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

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

April 10, 2008

TO: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY ADMINISTRATIVE OFFICERS
ALL COUNTY MEDI-CAL PROGRAM SPECIALIST/LIAISONS
ALL COUNTY HEALTH EXECUTIVES
ALL COUNTY MENTAL HEALTH DIRECTORS

Letter No.: 08-14

Subject: REVISED MAIL-IN HEALTHY FAMILIES PROGRAM AND MEDI-CAL JOINT APPLICATION
(Ref.: All County Welfare Directors Letter (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, 05-39, 07-12)

The purpose of this letter is to notify counties of recent revisions and to outline procedures relevant to the Healthy Families Program/Medi-Cal (HFP/MC), (MC 321 HFP, Rev 12/2007) application and Health-e-App for children and pregnant women.

It should be noted that the MC 321 HFP is a joint application with HFP, which is not impacted by the federal Deficit Reduction Act (DRA) of 2005 requirements. Therefore, the MC 321 HFP does not include the instructions to applicants to provide the various types of documents required by the DRA of 2005 for Medi-Cal eligibility. Counties must follow the instructions provided in ACWDL 07-12 to inform applicants of these requirements and obtain necessary verifications. Counties should refer to ACWDL 07-12 instructions beginning on page 10 for the procedures for informing applicants who apply at the county as well as to the instructions beginning on page 29 for procedures for processing applications that are submitted through the Single Point of Entry (SPE).

Background

In January 2005, Governor Schwarzenegger charged the Department of Health Care Services (DHCS) and the Managed Risk Medical Insurance Board (MRMIB) with revising the joint application to be easier for families to complete and thereby increasing the likelihood that families would apply.

Throughout the redevelopment process, the State consulted with impacted stakeholders and collected feedback and recommendations. Based on this input, the joint application was modified. Additionally, a readability assessment, focus groups, and field testing were conducted to ensure that the application met its goal of reducing barriers for families applying for health coverage.

This letter contains:

Section 1: An Overview of the Significant Modifications Made to the Revised HFP/Medi-Cal Joint Application.
Section 2: Description of the Significant Changes and the Required Actions for SPE and Counties as a Result of New Questions Added to the Joint Application Form.
Section 3: Discussion of Coordination between County Medi-Cal Offices and the County or Local-Sponsored Health Insurance Program, such as Healthy Kids.
Section 4: Description of Instructions and Use for the Four New Notices of Action, and the Medi-Cal Consent Form (MC 4035).
Section 5: Reminder on Application Processing and Obtaining Verifications.
Section 6: Availability and Distribution of the Revised Application Information.

Attachments:

- List of County Contacts for Children's Health Initiatives
- Four Notices of Action (MC 239 P2-P5) in English and Spanish
- Medi-Cal Consent Form (MC 4035) in English and Spanish

Section 1: Overview of Significant Modifications

Notable Improvements in the Revised Application compared to the Current HFP/MC Joint Application (MC 321, implemented in 2001):

- Eliminates 50 percent of the instructions
- Re-organizes remainder information into relevant topics
- Reduces colors
- Deletes all interior page photos

- Adds a table of contents to the cover
- Adds a Documents Needed Checklist
- Lowers reading level (from 9.8 to 7.5 grade level)
- Increases white space for easier reading
- Adds "Four Easy Steps to Apply" on the cover
- Presents information in a question and answer format
- Increases information for pregnant women applicants
- Eliminates numbered sections on the four-page application form (pages A1 through A4)
- Designates a separate column to use when applying for the HFP for an unborn child on pages A1 and A2
- Reorganizes the question sequence in the four-page application form to facilitate completion
- Incorporates HFP information throughout the four-page application instead of one page
- Specifies Medi-Cal retroactive coverage requests on an individual basis similar to the MC 210 Medi-Cal application form
- Provides one signature block rather than two for the applicant to sign on pages A1 through A4

Information and Consents Introduced in January 2006 Continue In the Revised HFP/MC Joint Application:

- **Health Care Options Information *(Page 6*).** Section 14016.51 of the Welfare and Institutions (W&I) Code requires the Heath Care Options toll-free number be added to Medi-Cal applications to enable Medi-Cal applicants to request and receive managed care enrollment materials before a Medi-Cal eligibility determination has been made.

- **Bridging Consent Statement *(Page A4, Number 44)*.** Section 14154 of the W&I Code requires that a consent statement be added to the joint application to allow a parent of a child to consent to forward the child's information to the HFP at a future time when the child's Medi-Cal status changes from no-cost Medi-Cal to share-of-cost Medi-Cal (e.g., at annual redetermination). The consent language has been updated in the revised application:

  [ ] We will share your child's application with Healthy Families if your child no longer qualifies for free Medi-Cal in the future. If you do not want us to send it, check here.

- **Certified Application Assistance Authorization *(Page A4*).**

[ ] Check this box and sign below to allow Healthy Families and Medi-Cal to speak to a representative of the Enrollment Entity listed below about the status of this Application. This permission ends when the program mails out its decision on this Application.

New Information for Applicants in the Revised HFP/MC Joint Application:

- **Out of Pocket Expenses for Medi-Cal Covered Services Received After an Application is Submitted —Per *Conlan v. Bontà; Conlan v. Shewry* (*Page 6*).**

  This informs Medi-Cal applicants that after they have applied for Medi-Cal, the Medi-Cal program only pays for covered services received from an enrolled Medi-Cal provider. This includes the time period between when an application is submitted and a Medi-Cal Beneficiary Identification Card (BIC) is issued, and the time period from when a BIC is issued and beyond.

- **Health Care Information for Children who don't Qualify for Medi-Cal or the HFP (*Page 6*).**

  This informs families about the availability of other free or low-cost county programs that are referred to as Healthy Kids in most counties.

Section 2: Significant Changes and Required SPE and County Actions

A description of significant changes to the application and the impact to SPE and county operations are provided below:

Application Question Deletion:

- **Opt Out Question**. Families have had an opportunity to opt out of Medi-Cal or the HFP when filling out the joint application. Often, this delayed children's enrollment in health care coverage when the family chose to opt-out of the program the child was initially screened to or was eligible to receive. Based on input from stakeholders, the question was deleted in the revised application.

