STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY GRAY DAVIS, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P Street
P.O. Box 942732
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(916) 657-0258

November 14, 2000

TO: All County Welfare Directors Letter No. 00-57
All County Administrative Officers
All County Medi-Cal Program Specialists/Liaisons
All County Outstationed Eligibility Workers Coordinators
All County Public Health Directors
All County Mental Health Directors

AGED AND DISABLED FEDERAL POVERTY LEVEL (A&D FPL) PROGRAM

The Governor's budget authorized funds for an A&D FPL Program which when implemented will provide no share-of-cost Medi-Cal to approximately 52,800 individuals. The effective date of this program is January 1, 2001. Given the importance of this program to many aged and disabled individuals, we are asking counties to make implementation of the A&D FPL program a top priority.

THE BASICS

- Qualified individuals/couples need to be aged or disabled and not in Long-Term Care.
- Eligibility of qualified individuals will be determined using the income and property medically needy rules.
- Qualified single individuals will have an effective income limit of $926 (100 percent of poverty $696 for one and a $230 disregard) and qualified couples will have an effective income limit of $1,248 (100 percent of poverty $938 for two and a $310 disregard).
- If qualified individuals have other family members applying for Medi-Cal benefits, qualified members will be ineligible member(s) of the other family member's Medi-Cal Family Budget Unit (MFBU). All ineligible family member's income will be used and be considered a part of the MFBU for purposes of determining the maintenance need size.
- Blind applicants or beneficiaries will need to be referred to the Disability Evaluation Division in order to determine if they meet disability criteria.
- January Social Security Cost-of-Living Allowance increases should be temporarily disregarded until the effective FPL increases are issued (generally in April).
- Disabled individuals in the A&D FPL program are not subject to an age limitation and as such children who are disabled need to be evaluated for this program.

FORMS

- Computations are to be completed using a Financial Eligibility Work Sheet-Federal Poverty Level Program (Enclosure 1) which is based on Part E & F of the Pickle

Eligibility Worksheet (DHS 7021). The form for manual computation is enclosed and an automated version (Excel spreadsheet) can be obtained by contacting Craig Yagi at Cyagi@dhs.ca.gov.

- Suggested language for approval and denial notices of action (Enclosure 2).

AID CODES

- 1H – full-scope FPL aged individuals
- 6H – full-scope FPL disabled individuals
- 1U - restricted FPL aged individuals
- 6U - restricted FPL disabled individuals

IMPLEMENTATION

Counties must identify individuals in Aid Codes 17, 27, and 67 with a share of cost between $1 and $326. These potentially eligible beneficiaries must be evaluated for the A&D FPL program before the end of January 2001. It is also likely as beneficiaries become aware of the A&D FPL program, direct contacts with eligibility workers will be made. Counties should promptly process said requests. Furthermore, counties must ensure that intake units are aware of this new program and apply these procedures to January 2001 applications.

If you have any questions or concerns regarding this All County Letter (ACL), please E-mail Mr. Craig Yagi of my staff at Cyagi@dhs.ca.gov, or fax it to (916) 657-3224. We will be addressing these questions and concerns on a subsequent ACL.

Sincerely,

ORIGINAL SIGNED BY

Glenda Arellano
Acting Chief
Medi-Cal Eligibility Branch

Enclosures

AGED & DISABLED FEDERAL POVERTY LEVEL PROGRAM
FINANCIAL ELIGIBILITY FORM

CASE NAME	COUNTY DISTRICT	COUNTY USE
APPLICANT'S NAME (If different from above)	CASE #	EFFECTIVE ELIG. DATE FOR THIS BUDGET Month_____ Year_____
NAME ADDITIONAL MFBU MEMBER (SPOUSE)	NAME OF ADDITIONAL MFBU MEMBER (CHILD)	OTHER COVERAGE

