STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY GEORGE DEUKMEJIAN, *Governor*

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

June 25, 1985

To: All County Welfare Directors
County Administrative Officers

Letter No. 85- 52

LYNCH V. RANK RETROACTIVE REIMBURSEMENT PROCESS

Background

In 1983 a Partial Summary Judgment was issued in the Lynch v. Rank lawsuit. This court order required that the Department of Health Services (DHS) revise its policies and procedures for treating Medi-Cal beneficiaries who were former SSI/SSP recipients and who would be eligible to receive SSI/SSP if specific Title II cost-of-living increases were disregarded.

These people were to be granted zero share-of-cost Medi-Cal benefits under the 1976 Pickle Amendment to the Social Security Act. The court order provided prospective relief for class members beginning in August 1983.

Since the time of the 1983 judgment, DHS has anticipated receiving an additional court order requiring that retroactive relief be provided to class members who were entitled to zero share-of-cost Medi-Cal benefits, but who were wrongfully denied these benefits. On May 21, 1985, this order was issued by the U.S. District Court of Northern California.

The order requires that retroactive reimbursement be provided to anyone who would have been eligible under the Pickle Amendment in any month from April 1, 1980 to the present, or to the time that he/she began receiving Medi-Cal benefits as aid types 16, 26 or 66.

Notices

On June 28, 1985 DHS will send a notice (Attachment 1) to the last known address of all class members, who are defined as:

1. All current Pickle eligibles;

2. All persons who received Medi-Cal under a Pickle Aid Code in any month since April 1980;

3. All persons who were sent a Pickle notice in November 1983 and February 1984.

Included with the notice will be a pre-paid envelope, addressed to the county contact person in the class member's county of residence. Persons receiving this notice will have forty-five (45) days from the postmark date to complete the top portion of the notice and return it to the county contact person in the envelope provided. On June 18, 1985 county welfare departments (CWDs) were sent a list of all persons to whom a notice is being sent. This list is in Social Security number order and is sorted by county of residence.

Application

If the person fails to return the notice or contact the CWD within forty-five (45) days, the CWD will take no further action. Notices received after the forty-five (45) days should be denied using Notice of Action 3 (Denial of Benefits). If contact is made within the forty-five (45) days the CWD must, within fifteen (15) days from that contact, provide the person with an application (Attachment 2) in either English or if requested, in Spanish. This application must provide the applicant with the name and telephone number of a person who is available to answer questions and to assist in completing the forms. Persons to whom an application is mailed have until October 30, 1985 (unless a thirty (30) day extension is granted) to return the application to the CWD. For this purpose, a thirty (30) day extension should be granted if it becomes apparent to the CWD that the applicant will not be able to return the completed application by October 30, 1985.

Each county must maintain a master list to monitor the application process of all persons from whom they have received a request for a retro application. This list must reflect the name, address and telephone number of each applicant, the date an application was mailed, the date the completed application was received by the CWD, the dates the required thirty (30) day and sixty (60) day personal contacts were made, the date a claim form was mailed, the date the required sixty (60) day personal contact was made and the date the completed claim form was received by the CWD. Two printouts with preprinted space to record this information are being provided to each CWD. One printout lists only those persons who met their share of cost during the retroactive period and the other is everyone who was sent the June 28, 1985 notice and may or may not have had a share of cost. These listings were sent, along with an initial supply of retro applications, to each County Medi-Cal Liaison, on June 21, 1985. During any contact, the CWD must attempt to obtain the telephone number of the applicant and that number must be recorded on the monitoring system printout.

Personal Contact (Application)

THIRTY DAY PERSONAL CONTACT:

In processing an application for retroactive reimbursement, the requirements of Title 22, CAC, Sections 50163(a)(3)(A)-(D) and 50165 are applicable. Additionally, in accordance with Section 50165, when the retro application is not returned within thirty (30) days from the date the CWD mailed it to the applicant, the county shall attempt to telephone the applicant and complete the Screening Worksheet (DHS 7020). If, during the screening the applicant answers "no" to questions two through four on the DHS 7020, the person may be ineligible for retroactive reimbursement. If he/she is ineligible, at this time, Notice of Action 3 (Attachment 4) must be sent. If the applicant has no telephone, the CWD shall send Information Notice 1 (Attachment 3), requesting that the applicant call the CWD.

If the applicant has been eligible for and in receipt of SSI/SSP and was subsequently discontinued from SSI/SSP several times during the retroactive period, he/she would only be potentially eligible during each period of discontinuance when a Title II COLA was received (Screening Question 4).

If, at the time of the thirty (30) day personal contact, the CWD determines that the applicant is potentially eligible for retroactive reimbursement, the CWD shall determine the reason that the applicant has failed to return the retro application and shall offer assistance, if necessary, in completing the application. In addition, the CWD shall orally request answers to questions 1-5 and 13 on the retro application at this time. This information must be recorded on an application and must be retained, by the county contact person in a readily accessible location.

SIXTY DAY PERSONAL CONTACT:

When the retro application is not returned within sixty (60) days of the date the CWD mails it, another personal contact must be made. At this time the CWD shall ensure that the answers to questions 1-5 and 13 on the retro application have been obtained and if not, the CWD shall offer assistance in completing the application. If the applicant has no telephone, the CWD shall send the applicant Information Notice 2 (Attachment 5), reminding him/her that all applications must be filed no later than October 30, 1985, and that another copy of the retro application indicating that questions 1-5 and 13, at a minimum, should be answered and returned. If it becomes apparent, at this time, that the applicant will not be able, for any reason, to return the application by October 30 the CWD shall allow an additional thirty (30) days (until November 29, 1985) to return it.

If the class member is deceased, the person submitting the application must provide proof of his/her relationship to the deceased or of authorization to represent the class member's estate. The Declaration of Right to Property (Probate Code Section 630) (Attachment 6) must be sent along with the retro application in all cases where someone other than a surviving spouse or an executor/administrator is applying on behalf of a deceased person. CWDs should reproduce this Declaration on county letterhead.

County of Responsibility

Applications are to be processed by the CWD in the county in which the applicant currently resides. When an applicant indicates that he/she has formerly resided in another county, the county of residence shall contact the prior county(ies) of residence to obtain any information necessary to complete the application. Information of this nature should be obtained by contacting the appropriate county contact person (Attachment 7).

If an application is sent to the wrong county, the county receiving the application is responsible for forwarding it to the correct county of residence.

Application Processing

Upon receipt, the county of residence shall screen the application without delay, to determine if further information is needed. If further information is necessary and the applicant fails to provide it within 15 days after the CWDs request is made, the CWD must contact the applicant and either obtain the necessary information, or provide the applicant with assistance in obtaining the information. If the information is still not received thirty (30) days after the initial request, or within such time as is reasonable, given the applicant's capabilities and the type of information needed, the CWD will process the application using the information: (1) on the application; (2) in any currently existing Medi-Cal case file, or (3) obtainable from a third party. If the information that is available from these sources is insufficient and/or outdated the application must be denied. At this time Notice of Action 3 (Denial of Benefits) is to be sent.

Once a completed application is received, it shall be processed in accordance with the time limits established in Title 22, CAC, Section 50177.

Eligibility is to be determined, for July of each year from 1980 to 1985 or until the date that the applicant was determined

Pickle eligible or until he/she was reinstated on SSI/SSP. When determining retroactive eligibility, any person found Pickle eligible in July of any year shall be considered to have been Pickle eligible for the remainder of that year (July 1 through June 30), unless: (1) the applicant entered long term care; (2) the applicant's Medi-Cal case file or his/her retro application contains evidence that he/she became ineligible for Medi-Cal under the Pickle Amendment at some time during the year; or (3) the applicant or his/her spouse received earned income or any other source of income that may have varied during the year. In these cases eligibility must be determined on a monthly basis.

Pickle eligibility must be determined using SSI/SSP eligibility criteria as it was during each of the retroactive years. Since the SSI/SSP treatment of income and resources has changed between April 1980 and the present, we have developed charts that identify these changes. These charts, as well as the SSI/SSP payment levels provided in these retro instructions, are to be used for each of the years between 1980-1985 when determining retro eligibility.

If an applicant has an active Medi-Cal case containing all of the information required by the retro application, or if there is an inconsistency between the information provided on the retro application and that in the Medi-Cal case, the case file shall be used in completing the eligibility determination. However, if the information is not in the Medi-Cal case file, the information on the retro application shall be accepted unless it is incomplete or contains discrepancies. If verification of required information cannot be obtained, the CWD must obtain the applicant's signed statement, attesting to the validity of the information under penalty of perjury.

For anyone whose application indicates ineligibility due to excess resources, the CWD must make a personal contact and determine the value of that applicant's excess countable resources for the relevant period.

If, during any contact, the CWD becomes aware that the applicant misunderstood the application and, as a result provided incorrect information, the CWD is required to assist the applicant in correcting the errors.

Statistical Reporting

1) Monitoring

The Retro Monitoring System Report (DHS 7042) (Attachment 8) shall be completed for each person requesting an application. It shall be sent to DHS following the final disposition of each person's application.

For the convenience of DHS and county staff, the prior month's DHS 7042 may be batched and sent monthly with the Retro Activity Report (DHS 7055). (Attachment 9.) See below.

2) Claiming

The DHS 7055 is the report counties shall use in lieu of the MC 237 to report Lynch v. Rank retro cases. Applications, approvals and denials for retro Pickle benefits shall not be entered on the monthly MC 237. See MCAC Letter 85-9 for further information concerning case reporting and claiming.

The DHS 7055 shall be completed monthly by the county contact person and must be received at DHS no later than the 10th working day following the report month.

Court Reports

The court has ordered DHS to provide two future monitoring reports. For the first report, CWDs must report the following to DHS, no later than January 3, 1986:

1. The number of current Pickle eligibles, as of October 1, 1985;

2. The number of requests for applications submitted to the county;

3. The number of applications sent by the county;

4. The number of applications returned to the county;

5. The total number of eligibility determinations made;

6. The number of eligibility determinations still pending;

7. The number of applications wholly denied, broken down by the following categories:

   a. failure to provide sufficient information;

   b. failure to cooperate (other than (a));

   c. application untimely;

   d. claimant in long-term care during entire retroactive reimbursement period;

   e. claimant received SSI/SSP in all months since April 1, 1980;

f. claimant ineligible due to excess resources;

g. claimant ineligible due to excess income;

h. not Pickle eligible at any time since April 1, 1980 (for reasons other than (d)-(g). (Specify each reason.)

This report is to be mailed to Kristi Banion, Department of Health Services, 714 P Street, Room 1692, Sacramento, CA 95814. Information regarding the second report, as well as the Notices, instructions on the claiming process and specific details concerning the reimbursement process will be sent in a subsequent All County Welfare Directors Letter.

Miscellaneous

During the 1985 Pickle Eligibility Training each county was given revised instructions and procedures to be used when determining a person's Medi-Cal eligibility under the Pickle Amendment. These procedures should be applied beginning August 1, 1985 for your current Pickle cases and for all ABD-MNs in the CWD Tickler system (ACWD Letter 83-74). State Quality Control staff will begin citing errors on any cases not converted by October 1, 1985. The 1985 procedures should be applied beginning January 1, 1985 for anyone applying for retroactive reimbursement for the calendar year 1985.

Thank you for your cooperation in complying with the complex requirements and the short deadlines in this case. Any questions should be directed to Kristi Banion (916) 324-4961 or ATSS 8-454-4961.

Sincerely,

Doris Z. Soderberg, Chief
Eligibility Branch

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

Expiration Date: July 1, 1986

REQUEST FOR RETROACTIVE
REIMBURSEMENT (LYNCH V RANK)
SOLICITUD DE REEMBOLSO RETROACTIVO

55-00-8030000-0-01 LR
LASTNAME FIRSTNAME
LASTNAME, FIRSTNAME
FIRST ADDRESS LINE
SECOND ADDRESS LINE
CITY, STATE 95814

Beneficiary ID Number:
55-00-8030000-0-01

IF YOU HAVE ANY QUESTIONS CONTACT:
SI USTED TIENE PREGUNTAS PONGASE E
CONTACTO CON:
SHARON MINOR
(209) 533-5734

MAKE ANY CORRECTIONS TO NAME AND
ADDRESS HERE AND INCLUDE
Phone Number or Message Number

HAGA AQUI CORRECCIONES DE NOMBRE
Y DIRECCION E INCLUYA SU NUMERO DE
TELEFONO O NUMERO DE MENSAJE
(_____) _____ - _________

____
____
____

__ CHECK HERE IF YOU NEED THE APPLICATION IN SPANISH
__ MARQUE AQUI SI UD. NECESITA LA SOLICITUD EN ESPANOL

RETURN THIS PORTION
(DEVUELVA ESTA PORCION)

- -

IMPORTANT: BECAUSE OF A COURT DECISION (LYNCH V. RANK), THE STATE MAY OWE YOU MONEY. PLEASE READ THIS NOTICE CAREFULLY AND FOLLOW THE INSTRUCTIONS BELOW.

IF THE ANSWER TO ALL OF THE FOLLOWING QUESTIONS IS "YES" THE STATE MAY OWE YOU MONEY FOR MEDICAL EXPENSES WHICH YOU PAID SINCE APRIL, 1980.
_____ SINCE APRIL, 1977, DID YOU EVER RECEIVE SSI BENEFITS (A GOLD CHECK)?
_____ DO YOU NOW RECEIVE SOCIAL SECURITY BENEFITS (GREEN CHECK)?
_____ DID YOU EVER RECEIVE SSI AND SOCIAL SECURITY BENEFITS IN THE SAME MONTH?

.O RECEIVE AN APPLICATION FOR REIMBURSEMENT, RETURN THE ABOVE PORTION OF THIS NOTICE BY AUGUST 15, 1985. A SELF ADDRESSED STAMPED ENVELOPE IS ENCLOSED FOR THIS PURPOSE.

WHO CAN FILE AN APPLICATION?

1. YOU CAN FILE AN APPLICATION YOURSELF; OR
2. A CONSERVATOR, RELATIVE, FRIEND, OR AN EMPLOYEE OF AN INSTITUTION CAN FILE AN APPLICATION IF YOU ARE AUTHORIZED TO DO SO; OR
3. AN EXECUTOR, ADMINISTRATOR, OR NEXT OF KIN CAN FILE AN APPLICATION FOR A DECEASED PERSON.

IMPORTANTE: DEBIDO A UNA DECISION DE TRIBUNAL (LYNCH V. RANK), ES POSIBLE QUE EL ESTADO LE DEBA DINERO A USTED. POR FAVOR LEA CON CUIDADO ESTA NOTICIA Y SIGA LAS INSTRUCCIONES DE ABAJO.

SI LA RESPUESTA A TODAS LAS SIGUIENTES PREQUNTAS ES "SI", ES POSIBLE QUE EL ESTADO LE DEBA DINERO POR GASTOS MEDICOS QUE USTED HA PAGADO DESDE ABRIL DE 1980.

__________ DESDE ABRIL DE 1977, HA RECIBIDO USTED BENEFICIOS DE SSI (CHEQUE DORADO)?

__________ RECIBE USTED AHORA BENEFICIOS DE SEGURO SOCIAL (CHEQUE VERDE)?

__________ HA RECIBIDO USTED BENEFICIOS DE SSI Y SEGURO SOCIAL EN EL MISMO MES?

PARA RECIBIR UNA SOLICITUD DE REEMBOLSO, DEVUELVA LA PORCION DE ARRIBA DE ESTA NOTICIA ANTES DEL 15 DE AGOSTO DE 1985. SE ADJUNTA A ESTE PROPOSITO UN SOBRE CON SELLO YA IMPRIMIDO CON LA DIRECCION DEL REMITENTE.

QUIEN PUEDE PRESENTAR UNA SOLICITUD?

1. USTED MISMO PUEDE PRESENTAR UNA SOLICITUD; O

2. UN(A) CONSERVADOR(-A), UN PARIENTE, UN(A) AMIGO(-A) OR UN(A) EMPLEADO(-A) DE UNA INSTITUCION PUEDE PRESENTAR UNA SOLICITUD SI ESTA AUTORIZADO(-A) A HACERLO; O

3. UN(A) EJECUTOR(A) TESTAMENTARIO(-A), UN(A) ADMINISTRADOR(A), O PARIENTES MAS PROXIMOS PUEDE(N) PRESENTAR UNA SOLICITUD POR UNA PERSONA DIFUNTA.

Date: _____

Applicant Name: _____

Applicant SSN: _____

Worker Name: _____

Worker Phone No.: _____

Enclosed is the *Lynch* v. *Rank* application for reimbursement which you requested. In order for us to process your application, you must complete the form and return it in the enclosed, self-addressed, stamped envelope. It is important to carefully follow the instructions that are attached to the form.

You may file the form yourself; *or*

A conservator, relative, friend, or an employee of an institution may file it if you are unable; *or*

An executor, administrator, or next of kin may file for a deceased person.

If you are married and *living with your spouse*, you only need to file one form for both of you.

You will not qualify for *Lynch* v. *Rank* benefits if:

1. You have received SSI benefits (a gold check) for every month since April 1980

or

2. You have been in a nursing home every month since April 1980.

Your completed application must be filed by October 30, 1985; however, the earlier it is received, the sooner it will be processed.

If you need help completing the form, please call the worker listed above for assistance.

