



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



EDMUND G. BROWN JR.
Governor

July 31, 2015

To: ALL COUNTY WELFARE DIRECTORS Letter No: 15-26
ALL COUNTY ADMINISTRATIVE OFFICERS
ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIAISONS
ALL COUNTY PUBLIC HEALTH DIRECTORS
ALL COUNTY MENTAL HEALTH DIRECTORS

SUBJECT: County Requirements for Issuing Appropriate Notices of Action for Failure to Respond and/or Provide Necessary Information at Application and Compliance with All County Welfare Directors' Letter 13-13
(Reference: All County Welfare Directors' Letters 08-32, 13-13 and Medi-Cal Eligibility Division Information Letters 14-61 and 15-11)

This All County Welfare Directors' Letter (ACWDL) provides instructions regarding denials at application for failure to respond to requests for additional information or verifications, and the requirement to provide adequate information on the Notice of Action (NOA).

Specifically, this policy affects the failure to respond reason outlined in this ACWDL for denials where the NOA does not list the specific information or verification(s) needed to establish eligibility. **All other denial reasons are not impacted and will follow current process and policy.** Additional guidance on Long Term Negative Action (LTNA) will be forthcoming in a separate Medi-Cal Eligibility Division Information Letter.

Adequate Information on the NOA

In order for a denial NOA, for the population described in this ACWDL, to be considered adequate, the NOA must list the specific information or verification(s) missing and needed to determine eligibility. The NOA must not use generic language to explain why the individual could not be found eligible, such as, "there was not enough information to determine eligibility," without explaining specifically which information or verification(s) is needed from the applicant, such as, "you did not provide proof of your income."

Suspension of Denials

The Department of Health Care Services (DHCS) is suspending denials for failure to provide required information or verification needed for an initial eligibility determination at application to the extent such NOA does not contain the specifically needed information or verification(s) as further described in this ACWDL. Effective July 23, 2015, any denial on this basis at application shall cease immediately until the appropriate system changes are made to ensure specific information regarding which information or verification(s) was missing is listed on the NOA.

Duration of Instructions

The above instructions are required and are in effect for the impacted denial actions until the counties and systems are able to confirm that adequate notices can be sent to deny individuals for failure to provide the needed information or verification(s) at initial application to establish Medi-Cal eligibility.

Short-Term Negative Action (STNA) or LTNA Process to be Used for Application Denials

It is DHCS' understanding that some counties, depending on their Statewide Automated Welfare System (SAWS), have the functionality to choose specific reasons to be included on a manual denial NOA, such as income verification was not provided. To the extent feasible, counties are to utilize existing processes within their respective SAWS to generate the adequate manual notices, which list the specific information or verification that was needed or provided.

Counties, which are able to utilize existing processes within their respective SAWS to generate the adequate notices may begin to immediately use either STNA or LTNA process to take the denial action within SAWS. Counties should consult with their SAWS on how to proceed with utilizing STNA or LTNA process to take the denial action. Utilizing either STNA or LTNA process will ensure the application is denied in SAWS, the Medi-Cal Eligibility Data System, and the California Healthcare Eligibility, Enrollment, and Retention System.

Counties must also ensure the adequate SAWS or county generated notice is mailed timely to the applicant upon taking STNA and LTNA action to ensure the adequate notice reaches the applicant.

NOA Policy Reminder and Modified Adjusted Gross (MAGI) Income NA Back 9

Counties are reminded to follow all NOA policy requirements as outlined in ACWDL 08-32 and 13-13, including the need to include the NA Back 9 appeal information and to adhere to established timelines for determinations, redeterminations, and NOAs, and the need to include a multilingual notification (DHCS form MCED 4304 or the California Department of Social Services (CDSS) form GEN 1365) with all NOAs to ensure limited English proficient individuals are aware of the translation services they are entitled to. For MAGI applicants, counties, which generate notices in SAWS using the above requirements, must also include the correct Affordable Care Act Fair Hearings Bureau contact information on the NOA. English and Spanish NA Back 9 forms with the correct contact information, as required by CDSS, are included with this ACWDL.