Application Question Additions:

New Questions:

- **Name of the teen's spouse or pregnant woman woman's husband** (if living in the home):

County Action Required:

To identify a teen's spouse or pregnant woman's husband, the county will need to review the responses to the Family Size questions 26 through 28. The applicant will list all family members who live in the home including children under 21, stepparents, and the spouse of any teenager or pregnant woman who lives in the home. The applicant will identify the name, gender, date of birth and how this person is related to the family member listed in Number 1. The county will contact the applicant to identify the teen's spouse or pregnant woman's husband if this information is not clearly stated.

- **Email Address (optional) *(Page A1, Number 5*).**

- **Is the child living away from home? (*Page A1, Number 10*).**
  This question was added to be consistent with questions asked on the MC 210 form.

- **Pregnant Woman Column *(Page A1*) adds two questions:**
  Number 14 *Baby's due date ___/___/___*
  Number 15 *Number of babies expected?* ____

  The question to elicit the number of babies expected is added at the request of stakeholders to more accurately collect family size. This is asked again in Number 29, "Is any person in the home pregnant? How many babies is she expecting?

SPE Action Required:

SPE will use the responses to the questions, "Number of babies expected?" and "How many babies is she expecting?" to determine family size of the pregnant woman and children applying. SPE will increase the family size as one per the stated number of babies expected and the application will be screened to the proper program based on family size and income. No verification is required to be submitted to SPE for purposes of calculating an increased family size. For applicants who complete the pregnant woman column or who respond to Number 29 affirmatively but do not list the number of babies expected (e.g., unknown, "?", left blank), SPE will count the pregnant woman and her unborn baby as a family size of two (2).

SPE will populate the Healthy Families to County Transmittal if the pregnant woman is expecting more than one baby to alert counties of the increased family size in the following manner:

The woman will be listed with "Y" for the pregnancy indicator. A second, third, etc., expected baby will be noted on the transmittal as "unborn" and identified, “N”, a non-applying member, in the "screened for" column.

County Action Required:

Counties should follow pregnancy verification policy guidance outlined in MEPM, Article 4, Section 4M, F. Pregnancy: http://www.dhs.ca.gov/mcs/mcpd/MEB/Medi-CalEligibilityProceduresManual/Articles/Article4-ApplicationProcess.pdf.
Counties are reminded there have been no changes to the following verification policies:

- The unborn is only counted as one child for maintenance need calculation purposes unless written medical pregnancy verification indicates multiple unborn children.
- Pregnant women requesting full-scope Medi-Cal may self-declare that the pregnancy has been medically verified and are allowed sixty (60) days to provide proof of pregnancy.
- Women seeking only pregnancy-related services whose income is at or below 200 percent of the federal poverty level or women who are requesting limited scope services do not need to supply proof of pregnancy.

- **Medi-Cal Benefits Identification Card (BIC) Number (*Page A2, Number 20).***
  Medi-Cal benefits card number (BIC), if you have it.

  This question is added at the request of stakeholders to improve Medi-Cal Eligibility Data System (MEDS) file clearance and reduce duplicate Client Identification Numbers. Applicants may provide a BIC number, if it is available.

SPE and County Action Required:

If the BIC Number information is provided by the applicant, SPE and counties should use it as an additional data element in selecting the correct existing record or recognize multiple existing records that belong to the applicant.

- **Request for Medi-Cal:** *Does the person in 1, anyone listed above, or any other person in the home want Medi-Cal? If Yes, who? (If you answer “Yes”, we will contact you.)* **(*Page A3, Number 38*).**

County Action Required:

The detail transmittal will indicate that an unlisted member wants Medi-Cal, but will not list the name of the person on the detail transmittal. Once SPE forwards the detail transmittal, application and supporting documents to the county Medi-Cal office, the county's role is to contact the applicant to determine the relationship of the person requesting Medi-Cal in Number 38 and to determine if this person is part of the applicant's family or whether a separate MC 210 form should be completed for this person. If a separate MC 210 form needs to be completed, the county should complete a SAWS 1 form on behalf of the person requesting Medi-Cal to preserve the application date and forward the application package to the person for completion. The date of the Medi-Cal application would be the date that the application was received at SPE. The date is found on the detail transmittal.

- **Disability *(Page A3, Number 39).*** *Does any person in the home have a physical, mental, emotional or developmental disability and want Medi-Cal? If Yes, who? (If you answer "Yes", we will contact you to see if you qualify.)*

  This question is added to the application to respond to stakeholders' concerns that children and household members who filed the joint application were not adequately screened for disability-based Medi-Cal benefits.

SPE Action Required:

SPE will send an application to the county when Number 39 is answered "Yes" and/or if the application lists a name of a person who has a disability on the application. The person identified in Number 39 may be a child applying for health coverage or another household member.

Healthy Families to County Transmittal

To alert counties that the application has a request for a disability evaluation, a new field, "Any member disabled" is added to the Healthy Families to County Transmittal. This field is coded "Y" (yes) or "N" (no). The name of person will not be listed on the transmittal.

With the addition of the disability screening question, under certain circumstances SPE will forward a child's application and supporting documents concurrently to both the HFP and the county Medi-Cal office.

Example: Number 39 is answered "Yes" and identifies the name of a child who is screened to the HFP based upon his/her age, family size and income. In this situation, the child's application will be reviewed for HFP eligibility and the child may be enrolled in HFP. At the same time, the county will evaluate the child for no-cost Medi-Cal based upon disability.

County Action Required:

Once SPE forwards the detail transmittal, application and supporting documents to the county Medi-Cal office, the county's role is to contact the applicant regarding the household member listed in Number 39 who is requesting Medi-Cal for a disability and to follow the customary process described in MEPM Article 22, Section C to evaluate eligibility for Medi-Cal based on disability: http://www.dhs.ca.gov/mcs/mcpd/MEB/Medi-CalEligibilityProceduresManual/Articles/Article22-DisabilityDeterminationReferrals.pdf The county Medi-Cal office will obtain standard disability forms from the family and refer the identified person for a disability determination. Additionally, the county staff should evaluate other Medi-Cal program linkage factors for the person alleging disability while the disability determination is pending.

