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Director

State of California—Health and Human Services Agency
Department of Health Services



GRAY DAVIS
Governor

July 1, 2003

TO: ALL COUNTY WELFARE DIRECTORS Letter No.: 03-40
ALL COUNTY ADMINISTRATIVE OFFICERS
ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIAISONS
ALL MEDS COORDINATORS/LIAISONS
ALL COUNTY MENTAL HEALTH DIRECTORS
ALL COUNTY HEALTH EXECUTIVES
ALL FOOD STAMP COORDINATORS

SUBJECT: WELFARE AND INSTITUTIONS (W&I) CODE SECTION 10618.5
(ASSEMBLY BILL 59, CHAPTER 894, STATUTES OF 2001) AND W&I
CODE SECTION 18925 (SENATE BILL 493, CHAPTER 897, STATUTES
OF 2001)
(Reference: All County Welfare Directors Letter 01-10 and 02-59)

The purpose of this letter is to provide guidance to county welfare departments regarding their responsibilities under W&I Code Sections 10618.5 and 18925. These provisions will expedite Medi-Cal and Healthy Families (HF) enrollment for Food Stamp applicants and recipients.

I. BACKGROUND

W&I Code Section 10618.5 requires the county welfare department to develop and send a notice to Food Stamp applicants who are determined eligible for the Food Stamp Program, but who did not indicate an interest in enrolling in the Medi-Cal program. The notice shall inform Food Stamp applicants that they may be entitled to receive Medi-Cal benefits and shall request their permission to use the information in the Food Stamp recipient's case file to make a determination for Medi-Cal eligibility. The notice shall also include a request for permission to forward the information in the Food Stamp recipient's case file to the HF program for an eligibility determination if the individual is determined ineligible for Medi-Cal or eligible with a share-of-cost.



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714 P STREET, ROOM 1692, P.O. BOX 942732, SACRAMENTO, CA 94234-7320
(916) 657-2941
Internet Address: www.dhs.ca.gov

W&I Code Section 18925 requires the Department of Health Services (DHS), in conjunction with the California Department of Social Services (CDSS), to implement a simplified eligibility process as part of the Food Stamp Program to expedite Medi-Cal and HF program enrollment for Food Stamp recipients, including children and their eligible parents or caretaker relatives who are not enrolled in those programs. Each county welfare department must develop a data list of family members residing in eligible Food Stamp households who are not enrolled in the Medi-Cal or the HF program. The county welfare department is further required to develop and send individuals identified from the data list a notice informing them that they may be entitled to receive benefits under the Medi-Cal or the HF programs. This notice shall be sent to identified individuals at the time of their Food Stamp annual recertification.

DHS issued ACWDL 01-10 instructing counties to use a current (within 12 months) Food Stamp Statement of Facts form DFA 285-A2 to determine eligibility when a Food Stamp recipient requests Medi-Cal benefits.

II. MANDATED NOTICES

W&I Code Sections 10618.5 and 18925 require the county to develop notices.

The notice pursuant to Section 10618.5 must:

- State that the recipient may be entitled to receive Medi-Cal benefits.
- Request permission to use information in the Food Stamp case file to make a Medi-Cal determination.
- Request permission to forward information in the Food Stamp case file to the HF program if the individual is Medi-Cal ineligible or Medi-Cal eligible with a share-of-cost.

The notice pursuant to Section 18925 must:

- State that the individual may be entitled to receive Medi-Cal or HF.
- Request permission to use information in the Food Stamp case file to make a Medi-Cal or HF determination.

Both notices must contain the following criteria:

- Be written in culturally and linguistically appropriate language and at an appropriate literacy level.
- Provide information on the Medi-Cal and HF programs.

- Request the Food Stamp recipient to sign, date and return the notice to the county welfare department.
- Include a telephone number to call for additional information.

In addition to the above criteria, the notices developed by the county welfare department must include the Medi-Cal Rights and Responsibilities, the Medi-Cal Confidentiality Notice and the Medi-Cal Privacy Notice information. To assist counties, the Department has developed a sample notice that complies with this requirement (enclosure). Counties may use this notice in lieu of the MC 219 form.