Medi-Cal Beneficiary ID Number: _____

RETURN THIS APPLICATION BEFORE: _____

APPLICATION FOR RETROACTIVE REIMBURSEMENT (*LYNCH* V. *RANK*)

IMPORTANT: *Do Not* send your medical bills with this form. If you are eligible for reimbursement, you will receive a claim form in the mail later. Keep your bills, receipts, and cancelled checks.

Please read the attached instructions before completing this application. When you complete this application, please return it to:

County Representative: _____

Address: _____

_____

Phone Number: _____

☐ If you need help to complete this application, check here and return it to the county representative listed above. The county representative will contact you to schedule an appointment to complete it.

PLEASE PRINT IN INK

1. Name: _____

   Spouse's Name: _____

2. Address: _____
   Street

   _____
   City Zip

   _____
   County

3. Telephone Number: ( )_____ Message Phone: ( )_____

4. Your Social Security Number: _____/_____/_____
   Current Spouse's Social Security Number: _____/_____/_____

5. Are you married *and* living with your spouse? ☐ Yes ☐ No

6. Did you ever receive SSI benefits (a gold check)? ☐ Yes ☐ No

   If so, when did you last receive SSI benefits? _____
   Month Year

7. Did your current spouse ever receive SSI benefits (a gold check)? ☐ Yes ☐ No

   If so, when did he/she last receive SSI benefits? _____
   Month Year

8. At any time since April 1977, did you ever receive both SSI benefits (a gold check) and Social Security benefits (a green check) in the same month? ☐ Yes ☐ No

9. At any time since April 1977, did your current spouse ever receive both SSI benefits (a gold check) and Social Security benefits (a green check) in the same month? ☐ Yes ☐ No

10. Do you now live in a nursing home? ☐ Yes ☐ No

If yes, when did you enter the nursing home? _____

11. Does your spouse now live in a nursing home? ☐ Yes ☐ No

If yes, when did he/she enter the nursing home? _____

12. At any time since April 1980, did you live with a spouse other than the spouse identified in question No. 1?
☐ Yes ☐ No

If yes, give the name(s) of the spouse(s), and the spouse(s) Social Security number (if known), and the dates during which you lived with the spouse(s).

Spouse's Name	Social Security Number	Dates You Lived Together

13. Since April 1980, did you or any spouse with whom you lived ever apply for Medi-Cal in any county?
☐ Yes ☐ No

If so, in which county(s) did you or your spouse apply and in what years?

Applicant's Name	Year	Name of County

14. State the amount and each source of *your* income which was received in July of each year. If you were married and were living with a spouse at any time since April 1, 1980, list your spouse's income also and identify it as being received by your spouse.

16. Did you or your spouse, in any month from July 1980 through January 1985, have an additional source of income that is not listed above in answer to No. 14 and No. 15? ☐ Yes ☐ No

If yes, state the date, amount, and source of that income and identify the person who received it.

Date	Amount	Source	Person Receiving Income
_____	$ _____	_____	_____
_____	$ _____	_____	_____
_____	$ _____	_____	_____

17. At any time between April 1, 1980 and January 1, 1985, did you (and your spouse, if applicable) have property that was worth more than the following amount: ☐ Yes ☐ No

Size of Family	Amount of Property
1 person	$1,500
2 persons	$2,250

18. If you answered yes to No. 17, state the month, year, value, and type of that property below.

Month	Year	Value	Type of Property
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

19. For July of each year, check the type of living arrangement which applied to you:

	House/Apt. With Cooking Facilities	House/Apt. Without Cooking Facilities	Household of Another	Board and Care Home
July 1980	_____	_____	_____	_____
July 1981	_____	_____	_____	_____
July 1982	_____	_____	_____	_____
July 1983	_____	_____	_____	_____
July 1984	_____	_____	_____	_____
July 1985	_____	_____	_____	_____

20. Are you legally blind? ☐ Yes ☐ No

21. Is your spouse legally blind? ☐ Yes ☐ No

I DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING IS TRUE AND CORRECT AND WAS EXECUTED IN _____ (City), CALIFORNIA.

DATED: _____ _____
Signature of Applicant

	Amount	Source	Person Receiving Income
July 1980	$		
	$		
	$		
July 1981	$		
	$		
	$		
July 1982	$		
	$		
	$		
July 1983	$		
	$		
	$		
July 1984	$		
	$		
	$		

15. State the amount and source of *your* income on January 1, 1985. If you are married and living with your spouse, list your spouse's income also and identify it as being received by your spouse.