SAWS and counties may not alter the contact information on the NA Back 9 forms included for the MAGI population; however, may include the contact information for the local legal aid office within the appropriate section.

Reminder on Verbal Requests to Withdraw Applications

DHCS understands counties have received verbal requests from applicants, or their authorized representatives, to withdraw an application. A request to withdraw at the client's request can be taken orally or in writing; however, the county must follow the normal process for denial including the normal noticing process. Although a written request is not required, the counties must properly identify the individual making the oral request and annotate the conversation in their case file notes. The notation needs to include the date and name of individual making the request. If the oral request is made by an authorized representative, the county must verify in the case record prior to taking action, that the representative has the authority to request such action.

If you have any questions about this ACWDL, please contact Alison Brown by phone at (916) 319-9565 or by email at Alison.Brown@dhcs.ca.gov.

Original Signed By:

Alice Mak
Acting Chief
Medi-Cal Eligibility Division

Enclosure

YOUR HEARING RIGHTS

You have the right to ask for a hearing if you disagree with any county action. You have only 90 days to ask for a hearing. The 90 days started the day after the county gave or mailed you this notice. If you have good cause as to why you were not able to file for a hearing within the 90 days, you may still file for a hearing. If you provide good cause, a hearing may still be scheduled.

If you ask for a hearing before an action on Cash Aid, Medi-Cal, CalFresh, or Child Care takes place:

- Your Cash Aid or Medi-Cal will stay the same while you wait for a hearing.
- Your Child Care Services may stay the same while you wait for a hearing.
- Your CalFresh benefits will stay the same until the hearing or the end of your certification period, whichever is earlier.

If the hearing decision says we are right, you will owe us for any extra Cash Aid, CalFresh or Child Care Services you got. To let us lower or stop your benefits before the hearing, check below:

Yes, lower or stop: ☐ Cash Aid ☐ CalFresh
☐ Child Care

While You Wait for a Hearing Decision for:

Welfare to Work:

You do not have to take part in the activities.

You may receive child care payments for employment and for activities approved by the county before this notice.

If we told you your other supportive services payments will stop, you will not get any more payments, even if you go to your activity.

If we told you we will pay your other supportive services, they will be paid in the amount and in the way we told you in this notice.

- To get those supportive services, you must go to the activity the county told you to attend.
- If the amount of supportive services the county pays while you wait for a hearing decision is not enough to allow you to participate, you can stop going to the activity.

Cal-Learn:

- You cannot participate in the Cal-Learn Program if we told you we cannot serve you.
- We will only pay for Cal-Learn supportive services for an approved activity.

OTHER INFORMATION

Medi-Cal Managed Care Plan Members: The action on this notice may stop you from getting services from your managed care health plan. You may wish to contact your health plan membership services if you have questions.

Child and/or Medical Support: The local child support agency will help collect support at no cost even if you are not on cash aid. If they now collect support for you, they will keep doing so unless you tell them in writing to stop. They will send you current support money collected but will keep past due money collected that is owed to the county.

Family Planning: Your welfare office will give you information when you ask for it.

Hearing File: If you ask for a hearing, the State Hearing Division will set up a file. You have the right to see this file before your hearing and to get a copy of the county's written position on your case at least two days before the hearing. The state may give your hearing file to the Welfare Department and the U.S. Departments of Health and Human Services and Agriculture. **(W&I Code Sections 10850 and 10950.)**

TO ASK FOR A HEARING:

- Fill out this page.
- Make a copy of the front and back of this page for your records. If you ask, your worker will get you a copy of this page.
- Send or take this page to:

OR

- Call toll free: 1-855-795-0634 or for hearing or speech impaired who use TDD, 1-800-952-8349.

To Get Help: You can ask about your hearing rights or for a legal aid referral at the toll-free state phone numbers listed above. You may get free legal help at your local legal aid or welfare rights office.

If you do not want to go to the hearing alone, you can bring a friend or someone with you.

HEARING REQUEST

I want a hearing due to an action by the Welfare Department of _____ County about my:

- ☐ Cash Aid ☐ CalFresh ☐ Medi-Cal
☐ Other (list) _____

Here's Why: _____

- ☐ If you need more space, check here and add a page.
☐ I need the state to provide me with an interpreter at no cost to me. (A relative or friend cannot interpret for you at the hearing.)

My language or dialect is: _____

NAME OF PERSON WHOSE BENEFITS WERE DENIED, CHANGED OR STOPPED

BIRTH DATE

PHONE NUMBER

STREET ADDRESS

CITY

STATE

ZIP CODE

SIGNATURE

DATE

NAME OF PERSON COMPLETING THIS FORM

PHONE NUMBER

- ☐ I want the person named below to represent me at this hearing. I give my permission for this person to see my records or go to the hearing for me. (This person can be a friend or relative but cannot interpret for you.)

NAME

PHONE NUMBER

STREET ADDRESS

CITY

STATE

ZIP CODE

SU DERECHO A UNA AUDIENCIA

Usted tiene derecho a solicitar una audiencia si no está de acuerdo con cualquier acción que el Condado tome. Solamente tiene 90 días para solicitar una audiencia. Los 90 días comenzaron el día después de la fecha en que el Condado le dio o envió esta notificación. Si tiene un motivo justificado para no haber solicitado una audiencia antes de los 90 días, usted todavía puede solicitar una audiencia. Si proporciona un motivo justificado, es posible que todavía se programe una audiencia.

Si solicita una audiencia antes de que entre en vigor una acción en relación a la asistencia monetaria, Medi-Cal (Programa de Asistencia Médica de California), CalFresh, o cuidado de niños:

- Su asistencia monetaria/Medi-Cal no cambiará mientras espera a que se lleve a cabo la audiencia.
- Es posible que sus servicios de cuidado de niños no cambien mientras espera a que se lleve a cabo la audiencia.
- Sus beneficios de CalFresh no cambiarán mientras espera a que se lleve a cabo la audiencia o hasta el final de su período de certificación, lo que ocurra antes.

Si la decisión de la audiencia indica que estamos en lo correcto, usted nos deberá cualquier asistencia monetaria, beneficios de CalFresh o servicios de cuidado de niños que haya recibido de más. Para que reduzcamos o descontinúemos sus beneficios antes de la audiencia, marque a continuación:

Sí, reduzcan o descontinúen: ☐ Asistencia monetaria ☐ CalFresh ☐ Cuidado de niños

Mientras que espera la decisión de una audiencia relacionada a:

Programa para la Transición de la Asistencia Pública al Trabajo (Welfare to Work):

No tiene que participar en las actividades.

Es posible que reciba pagos en relación al cuidado de niños para trabajar y participar en actividades aprobadas por el Condado antes de esta notificación.

Si le dijimos que los pagos para sus otros servicios de apoyo se iban a descontinuar, no recibirá más pagos, aunque participe en la actividad.

Si le dijimos que pagaríamos sus otros servicios de apoyo, se le pagarán de acuerdo a la cantidad y de la manera que le indicamos en esta notificación.

- Para recibir esos servicios de apoyo, tiene que participar en la actividad en que el Condado le pidió que participara.
- Si la cantidad que el Condado le paga para servicios de apoyo mientras que espera la decisión de la audiencia no es suficiente para que usted pueda participar, puede dejar de participar en la actividad.

Cal-Learn (un programa de California para la educación de los padres adolescentes que reciben asistencia monetaria):

- No puede participar en el Programa de Cal-Learn si le dijimos que no le podemos asistir.
- Solamente pagaremos los servicios de apoyo de Cal-Learn si se trata de una actividad aprobada.

OTRA INFORMACIÓN

Miembros de planes de cuidado médico administrado de Medi-Cal: Es posible que la acción de esta notificación no le permita recibir servicios de su plan de salud de cuidado médico administrado. Puede comunicarse con la oficina de servicios de membresía de su plan de salud si tiene preguntas.

Mantenimiento de niños y/o en relación al cuidado de la salud: La oficina local de mantenimiento de hijos le ayudará gratuitamente a cobrar mantenimiento de hijos, aunque usted no esté recibiendo asistencia monetaria. Si ahora cobran mantenimiento de hijos para usted, continuarán haciéndolo a no ser que usted les pida por escrito que lo dejen de hacer. Le mandarán la cantidad actual de mantenimiento que se cobre pero se quedarán con los atrasos que se cobren que se le deban al Condado.

Planificación familiar: La oficina de bienestar público le dará información cuando usted la pida.

Expediente de audiencia: Si solicita una audiencia, la División de Audiencias con el Estado abrirá un expediente. Usted tiene derecho a ver este expediente antes de la audiencia y a recibir una copia de la declaración escrita de posición del Condado relacionada a su caso por lo menos dos días antes de la audiencia. Es posible que el Estado le dé el expediente de audiencia de usted al Departamento de Bienestar, y a los Departamentos de Salud y Servicios Humanos y de Agricultura de los Estados Unidos. **(Secciones 10850 y 10950 del Código de Bienestar Público e Instituciones - W&IC.)**

PARA SOLICITAR UNA AUDIENCIA:

- **Complete esta página.**
- Haga una copia de esta página y de la primera página para sus expedientes.
Si la pide, su trabajador le dará una copia de esta página.
- **Envíe o lleve esta página a:**

O fax a 1-916-651-2789

- **Llame gratuitamente al: 1-855-795-0634.** Las personas sordas/con problemas del habla que usan TDD* pueden llamar al 1-800-952-8349.

Para obtener ayuda: Puede pedir información acerca de su derecho a una audiencia o sobre oficinas de asesoramiento legal llamando a los teléfonos estatales gratuitos mencionados arriba. Es posible que pueda recibir asesoramiento legal gratuito en la oficina local de asesoramiento legal o en la oficina de defensa de los derechos relacionados a la asistencia pública.

Si no quiere ir a la audiencia solo, puede llevar a un amigo o a otra persona con usted.

PETICIÓN PARA UNA AUDIENCIA

Deseo solicitar una audiencia a causa de una acción tomada por el Departamento de Bienestar Público del Condado de _____ acerca de mí(s):

☐ Asistencia monetaria ☐ CalFresh ☐ Medi-Cal

☐ Otro (anote) _____

La razón es la siguiente: _____

☐ Si necesita más espacio, marque aquí y adjunte otra página.

☐ Necesito que el Estado me proporcione un intérprete gratuitamente. (Un familiar o un amigo no puede actuar como intérprete de usted en la audiencia.)

Mi idioma o dialecto es el: _____

NOMBRE DE LA PERSONA A QUIEN LE NEGARON, CAMBIARON O DESCONTINUARON LOS BENEFICIOS

FECHA DE NACIMIENTO NÚMERO DE TELÉFONO

DIRECCIÓN: CALLE

CIUDAD ESTADO CÓDIGO POSTAL

FIRMA FECHA

NOMBRE DE LA PERSONA QUE COMPLETA ESTE FORMULARIO NÚMERO DE TELÉFONO

☐ Quiero que la persona nombrada a continuación me represente en esta audiencia. Doy permiso para que esta persona vea mis expedientes o vaya a la audiencia por mí. (Esta persona puede ser un amigo o familiar, pero no puede actuar como su intérprete.)

NOMBRE NÚMERO DE TELÉFONO

DIRECCIÓN: CALLE

CIUDAD ESTADO CÓDIGO POSTAL

*TDD: aparato de telecomunicaciones para las personas sordas