A prepaid self-addressed return envelope must be provided for each notice given to the applicant or recipient. The county may choose to create one notice for Food Stamp applicants and recipients, if that notice meets the conditions of both W&I Code Sections 10618.5 and 18925.

III. DATA LIST

As previously stated, W&I Code Section 18925 requires the county welfare department to develop a data list of family members residing in eligible Food Stamp households who are not enrolled in the Medi-Cal program or the HF program.

County automated systems do not contain information on HF or Medi-Cal eligibility based on a determination made outside the county welfare department. Therefore, to assist counties in meeting this new requirement, DHS will modify the Medi-Cal Eligibility Data System (MEDS) to generate a new optional Renewal alert message that will identify recipients who must receive a notice. The new message will identify Food Stamp recipients due for an annual recertification who are not enrolled in the Medi-Cal program or the HF program. The new MEDS alert message will be generated at MEDS Renewal for the month prior to the month in which the recertification is due to be completed (i.e., at the end of October for recertifications due to be completed in December). The new MEDS alert message will be generated based on the Food Stamp recertification date, if that information has been reported to MEDS (currently LEADER and ISAWS report that date to MEDS).

Counties may choose to receive the new MEDS alert message via the hard copy Worker Alert Report or an electronic file of alert records or both of these methods. Receiving the new MEDS alert message via the electronic file allows the county to unduplicate the recertification alerts by case and match identified cases with their recertification mailing file, thereby splitting off those cases that require the new notice for separate mailing. Counties that want to receive the optional message on the Food Stamp Alert Report must contact their county MEDS Coordinator to request receipt of the optional message. Counties that do not already receive an electronic file of MEDS

alert records must contact their MEDS Coordinator if they wish to initiate receipt of an electronic file of MEDS alerts.

Counties with automated systems not currently reporting the Food Stamp annual recertification date on MEDS transactions may choose to:

- Modify automated systems to transmit the Food Stamp annual recertification date, or
- Create their own data list that complies with the requirements of W&I Code Section 18925.

The notices required by W&I Code Sections 10618.5 and 18925 are intended only for individuals who are not currently receiving Medi-Cal or HF. The Department has been informed that some counties may require a period of time to modify their automated systems to generate the new MEDS alert message or develop their own data list. Consequently during this interim period, the notices from these counties potentially may be received by recipients who may already be in receipt of Medi-Cal or HF. To prevent confusion, counties using this interim process are directed to include with the notice a statement informing the Food Stamp recipient that he or she may disregard the notice and does not need to complete and return the notice if he or she is already a Medi-Cal or HF recipient.

IV. IMPLEMENTATION

County welfare departments are required to meet the mandate of the W&I Code Sections 10618.5 and 18925 effective July 1, 2003. The county may choose the best method to distribute notices. To meet the requirements of Section 18925, the county may choose to incorporate the notice into the recertification packets or recertification notice-of-actions. The county may also choose to mail notices under a separate mailing to meet the requirements of Sections 18925 and 10618.5. Completed and signed notices returned to the county office shall be processed in the following manner:

A). Medi-Cal

The Medi-Cal date of application is the date a signed notice is received at the county welfare department. Medi-Cal eligibility staff must use the information in the Food Stamp case file or paper application to make a Medi-Cal eligibility determination. If a Medi-Cal eligibility determination cannot be made, then Medi-Cal staff must contact the Food Stamp recipient either orally or in writing to request the information.

The SAWS1 is not required when the county has the signed notice from the Food Stamp recipient authorizing the use of the Food Stamp case file to determine Medi-Cal eligibility. The 45 or 90-day Medi-Cal approval or denial timeframes remain the same for all Food Stamp notices returned to the county. This timeframe

will commence upon receipt of a completed notice. Additionally, a timely and adequate notice-of-action must be provided to each Food Stamp recipient upon completion of the Medi-Cal eligibility determination.