In the case where a child who is enrolled in the HFP is determined eligible for no cost Medi-Cal based on a disability, the county must inform the family that in order to access free Medi-Cal services the parent/guardian must write a letter asking to end the child's enrollment in the HFP. The letter requesting that the child's enrollment in HFP be discontinued can be faxed to 1-866-848-4974 or mailed to the following address:

Healthy Families
Attn: Eligibility
P.O. Box 138005
Sacramento, CA 95813-8005

If the family has any questions about their child's enrollment in HFP they can call the HFP at 1-866-848-9166 Monday - Friday 8:00 a.m. to 8:00 p.m., and Saturday 8:00 a.m. to 5:00 p.m.

New Consent:

- **Healthy Kids Program *(Page A3, Number 43)*.**
  [ ] *Medi-Cal will send your application to the Healthy Kids program or a similar county program if your child does not qualify for full Medi-Cal or Healthy Families. If you do not want us to send it, check here.*

  This consent was recommended to be included in the application by stakeholders to increase the number of children who receive comprehensive health coverage when they are not eligible for full-scope Medi-Cal or the HFP.

County Action Required:

The following section describes the county's role in forwarding applications to the county's Healthy Kids program. The county's role was previously outlined in ACWDL 05-39, Expansions to "Express Enrollment" for Children Enrolled in Free School Lunch Program, which authorized sharing children's applications with the county- or local-sponsored health program, known as the Healthy Kids Program.

If the check box in Number 43 is not marked, the county forwards a copy of the joint application of the child determined ineligible for full scope Medi-Cal to the county- or local-sponsored health insurance program, (such as Healthy Kids) for purposes of determining eligibility for that program.

The information to be shared with the Healthy Kids program is limited to the MC 321HFP application. No information regarding Medi-Cal eligibility or information regarding the county's Medi-Cal determination shall be shared by the county directly with the county- or local-sponsored health insurance program, such as Healthy Kids.

Enclosed is contact information for the counties that currently have identified a county- or local-sponsored health insurance program, such as Healthy Kids. If a county does not have an established referral process with this program, the county should use this information to initiate the contact and establish a process for sharing the applications of children whose family have provided permission.

Please note that the Medi-Cal Eligibility Procedures Manual (MEPM), Article 4 X, Single Point of Entry Processing and Referrals To and From Healthy Families, will be updated to correspond to the application form revisions described herein and will be distributed to counties and posted on the Department's website at http://www.dhcs.ca.gov.

Section 3: Coordination between County Medi-Cal Offices and the County- or Local- Sponsored Health Insurance Program, such as Healthy Kids

The Medi-Cal program requires strict confidentiality of Medi-Cal applicant data. Counties should develop protocols for transmitting applications to the county- or local-sponsored health insurance program, such as Healthy Kids. A Medi-Cal office that shares the MC 321 HFP application with another program must enter into a Memorandum of Understanding (MOU) with that program. The MOU should include a description of the process and the responsibility for sharing information. The MOU must address the actions both parties must adhere to in maintaining the confidentiality of the applicant's information.

Suggested types of information that the MOU should include:

- The county must obtain parents' permission to share their child's application information with the county- or local-sponsored health insurance program, such as Healthy Kids, for purposes of applying for that program when the county does not have this permission on file.
- The eligibility criteria of children to be referred, such as age limits, income levels, and citizenship status. (e.g., will the program enroll children eligible for limited Medi-Cal benefits because acceptable proof of citizenship/national status or identity was not provided to the county)
- How each agency will implement this provision and how each agency will protect the privacy and confidentiality of the information contained in the application. These confidentiality and privacy standards must be specific to Welfare and Institutions Code, Section 10850 and 14100.2 that govern the Medi-Cal program.
- The transmittal format and procedure to forward the MC 321 HFP application once Medi-Cal eligibility is determined. (Example: paper, electronic, frequency- daily or weekly)
- County application data tracking information. This should include information such as the number of referrals that are made to the program by the county Medi-Cal office, and the number of children referred by the county Medi-Cal office that are enrolled in the local program.
- Contact persons at the county Medi-Cal office and at the county- or local-sponsored health insurance program, such as Healthy Kids.
- Any other referrals or outreach efforts that the county Medi-Cal office and the county- or local-sponsored health insurance program, such as Healthy Kids will participate in to enroll eligible children. (Examples: flyers, or other notices for parents)

Section 4: Notices of Action (NOA) for Referrals to County- or Local-Sponsored Program, such as Healthy Kids

DHCS developed four NOAs for informing families that the child's application resulted in eligibility for restricted benefits and the child's application would be sent to the county- or local-sponsored health insurance program (such as Healthy Kids) for purposes of applying for that program. DHCS is providing the following NOAs in English and Spanish in this ACWDL. Copies of all threshold languages will be made available to counties in the near future.

MC 239 P-2 Approval of Restricted Benefits – Referred to County- or Local Sponsored Health Insurance Program
MC 239 P-3 Approval of Restricted Benefits with Share of Cost – Referred to County- or Local-Sponsored Health Insurance Program
MC239 P-4 Approval of Restricted Benefits – Not Referred to County- or Local-Sponsored Health Insurance Program
MC239 P-5 Approval of Restricted Benefits with Share of Cost – Not Referred to County- or Local-Sponsored Health Insurance Program

On these NOAs, each county Medi-Cal office should insert the appropriate name of the county program, such as Healthy Kids, in the space for the name of the county program along with the program's telephone number and contact person.

Medi-Cal Consent Form (MC 4035)

At the request of counties and advocates, DHCS developed a Medi-Cal consent form, MC 4035, that must be used by counties to obtain parents' permission to share their child's application information with the county- or local-sponsored health insurance program, such as Healthy Kids, for purposes of applying for that program when the county does not have this permission on file.

