DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814

November 19, 1982

To: All County Welfare Directors Letter No. 82-61

MEDICALLY INDIGENT ADULTS (MIA) DISCONTINUANCE PROCESS -- NOTICE OF ACTION

This letter is to inform you that the State has developed a notice of action for discontinuing medically indigent adults from the Medi-Cal program effective January 1, 1983. The State will generate the notice (in English only) for all Medi-Cal recipients, except those in paper counties, whose aid code was either 84, 85, 88, or 89 on the main file for December 1982 month of eligibility for CID/MEDS. The paper counties have received a letter describing their discontinuance process.

It is important that you reclassify those MIA persons who will still be eligible for Medi-Cal after January 1, 1983, as aid codes 02, 53, 86, or 87; otherwise those persons will receive erroneous discontinuances. Our Department will hand pull the notice for any MIA whose aid code is changed into one of these new aid codes as long as the information is received by December 8, 1982:

CID/MEDS Data Guidance Unit
Attention: Al Brinsfield
744 P Street, Room 1050
Sacramento, CA 95814

and contains the 14-digit ID and the zip code. It would be helpful if your list is in zip code order.

We will be sending a camera-ready copy of the notice in English and Spanish, and a Vietnamese translation. You will have to send a discontinuance notice to any person who becomes eligible for Medi-Cal as an MIA after the CID/MEDS cutoff date for December 1982 eligibility data. In addition you should give a Spanish/Vietnamese translation to those persons who do not speak English when there is no one in the household who can translate.

If an individual becomes eligible as a MIA after December 21, 1982, you will be unable to give them a ten-day notice prior to January 1, 1983. Nevertheless, you should discontinue them immediately (effective January 1) and document your actions in the case record. You should also inform them at the time of application that their Medi-Cal eligibility will end on December 31, 1982, and the notice of action approving eligibility should state this fact. Our legal staff has advised that the ten-day notice requirement may be waived in such cases.

If you have any questions on this process please contact Martin Bornstein of my staff at (916) 445-1797.

Sincerely,

Original signed by

Carol Goodman for
Madalyn M. Martinez, Chief
Medi-Cal Eligibility Branch

Attachment
cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

Peter Abbott, Chief
County Health Services
8/1350

State of California - Department of Health Services

NOTICE PREPARATION DATE:
** A **

Si Ud. necesita un interprete, favor de comunicarse con su trabajador del condado.

Neu ban can thong-dich-vien xin lien-lac voi nguoi can-su xa-hoi cua ban.

Beneficiary ID Number:
** C **

MEDI-CAL NOTICE OF ACTION

** B **

You have been receiving Medi-Cal benefits under a special State-funded program for medically indigent adult persons. However, the law has been changed, and you will no longer be eligible to receive Medi-Cal beginning January 1, 1983. Starting January 1, 1983, the State program serving medically indigent persons is limited to children under 21 years of age, pregnant women, refugees who have resided in the U.S. for 18 months or less, and adults residing in a skilled nursing or intermediate care facility (W&I Code 14005.4 amended by Statutes of 1982, Chapter 1594, Section 19). According to our records, you are not under 21 years of age, a pregnant woman, an eligible refugee, or an adult residing in a skilled nursing or intermediate care facility; thus your Medi-Cal eligibility will end on December 31, 1982.

You may apply to have your health needs met by your county of residence beginning January 1, 1983. IF YOU ARE A PREGNANT WOMAN, UNDER 21, A REFUGEE, OR IN A NURSING HOME, YOU SHOULD CONTACT YOUR ELIGIBILITY WORKER IMMEDIATELY SINCE YOU MAY BE ABLE TO GET MEDI-CAL BENEFITS AGAIN. Please contact your county welfare department for assistance in applying for benefits or if you have questions about this notice.

If you disagree with this determination and believe you have a right to continued Medi-Cal benefits, you may request a "fair hearing." If you decide to request a hearing, you must do so within 90 days of the mailing date of this notice.

State regulations, including those covering hearings, are available at the county welfare department. Anyone, including yourself, may represent you at the hearing, but you are expected to arrange for this yourself. You can get help in locating free legal assistance by calling the toll-free number listed below.

TO REQUEST A HEARING -- Fill in the information at the bottom of the page (you may attach a separate sheet or use the reverse side as well if you need more room) and send it to:

Office of Chief Referee
State Department of Social Services (DSS)
744 P Street, Mail Station 6-100
Sacramento, CA 95814

Los Angeles County Residents send to:
Fair Hearing Section
P.O. Box 10260
Glendale, CA 91205

The information that you provide is needed to process your request. Processing may be delayed if it is incomplete. If you wish to examine any of the materials that were used to make a determination, contact the Public Inquiry and Response Unit (see number below). Any information you provide may be shared with the county welfare department and the U.S. Department of Health and Human Services (Authority: W&I Code Section 14100.2).

You may also request a hearing by calling the toll-free number listed below. They can provide you with further information about your hearing rights. Assistance is available in some languages other than English, including Spanish. You may phone, write, or come in to the Public Inquiry and Response Unit, DSS, 744 P Street, Mail Station 16-23, Sacramento, CA 95814, TOLL FREE NUMBER 1-800-952-5253.

REQUEST FOR FAIR HEARING

Name _____ Phone Number _____

Address _____ City _____ State _____ Zip Code _____

I am requesting a state hearing because of an action by the welfare department of _____ county related to Medi-Cal. Reasons for my request:

|_| I am under 21. |_| I am pregnant. |_| I am in an intermediate care or skilled nursing facility.

|_| I am a refugee. |_| Other (Please specify) _____

I speak a language other than English and need an interpreter for my hearing. (The State will provide the interpreter at no cost.) Language _____ Dialect _____