHCS after MEDS renewal ***(automatic)***	Request file picked up and submitted by vendor between 1st and 5th of each month	Response file received by DHCS on or before the 15th of each month	Response file received by CEWs via SAWS 1-3 business days later
			Response file (spreadsheet format) received by participating counties after the 20th of each month		

<u>IMPORTANT:</u> DHCS will transmit annual renewal AVP request files in November and December 2025 to ensure AVP results are available prior to the mailing of renewal packets for the January and February 2026 renewal populations. These early transmissions are necessary to ensure counties process annual renewals in compliance with the reinstated asset limit requirements effective January 1, 2026. For these two renewal months, the AVP results will be viewable exclusively in MEDS via the Financial

Institution, Real Property, Aircraft, and Watercraft screens. For more information about these screens, please refer to MEDIL I 21-03. DHCS will also redistribute the MEDS Manual update showing step-by-step instructions for accessing these screens to CWDA and/or county AVP contact(s). DHCS and CalSAWS are working together to re-establish the annual renewal batch process, with work efforts currently underway to validate timelines, system readiness, and data accuracy. AVP reports for applications, CIC, and RR searches (*weekly batch process*) are already available for use in SAWS and MEDS.

Use of Self-Attestation and Reasonable Compatibility for Non-MAGI Eligibility Determinations

The Centers for Medicare & Medicaid Services (CMS) permit the use of attested information that is "reasonably compatible" with electronic data sources to streamline Non-MAGI eligibility determinations.[3] Self-attestation by an individual, or attestation by the individual's household, family member, or authorized representative, is unverified information collected during the application process. CEWs must determine whether attested values are reasonably compatible with electronic data sources, such as the asset verification reports. If both the attested value and the electronic data are at or below the asset limits, they are considered reasonably compatible. CEWs must rely on attested asset information provided during the application process, wherever possible, and subsequently verify that information using the AVP reports pre or post Medi-Cal enrollment as stipulated in 42 CFR § 435.945.

For applicants and RRs without an SSN, CEWs must accept self-attestation and administratively verify the information provided, if applicable. As the use of attested values can expedite the provision of care, CEWs should facilitate use of the SAWS2 Plus in lieu of the Single Streamlined Application (SSApp) for applicants with a property component to their eligibility determination wherever possible.

To be accepted within the context of California's AVP, attestation must include:

- The minimum necessary information for all asset types listed in MEDIL I 22-49 (defined as "complete attestation"); and/or,
- An attested absence of asset(s). For example:
    - Client states they do not have any assets during intake; or,

[3] See, Streamlined Eligibility and Enrollment for Non-MAGI Populations, p. 16. https://www.medicaid.gov/state-resource-center/mac-learning-collaboratives/downloads/non-magi-populations.pdf.

  - Client states they do not have any assets under penalty of perjury[4].

As of January 1, 2026, CEWs must grant Medi-Cal eligibility for all LTC and non-LTC ABD applicants and their RRs if:

- The attested asset information and/or information found on electronic verification sources are at, or under $130,000 for one person and $65,000 for each additional person (up to 10 maximum).

A complete attestation (and/or the attested absence of asset(s)) is needed to approve eligibility using this method. However, attestation cannot be accepted for trusts (including special needs trusts), annuities, and Spousal Impoverishment (SI) cases. For these scenarios, CEWs must continue to obtain administrative verification and follow standard eligibility approval procedures.

Attested values can be used to expedite the approval of Medi-Cal, but they cannot be used to maintain benefits in the absence of AVP reports or administrative verification. If eligibility is approved based on attested values, please refer to Member/CIC Scenarios #1-3 on pages 11-13 for actions to be taken based on the timely receipt or non-receipt of the AVP report.

Ex-Parte Processing

Consistent with federal and state policy, counties must conduct ex-parte reviews at the start of processing an application, CIC, or annual redetermination for Medi-Cal. This process allows CEWs to use existing case information, AVP results, and other electronic data sources to complete eligibility determinations without contacting the individual, provided all necessary information is available and the case meets reasonable compatibility standards. Ex-parte processing helps minimize delays, reduce administrative burden, and ensure uninterrupted access to coverage for eligible individuals.

CMS previously granted DHCS Section 1902(e)(14)(A) waiver flexibilities for use in ex-parte eligibility determinations and redeterminations during the Public Health Emergency (PHE) and Continuous Coverage Unwinding Period. The following waiver flexibilities, once used for AVP, were sunset as of June 30, 2025:

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4 See, ACWDL 21-12 for affidavits signed under penalty of perjury; *See,* ACWDL 19-17E for telephonic and electronic signature requirements for affidavits.

