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

DEPARTMENT OF HEALTH SERVICES
714/744 P Street
P.O. Box 942732
Sacramento, CA 94234-7320
(916) 657-2941

October 15, 1999

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

Letter No.: 99-48

PROCEDURES FOR USING THE HEALTHY FAMILIES ANNUAL ELIGIBILITY REVIEW FORM AS AN APPLICATION FOR MEDI-CAL FOR CHILDREN

Ref.: All County Welfare Directors Letters (ACWDL) Nos. 95-28, 95-52, 98-06, 98-09, 98-16, 98-19, 98-39, 98-42, 99-01, 99-16, and EMC2 DHS No. 98104

The purpose of this letter is to provide counties with information and instructions on the Healthy Families Annual Eligibility Review (AER) Form. A sample of the Healthy Families AER and the AER cover letter are enclosed with this ACWDL.

Counties are instructed to accept and use the Healthy Families Annual Eligibility Review Form as an application for Medi-Cal for Children.

The Healthy Families Program offers a continuous twelve-month eligibility period based on the last enrollment date of a child in the household. This is called the "anniversary date." Sixty days before the anniversary date, an annual eligibility review form is mailed to the applicant. This form contains pre-printed information, such as names of adults and children living in the household and their address. The application asks that the applicant provide current information on the household size and income of the family members.

If an applicant wants to apply for Medi-Cal benefits for their child(ren), and provides their AER form to the local county office, the county is to accept the AER in lieu of the MC210 or the mail-in application for children and pregnant women. The date of application is the date the county receives the AER. Counties are not to send the AER to the single point of entry.

VERIFICATIONS

Counties are not to require information or verification beyond that requested in the mail-in application.

CITIZENSHIP/ALIENAGE

The AER form will only include information on children who were determined to be United States citizens or eligible qualified aliens. The AER does not include a question about the child's citizenship or immigration status. Applicants using the AER form as an application are required to complete an MC 13.

MEDI-CAL RIGHTS AND RESPONSIBILITIES

The AER form does not include Medi-Cal rights and responsibilities. Counties must obtain a signed copy of the MC 219, or document in the case file that the MC 219 was sent to the applicant and when.

CHDP

The AER form does not include a Child Health and Disability prevention (CHDP) Program brochure. Upon receipt of the AER form , the county shall send the CHDP brochure to the applicant.

Counties are to follow the instructions outlined in ACWDL 99-16, Section III, CHANGE IN VERIFICATION REQUIREMENTS and section IV, COUNTY FOLLOW-UP FOR OTHER FAMILY MEMBERS AND FURTHER CASE ACTION, when processing an AER application.

The Healthy Families AER form is currently being revised by the Managed Risk Medical Insurance Board, the agency responsible for the Healthy Families program. The form will be revised to allow a family to request that their AER form be forwarded to the county for a Medi-Cal determination, if the child(ren) is no longer eligible for the Healthy Families program. Counties will be notified by ACWDL when the AER form is revised.

If you have any questions on the AER form application procedure, please contact Ms. Linda Rahmeyer at (916) 657-0398. If you have questions on verification requirements, please contact Mr. Edmund Carolan, at (916) 657-3184. If you have any questions on immigration and alienage, please contact Mr. John Zapata, at (916) 657-0725.

Sincerely,

ORIGINAL SIGNED BY

ANGELINE MRVA, Chief
Medi-Cal Eligibility Branch

Dear Applicant,

The Healthy Families Program offers your child(ren) health, dental, and vision coverage for 12 months. The end of this 12 month period will be here soon. To qualify for another 12 months of coverage, we must verify that your family still meets Healthy Families eligibility guidelines. **Healthy Families must receive the enclosed Annual Eligibility Review Form and *all required* income documents no later than: . If we do not receive these documents, your child(ren) will be disenrolled.** If your child is disenrolled and receives health, dental, or vision services after the disenrollment date, you may have to pay for the cost of the services provided.

After your documents have been processed, you will receive a letter stating whether your child qualifies for another 12 months of coverage. If your child no longer qualifies for Healthy Families, you will receive a letter with the reason.

Do you wish to add additional children to Healthy Families? If you would like to apply for additional children whose names do not appear on the Annual Eligibility Review Form, please fill out the enclosed **Add New Children Form**. Then, return the **Add New Children Form** along with the Annual Eligibility Review Form in the enclosed postage paid envelope.

If you have any questions, or would like to find a Certified Application Assistant in your area, call 1-888-439-4741, Monday - Friday 8:00 A.M. - 8:00 P.M. Certified Application Assistants will assist you with these forms at no cost to you.

Sincerely,
Healthy Families Program

- The Healthy Families Program is not Medi-Cal. If you have other children enrolled in no-cost Medi-Cal, your Medi-Cal eligibility worker will send you a separate Annual Eligibility Redetermination Packet.

ANNUAL ELIGIBILITY REVIEW FORM

Please return this form immediately to continue coverage for your children

Account Number

If any of the pre-printed information on this form is incorrect, please cross it out and write the correct information.

Questions?
Please call 1-888-439-4741 Monday - Friday, 8:00 a.m. to 8:00 p.m.

