

## DEPARTMENT OF HEALTH SERVICES

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July 6, 1994

TO: All County Welfare Directors  
All County Administrative Officers  
All County Medi-Cal Program Specialists/Liaisons

Letter No.: 94-58

## INTERCOUNTY TRANSFER SIMPLIFICATION, FORM CA 215

Ref.: California Code of Regulations, Sections 50136 and 50137; Department of Social Services' (DSS) All County Letter (ACL) No. 94-39; Manual of Policy and Procedures No. 40-187 and 40-195

The purpose of this letter is to provide counties with information regarding changes to the intercounty transfer (ICT) process for the Medi-Cal program. Additionally, this letter transmits a camera ready copy of the new ICT form, the CA 215. The CA 215 will not be stocked in the state warehouse at this time. Counties may implement the CA 215 immediately but no later than September 1, 1994.

The new form incorporates information needed for the Aid to Families with Dependent Children, Food Stamps, and Medi-Cal programs. DSS issued ACL No. 94-39 which addressed specific changes required for DSS program ICT's. This letter will not repeat that information. However, the county should refer to ACL No. 94-39 for general discussion.

In an effort to streamline the ICT process, Department of Health Services will waive the requirement for the initiating county to send a copy of the MC 210 Statement of Facts. The MC 210 will be optional but, if the second county request the Statement of Facts, the initiating county must forward a copy with any additional verifications.

Counties are also reminded that current regulations allow for the second county's effective date to be "the first day of the month following the month in which the initiating county department discontinues eligibility" {Title 22, Section 50137 (b)}. Also regulations allow for an earlier effective date if the initiating county is able to suppress it's responsibility for the following month {Section 50137 (c)}.

**FORM COMPLETION**

Specific Medi-Cal case information must be entered as follows:

- \* **CASE STATUS:** The initiating county must enter their discontinuance date in the MC box.
- \* **MEDI-CAL ONLY CASE INFORMATION:** If appropriate, the share of cost (SOC) will be entered for specific Family Budget Unit (FBU) members. If there are more SOC FBU's that cannot be entered in the three boxes provided, the county should enter that information in the "OTHER INFORMATION" area.

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Hunt v. Kizer or any Sneeve cases should be checked in the "COURT CASES" area.

Any **Percentage Programs** based on the Federal Poverty Level must be indicated by checking this box.

For any **Long-Term Care (LTC)** case with a Community Spouse Resource Allocation (CSRA) the amount of the CSRA must be entered in that box.

LTC period of ineligibility and any continued eligibility persons must be indicated in those two boxes.

\* **DOCUMENTATION SENT:** The county must check any of the appropriate boxes to indicate documentation being sent with the CA 215. Any other information which the initiating county believes is important for the second county to receive should also be notated in this area.

\* **SUMMARIES OF ELIGIBILITY:** Property and income amounts and sources must be indicated in this area. Any important extraneous information should be noted in the **OTHER INFORMATION** area.

If you have any further questions regarding this form or its implementation, please contact Kveta Simon of my staff at (916) 657-2767.