This consent form should be sent in conjunction with NOAs MC 239 P-4 or MC239 P-5 described above when the parent checks the box in question Number 43 on the MC 321 HFP application indicating that permission has not been provided for the child's application form to be forwarded to the local program.

Additionally, as part of the counties MOU with the county- or local-sponsored health insurance program, the MC 4035 consent form may be sent to families who complete the Medi-Cal mail-in application (MC 210) or the Annual Redetermination form (MC 210 RV) and whose children are ineligible for full-scope Medi-Cal or HFP, as the children may benefit from services available through the county- or local-sponsored health coverage program.

DHCS is providing this form in English and Spanish in this ACWDL. Copies of all threshold languages will be made available to counties in the near future.

Section 5: Reminder on Application Processing and Obtaining Verifications

Verifications (excluding DRA Citizenship/Identity Verifications)
Counties are reminded that there are no changes to previously issued application processing and verification policies. Counties are required to determine eligibility within the 45 or 90 days timeframe. Counties must obtain verification prior to approval of eligibility.

When documentary evidence is required but is unavailable and all other verification attempts have been unsuccessful, an applicant may sign an affidavit under penalty of perjury as acceptable verification, except in the case of verifying the social security number. (This is not the same affidavit that is allowed under DRA for citizenship or identity.)

Counties may grant eligibility for applicants who are otherwise eligible, pending receipt of certain documents described below:

- Applicants have up to 30 days to provide the county with documents that prove satisfactory immigration status.
- Applicants have up to 60 days to provide counties with a social security number for persons applying for full-scope Medi-Cal benefits.
- Pregnant applicants have up to 60 days to send the county verification of pregnancy when applying for full-scope Medi-Cal benefits. No pregnancy verification is required to receive only pregnancy-related services.

DRA Citizenship/Identity Verifications
As noted previously, proof of identity and U.S. citizenship/U.S. national status are required as a condition of Medi-Cal eligibility. Counties must follow the instructions provided in ACWDL 07-12, to inform applicants of these requirements and obtain necessary verifications. Counties should refer to ACWDL 07-12 for these procedures.

Section 6: Availability and Distribution of the Revised Application

The revised application will be available in April 2008 and printed in English and 11 threshold languages (Spanish, Chinese, Vietnamese, Khmer (Cambodian), Farsi, Armenian, Korean, Russian, Hmong, including two new threshold languages: Arabic and Tagalog).

Links to copies of the revised application in all languages are available at:
http://www.dhcs.ca.gov/formsandpubs/forms/Pages/Medi-CalForms.aspx

The link to the Order Form (MC 370) is available at: http://www.dhcs.ca.gov/formsandpubs/forms/Pages/MCEBbyNumber.aspx for requesting bulk orders.

The new application forms will be distributed immediately. However, due to wide distribution of the current version of the HFP/MC joint application to community partners, the SPE and counties must continue to receive and process the current version of the HFP/MC joint application until the community partners have the revised application forms.

If you have any questions regarding the revised mail-in application, please contact Ms. Angelica Perez by email angelica.perez@dhcs.ca.gov or (916) 552-9511. If you have any questions about SPE referrals to the county, please contact Ms. Guadalupe (Lu) Sanchez at email Guadalupe.sanchez@dhcs.ca.gov or (916) 552-9474.

Sincerely,

ORIGINAL SIGNED BY

Vivian Auble, Chief
Medi-Cal Eligibility Division

Enclosures

MEDI-CAL
CONSENT FORM

County Return Address

Medi-Cal Recipient Address

Notice Date: _____
Case Number: _____
Worker Name: _____
Worker Number: _____
Worker Telephone Number: _____
Office Hours: _____
Notice For: _____

Your child listed above may be eligible for free or low-cost health coverage through the _____; a program that provides health care for children who do not qualify for full
(Insert name of program)
Medi-Cal or Healthy Families. If you give us your consent, we will forward your child's application to this program.

If you consent to our sending your child's Medi-Cal application to the program mentioned above, they will review the information to see if your child is eligible. If you consent, you will not have to complete a new application to apply for the program mentioned above, and a program representative will contact you to let you know what additional information is needed to enroll your child.

IMPORTANT If you wish to give consent to forward your child's information, you must check the box below that shows, **"I give my consent to forward my child's Medi-Cal application form to _____."**
(Insert name of program)

You must sign and date this form and return it to the county address above. You may also call your Medi-Cal worker to tell him/her that you wish to give consent.

If you do not wish to give consent, do NOT return this form. If you do not return this form, consent is NOT given. Your child's Medi-Cal application will not be sent and your child will not get health care coverage through other county programs unless you apply.

☐ **I give my consent to forward my child's Medi-Cal application form to _____**
(Insert name of program)

Sign:_____ Date:_____Phone:_____
(Return this form or call-in your response, within five days, to your worker at the address or phone number listed above)

If you have any questions or need additional information, please contact your Medi-Cal worker listed on the top right corner of this notice. Please call _____ if you want additional information
(Insert program phone number)
about _____.
(Insert name of program)

MEDI-CAL
FORMULARIO PARA EL CONSENTIMIENTO

County Return Address

Medi-Cal Recipient Address

Fecha de Notificación: _____
Número del Caso: _____
Nombre del Trabajador: _____
Número del Trabajador: _____
Número de Teléfono del Trabajador: _____
Horas de Oficina: _____
Notificación Para: _____

Su niño mencionado arriba puede ser elegible para recibir cobertura de salud gratis o a bajo costo a través del programa _____; un programa que da cuidado médico para niños que no califican para Medi-Cal completo o para el programa Healthy Families. Si nos da su consentimiento, enviaremos la solicitud de su niño a este programa.
(Insert name of program)

Si nos da su consentimiento para que nosotros enviemos la solicitud de Medi-Cal de su niño al programa mencionado arriba, ellos revisarán la información para verificar si su niño es elegible. Si da su consentimiento, no tendrá que llenar otra solicitud para el programa mencionado arriba, y un representante del programa lo contactará para dejarle saber qué información adicional se necesita para inscribir a su niño.