1. Renew Medi-Cal eligibility without regard to the asset test for Non-MAGI members subject to an asset test (*prior to January 1, 2024*).
2. Renew Medi-Cal for individuals for whom Asset Verification data is not returned or returned within a reasonable timeframe

Due to the sunsetting of Section 1902(e)(14)(A) waiver flexibilities, the application, CIC, and annual renewal scenarios as presented in ACWDL 22-13E are obsolete. Please refer to the scenarios below for the most up-to-date information.

However, despite the sunset of waiver flexibilities, DHCS will continue to maintain the reasonable timeframe counts for AVP reports established in MEDIL I 22-20E to simplify the ex-parte process and provide counties with a deadline for when administrative verification must be requested due to the non-receipt or untimely receipt of AVP reports.

Determining Counts

- The 20- calendar day reasonable timeframe count applies to applications, CIC, and RR searches (*weekly batch process*) and must begin on the Monday after counties request the AVP report in MEDS or SAWS.
- The 30- calendar day reasonable timeframe count applies to annual renewals (*monthly batch process*) and must begin on the 5th of each month.
- If either the Monday or the 5th of the month falls on a weekend or holiday, CEWs must begin the reasonable timeframe count on the following business day.

Application and CIC scenarios and actions CEWs must take to determine or redetermine eligibility for Non-MAGI Medi-Cal programs requiring an asset test (effective January 1, 2026):

Application Scenario		Actions CEWs Must Take
1.	• Complete attestation is provided • AVP report is received within 20- calendar day timeframe • *(This scenario assumes the application is still pending approval)*	Calculate property reserve using the most recent values from the AVP report (*do not document AVP report values in the case file*). For asset(s) not detected by the AVP report, utilize attested or administratively verified values in the case file to determine eligibility. If present, administratively verified values should be used in lieu of attested values. Example 1: John attested to owning a Bank of America checking account with a $500 balance which is documented in the case file, but the AVP report

Application Scenario		Actions CEWs Must Take
		does not detect the account. In this scenario, CEWs would use the attested value of $500 when calculating the property reserve. **__Under limit:__** The attested and AVP report values are reasonably compatible. Approve Medi-Cal eligibility and do not request further verification of assets. **__Over limit:__** The attested and AVP report values are not reasonably compatible. Request administrative verification of assets such as banking statements and/or property valuation reports and follow normal business processes to complete the eligibility determination. __NOTE:__ Counties must follow Second Contact requirements prior to denial at application to obtain necessary verifications. Please refer to Second Contact guidance reminders and scenario examples in ACWDL 22-12.
2.	• Complete attestation is provided • AVP report is not received but still within 20-calendar day timeframe • *(This scenario assumes the application is still pending approval)*	Calculate property reserve using attested value(s). **__Under limit__:** Approve Medi-Cal eligibility and recalculate property reserve once AVP report is received. Refer to Member/CIC Scenarios #1-3 on pages 11-13 for next steps to be taken. **__Over limit:__** Request administrative verification of assets such as banking statements and/or property valuation reports and recalculate the property reserve to determine eligibility. __NOTE:__ Counties must follow Second Contact requirements prior to denial at application to obtain necessary verifications. Please refer to Second Contact guidance reminders and scenario examples in ACWDL 22-12.

Application Scenario		Actions CEWs Must Take
3.	• Complete attestation is provided • AVP report is not received within 20-calendar day timeframe • *(This scenario assumes the application is still pending approval)*	Calculate property reserve using attested value(s). **<u>Under limit:</u>** Reasonable compatibility cannot be established. Request administrative verification of assets, such as banking statements and/or property valuation reports, and reconcile attested value(s) with administratively verified values to determine eligibility. Document in the case file that ex-parte review was unsuccessful due to the non-receipt or untimely receipt of the AVP report. **<u>Over limit:</u>** Request administrative verification of assets such as banking statements and/or property valuation reports and recalculate the property reserve to determine eligibility. Document in the case file that ex-parte review was unsuccessful due to the non-receipt or untimely receipt of the AVP report. <u>NOTE:</u> Counties must follow Second Contact requirements prior to denial at application to obtain necessary verifications. Please refer to Second Contact guidance reminders and scenario examples in ACWDL 22-12.
4.	• No or incomplete attestation provided • AVP report is not received but still within 20-calendar day timeframe	**Application is incomplete.** A determination of eligibility cannot be made until complete attestation is obtained. Request the MC 604 IPS and other supplemental forms necessary for Non-MAGI eligibility determinations in accordance with ACWDL 17-26E. CEWs can also obtain attestation via writing, telephone or in-person interview. <u>NOTE:</u> Counties must follow Second Contact requirements prior to denial at application to obtain necessary verifications. Please refer to Second Contact guidance reminders and scenario examples in ACWDL 22-12. If/when a complete attestation is obtained, please follow Application Scenario # 1 or 2 above.

