

DEPARTMENT OF HEALTH SERVICES

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July 13, 2001

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

Letter No: 01-39

MEDI-CAL REQUEST FOR INFORMATION FORM (MC 355)

Ref: All County Welfare Directors Letter (ACWDL) No. 01-36

Senate Bill (SB) 87 mandated the Department of Health Services (DHS) in collaboration with counties and consumer advocates to create a request for information form which shall highlight the information needed to complete a Medi-Cal eligibility determination. In addition, this form is to be accompanied by a cover letter indicating the various categories in which to apply for Medi-Cal eligibility. To comply with SB 87 requirements, DHS in collaboration with counties and consumer advocates created the MC 355. This form serves both as a request for information and Medi-Cal informational cover letter.

Under the provisions of SB 87, counties are precluded from requesting information from a Medi-Cal beneficiary which has been previously provided, not subject to change or not absolutely necessary to complete a Medi-Cal eligibility review. ACDWL No. 01-36 instructed counties to initiate a Medi-Cal eligibility review at annual redetermination and whenever there is a change in beneficiary circumstances that affects Medi-Cal eligibility. Counties were instructed to follow the *ex parte* process and telephone contact requirements to complete a Medi-Cal eligibility review. However, when these methods proved ineffective, counties were further instructed to notify the beneficiary through written correspondence to provide needed information in completing the eligibility review.

Therefore, effective July 1, 2001 counties are instructed to use the MC 355 as the request for information form when requesting information from a beneficiary to complete their Medi-Cal eligibility determination.

MC 355 – REQUEST FOR INFORMATION FORM

A. DESCRIPTION

Front (cover letter)

- Instructs beneficiary to **READ THIS SIDE FIRST**.
- Lists pertinent case information completed by the county: *notice date, case number, worker name/telephone number, office hours, etc.*
- Explains to beneficiary why information is being requested.
- Informs beneficiary about the basic eligibility categories of the Medi-Cal program.
- Instructs the beneficiary to contact his/her eligibility worker immediately if they qualify for Medi-Cal under a new or different eligibility category.
- Instructs beneficiary to contact his/her eligibility worker if they have questions or want more information about this form.

Back (information request)

- Highlights key eligibility categories to identify requested information. County staff shall check the appropriate box or use the OTHER category and manually write in the requested information.
- Instructs beneficiary to provide requested information by a due date. County staff shall insert due date (see "Processing Procedures and Timeframes" section C).
- Informs beneficiary to contact their eligibility worker if they have a change of address or telephone number.

B. INSTRUCTIONS

County staff unable to complete a Medi-Cal eligibility review through the ex parte process and telephone contact shall use the MC 355 to complete this review. County staff shall take the following steps:

1. Complete all necessary case information on the front of the MC 355.
2. Request only the information that is needed to complete the Medi-Cal eligibility review on the back of the MC 355. County staff shall refer to

ACWDL No. 01-36 Sections "Exhausting All Avenues of Eligibility" and "Requesting Additional Information" when completing the back of the MC 355. County staff must clearly evaluate each individual and case circumstance before requesting information or verification from the beneficiary through the MC 355. County staff are reminded that the verification documentation listed on the back of the MC 355 is not all-inclusive, therefore, county staff shall review program regulations and other correspondence (i.e., ACWDL's, ACIN's, etc.) regarding further acceptable verification documentation.

3. Insert a due date for the return of the requested form and information and provide the beneficiary with a self-addressed prepaid return envelope.

C. PROCESSING PROCEDURES AND TIMEFRAMES

SB 87 defines specific processing procedures and timeframes for obtaining information from all Medi-Cal beneficiaries. Therefore, the processing procedures and timeframes described below shall also apply to the annual redetermination form (MC 210RV).

Beneficiaries shall have no less than twenty (20) days from the date the MC 355 or MC 210RV is mailed to respond. County staff shall take one of the following actions when these forms are forwarded to the beneficiary:

1. If the requested information is not received within the 20 day timeframe, county staff shall follow current procedures to begin adequate and timely discontinuance of Medi-Cal benefits.
2. If the requested information is received incomplete within the 20 day timeframe county staff shall attempt to contact the beneficiary either by telephone or in writing to request the completed information. If the beneficiary does not comply within 10 days from the date the county contacts the beneficiary, then county staff shall follow current procedures to begin adequate and timely discontinuance of Medi-Cal benefits.
3. If the requested information is received after the Medi-Cal case is discontinued and within 30 days from the discontinuance date, then county staff shall evaluate continued Medi-Cal eligibility using the information received and rescind the discontinuance action if continued eligibility exists. Otherwise, the case shall remain discontinued.