IMPORTANTE Si desea dar su consentimiento de enviar la información de su niño, usted debe marcar la caja que aparece debajo y que dice, **"Yo doy mi consentimiento para que se envíe la solicitud de Medi-Cal de mi niño al programa_____."**
(Insert name of program)

Usted tiene que firmar y fechar esta forma y regresarla a la dirección del condado mencionada arriba. Usted también puede llamar a su trabajador de Medi-Cal para decirle que usted desea dar consentimiento.

Si no desea dar consentimiento, NO regrese esta forma. Si no regresa esta forma, No se dará el consentimiento. La solicitud de Medi-Cal de su niño no será enviada y su niño no tendrá cobertura de salud del programa _____a menos que usted lo solicite.
(Insert name of program)

☐ **Yo doy mi consentimiento para que se envíe la solicitud de Medi-Cal de mi niño al programa_____.**
(Insert name of program)

Firma:_____ Fecha:_____ Teléfono:_____
(Regrese este formulario o llame con su respuesta, en el plazo de cinco días, a su trabajador al domicilio o teléfono mencionado arriba.)

Si usted tiene cualquier pregunta o necesita información adicional, por favor póngase en contacto con su trabajador de Medi-Cal mencionado arriba, en la esquina derecha de esta notificación. Por favor llame al _____ si usted desea información adicional sobre el programa_____.
(Insert program phone number)
(Insert name of program)

MEDI-CAL NOTICE OF ACTION
RESTRICTED BENEFITS APPROVAL WITH NO SHARE OF COST: REFERRED TO THE COUNTY OR LOCAL-SPONSORED HEALTH INSURANCE PROGRAM

County Stamp

Address Label

Notice Date: _____
Case Number: _____
Worker Name: _____
Worker Number: _____
Worker Telephone Number: _____
Office Hours: _____
Notice For: _____

Your child _____ will now receive restricted Medi-Cal benefits instead of full scope benefits under the Accelerated Enrollment program, which is temporary coverage that will end on _____.

The change in scope of benefits is due to the lack of Satisfactory Immigration Status for full scope services, as required by federal law. Your child will receive restricted Medi-Cal benefits beginning _____.

Your child may use the Benefit Identification Card (BIC) for no-cost Medi-Cal benefits until _____, but beginning _____, your child's benefits will change to emergency Medi-Cal benefits only.

An emergency medical condition is defined as a medical condition that, if left untreated, could directly result in the patient's health being in serious jeopardy or severe damage to or loss of bodily functions or organs. The emergency must be certified by a physician or other medical provider (in accordance with Section 51056 of Title 22 of the California Code of Regulations). The Department of Heath Care Services may review the provider's decision that an emergency existed and that certain follow-up treatment services were medically justified.

Your child may be eligible for free or low-cost health coverage through _____.
(Insert name of program)

Because you have given us permission, we will forward your child's application to _____.
(Insert name of program)

Your child will be automatically enrolled in _____ without a new application if he/she qualifies.
(Insert name of program)

The _____ will contact you or you may contact _____ by calling
(Insert name of program) (Insert name of program)

_____. Your child's emergency Medi-Cal will continue whether or not you enroll in
(Insert phone number)

_____.
(Insert name of program)

If you have never received a plastic BIC, you will soon receive one in the mail. If you already have a BIC, you should keep using that card. The BIC is good as long as you are eligible for Medi-Cal. If you previously received a BIC but no longer have that BIC, contact your worker for a replacement. You should bring this card to your medical provider whenever you need care. You should not throw away your plastic BIC.

This action is required by Section 14007.5 of the Welfare and Institutions Code. If you think this action is incorrect, you can request a hearing. The back of this page explains how to request a hearing.

NOTIFICACIÓN DE ACCIÓN DE MEDI-CAL
BENEFICIOS LIMITADOS APROBADOS SIN PARTE DEL COSTO: ENVIADO AL CONDADO O AL PROGRAMA DE SEGURO DE SALUD PATROCINADO LOCALMENTE

County Stamp

Address Label

Fecha de Notificación: _____
Número del Caso: _____
Nombre del Trabajador: _____
Número del Trabajador: _____
Número de Teléfono del Trabajador : _____
Horas de Oficina: _____
Notificación Para: _____

Su niño _____ ahora recibirá beneficios limitados de Medi-Cal en vez de los beneficios completos bajo el programa de Inscripción Acelerada (Accelerated Enrollment), de la cual es cobertura temporal que terminará el _____.

Este cambio de beneficios se debe a que su Estado Migratorio no es Satisfactorio para recibir servicios completos, como lo requiere la ley federal. Su niño recibirá beneficios limitados de Medi-Cal comenzando _____.

Su niño puede utilizar la tarjeta de Identificación para Beneficios llamada "BIC" para recibir beneficios de Medi-Cal sin costo hasta _____, pero comenzando _____, los beneficios de su niño cambiarán solamente a beneficios de emergencia de Medi-Cal.

Una condición médica de emergencia se define como una condición médica a la cual, si no se atiende, podría directamente poner la salud del paciente en grave peligro, o resultar en daño severo o pérdida de las funciones del cuerpo u órganos. La emergencia tiene que ser certificada por un médico u otro proveedor médico (de acuerdo con la Sección 51056 del Título 22 del Código de Reglamentaciones de California). El Departamento de Servicios del Cuidado de la Salud puede revisar la decisión del proveedor que indica que existió una emergencia y que ciertos servicios del tratamiento fueron justificados médicamente.

Su niño puede ser elegible para recibir cobertura de salud gratis o a bajo costo a través del programa _____. Porque usted nos ha dado el permiso, enviaremos la solicitud de su
(Insert name of program)

niño al programa _____. Si califica, su niño será inscrito automáticamente en
(Insert name of program)

el programa _____ sin tener que llenar otra solicitud para el/ella.
(Insert name of program)

El programa _____lo contactará o usted puede contactar el programa
(Insert name of program

_____ llamando al_____.
(Insert name of program) (Insert phone number)

La cobertura de emergencia de Medi-Cal para su niño continuará aún si no inscribe a su niño en el programa _____.
(Insert name of program)

Si nunca ha recibido la tarjeta BIC de plástico, usted pronto recibirá una en el correo. Si ya tiene una tarjeta BIC, usted debe continuar usando esa tarjeta. La tarjeta BIC es válida mientras usted sea elegible para Medi-Cal. Si recibió previamente una tarjeta BIC pero ya no la tiene, póngase en contacto con su trabajador para reemplazarla. Usted debe de llevar esta tarjeta a su proveedor médico siempre que usted necesite asistencia médica. No tire su tarjeta BIC de plástico.