B). Healthy Families

W&I Code Section 10618.5 requires the mandated notice to indicate the Food Stamp recipient's permission to forward the notice and Food Stamp case file information to the HF program for a determination, when the Medi-Cal eligibility determination results in ineligibility or in a share-of-cost. W&I Code Section 18925 requires the notice to request permission to use information in the Food Stamp case file to make a Medi-Cal or HF eligibility determination. If the county determines that the person is ineligible for Medi-Cal or eligible with a share-of-cost, the county welfare department shall forward information pertinent to the Food Stamp recipient's potential HF eligibility to the HF program for immediate processing.

The HF program requires the following documentation:

- Medi-Cal to HF Transmittal form MC 363.
- Signed notice authorizing the information to be forwarded to the HF Program.
- Copy of the Food Stamp Application form DFA 285-A1.
- Copies of birth certificates and Bureau of Citizenship and Immigration Services documentation (if available).
- The notice-of-action showing the share-of-cost computation or reason for denial. (County case number must be included.)
- Appropriate case budget if not shown on the notice-of-action.

C). Returned notices from recipients currently enrolled in Medi-Cal or HF

When a notice is returned from a Food Stamp household currently enrolled in either Medi-Cal or HF, the county shall notify the household by telephone or written correspondence about their Medi-Cal or HF eligibility status.

V. EXCHANGE OF INFORMATION

DHS encourages each county welfare department to establish inter-office procedures between the Food Stamp and Medi-Cal program staff when notices are received requesting a Medi-Cal eligibility determination. Exchange of important eligibility information and verification is crucial to meet Medi-Cal granting or denial timelines.

Should you have any questions regarding these instructions, please contact either Mr. Mack Guynn, Policy Analyst for the DHS Medi-Cal Eligibility Branch, at (916) 657-1064 or Ms. Sharon Brown, Policy Analyst for the CDSS Food Stamp Policy Bureau at (916) 654-0737.

ORIGINAL SIGNED BY

Beth Fife, Chief
Medi-Cal Eligibility Branch
Department of Health Services

ORIGINAL SIGNED BY

Richton Yee, Chief
Food Stamp Branch
California Department of Social Services

Enclosure (1)

Good news for California families receiving Food Stamps.

Many family members that receive Food Stamps may qualify for Medi-Cal benefits. The Medi-Cal Program pays for health care for eligible persons with limited income and resources. Children and adults may qualify for free medical, dental and vision coverage through the Medi-Cal Program.

Children under age 19 who do not qualify for free Medi-Cal may be eligible for the low-cost Healthy Families Program.

Medi-Cal and Healthy Families benefits include:

- ☆ Visits to the doctor when you or your children are sick
- ☆ Visits to the doctor to keep you and your children healthy
- ☆ Visits to the dentist when you or your children need services
- ☆ Eye exams and glasses if you or your children need them
- ☆ Prescription medicine and shots

It's easy to apply:

→ 1) Fill out this form. → 2) Mail the form in the envelope provided. (No stamp is needed.)

I give permission for my county social services agency to use information available in my Food Stamp case file to make a Medi-Cal determination for my family. Yes No

I have read and understand the rights and responsibilities on the other side of this form. Yes No

If I am not eligible for free Medi-Cal, I give permission for the county social services agency to forward the information in my Food Stamp case file to the Healthy Families Program to determine my eligibility for the low-cost Healthy Families Program. Yes No

Signature _____ Date _____
(if child in household, signature of the parent/guardian is required)

Printed Name: _____ Date of Birth: _____

Address: _____

Phone number: _____

Someone in my family currently has health insurance or had health insurance in the past 90 days. Yes No (You can answer "Yes" and still be eligible!)

QUESTIONS? Call your county social services office at: _____

MEDI-CAL CONFIDENTIALITY NOTICE

The information given in this application is private and confidential under Welfare and Institutions Code Sections 10850 and 14100.2. The information will be disclosed only in accordance with those laws.

MEDI-CAL RIGHTS, RESPONSIBILITIES AND DECLARATIONS

I have the right to:

- Be treated fairly and equally regardless of my race, color, religion, national origin, sex, age, or political beliefs.
- Ask for an interpreter.
- Ask for a fair hearing if I think a decision on my Medi-Cal case is unfair or wrong. I must ask for a hearing within 90 days after I get a "Notice of Action". To find out about Medi-Cal fair hearings call toll-free, 1-800-952-5253.

