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

DEPARTMENT OF HEALTH SERVICES
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February 13, 2002

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.: 02-10

REVISED MC 219 (Revised December 2001) – "IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL"

This letter is to inform counties that the MC 219 (Revised December 2001) – "Important Information for Persons Requesting Medi-Cal" form has been revised. A copy has been enclosed with this letter for your reference. Counties shall discard any remaining MC 219 (March 1999) by March 31, 2002, and print copies of the newest revision for use beginning April 1, 2002, until a supply is received from the Department of Health Services warehouse. The new MC 219 should be available from the warehouse by mid-March.

Some highlights of the changes to the MC 219 are:

- Additional language to inform the Applicant that they have the right to:
    - Request a face-to-face interview,
    - Receive information about Personal Care Service Program,
    - Receive information about Early and Periodic Screening, Diagnosis and Treatment Program.
- The signature section has been reformatted to reflect that an Applicant's signature is not necessary. It also allows the county eligibility worker to indicate how the MC 219 was provided to the Applicant and provide a copy of Page 4 for the case file.

If you have any questions regarding the use of the MC 219 (Revised December 2001) as described in this letter, please contact Mr. John McDaniel at (916) 657-0791 or E-mail jmcdanie@dhs.ca.gov .

Sincerely,

ORIGINAL SIGNED BY

Richard Brantingham,
Acting Chief
Medi-Cal Eligibility Branch

Enclosure

ENGLISH

IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL

PRIVACY AND CONFIDENTIALITY NOTIFICATION

Sections 14011 and 14012 of the Welfare and Institutions Code allow county welfare departments to get certain facts from you to decide if you, or the persons you represent, can get Medi-Cal benefits. You must provide these facts to get Medi-Cal benefits. The information will be used:

1. By the county welfare department to establish first time and ongoing Medi-Cal eligibility.
2. By the Administrative Vendor (AV) to process claims and make Benefits Identification Cards (BICs).
3. By the United States (U.S.) Department of Health and Human Services to make audit and quality control reviews and verify Medicare Buy-In and Social Security Numbers (SSNs).
4. To verify alien status with the U.S. Immigration and Naturalization Service (INS) only for aliens who claim to be lawfully admitted for permanent residence or Permanently Residing in the U.S. Under Color of Law (PRUCOL) or Amnesty Aliens with a valid and current I-688 card. The information the INS receives can only be used to determine Medi-Cal eligibility, and cannot be used for immigration enforcement unless you are committing fraud.
5. By medical services providers and health maintenance organizations to certify eligibility.
6. To identify health insurance coverage and take recovery actions.

MEDI-CAL APPLICANT/BENEFICIARY RIGHTS, RESPONSIBILITIES, AND UNDERSTANDINGS

I HAVE THE RIGHT TO:

1. Ask for an interpreter to help me in applying for Medi-Cal if I have difficulty in speaking or understanding the English language.
2. Request a face-to-face interview with a county representative.
3. Be treated fairly and equally regardless of my race, color, religion, national origin, sex, age, or political beliefs.
4. Apply as a disabled person if I think I am disabled.
5. Receive information about the rules for retroactive Medi-Cal eligibility.
6. Apply for Medi-Cal and to be told in writing whether I qualify for any Medi-Cal program.
7. Review Medi-Cal program rules and regulation manuals if I want to question the basis on which my eligibility is approved or denied.
8. Have all facts that I give to the county welfare department kept in the strictest confidence and to look at those facts during regularly scheduled office hours.
9. Receive an immediate need card, **when possible and eligible,** if I have a medical emergency or I am pregnant.
10. Receive Medi-Cal, as authorized, while my satisfactory immigration status is being documented and verified, if I am otherwise eligible. **Aliens who are lawfully admitted for permanent residence or PRUCOL or Amnesty Aliens** with a **valid and current I-688 card are in a satisfactory immigration status.**
11. Receive information about the Child Health and Disability Prevention Program (CHDP) and the Special Supplemental Food Program for Women, Infants, and Children (WIC), and to ask for help in receiving those services.
12. Receive information about the Personal Care Service Program (PCSP), and to ask for help in receiving those services.
13. Receive information about the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT).
14. Ask for and receive information about the Family Planning Program and be told if I am eligible for those services.
15. Speak to a social worker about other public or private services or resources that I can get.

IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL
(CONTINUED)

16. Receive information about Medi-Cal Health Care Plans that my family and I can join to get a doctor and other medical care, and to choose the option I prefer.

17. Lower my share of cost by providing past unpaid medical bills (that I still owe).

18. Reduce my property reserve to within the Medi-Cal property limit by the last day of a month for which I want Medi-Cal, including the month I apply and to be told how I may spend my excess property.

19. Divide countable (nonexempt) community (MY SPOUSE'S AND MY) property by written agreement into equal shares of separate property if either of us entered a long-term care (LTC) facility before September 30, 1989.

20. Keep a certain amount of countable separate and community property if I enter an LTC facility on or after January 1, 1990. My spouse and I have the right to be told the amount.

21. Have a state hearing if I am dissatisfied with an action taken (or not taken) by the county welfare department or the State Department of Health Services, except actions relating to the Health Insurance Premium Payment (HIPP) and Employer Group Health Plan (EGHP) programs. If I want a state hearing to appeal the decision, I must ask for it within **90 days** of the date the Notice of Action (NOA) was mailed to me. If I do not receive a NOA, I must request a hearing within **90 days** from the date I discover the action (or inaction) with which I am dissatisfied. The date of discovery is the date I know, or should have known, of the action. The best way to ask for a hearing is to contact the nearest county welfare department.

I HAVE THE RESPONSIBILITY TO TELL MY COUNTY REPRESENTATIVE WITHIN TEN (10) DAYS WHENEVER:

1. Income received by me or any member of my family increases, decreases, starts, or stops. This includes income from Social Security Administration (SSA), loans, settlements, or any other source.
2. I plan to change or have already changed my place of residence or mailing address.
3. A person, including a newborn child, whether or not related to me or my family, moves into or out of my home.
4. An absent parent returns to the home.
5. I or a member of my family gives birth, becomes pregnant, or ends a pregnancy.
6. I, my spouse, or any member of my family enters or leaves a nursing home or an LTC facility.
7. I receive, transfer, give away, or sell real or personal property (including money) or when someone gives me or a member of my family such things as a car, house, insurance payments, etc.
8. I have any expenses that are paid for by someone other than myself.
9. I or a member of my family gets a job, changes jobs, or no longer has a job.
10. I have a change in expenses related to my job or education. (For example: child care, transportation, etc.)
11. I or a member of my family becomes physically or mentally impaired (this would include a child in the family)
12. I or a member of my family applies for disability benefits with the SSA, Veterans Administration, or Railroad Retirement.
13. One of my children drops out of school or returns to school.
14. There is a change in the citizenship/immigration status of any family member applying for or receiving Medi-Cal.
15. Health insurance coverage for me or a member of my family changes.

I HAVE THE RESPONSIBILITY TO:

1. Complete and return a status report by the date required when requested.
2. Give proof that I am a resident of California.
3. Make a declaration about my citizenship/immigration status.

IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL
(CONTINUED)

4. Provide an SSN for myself and/or for any member of my family who has an SSN and wants Medi-Cal benefits. If I am an U.S. citizen, a U.S. national, or an alien in a satisfactory immigration status, I must apply for an SSN and provide it to the county if I do not already have one. If I need to apply for an SSN, I can get help from my eligibility worker, but I must work with the SSA to clear up any questions or my Medi-Cal will be denied or stopped. (Aliens who are not in a satisfactory immigration status and do not have an SSN can get **restricted Medi-Cal** without applying for an SSN if they meet all the rules.)
5. Apply for any income that may be available to me or any member of my family.
6. Apply for Medicare benefits if I am blind, disabled, have End Stage Renal Disease, or am 64 years and 9 months of age or older and eligible. I am responsible for telling my providers that I have both Medi-Cal and Medicare coverage.
7. Apply for and enroll in any health insurance if that is available to me and my family at no cost. I have the responsibility to remain enrolled in the health plan when Medi-Cal approves payment of plan premiums by the State of California.
8. Report to the county department, and to the health care provider, any health care coverage/insurance I carry or am entitled to use, including Medicare. If I willfully fail to give this fact, I may be guilty of a criminal offense, or may be billed by my provider.
9. Go to my health care plan (such as Kaiser, CHAMPUS, or a Medicare HMO) for medical care. (Medi-Cal will not pay for any services covered by the plan.)
10. Give any insurance payments I receive to the State if Medi-Cal has already paid for my care.
11. Go to a presentation, if presentations are given, and make a written choice, **or** answer if received by mail, about how I want to get my Medi-Cal benefits. If I do not go and make a choice, **or** choose by mail, my eligible family members and I may be signed up in a Medi-Cal Health Care Plan near my home.
12. Sign and date my BIC when I get it and ensure it is used only to get necessary health care for myself or eligible family members.
13. Take my BIC to my medical provider when I am sick or have an appointment. In emergencies when the BIC is not in hand, I must get the BIC to the medical provider when possible.
14. Report to the county department when I receive health care services because of an accident or injury caused by another person's action or failure to act, for which Medi-Cal has been, or may be billed.
15. Cooperate with the State or county in establishing paternity and identifying any possible medical coverage I or my family may be entitled to through an absent parent.
16. Cooperate with the State of California if my case is selected for review by the quality control review team. If I refuse to cooperate, my Medi-Cal benefits will be stopped.