Application Scenario		Actions CEWs Must Take
5.	• No or incomplete attestation provided • AVP report is not received within 20- calendar-day timeframe	**Application is incomplete**. A determination of eligibility cannot be made until complete attestation is obtained. Request the MC 604 IPS and other supplemental forms necessary for Non-MAGI eligibility determinations in accordance with ACWDL 17-26E. CEWs can also obtain attestation via writing, telephone, or in-person interview. NOTE: Counties must follow Second Contact requirements prior to denial at application to obtain necessary verifications. Please refer to Second Contact guidance reminders and scenario examples in ACWDL 22-12. If/when a complete attestation is obtained, please follow Scenario # 3 above.

Member/CIC Scenario*		Actions CEWs Must Take
1.	• Eligibility was approved based on complete attestation • AVP report is received within 20- calendar day timeframe *Note: This scenario is a continuation of Application Scenario #2.*	Recalculate property reserve using the most recent values from the AVP report (*do not document AVP report values in the case file*) and information known in the case file for asset(s) not detected by the AVP report. Values for asset(s) not detected by the AVP report can include attested or administratively verified values. If present, administratively verified values should be used in lieu of attested values. Example 1: Jennifer attested to owning a checking account at Golden 1 Credit Union with a $500 balance, which is documented in the case file. She was approved for Medi-Cal based on attested values, but the AVP report does not detect the Golden 1 checking account when it returns. In this scenario, CEWs would use the attested value of $500 when recalculating the property reserve.

Member/CIC Scenario*		Actions CEWs Must Take
		<u>Example 2:</u> Ernesto was approved for Medi-Cal based on attested values and a previously verified Mechanics Bank trust account valued at $50,000. All assets were documented in the case file, but the AVP report does not detect the trust account when it returns. In this scenario, CEWs would use the administratively verified value of $50,000 when recalculating the property reserve if the verification is 90 or less days old (new trust documentation must be requested if over 90 days old). **<u>Under limit:</u>** The attested and AVP report values are reasonably compatible. Maintain Medi-Cal eligibility and do not request further verification of assets (including closed accounts and those not detected by the AVP report). **<u>Over limit:</u>** The attested and AVP report values are not reasonably compatible. Request administrative verification of all assets, including closed accounts and those asset(s) not detected by the AVP report, with banking statements and/or property valuation reports. Redetermine eligibility in accordance with 42 CFR § 435.916(d) and W&I Section 14005.37.
2.	• Eligibility was approved based on complete attestation • AVP report is not received but still within 20-calendar day timeframe *<u>Note:</u> This scenario is a continuation of Application Scenario #2.*	Maintain Medi-Cal eligibility. If AVP report is received, recalculate property reserve and take action in accordance with Member/CIC Scenario #1. If AVP report is not received, take action in accordance with Member/CIC Scenario #3.

Member/CIC Scenario*		Actions CEWs Must Take
3.	• Eligibility was approved based on complete attestation • AVP report is not received within 20- calendar day timeframe *<u>Note:</u> This scenario is a continuation of Application Scenario #2.*	If after the 30-day period following the mailing of the MC 355 and the second attempted contact, the member does not provide the administrative verification of assets requested, the county shall send a timely 10-day NOA explaining the reason for discontinuance from Medi-Cal.
4.	• Member reports a CIC or • There is an unreported CIC (e.g., client turns 65 and is being evaluated for Non-MAGI Medi-Cal) • AVP report is received within 20- calendar day timeframe	Recalculate property reserve using the most recent values from the AVP report (*do not document AVP report values in the case file*) and information known in the case file for asset(s) not detected by the AVP report. Values for asset(s) not detected by the AVP report can include attested or administratively verified values. If present, administratively verified values should be used in lieu of attested values. <u>Example 1:</u> At application, Nathan attested to owning a checking account at Umpqua Bank with a $500 balance. During the initial run, the AVP report detected the Umpqua Bank account but because his attestation was reasonably compatible with the AVP report, the $500 value was documented in the case file. ***AVP is run after Nathan reports a CIC***, and it does not detect the Umpqua Bank account. In this scenario, CEWs would use the attested value of $500 when recalculating the property reserve. <u>Example 2:</u> Sharice turned 65 and is being evaluated for Non-MAGI Medi-Cal. As part of her evaluation, she provides administrative verification of a Wells

Member/CIC Scenario*		Actions CEWs Must Take
		Fargo trust account valued at $50,000. The AVP report does not detect the Wells Fargo trust when it returns. In this scenario, CEWs would use the administratively verified value of $50,000 when recalculating the property reserve if the verification is 90 or less days old (new trust documentation must be requested if over 90 days old). **<u>Under limit:</u>** The case file and AVP report values are reasonably compatible. Maintain Medi-Cal eligibility and do not request further verification of assets (including closed accounts and those not detected by the AVP report). **<u>Over limit:</u>** The case file and AVP report values are not reasonably compatible. Request administrative verification of all assets, including closed accounts and those assets not detected by the AVP report, with banking statements and/or property valuation reports. Recalculate property reserve using the most recent combined value of all assets provided on all administrative verification documents, including those asset(s) previously disclosed but not returned by the AVP report. <u>NOTE:</u> Counties must follow ACWDL 22-33 requirements to obtain necessary verifications at CIC and discontinue when necessary information is not received.
5.	• Member reports a CIC or • There is an unreported CIC (e.g., client turns 65 and is being evaluated for Non-MAGI Medi-Cal)	If after the 30-day period following the mailing of the MC 355 and the second attempted contact, the member does not provide the administrative verification of assets requested, the county shall send a timely 10-day NOA explaining the reason for discontinuance from Medi-Cal.