Esta acción es requerida por la Sección 14007.5 del Código del Bienestar e Instituciones. Si piensa que esta acción es incorrecta, usted puede solicitar una audiencia. La parte posterior de esta página explica cómo solicitar una audiencia.

MEDI-CAL NOTICE OF ACTION
RESTRICTED BENEFITS APPROVAL WITH SHARE OF COST: REFERRED TO THE COUNTY OR LOCAL-SPONSORED HEALTH INSURANCE PROGRAM

County Stamp

Address Label

Notice Date: _____
Case Number: _____
Worker Name: _____
Worker Number: _____
Worker Telephone Number: _____
Office Hours: _____
Notice For: _____

Your child _____ will now receive restricted Medi-Cal benefits instead of full scope benefits under the Accelerated Enrollment program, which is temporary coverage that will end on _____.

The change in scope of benefits is due to the lack of Satisfactory Immigration Status for full scope services, as required by federal law.

Your child may use the Benefit Identification Card (BIC) for no-cost Medi-Cal benefits until _____, but beginning _____, your child's benefits will change to emergency Medi-Cal benefits only.

An emergency medical condition is defined as a medical condition that, if left untreated, could directly result in the patient's health being in serious jeopardy or serve damage to or loss of bodily functions or organs. The emergency must be certified by a physician or other medical provider (in accordance with Section 51056 of Title 22 of the California Code of Regulations). The Department of Health Care Services may review the provider's decision that an emergency existed and that certain follow-up treatment services were medically justified.

Your income is too high to receive Medi-Cal at no cost. Since your income was more than the amount allowed for living expenses, you have a share of cost you must pay or agree to pay toward the cost of medical care received. Your share of cost is $_____ beginning _____. Your share of cost was computed as follows:

Gross Income	$_____
Net Nonexempt Income	$_____
Maintenance Need	$_____
Excess Income/Share of Cost	$_____

Your child may be eligible for free or low-cost health coverage through _____.
(Insert name of program)

Because you have given us permission, we will forward your child's application to **_____.**
(Insert name of program)

The _____ will contact you or you may contact _____ by calling
(Insert name of program) (Insert name of program)

_____**.** Your child's emergency Medi-Cal will continue whether or not you enroll in
(Insert program number)

_____.
(Insert name of program)

If you have never received a plastic BIC, you will soon receive one in the mail. If you already have a BIC, you should keep using that card. The BIC is good as long as you are eligible for Medi-Cal. If you previously received a BIC but no longer have that BIC, contact your worker for a replacement. You should bring this card to your medical provider whenever you need care. You should not throw away your plastic BIC.

This action is required by Section 14007.5 of the Welfare and Institutions Code and California Code of Regulations, Title 22, Section 50653. If you think this action is incorrect, you can request a hearing. The back of this page explains how to request a hearing.

NOTIFICACIÓN DE ACCIÓN DE MEDI-CAL
BENEFICIOS LIMITADOS APROBADOS CON PARTE DEL COSTO: ENVIADO AL CONDADO O AL PROGRAMA DE SEGURO DE SALUD PATROCINADO LOCALMENTE

County Stamp

Address Label

Fecha de Notificación: _____
Número del Caso: _____
Nombre del Trabajador: _____
Número del Trabajador: _____
Número de Teléfono del Trabajador: _____
Horas de Oficina: _____
Notificación Para: _____

Su niño _____ ahora recibirá beneficios limitados de Medi-Cal en vez de los beneficios completos bajo el programa de Inscripción Acelerada (Accelerated Enrollment), de la cual es cobertura temporal que terminará el _____.

Este cambio de beneficios se debe a que su Estado Migratorio no es Satisfactorio para recibir servicios completos, como lo requiere la ley federal.

Su niño puede utilizar la tarjeta de Identificación para Beneficios llamada "BIC" para recibir beneficios de Medi-Cal sin costo hasta _____, pero comenzando _____, los beneficios de su niño cambiarán solamente a beneficios de emergencia de Medi-Cal.

Una condición médica de emergencia se define como una condición médica a la cual, si no se atiende, podría directamente poner la salud del paciente en grave peligro, o resultar en daño severo o pérdida de las funciones del cuerpo u órganos. La emergencia tiene que ser certificada por un médico u otro proveedor médico (de acuerdo con la Sección 51056 del Título 22 del Código de Reglamentaciones de California). El Departamento de Servicios del Cuidado de la Salud puede revisar la decisión del proveedor que indica que existió una emergencia y que ciertos servicios del tratamiento fueron justificados médicamente.

Su ingreso es demasiado alto para recibir Medi-Cal sin costo. Puesto que su ingreso era más que la cantidad permitida para los gastos necesarios para vivir, usted tiene que pagar una parte del costo o estar de acuerdo en pagar hacia el costo de asistencia médica recibida. Su parte del costo es $_____ comenzando _____. Su parte del costo fue determinada así:

Ingreso Bruto:	$_____
Ingreso Neto no Exento:	$_____
Ingreso Necesario para Mantenerse:	$_____
Ingreso Excesivo/Parte del Costo:	$_____

Su niño puede ser elegible para recibir cobertura de salud gratis o a bajo costo a través del programa

_____. Porque usted nos ha dado el permiso, enviaremos la solicitud de su niño al programa
(Insert name of program)

_____. El programa _____ lo contactará o usted puede contactar el
(Insert name of program) (Insert name of program)

programa llamando al _____. La cobertura de emergencia de Medi-Cal para su niño
(Insert phone number)

continuará aún si no inscribe a su niño en el programa _____.
(Insert name of program)

Si nunca ha recibido la tarjeta BIC de plástico, usted pronto recibirá una en el correo. Si ya tiene una tarjeta BIC, usted debe continuar usando esa tarjeta. La tarjeta BIC es válida mientras usted sea elegible para Medi-Cal. Si recibió previamente una tarjeta BIC pero ya no la tiene, póngase en contacto con su trabajador para reemplazarla. Usted debe de llevar esta tarjeta a su proveedor médico siempre que usted necesite asistencia médica. No tire su tarjeta BIC de plástico.