I UNDERSTAND THAT-

1. Failure to give necessary facts or deliberately giving false facts can result in Medi-Cal benefits being denied or stopped. My case may also be investigated for suspected fraud.
2. The facts I give will be checked by computer with facts given by employers, banks, SSA, Franchise Tax Board, welfare, and other agencies. I will have the right to give proof to correct any facts which are found to be wrong.
3. Aliens who are not in a satisfactory immigration status and do not have an SSN can get **restricted** Medi-Cal without applying for an SSN if they meet all the rules.
4. Immigration status data given as part of the Medi-Cal application is confidential.
5. Based on my income, I will have to pay or be billed for part of my medical expenses before I can get Medi-Cal.
6. If I do not report changes promptly, and because of this, receive Medi-Cal benefits that I am not eligible for, I may have to repay the State Department of Health Services.

IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL
(CONTINUED)

7. If I am receiving Medi-Cal based on disability and I apply for disability benefits from the **SSA, and the SSA** denies my disability claim, my Medi-Cal may be stopped. If I appeal my SSA denial right away, my Medi-Cal will continue until the SSA makes a final decision. If the SSA allows my claim, then my Medi-Cal benefits will continue. If the SSA does not allow my claim, then my Medi-Cal benefits will stop.

8. As a condition of Medi-Cal eligibility, all rights to medical support and/or payment for medical services for myself and any eligible persons that I have legal responsibility for, are automatically assigned to the State.

9. If medical support is court-ordered from an absent parent for my children, the insurance carrier must allow me to enroll and provide benefits to my children without the absent parent's consent.

10. If I don't apply for or keep no-cost health coverage or state-paid coverage, my Medi-Cal benefits and/or eligibility will be denied or stopped.

11. When I apply for Medi-Cal, I will be evaluated for potential eligibility under other medical assistance programs, including the HIPP and EGHP programs.

12. If I ask a Medi-Cal provider for any services not covered by my **non-Medi-Cal** health insurance plan, I must give the medical provider a written statement from my health plan saying it does not offer the Medi-Cal-covered services.

13. Medi-Cal providers cannot collect insurance copayment, coinsurance, or deductibles from me unless the payment is used to meet my Medi-Cal share of cost and/or copayment.

14. If I am admitted to a nursing facility and I have no intention of returning to my home, the State may impose a lien against my property.

15. After my death, the State has the right to seek reimbursement from my estate for all Medi-Cal benefits I received after age 55 unless I have a surviving spouse (during his or her lifetime), minor children, blind or permanently and totally disabled children, or it would create a hardship for my heirs.

16. After the death of my surviving spouse, the State has the right to claim from the part of his or her estate received from me, all Medi-Cal benefits I received after age 55 up to the amount of property my spouse received from my estate.

(Sign and keep for your records) I hereby state that I have reviewed the information on this form with a county representative and that I fully understand my Rights and Responsibilities to have my eligibility determined for Medi-Cal and to maintain that eligibility.

_____ _____

Applicant/Representative Signature *(optional)* Date

COUNTY USE SECTION

I have provided (check one) □ In Person □ By Mail to the applicant the rights, responsibilities, and other information listed on this form.

_____ _____ _____

Eligibility Worker's Signature worker number Date

APPLICANT

IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL

(CONTINUED)

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