4. If the reason for the Medi-Cal eligibility review is loss of contact and the MC 355 or MC 210RV is returned with no forwarding address and marked undeliverable, county staff shall terminate the Medi-Cal case and send an immediate discontinuance notice of action to the last known address.

The MC 355 is currently unavailable through the DHS warehouse and a camera ready copy is attached for county use. The MC 355 is currently being translated into Spanish and will be made available to counties when completed. In addition, other language translations of the MC 355 will be made available in the near future.

Should you have any questions regarding the MC 355 or this ACWDL, please contact Mack Guynn of my staff at (916) 657-1064 or via e-mail at mguynn@dhs.ca.gov.

Sincerely,

ORIGINAL SIGNED BY

Shar Schroepfer, Chief
Medi-Cal Eligibility Branch

Enclosures (1)

MEDI-CAL REQUEST FOR INFORMATION

ATTENTION: READ THIS SIDE FIRST

Notice date: _____
Case number: _____
Worker name: _____
Worker number: _____
Worker telephone number: _____
Office hours: _____
Notice for: _____

The information requested on the back of this form is needed to complete our review of your eligibility for Medi-Cal benefits.

— REMINDER —

Persons are eligible for Medi-Cal benefits when they are residents of California, do not own property over the allowable property limits (except for pregnant women and children under age 19, property is not counted for them), and meet at least one of the following eligibility categories:

- under the age of 21 or at least age 65 or older
- blind or disabled
- pregnant
- a parent or caretaker relative of a child (under the age of 21) who has at least one parent either absent, deceased, incapacitated, or unemployed/underemployed
- have tuberculosis or receive dialysis
- reside in a long-term care facility
- a refugee in the country eight months or less
- receiving SSI benefits
- receiving CalWORKs benefits
- eligible for special programs (i.e., TMC, QMB, percentage programs, etc.)

If you qualify for Medi-Cal benefits under a new or different eligibility category, contact your eligibility worker immediately!

- Even if you are employed, you may be eligible to receive Medi-Cal benefits.
- You do not have to receive CalWORKs cash aid to receive Medi-Cal benefits.
- Receipt of Medi-Cal benefits **does not** count against any CalWORKs time limits.

If you have any questions or need more information about this form, call your eligibility worker whose name and telephone number are listed at the top of this form.

PLEASE READ THE OTHER SIDE OF THIS FORM.

MEDI-CAL REQUEST FOR INFORMATION
WE NEED *ONLY* THE INFORMATION CHECKED.

Income

- ☐ A copy of the most recent pay stub or statement from your employer about your job (how much you are paid, how often you are paid, how many hours you work) for each of your jobs (if you have more than one) or a copy of your most recent tax return. This will help us decide if you are eligible for free Medi-Cal or will have a "share-of-cost."
- ☐ Your signed statement about your job (or jobs) if you do not get pay stubs and cannot get a statement from your employer (or employers).
- ☐ Schedule C if self-employed.
- ☐ Proof of unemployment or disability benefits—a copy of benefits stub or award letter.
- ☐ Proof of social security benefits received—a copy of paid benefits stub or award letter.

Income Deductions

- ☐ A copy of checks or receipts of child care, child support, alimony, or health insurance paid.

Personal or Real Property

- ☐ A copy of vehicle registration (if more than one vehicle owned).
- ☐ A copy of your most recent bank statement (checking, savings account, etc.)
- ☐ A copy of life insurance policy, stocks, bonds, retirement account statement.

Identity of Family Members—Provide for Each Family Member

(If you are an immigrant and don't have a social security card or immigration documentation to give us, you may still qualify for emergency and pregnancy-related services.)

- ☐ Social security number.
- ☐ A copy of your California driver's license or a photo ID.
- ☐ A copy of immigration documentation or card (if card, a copy of both sides).

Residence

- ☐ Verification of your current address (rent receipt, utility bill, etc.).

Disability/Incapacity

- ☐ Social security award letter for disability.
- ☐ Other proof that you have a physical, mental, or emotional disability that will last 12 months or more.
- ☐ Proof of incapacity—such as a doctor's statement that you can't work for at least 30 days.

Other

☐ _____

We must receive this information by _____ . Otherwise, we may begin the process to stop your Medi-Cal benefits! (A prepaid self-addressed envelope is provided for your convenience.)

HELP US TO KEEP IN TOUCH WITH YOU!

Call your eligibility worker if you have a change of address or telephone number.
(Their name and telephone number are listed on the other side of this page at the top.)