Esta acción es requerida por la Sección 14007.5 del Código del Bienestar e Instituciones y del Código de Reglamentaciones de California, Título 22, Sección 50653. Si piensa que esta acción es incorrecta, usted puede solicitar una audiencia. La parte posterior de esta página explica cómo solicitar una audiencia.

MEDI-CAL NOTICE OF ACTION
RESTRICTED BENEFITS APPROVAL WITH NO SHARE OF COST: NOT REFERRED TO THE COUNTY OR LOCAL-SPONSORED HEALTH INSURANCE PROGRAM

County Stamp

Address Label

Notice Date: _____
Case Number: _____
Worker Name: _____
Worker Number: _____
Worker Telephone Number: _____
Office Hours: _____
Notice For: _____

Your child _____ will now receive restricted Medi-Cal benefits instead of full scope benefits under the Accelerated Enrollment program, which is temporary coverage that will end on _____.

The change in scope of benefits is due to the lack of Satisfactory Immigration Status for full scope services, as required by federal law. Your child will receive restricted Medi-Cal benefits beginning _____.

Your child may use the Benefit Identification Card (BIC) for no-cost Medi-Cal benefits until _____, but beginning _____, your child's benefits will change to emergency Medi-Cal benefits only.

An emergency medical condition is defined as a medical condition that, if left untreated, could directly result in the patient's health being in serious jeopardy or severe damage to or loss of bodily functions or organs. The emergency must be certified by a physician or other medical provider (in accordance with Section 51056 of Title 22 of the California Code of Regulations). The Department of Health Care Services may review the provider's decision that an emergency existed and that certain follow-up treatment services were medically justified.

Your child may be eligible for free or low-cost health coverage through_____. If you want
(Insert name of program)

_____ for your child, you have to apply unless you tell us you want us to forward your Medi-Cal
(Insert name of program)

application. You may fill out the enclosed consent form or call your worker listed above. Your child's emergency Medi-Cal will continue whether or not you enroll in_____.
(Insert name of program)

If you have never received a plastic BIC, you will soon receive one in the mail. If you already have a BIC, you should keep using that card. The BIC is good as long as you are eligible for Medi-Cal. If you previously received a BIC but no longer have that BIC, contact your worker for a replacement. You should bring this card to your medical provider whenever you need care. You should not throw away your plastic BIC.

This action is required by Section 14007.5 of the Welfare & Institutions Code. If you think this action is incorrect, you can request a hearing. The back of this page explains how to request a hearing.

NOTIFICACIÓN DE ACCIÓN DE MEDI-CAL
BENEFICIOS LIMITADOS APROBADOS SIN PARTE DEL COSTO: NO ENVIADO AL CONDADO O AL PROGRAMA DE SEGURO DE SALUD PATROCINADO LOCALMENTE

County Stamp

Address Label

Fecha de Notificación: _____
Número del Caso: _____
Nombre del Trabajador: _____
Número del Trabajador: _____
Número del Teléfono del Trabajador : _____
Horas de Oficina: _____
Notificación Para: _____

Su niño _____ ahora recibirá beneficios limitados de Medi-Cal en vez de los beneficios completos bajo el programa de Inscripción Acelerada (Accelerated Enrollment), de la cual es cobertura temporal que terminará el _____.

Este cambio de beneficios se debe a que su Estado Migratorio no es Satisfactorio para recibir servicios completos, como lo requiere la ley federal. Su niño recibirá beneficios limitados de Medi-Cal comenzando_____.

Su niño puede utilizar la tarjeta de Identificación para Beneficios llamada “BIC” para recibir beneficios de Medi-Cal sin costo hasta _____, pero comenzando _____, los beneficios de su niño cambiarán solamente a beneficios de emergencia de Medi-Cal.

Una condición médica de emergencia se define como una condición médica a la cual, si no se atiende, podría directamente poner la salud del paciente en grave peligro, o resultar en daño severo o pérdida de las funciones del cuerpo u órganos. La emergencia tiene que ser certificada por un médico u otro proveedor médico (de acuerdo con la Sección 51056 del Título 22 del Código de Reglamentaciones de California). El Departamento de Servicios del Cuidado de la Salud puede revisar la decisión del proveedor que indica que existió una emergencia y que ciertos servicios del tratamiento fueron justificados médicamente.

Su niño puede ser elegible para recibir cobertura de salud gratis o a bajo costo a través del programa

_____.
(Insert name of program)

Si usted desea el programa _____para su niño, usted tiene que solicitar a menos
(Insert name of program)

que nos diga que usted quiere que nosotros enviemos su solicitud de Medi-Cal. Usted puede llenar el formulario para el consentimiento o llamar a su trabajador mencionado arriba. La cobertura de emergencia de Medi-Cal para su niño continúa aunque usted no inscriba a su niño en _____.
(Insert name of program)

Si nunca ha recibido la tarjeta BIC de plástico, usted pronto recibirá una en el correo. Si ya tiene una tarjeta BIC, usted debe continuar usando esa tarjeta. La tarjeta BIC es válida mientras usted sea elegible para Medi-Cal. Si recibió previamente una tarjeta BIC pero ya no la tiene, póngase en contacto con su trabajador para reemplazarla. Usted debe de llevar esta tarjeta a su proveedor médico siempre que usted necesite asistencia médica. No tire su tarjeta BIC de plástico.

Esta acción es requerida por la Sección 14007.5 del Código del Bienestar e Instituciones. Si piensa que esta acción es incorrecta, usted puede solicitar una audiencia. La parte posterior de esta página explica cómo solicitar una audiencia.