☐ NEW APP. ☐ REDETERMINATION ☐ CHANGE ☐ RETRO ELIG. ☐ CORRECTION

PART A Is the applicant(s)/beneficiary(ies) aged or disabled per Title 22, Sections 50221, 50223, & 50167:
☐ Yes, then go to Part B ☐ No: Do not complete this form; if not aged refer for disability determination

PART B INCOME ELIGIBILITY DETERMINATION

I UNEARNED INCOME

		Elig. Individual	Elig. Spouse/Child/Parent	Inelig. Family Membr #1	Inelig. Family Membr #2
1	OASDI	$	$	$	$
2	PROPERTY NET INCOME	$	$	$	$
3	IN-KIND INCOME	$	$	$	$
4	OTHER INCOME (Include Source of Other Income)	$ Source:	$ Source:	$ Source:	$ Source:
5	OTHER INCOME (Include Source of Other Income)	$ Source:	$ Source:	$ Source:	$ Source:
6	TOTAL INCOME INDIVIDUAL UNEARNED INCOME (ADD 1 THRU 5 IN EACH COLUMN)	Total of Above Boxes: $	Total of Above Boxes: $	Total of Above Boxes: $	Total of Above Boxes: $
7	COMBINED UNEARNED INCOME (Add Totals From Row 6)	TOTAL OF BOXES IN ROW 6: $			
8	SUBTRACT $20 (Any Income Deduction)	- $20			
9	REMAINING UNEARNED INCOME	$			

II EARNED INCOME

		Elig. Individual	Elig. Spouse/Child/Parent	Inelig. Family Membr #1	Inelig. Family Membr #2
10	GROSS EARNED INCOME	$	$	$	$
11	COMBINED EARNED INCOME (Add Amounts In Row 10)	$			
12	$ 65 EARNED INCOME DEDUCTION PLUS $____ FROM UNUSED $20 DEDUCTION	- $			
13	REMAINING EARNED INCOME (Subtract line 12 from Line 11)	=			
14	50% EARNED INCOME DEDUCTION (Divide line 13 by 2)	$			

III NET NONEXEMPT INCOME AND ELIGIBILITY DETERMINATION

15	TOTAL EARNED AND UNEARNED INCOME (Add lines 9 and 14)	$
16	DISREGARD FOR QUALIFIED INDIVIDUALS OR QUALIFIED COUPLES	- $
17	HEALTH INSURANCE PREMIUMS	- $
18	AGED & DISABLED MEDICALLY NEEDY DEDUCTIONS: SPECIFY	- $
19	Deduction for Allocation to Ineligible Fam. Mbrs (= MNL for number of Ineligible Family Members)	- $
20	NET NONEXEMPT INCOME (Line 15 – Lines 16 thru 19)	= $
21	PROGRAM INCOME LIMIT (100% FPL For Number of Individuals Being Evaluated For Eligibility)	$
22	ELIGIBLE IF LINE 20 AMT IS LESS THAN OR EQUAL TO LINE 21 AMT	☐ ELIGIBLE ☐ NOT ELIGIBLE
23	NOTE: If ineligible, assess for eligibility for other Medi-Cal programs	

Enclosure 2

You will receive a separate Notice of Action if another application has been made for other family members.

AGED AND DISABLED POVERTY LEVEL PROGRAM
(Zero Share-of-Cost Program)
Notice of Action

Approval Language
Your application dated ____/____/____ for the Aged and Disabled Federal Poverty Level Program has been approved effective ____/____/____.
Denial Language
Your application dated ____/____/____ for the Aged and Disabled Federal Poverty Level Program has been denied because:
____ Your net countable income exceeds the Aged and Disabled Federal Poverty Level Program income limits.
____ You do not meet the medically needy program requirement because:
Discontinued Language
Your eligibility for the Aged and Disabled Federal Poverty Level Program will stop as of ____/____/____ because:
____ Your income exceeds the Aged and Disabled Federal Poverty Level Program limit.
____ You no longer meet other medically needy program requirements because: