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

DAVID MAXWELL-JOLLY
Director

ARNOLD SCHWARZENEGGER
Governor

June 30, 2010

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.: 10-11

SUBJECT: CORRECTIONS TO AND INSTRUCTIONS FOR INMATE/WARD TRANSMITTAL FORM (MC 0025) (Reference: ACWDL 09-16)

The purpose of this letter is to:

- Provide County Welfare Departments (CWDs) with an updated copy of the "Transmittal to CDCR Public Benefit Specialist on Determination of a Ward's/Inmate's Medi-Cal Eligibility" (newly numbered MC 0025) form (enclosure 1).
- Provide counties with clarification regarding the use of the MC 0025 form.
- Provide questions and answers to clarify requirements related to the new MC 0025 form and timeliness for information transmittal.

BACKGROUND

Pursuant to the January 2008 Memorandum of understanding (MOU) between the California Department of Corrections and Rehabilitation (CDCR) and DHCS, as outlined in All County Welfare Directors Letter (ACWDL) 09-16, each County is required to:

- Provide a point of contact (POC), for use by CDCR staff that prepare Medi-Cal applications for CDCR wards/inmates prior to their release.

- Acknowledge receipt of an application from CDCR within 10 days.
- Process Medi-Cal applications submitted by CDCR.
- Inform CDCR about the outcome of the determination (using the enclosed MC 0025 form).

THE MC 0025 FORM (enclosure 1)

The MC 0025 form is intended to assist the counties in providing CDCR with necessary information regarding a ward's/inmate's pending Medi-Cal eligibility status as well as providing a means to request additional information about an applicant when necessary. It is not a Notice of Action (NOA) nor is it to be given to CDCR Medi-Cal applicants. The MC 0025 form is only to be used by CWD staff to inform CDCR of the outcome of an eligibility determination or to request additional information via CDCR staff. The MC 0025 form should reflect the most accurate information pertaining to an applicant's pending Medi-Cal eligibility upon their parole/release from incarceration.

PERSONALLY IDENTIFIABLE INFORMATION (PII)

Counties must not include PII, such as social security or client identification numbers, anywhere on the MC 0025 form. Instead the CDCR prisoner number (the number CDCR assigns to a ward/inmate) should be used. To ensure counties are provided this number, CDCR facilities will include the ward's/inmate's CDCR number in the cover letter that is submitted along with the ward's/inmate's Medi-Cal application (enclosure 2). The CDCR number will act as the primary means of identifying individuals on the MC 0025 form. Note that there is a space to include this number in the upper right-hand corner of the MC 0025.

CHANGES TO THE MC 0025 FORM

On the MC 0025, the word 'inmate' has been added where appropriate. This form will also be uploaded to the DHCS website concurrent with the release of this ACWDL and can be found at:
http://www.dhcs.ca.gov/formsandpubs/forms/Pages/MCEBbyNumber.aspx

QUESTIONS AND ANSWERS:

1. **How will CDCR notify the CWD about a change in a ward's/inmate's release date?**

CDCR has developed two cover letters, one for wards and another for inmates, which will be transmitted to counties informing them of changes to a ward's/inmate's parole/release date. Copies of these forms are enclosed (enclosure 2).

2. Will CWDs be required to submit an additional MC 0025 reflecting a change in the status of a ward's/inmate's pending Medi-Cal eligibility when there is a change to the parole/release date?

If there is a change to a ward's/inmate's parole/release date a MC 0025 form reflecting the impact of this change on suspension status and/or eligibility (as appropriate) must be sent to the appropriate CDCR Public Benefits Specialist.

3. How will the department ensure that information requested of CDCR is provided to the counties in a timely manner?

In accordance with current Medi-Cal application requirements, Medi-Cal applicants (including CDCR staff acting on an inmate's/ward's behalf) are required to respond to County information requests in a timely manner. Failure to provide requested information may result in a denial of Medi-Cal eligibility for a ward/inmate. If eligibility is denied for this reason, proper notice is required; however, counties should contact CDCR Public Benefits Specialists before denying eligibility for failure to receive information requested from CDCR staff.

4. Can counties send CDCR facilities the MC 0025 form instead of a cover letter acknowledging receipt of a inmate's/ward's Medi-Cal application?

The MC 0025 form may be sent to designated CDCR staff instead of a cover letter acknowledging receipt of a Medi-Cal application. Acknowledgement of the application must be sent within ten days of receipt of a ward's/inmate's Medi-Cal application (as required in ACWDL 09-16). If a MC 0025 form cannot be completed and sent to designated CDCR within ten days of receiving a ward's/inmate's Medi-Cal application, a cover letter acknowledging receipt of a ward's/inmate's Medi-Cal application must be sent.

5. Will Counties be provided CDCR Public Benefit Specialist POCs?

A pre-release Medi-Cal application, submitted to counties from a CDCR Public Benefits Specialist, must include a cover letter indicating a CDCR staff member POC. Specific questions regarding a ward's/inmate's pre-release Medi-Cal application must be directed to the CDCR staff member indentified on the cover letter. General questions about CDCR application processing as required by ACWDL 09-16 may be directed to the DHCS staff member responsible for institutional status eligibility issues.

If you have any questions regarding this letter please contact Mr. Thomas (Antonio) Weary at (916) 322-4863 or by email at Thomas.weary@dhcs.ca.gov.

Sincerely,

ORIGINAL SIGNED BY

René Mollow, MSN, RN, Chief
Medi-Cal Eligibility Division

Enclosures

TRANSMITTAL TO CDCR PUBLIC BENEFIT SPECIALIST ON DETERMINATION OF A WARD'S/INMATE'S MEDI-CAL ELIGIBILITY

Date:	**CDCR Number:**
Benefits Information for:	

ELIGIBILITY PENDING *(Note: The eligibility status information provided below is subject to change if all eligibility requirements are not met at the time the ward/inmate is released.*

☐ This ward/inmate will be eligible to receive no-cost Medi-Cal benefits beginning on the following date: _____.

☐ This ward/inmate will be eligible to receive Medi-Cal benefits with a share-of-cost beginning on the following date: _____.

☐ This ward/inmate will be eligible to receive limited Medi-Cal benefits beginning on the following date: _____.

☐ Due to a change of his or her release date, this ward/inmate will not be eligible to receive Medi-Cal on _____; instead he or she will be eligible to receive Medi-Cal benefits on the following date: _____.

ELIGIBILITY DENIED

☐ This ward's/inmate's application for Medi-Cal, dated _____, has been denied. The reason for this denial is:

INFORMATION REQUEST *(Please contact the County immediately if you have questions or concerns regarding the denial of eligibility)*

☐ In order to determine the ward's/inmate's eligibility we need the following information:

DIVISION OF ADULT PAROLE OPERATIONS
1515 S Street, Room 212-N, Sacramento, CA 95814
P.O. Box 942883, Room 212-N
Sacramento, CA 94283-0001

<INSERT DATE>

County Welfare Department:
<INSERT COUNTY REPRESENTATIVE>
<INSERT COUNTY>

In accordance with the Memorandum of Understanding between the California Department of Corrections and Rehabilitation (CDCR) and the California Department of Health Care Services (DHCS) attached is a Medi-Cal application for processing.

INMATE NAME:

INMATE CDCR NUMBER:

DATE OF BIRTH:

PAROLE DATE:

COUNTY OF PAROLE:

HAS RESIDENCE PLANS UPON RELEASE:	YES	NO
If no, he/she intends to reside in this area of the county:		
PLANS TO WORK UPON RELEASE:	YES	NO
APPLIED FOR SOCIAL SECURITY BENEFITS:	YES	NO

Questions regarding the Medi-Cal application for the above mentioned inmate may be directed to the contracted authorized representative at **<INSERT TELEPHONE NUMBER>, <INSERT E-MAIL ADDRESS>**. The authorized representative fax number is **<INSERT FAX NUMBER>**. Thank you for your assistance.

<INSERT YOUR NAME>, <INSERT YOUR TITLE>
<INSERT YOUR INSTITUION>
Transitional Case Management Program

DIVISION OF ADULT PAROLE OPERATIONS
1515 S Street, Room 212-N, Sacramento, CA 95814
P.O. Box 942883, Room 212-N
Sacramento, CA 94283-0001

<INSERT DATE>

County Welfare Department:
<INSERT COUNTY REPRESENTATIVE>
<INSERT COUNTY>

In accordance with the Memorandum of Understanding between the California Department of Corrections and Rehabilitation (CDCR) and the California Department of Health Care Services (DHCS), this is to notify you that the Parolee's release date has changed.

INMATE NAME:

INMATE CDCR NUMBER:

DATE OF BIRTH:

UPDATED PAROLE DATE:

COUNTY OF RECORD:

Questions regarding the parole release date for the above mentioned inmate may be directed to the contracted authorized representative at **<INSERT TELEPHONE NUMBER>, <INSERT E-MAIL ADDRESS>**. The authorized representative fax number is **<INSERT FAX NUMBER>**.

Thank you for your assistance.

<INSERT YOUR NAME>, <INSERT YOUR TITLE>
<INSERT YOUR INSTITUION>
Transitional Case Management Program

DIVISION OF JUVENILE JUSTICE FACILITIES
4241 WILLIAMSBOURGH DRIVE
SACRAMENTO, CA 95823

<INSERT DATE>

County Welfare Department:
<INSERT COUNTY REPRESENTATIVE>
<INSERT COUNTY>

In accordance with the Memorandum of Understanding between the California Department of Corrections and Rehabilitation (CDCR) and the California Department of Health Care Services (DHCS), attached is a Medi-Cal application for processing.

WARD NAME:

WARD CDCR NUMBER:

DATE OF BIRTH:

PAROLE DATE:

COUNTY OF PAROLE:

HAS RESIDENCE PLANS UPON RELEASE: YES NO

If no, he/she intends to reside in this area of the county:

PLANS TO WORK UPON RELEASE: YES NO

APPLIED FOR SOCIAL SECURITY BENEFITS: YES NO

Questions regarding the parole release date for the above mentioned ward may be directed to the contracted authorized representative at **<INSERT TELEPHONE NUMBER>, <INSERT E-MAIL ADDRESS>**. The authorized representative fax number is **<INSERT FAX NUMBER>**.

Thank you for your assistance.

<INSERT YOUR NAME>, <INSERT YOUR TITLE>
<INSERT YOUR PROGRAM>

DIVISION OF JUVENILE JUSTICE FACILITIES
4241 WILLIAMSBOURGH DRIVE
SACRAMENTO, CA 95823

<INSERT DATE>

County Welfare Department:
<INSERT COUNTY REPRESENTATIVE>
<INSERT COUNTY>

In accordance with the Memorandum of Understanding between the California Department of Corrections and Rehabilitation (CDCR) and the California Department of Health Care Services (DHCS), this is to notify you that the Ward's release date has changed. See information below:

WARD NAME:

WARD CDCR NUMBER:

DATE OF BIRTH:

UPDATED PAROLE DATE:

COUNTY OF RECORD:

Questions regarding the parole release date for the above mentioned ward may be directed to the contracted authorized representative at **<INSERT TELEPHONE NUMBER>, <INSERT E-MAIL ADDRESS>**. The authorized representative fax number is **<INSERT FAX NUMBER>**.

Thank you for your assistance.

<INSERT YOUR NAME>, <INSERT YOUR TITLE>
<INSERT YOUR PROGRAM>