Member/CIC Scenario*		Actions CEWs Must Take
	• AVP report is not received within 20- calendar day timeframe	

**This section does not apply to members with an upcoming annual redetermination. Actions to be taken for annual renewals can be found in the Annual Renewal Scenario table below.*

Annual Renewal scenarios and actions CEWs must take to redetermine eligibility for Non-MAGI Medi-Cal programs requiring an asset test (effective January 1, 2026):

Annual Renewal Scenario		Actions CEWs Must Take
1.	• AVP report is received within 30-calendar day timeframe	Calculate property reserve using the most recent values from the AVP report (*do not document AVP report values in the case file*) and information known in the case file for asset(s) not detected by AVP. Values for asset(s) not detected by AVP can include attested or administratively verified values. If present, administratively verified values should be used in lieu of attested values. <u>Example 1:</u> At application, Thomas was approved based on attested values which were reasonably compatible with the AVP report. All attested values were documented in the case file, including a Golden 1 Credit Union checking account valued at $500. ***When AVP was run at annual renewal***, it did not detect the Golden 1 checking account. In this scenario, CEWs would use the attested value of $500 when calculating the property reserve. <u>Example 2:</u> At application, Julia was approved based on attested values, but when AVP returned the attested values were not reasonably compatible with the AVP report. After requesting administrative

Annual Renewal Scenario		Actions CEWs Must Take
		verification of all assets, Julia was found to be under limits and eligibility was maintained. All of the administratively verified assets were documented in the case file, and one of these was a Redwood Credit Union savings account with a $5,000 balance. ***When AVP was run at annual renewal***, it did not detect the Redwood Credit Union savings account. In this scenario, CEWs would use the previously verified value of $5,000 when calculating the property reserve. **Under limit:** The case file and AVP report values are reasonably compatible. Maintain Medi-Cal eligibility and do not request further verification of assets (including closed accounts and those not detected by AVP). **Over limit:** The case file and AVP report values are not reasonably compatible. Request administrative verification of all assets, including closed accounts and those not detected by AVP, with banking statements and/or property valuation reports. Recalculate property reserve using the most recent combined value of all assets provided on administrative verification documents, including assets previously disclosed but not returned by the AVP report. NOTE: Counties must follow ACWDL 22-33 requirements to obtain necessary verifications at annual renewal and discontinue when necessary information is not received.
2.	• AVP report is not received within 30-calendar day timeframe	If after the 30-day period following the mailing of the MC 355 and the second attempted contact, the member does not provide the administrative verification of assets requested, the county shall send a timely 10-day NOA explaining the reason for discontinuance from Medi-Cal.

Reminders and Best Practices

CEWs must not request AVP reports to assist in eligibility determinations for other welfare programs, such as CalWORKS or CalFresh. In cases where individuals are applying for or dually enrolled in Medi-Cal and CalWORKS or CalFresh, counties are to use the AVP reports solely to determine or redetermine Medi-Cal eligibility. In addition, CEWs must not request AVP reports for MAGI Medi-Cal cases, except when members transition from MAGI to Non-MAGI Medi-Cal. To ensure access to and continuity of care, CEWs must assist clients in obtaining administrative verification of assets whenever needed.

Documentation of Attested Values

CEWs should document only attested values and values obtained through administrative verification in the case file (as a reminder, AVP report values must not be documented in the case file). If a client is over limits or AVP is not received timely, attested values should be updated with administratively verified values.

Documentation of Closed Assets

If the AVP report provides evidence that a previously known asset has been closed, then the CEW should remove that asset in the case record. If the record is known in SAWS, then the case should be updated to reflect that the asset is closed by using the AVP report to end date the asset listing.

All supporting information and/or documentation used in eligibility determinations must be retained in the case notes/files to be compliant with audits and appeals requirements. This may include person(s) contacted, dates, times, and other applicable information or documentation to support the case file.

If you have any questions, or if we can provide further information, please contact the Medi-Cal Eligibility Division (MCED) Policy Inbox at MCED-Policy@dhcs.ca.gov.

Sincerely,

Sarah Crow, Chief
Medi-Cal Eligibility Division