I have the responsibility to:

- Send in a status report when the county asks me to.
- Report any changes within 10 days in the information I gave on this application.
- Let the county know if a family member applies for disability benefits, is in a public institution, or gets medical care for any accident or injury caused by another person.
- Cooperate if my case is reviewed.

I understand that each person I am applying for:

- Must live in California
- Must not be getting public assistance from outside California.
- Must not be in jail, prison, or any other correctional facility.

I further understand that:

- As a condition of Medi-Cal eligibility, all rights to medical support are automatically assigned to the State of California.
- If I am not eligible for this Medi-Cal program, I understand I may qualify for other programs and have the right to apply for them.
- If I purposely do not give needed facts, or if I give false facts, I understand benefits may be denied or ended and repayment may be required. I may also be investigated for fraud.

MEDI-CAL PRIVACY NOTICE

The Information Practices Act of 1977 and the Federal Privacy Act require the Department of Health Services to provide the following information: Welfare and Institutions Code Section 14011 and regulations in Title 22, CCR, require applicants for the Medi-Cal program to provide the eligibility information requested in this application. This information may be shared with federal, state, and local agencies for purposes of verifying eligibility and for other purposes related to the administration of the Medi-Cal program, including confirmation with the Bureau of Citizenship and Immigration Services of the immigration status of only those persons seeking full scope Medi-Cal benefits. (Federal law says the Bureau of Citizenship and Immigration Services cannot use the information for anything else except in cases of fraud.) The information will be used by the fiscal intermediary to process claims and make Benefits Identification Cards (BICs). Failure to provide the required information may result in denial of the application.

Information required by this form is mandatory, with the exception of ethnicity information, and any other item marked voluntary or optional. Social Security Numbers are required by Section 1147(a)(1) of the Social Security Act and by Welfare and Institutions Code Section 14011.2, unless applying for emergency or pregnancy related benefits only.

An individual has a right of access to records containing his/her personal information that are maintained by the Department of Health Services. Contact your county health and human services/social services office to request your records.

Buenas noticias para las familias de California que reciben Estampillas de Comida.

Algunos miembros de la familia que reciben Estampillas de Comida quizás califiquen para beneficios de Medi-Cal. El programa Medi-Cal paga por el cuidado de salud de personas elegibles con ingresos y recursos limitados. Niños y adultos quizás califiquen para atención médica, dental y de la vista, gratis, por medio del programa de Medi-Cal.

Niños menores de 19 años de edad que no califiquen para Medi-Cal gratis pueden ser elegibles para el Programa Healthy Families que es de bajo costo.

Los beneficios incluidos en Medi-Cal y Healthy Families son:

- ☆ Visitas al doctor cuando usted o sus niños estén enfermos
- ☆ Visitas al doctor para que usted y sus niños se mantengan sanos
- ☆ Visitas al dentista cuando usted o sus niños necesiten los servicios
- ☆ Exámenes de la vista y lentes si usted o sus niños los necesitan
- ☆ Medicinas recetadas y vacunas

Es fácil de solicitar:

→ 1) Llene esta forma. → 2) Mande la forma en el sobre proveído. (No necesita franqueo.)

Doy Permiso a la agencia de servicios sociales del condado para que use esta información disponible en mi archivo de Estampillas de Comida para determinar si mi familia califica para Medi-Cal. **Sí** **No**

Yo he leído y entiendo los derechos y las responsabilidades que aparecen al otro lado de este formulario. **Sí** **No**

Si no soy elegible para recibir Medi-Cal gratis, doy permiso para que la agencia de servicios sociales del condado mande la información en mi archivo de Estampillas de Comida al Programa de Healthy Families para determinar si califico para el programa de bajo costo de Healthy Families. **Sí** **No**

Firma _____ Fecha _____
(Si hay un niño en el hogar, se requiere la firma del padre o el tutor)

Nombre en Letra de Molde: _____ Fecha de Nacimiento: _____

Domicilio: _____

Número de Teléfono: _____

Alguien en mi familia tiene seguro de salud o ha tenido seguro de salud en los últimos 90 días. **Sí** **No** (Usted puede contestar "Sí" y aún ser elegible.)

