April 23, 1990
Letter No: 90-39

TO: All County Welfare Directors
    All County Administrative Officers

SUBJECT: MEDI-CAL CARD ISSUANCE - SSI/SSP RECEPIENTS

Enclosed is a copy of a form used by the Social Security Administration (SSA) authorizing the county to issue Medi-Cal cards to Supplemental Security Income/State Supplemental Payment (SSI/SSP) program recipients. Some counties have expressed concern about recognizing this as an official form because it lacks SSA-identifying information (i.e., an official seal, letterhead, or form number).

Department of Health Services staff contacted the SSA and were assured that this form is an official SSA document. It is most likely used only by the Los Angeles Teleservice Center (TSC) because of the high volume of SSI cases handled by that office.

Therefore, this is to advise you that counties may use this form as SSA verification of entitlement to SSI benefits and issue SSI-based Medi-Cal cards to the client. Counties are reminded to follow the instructions in Medi-Cal Eligibility Manual Procedures Section 14B, 2e (Handling Erroneous Nonreceipt of [SSI/SSP] Medi-Cal Cards) when issuing the cards.

If you have questions regarding the information in this letter, please contact Maggie Roggero of my staff at (916) 324-4966.

Sincerely,

ORIGINAL SIGNED BY

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Enclosure

cc: Medi-Cal Liaison
    Medi-Cal Program Consultants

Expiration Date: April 23, 1991
MEDI-CAL REFERRAL

TO: MEDI-CAL OFFICE, COUNTY

FROM: SOCIAL SECURITY ADMINISTRATION

SSA Office Address/Phone: Los Angeles TSC, PO Box 76988, Los Angeles 90076, (800) 234-5772

Name of Issuing Representative Pos #

The recipient named below has not received Medi-Cal cards for the months of ____________________________.

According to SSA records, the recipient was eligible for SSI/SSP payments for these months.

RECIPIENT IDENTIFICATION

Name ____________________________

SSN ____________________________

Date of Birth ____________________________

Address ____________________________

Phone ____________________________

If unable to act on own behalf:

Contact's Name ____________________________

Contact's Phone ____________________________

REFERRAL INFORMATION

SSI Category: Aged Blind

Prepaid Health Plan: Yes No

Other Health Insurance: Yes No

Medicare: Yes No

Claim # ____________________________

SSI Payment Status Code A A

If COA, Date of Input ____________________________

If Deceased, Date of Death ____________________________

REASON FOR REFERRAL

1 - New Eligible

2 - Lost Card

3 - Labels Used Up

4 - Not Received

5 - Error/Mutilated

6 - Needs MEDI Labels

SSA DATE STAMP

LOS ANGELES, CALIF

NOV 29 1989

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SSA TELESERVICE CENTER