NOTIFICACIÓN DE ACCIÓN DE MEDI-CAL
BENEFICIOS LIMITADOS APROBADOS CON PARTE DEL COSTO: NO ENVIADODO AL CONDADO O AL PROGRAMA DE SEGURO DE SALUD PATROCINADO LOCALMENTE

County Stamp

Address Label

Fecha de Notificación: _____
Número del Caso: _____
Nombre del Trabajador: _____
Número del Trabajador: _____
Número de Teléfono del Trabajador : _____
Horas de Oficina: _____
Notificación Para: _____

Su niño _____ ahora recibirá beneficios limitados de Medi-Cal en vez de los beneficios completos bajo el programa de Inscripción Acelerada (Accelerated Enrollment) de la cual es cobertura temporal que terminará el _____.

Este cambio de beneficios se debe a que su Estado Migratorio no es Satisfactorio para recibir servicios completos, como lo requiere la ley federal.

Su niño puede utilizar la tarjeta de Identificación para Beneficios llamada "BIC" para recibir beneficios de Medi-Cal sin costo hasta _____, pero comenzando _____, los beneficios de su niño cambiarán solamente a beneficios de emergencia de Medi-Cal.

Una condición médica de emergencia se define como una condición médica a la cual, si no se atiende, podría directamente poner la salud del paciente en grave peligro, o resultar en daño severo o pérdida de las funciones del cuerpo u órganos. La emergencia tiene que ser certificada por un médico u otro proveedor médico (de acuerdo con la Sección 51056 del Título 22 del Código de Reglamentaciones de California). El Departamento de Servicios del Cuidado de la Salud puede revisar la decisión del proveedor que indica que existió una emergencia y que ciertos servicios del tratamiento fueron justificados médicamente.

Su ingreso es demasiado alto para recibir Medi-Cal sin costo. Puesto que su ingreso era más que la cantidad permitida para los gastos necesarios para vivir, usted tiene que pagar una parte del costo o estar de acuerdo en pagar hacia el costo de asistencia médica recibida. Su parte del costo es $_____ que comienza _____. Su parte del costo fue determinada así:

Ingreso Bruto:	$_____
Ingreso Neto no Exento:	$_____
Ingreso Necesario para Mantenerse:	$_____
Ingreso Excesivo/Parte del Costo:	$_____

Su niño puede ser elegible para recibir cobertura de salud gratis o a bajo costo a través del programa _____ (Insert name of program). Si usted desea el programa _____ (Insert name of program) para su niño, usted tiene que solicitar a menos que nos diga que usted quiere que nosotros enviemos su solicitud de Medi-Cal. Usted puede llenar el formulario para el consentimiento o llamar a su trabajador mencionado arriba. La cobertura de emergencia de Medi-Cal para su niño continúa aunque usted no inscribe a su niño en _____ (Insert name of program).

Si nunca ha recibido la tarjeta BIC de plástico, usted pronto recibirá una en el correo. Si ya tiene una tarjeta BIC, usted debe continuar usando esa tarjeta. La tarjeta BIC es válida mientras usted sea elegible para Medi-Cal. Si recibió previamente una tarjeta BIC pero ya no la tiene, póngase en contacto con su trabajador para reemplazarla. Usted debe de llevar esta tarjeta a su proveedor médico siempre que usted necesite asistencia médica. No tire su tarjeta BIC de plástico.

Esta acción es requerida por la Sección 14007.5 del Código del Bienestar e Instituciones y del Código de Reglamentaciones de California, Título 22, Sección 50653. Si piensa que esta acción es incorrecta, usted puede solicitar una audiencia. La parte posterior de esta página explica cómo solicitar una audiencia.

MEDI-CAL NOTICE OF ACTION
RESTRICTED BENEFITS APPROVAL WITH SHARE OF COST: NOT REFERRED TO THE COUNTY OR LOCAL-SPONSORED HEALTH INSURANCE PROGRAM

County Stamp

Address Label

Notice Date: _____
Case Number: _____
Worker Name: _____
Worker Number: _____
Worker Telephone Number: _____
Office Hours: _____
Notice For: _____

Your child _____ will now receive restricted Medi-Cal benefits instead of full scope benefits under the Accelerated Enrollment program, which is temporary coverage that will end on _____.

This change in scope of benefits is due to the lack of Satisfactory Immigration Status for full scope services, as required by federal law.

Your child may use the Benefit Identification Card (BIC) for no-cost Medi-Cal benefits until _____, but beginning _____, your child's benefits will change to emergency Medi-Cal benefits only.

An emergency medical condition is defined as a medical condition that, if left untreated, could directly result in the patient's health being in serious jeopardy or severe damage to or loss of bodily functions or organs. The emergency must be certified by a physician or other medical provider (in accordance with Section 51056 of Title 22 of the California Code of Regulations). The Department of Health Care Services may review the provider's decision that an emergency existed and that certain follow-up treatment services were medically justified.

Your income is too high to receive Medi-Cal at no cost. Since your income was more than the amount allowed for living expenses, you have a share of cost you must pay or agree to pay toward the cost of medical care received. Your share of cost is $_____ beginning _____. Your share of cost was computed as follows:

Gross Income	$_____
Net Nonexempt Income	$_____
Maintenance Need	$_____
Excess Income/Share of Cost	$_____

Your child may be eligible for free or low-cost health coverage through _____. If you want
(Insert name of program)

_____ for your child, you have to apply unless you tell us you want us to forward your Medi-Cal
(Insert name of program)

application. You may fill out the enclosed consent form or call your worker listed above. Your child's emergency Medi-Cal will continue whether or not you enroll in _____.
(Insert name of program)

If you have never received a plastic BIC, you will soon receive one in the mail. If you already have a BIC, you should keep using that card. The BIC is good as long as you are eligible for Medi-Cal. If you previously received a BIC but no longer have that BIC, contact your worker for a replacement. You should bring this card to your medical provider whenever you need care. You should not throw away your plastic BIC.

This action is required by Section 14007.5 of the Welfare and Institutions Code and California Code of Regulations, Title 22, Section 50653. If you think this action is incorrect, you can request a hearing. The back of this page explains how to request a hearing.

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