¿PREGUNTAS? Llame a la oficina de servicios sociales de su condado al: _____

AVISO DE CONFIDENCIALIDAD DE MEDI-CAL:

Los Artículos 10850 y 14100.2 del Código de Beneficencia e Instituciones (Welfare and Institutions Code) establecen que la información que se proporciona en esta solicitud es confidencial y privada. La información se podrá revelar sólo en conformidad con esas leyes.

DECLARACIONES, DERECHOS Y RESPONSABILIDADES DE MEDI-CAL:

Tengo derecho a:

- Ser tratado con decencia e igualdad, sin importar mi raza, color, religión, origen nacional, género, edad o creencia política.
- Solicitar un intérprete.
- Solicitar una audiencia imparcial si considero que una decisión relacionada con mi caso de Medi-Cal es injusta o incorrecta. Debo solicitar una audiencia dentro de los 90 días después de haber recibido una Notificación de Acción. Para información sobre audiencias imparciales de Medi-Cal, llame gratis al 1-800-952-5253.

Tengo las siguientes responsabilidades:

- Mandar al condado un informe de ajuste cuando éste lo solicite.
- Notificar dentro de un plazo de 10 días cualquier cambio en la información que estoy dando en esta solicitud.
- Notificar al condado si un miembro de mi familia solicita beneficios por incapacidad, vive en una institución pública o si recibe atención médica por algún accidente o lesión provocada por otra persona.
- Cooperar si mi caso es revisado.

Declaro que cada persona para quien solicito beneficios:

- Tiene que vivir en California.
- No tiene que recibir asistencia pública fuera de California.
- No tiene que estar en la cárcel, la prisión ni en ninguna otra institución correccional.

Asimismo declaro que:

- Como condición de mi elegibilidad para Medi-Cal, comprendo que todos los derechos a recibir asistencia médica se asignan automáticamente al estado de California.
- Si no soy elegible para este programa de Medi-Cal, comprendo que es posible que califique para otros programas y tengo derecho a solicitarlos.
- Comprendo que si intencionalmente no doy información necesaria o si doy información falsa, se me pueden negar beneficios o estos pueden ser anulados o se me podrá requerir que reembolse el pago de dichos beneficios. Asimismo, podré ser investigado por fraude.

AVISO DE PRIVACIDAD DE MEDI-CAL:

La Ley de Prácticas de Información de 1977 y la Ley Federal sobre Privacidad requieren que el Departamento de Servicios para la Salud informe lo siguiente: El Artículo 14011 del Código de Beneficencia e Instituciones y las normas incluidas en el Título 22 del Código de Normas de California (CCR), establecen que las personas que solicitan inscribirse en el programa Medi-Cal deben entregar la información sobre elegibilidad que requiere esta solicitud. Esta información podrá ser compartida con las agencias federales, estatales y locales para verificar la elegibilidad y para otros fines relacionados con la administración del programa Medi-Cal, incluyendo la confirmación con la Oficina de Ciudadanía y Servicios de Inmigración del estado inmigratorio, solamente para aquellas personas que solicitan beneficios completos de Medi-Cal. (La legislación federal establece que la Oficina de Ciudadanía y Servicios de Inmigración no puede utilizar la información con ningún otro propósito, excepto en casos de fraude.) La información será utilizada por un intermediario fiscal para procesar reclamos y para fabricar las Tarjetas de Identificación para Beneficios (BIC). Si no se proporciona la información requerida, la solicitud de inscripción podrá ser rechazada.

Es obligatorio entregar toda la información solicitada en este formulario, excepto la información étnica y cualquier otro dato identificado como voluntario u opcional. Los números de Seguro Social se requieren de acuerdo con el Artículo 1147(a)(1) de la Ley de Seguro Social, y el Artículo 14011.2 del Código de Beneficencia Pública e Instituciones, a menos que se soliciten únicamente servicios de emergencia o relacionados con el embarazo. Todas las personas tienen derecho de acceso a los archivos con su información personal que se encuentran en poder del Departamento de Servicios para la Salud en su condado.