Sincerely,

ORIGINAL SIGNED BY

Frank S. Martucci, Chief  
Medi-Cal Eligibility Branch

Enclosures

NOTIFICATION OF INTERCOUNTY TRANSFER

SENDING COUNTY AND ADDRESS			CASE NAME		CASE NUMBER
			RECIPIENT ADDRESS NUMBER/STREET CITY		ZIP CODE
RECEIVING COUNTY			PAYEE'S NAME (IF DIFFERENT)		RECIPIENT'S PHONE NUMBER(S)
<b>CASE STATUS</b>			RELATIONSHIP TO AIDED CHILD(REN) (IF DIFFERENT)		
DISC. DATES:	AFDC/CAAP	FS	MC		
END DATES:	NET/TCC	TMC			
<b>OVERPAYMENTS</b>			<b>RESEARCH COUNTIES ONLY</b>		
PROGRAM	BALANCE OWED	ADJUSTMENT		<input type="checkbox"/> APDP/CWPDP <input type="checkbox"/> CONTROL <input type="checkbox"/> EXPERIMENTAL <input type="checkbox"/> LINK-UP <input type="checkbox"/> CONTROL <input type="checkbox"/> EXPERIMENTAL <input type="checkbox"/> CAL-LEARN <input type="checkbox"/> CONTROL <input type="checkbox"/> EXPERIMENTAL	
AFDC .....	\$ .....	<input type="checkbox"/> 90% <input type="checkbox"/> 95%		<b>RESEARCH COUNTIES AND MEDI-CAL ONLY</b>	
CHILD CARE PROGRAMS .....	\$ .....	%		<input type="checkbox"/> \$30 1/3 received    WHO        FROM        TO ----- <input type="checkbox"/> \$30 1/3 received    WHO        FROM        TO ----- <input type="checkbox"/> \$30 - 8 months      WHO        FROM        TO -----	
GAIN (Other Supportive services) .....	\$ .....	<input type="checkbox"/> 90% <input type="checkbox"/> 95%		<b>DOCUMENTATION SENT</b>	
CAL-LEARN BONUS .....	\$ .....	<input type="checkbox"/> 90% <input type="checkbox"/> 95%		<input type="checkbox"/> MOST RECENT CA 1/SAWS 1 <input type="checkbox"/> PE/FED ELIG. DETERMINATION (Work History Page from JA 2/SAWS 2) <input type="checkbox"/> INCAP/DED VERIFICATION ATTACHED <input type="checkbox"/> OP/OI RECORDS <input type="checkbox"/> OTHER	
FOOD STAMP OI .....	\$ .....	TYPE OF OI: <input type="checkbox"/> IPV <input type="checkbox"/> Inadvertent Household Error <input type="checkbox"/> Agency Error			
<b>SANCTIONS</b>			<b>SUMMARIES OF ELIGIBILITY</b>		
<input type="checkbox"/> AFDC IPV	<input type="checkbox"/> FIRST	<input type="checkbox"/> SECOND	<input type="checkbox"/> THIRD		
<input type="checkbox"/> FS IPV	<input type="checkbox"/> FIRST	<input type="checkbox"/> SECOND	<input type="checkbox"/> THIRD		
<input type="checkbox"/> GAIN	<input type="checkbox"/> FIRST	<input type="checkbox"/> SECOND	<input type="checkbox"/> THIRD		
WHO	ENDING DATE(S)				
<b>AFDC CASE INFORMATION</b>			EARNED INCOME:		
GRANT	PRIOR MONTH	CURRENT MONTH			
AMOUNT	\$	\$			
SPECIAL NEEDS:	WHO	TYPE	AMOUNT		
HOMELESS ASSISTANCE	DATE FIRST ISSUED				
<input type="checkbox"/> TEMPORARY RECEIVED	_____				
<input type="checkbox"/> PERMANENT RECEIVED	_____				
PERIOD OF INELIGIBILITY:	PROPERTY:				
<input type="checkbox"/> LUMP SUM: ENDING DATE _____ REMAINDER \$ _____	<input type="checkbox"/> Restricted Account(s)				
<input type="checkbox"/> RESTRICTED ACCOUNT(S): ENDING DATE _____	OTHER:				
<input type="checkbox"/> RECEIVED O8 EXEMPTION: CHILD'S NAME _____	OTHER:				
<b>CAL-LEARN/GAIN CASE INFORMATION</b>			OTHER:		
<input type="checkbox"/> C-L BONUS DUE: WHO AND AMOUNT	REPORT CARD PERIOD ENDING	<input type="checkbox"/> C-L SANCTION: WHO	REPORT CARD PERIOD ENDING		
<input type="checkbox"/> GAIN, One-Time Through - Job Services Only - WHO:					
<b>MEDI-CAL ONLY CASE INFORMATION</b>					
<input type="checkbox"/> SOC:	WHO AND AMOUNT	WHO AND AMOUNT	WHO AND AMOUNT		
<input type="checkbox"/> COURT CASES:					
<input type="checkbox"/> HUNT V. KIZER <input type="checkbox"/> SNEEDE					
<input type="checkbox"/> PERCENT/FPL PROGRAM	<input type="checkbox"/> LTC: CSRA		NAME		
_____ %	\$ _____		EW FILE NUMBER		
<input type="checkbox"/> PERIOD OF INELIGIBILITY FOR	<input type="checkbox"/> CONTINUED ELIGIBILITY: (Specify)		PHONE NUMBER		DATE COMPLETED
<input type="checkbox"/> NAME: _____	WHO: _____		FAX		
<input type="checkbox"/> LTC MONTHS: _____	WHO: _____		( )		( )

## ABBREVIATIONS SUMMARY

<b>AFDC:</b> .....	Aid to Families with Dependent Children	<b>IPV:</b> .....	Intentional Program Violation
<b>APDP:</b> .....	Assistance Payments Demonstration Project	<b>LTC:</b> .....	Long Term Care
<b>CAAP:</b> .....	California Alternative Assistance Program	<b>NET:</b> .....	Non-Gain Education and Training
<b>C-L:</b> .....	Cal-Learn	<b>OI:</b> .....	Overissuance
<b>CSRA:</b> .....	Community Spouse Resource Allowance	<b>OP:</b> .....	Overpayment
<b>CWPDP:</b> .....	California Work Pays Demonstration Project	<b>PE:</b> .....	Principal Earner
<b>DED:</b> .....	Disability Evaluation Division	<b>SCC:</b> .....	Supplemental Child Care
<b>DIB:</b> .....	Disability Insurance Benefits	<b>SSA:</b> .....	Social Security Administration
<b>DISC. DATES:</b> ....	Discontinuation Dates	<b>SSI:</b> .....	Supplemental Security Income
<b>FPL:</b> .....	Federal Poverty Level	<b>SOC:</b> .....	Share of Cost
<b>Fed Elfg.:</b> .....	Federal Eligibility	<b>TCC:</b> .....	Transitional Child Care
<b>FS:</b> .....	Food Stamps	<b>TMC:</b> .....	Transitional Medi-Cal
<b>GAIN:</b> .....	Greater Avenues to Independence	<b>UIB:</b> .....	Unemployment Insurance Benefits
<b>INCAP:</b> .....	Incapacity		