1. Children Currently Enrolled in Healthy Families

*Please fill in the sections **Monthly Income** and **Relationship to Applicant**. Cross out any children who no longer live in the household.*

Enrolled Child	Date of Birth	Monthly Income (if any)	Relationship to Applicant
		$	☐ Child ☐ Stepchild ☐ Other _____
		$	☐ Child ☐ Stepchild ☐ Other _____
		$	☐ Child ☐ Stepchild ☐ Other _____
		$	☐ Child ☐ Stepchild ☐ Other _____
		$	☐ Child ☐ Stepchild ☐ Other _____
		$	☐ Child ☐ Stepchild ☐ Other _____
		$	☐ Child ☐ Stepchild ☐ Other _____

Are any of these children now enrolled in employer sponsored health insurance? If yes, please list the children: _____

2. Adults in the Household

*Please fill in the following information. **Refer to the Household Information Worksheet to determine what income counts and who counts as a family member.***

Adult Family Members living with the Children	Relationship to Applicant	Relationship to Children	You are paid:	Gross Monthly Income
	APPLICANT		☐ once every week ☐ every two weeks ☐ twice a month ☐ once a month	$
	☐ Spouse ☐ Other _____	☐ Parent ☐ Stepparent ☐ Other _____	☐ once every week ☐ every two weeks ☐ twice a month ☐ once a month	$

Remember to attach your most recent income documentation.

3. Children *not* enrolled in Healthy Families

Please fill in the sections ***Monthly Income*** *and* ***Relationship to Applicant****. Cross out any children who no longer live in the household. If you wish to enroll any of the children listed below in Healthy Families, check the box by the child's name.* ***If you wish to add children whose names do not appear below, you must fill out and return the ADD NEW CHILDREN Form.***

	Child	Date of Birth	Monthly Income (if any)	Relationship to Applicant
❑			$	◻ Child ◻ Stepchild ◻ Other _____
❑			$	◻ Child ◻ Stepchild ◻ Other _____
❑			$	◻ Child ◻ Stepchild ◻ Other _____
❑			$	◻ Child ◻ Stepchild ◻ Other _____
❑			$	◻ Child ◻ Stepchild ◻ Other _____

4. Other Children in Household who you *do not* wish to apply for.

Refer to the Household Information worksheet to determine which children to count. If there is an unborn child, write "Unborn Child" in the space for Child Name. Attach a separate sheet if necessary.

Child Name	Date of Birth	Monthly Income if any	Relationship to Applicant
	- -	$	◻ Child ◻ Stepchild ◻ Other _____
	- -	$	◻ Child ◻ Stepchild ◻ Other _____

5. Income Deductions

The parent(s) *who the child(ren) live with* must answer the following:

Monthly Child Care expenses you paid for children under age 2	$
Monthly Child Care expenses you paid for children age 2 and over	$
Monthly Disabled Dependent Care expenses you paid	$
Monthly Alimony you paid	$
Monthly Child support you paid	$

I, the applicant, certify that the information provided is true and correct. I understand that a change in income from last year may result in a higher monthly premium or may make my child(ren) ineligible for the Healthy Families Program.

Applicant Signature X_____ **Date:**_____

Reimbursement for Application Assistance. For Certified Application Assistant use only.

I certify that I had help completing this form by the Certified Application Assistant listed below. This CAA help was Free of char The state will not issue a reimbursement unless this section is completely filled out at the time this form is submitted.

Applicant Signature_____ **Date**_____

CAA#_____ **EE#**_____ **CAA Signature** _____

Household Information Worksheet

Who counts as a family member living in the home with the child?

Adults:

- Natural or adoptive parents of the child to receive benefits

Children:

- Unborn child
- All children under age 21 living in the home
- All children under age 21 away at school and claimed as tax dependents

What Income counts?

- Earnings from a job
- Self-employment net profits
- Child support
- Alimony/Spousal Support
- Pension and retirement benefits
- Government benefits such as Social Security, Retirement Survivor Disability Insurance (RSDI), Veterans, Disability, Workers' Compensation, Unemployment, etc.
- Other income such as: grants for living expenses, settlement benefits, net profit from rentals, gifts, lottery/bingo winnings, interest income

What income does NOT count?

- **Earnings from a job of a child under age 14 or a child who attends school**
- Supplementary Security Income/State Supplementary Program (SSI/SSP) Payments
- Foster Care Payments
- CalWORKS payments (replaces AFDC)
- General Relief
- Certain Other government benefits
- Grants or scholarships
- Loans
- College Work Study

Acceptable Income Documents:

- Your most recent paycheck stub
- Signed statement from the employer stating the most recent gross monthly income and the date received
- Last year's Federal Income Tax Return
- Award letters or bank statement indicating monthly disability, retirement income, or Social Security Benefits
- Most recent three month's Profit and Loss Statements (self-employed only)
- Copies of checks, receipts, or payment statement from the District Attorney's Family Support Division for child support, alimony, or spousal support received during the last 30 days
- Notice of Action (NOA) dated within the last 30 days from the County Department of Social Services listing income and date Share-of-Cost Medi-Cal begins.

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