	Amount	Source	Person Receiving Income
January 1, 1985	$		
	$		
	$		

IF SOMEONE OTHER THAN THE CLAIMANT FILLED IN OR ASSISTED WITH THIS APPLICATION, HE/SHE SHOULD COMPLETE THIS PART:

Name: _____

Address: _____

_____

Telephone Number: ( ) _____

Your relationship to the claimant: _____

Reasons you filled in or helped with this application:

_____

_____

_____

INSTRUCTIONS FOR COMPLETING APPLICATION FORM

I. Who May Complete the Application?

A. A friend or relative can help you complete the application. You must sign it at the end or mark with an "X" if you cannot sign your name.

B. If the claimant is unable to complete the application, the following persons may submit and sign an application on his/her behalf:

1. a conservator
2. a relative
3. a friend
4. an employee of an institution caring for the claimant

C. If the claimant has died, you may submit and sign an application if you are any of the following:

1. an executor or administrator
2. a surviving spouse
3. a son or daughter
4. next of kin

D. IF YOU ARE MARRIED *AND* LIVING WITH YOUR SPOUSE, YOU ONLY HAVE TO COMPLETE ONE FORM FOR BOTH OF YOU.

II. How to Complete the Application

Fill out the application as completely as you can. An incomplete application will delay your claim for reimbursement.

If you need help in getting information or do not understand the questions, check the box at the end of the application and return it in the enclosed envelope. A county worker will contact you to help you.

BE SURE TO SEND THE APPLICATION BACK, EVEN IF YOU CAN'T COMPLETE IT.

INSTRUCTIONS FOR PARTICULAR QUESTIONS THAT MIGHT CONFUSE YOU

Question No. 1:

Fill in spouse's name only if he/she has lived with you in any month since April 1980.

Question No. 4:

Fill in spouse's Social Security number only if he/she has lived with you in any month since April 1980.

Question No. 6:

If you are not receiving Medi-Cal or you have a share of cost,, this information must be provided in order to process your application. If you cannot remember when you last received SSI benefits, you may obtain the information from your local Social Security office. If you have a problem, your county representative listed on page one of the application can help you.

Question No. 7:

This question applies to you only if you are married *and* living with your spouse.

If your spouse is not receiving Medi-Cal or if he/she has a share of cost, this information must be provided. If you cannot remember when he/she last received SSI benefits, you may obtain the information from your local Social Security office. If you have a problem, your county representative listed on page one of the application can help you.

Questions No. 10 and No. 11:

"Nursing home" means a convalescent hospital. It does not include a community board and care home.

Question No. 13:

If you (and/or your spouse) applied for Medi-Cal in more than one county during the same year, list all counties.

Question No. 14:

Income includes money from sources like Social Security, veteran's benefits, and pensions. List the amounts of your own check(s) and/or your spouse's check(s) separately. List your spouse's income only if he/she was living with you in July of that year.

If either of you were working, list the *gross* amount of your monthly salary *before deductions*.

Question No. 15:

Income includes money from sources like Social Security, veteran's benefits, and pensions. List the amount of your own check(s) and/or your spouse's check(s) separately. List your spouse's income only if he/she was living with you on January 1, 1985 and if he/she is still living with you.

Question No. 16:

Do not answer this question if you have already listed all of your own (and your spouse's) income in questions 14 and 15.

Question No. 18:

Property includes, but is not limited to, the following:

- Bank Accounts
- Cash Value of Insurance Policies
- Mortgages and Trust Deeds
- Boats, Recreational Vehicles
- Stocks and Bonds
- Notes
- Real Estate *Other* Than Your Home
- Any individual household or personal items valued at more than $500.

Numero de ID de Medi-Cal del Beneficiario: _____

DEVUELVA ESTA SOLICITUD ANTES DEL: _____

SOLICITUD POR REEMBOLSO RETROACTIVO *(LYNCH V. RANK)*

IMPORTANTE: *No* envíe sus facturas por gastos médicos con este formulario. Si Ud. es elegible para recibir un reembolso, Ud. recibirá posteriormente por correo un formulario para efectuar el reclamo. Guarde sus facturas, recibos y cheques cancelados.

Por favor lea las instrucciones inclusas antes de completar esta solicitud. Si Ud. llena esta solicitud, por favor devuelvala a:

Representante del Condado: _____

Dirección: _____

_____

Número Telefónico: _____

☐ Si Ud. necesita ayuda para completar esta solicitud, marque aquí y devuélvala al representante del condado indicado más abajo. Este representante se pondrá en contacto con Ud. para tener una reunión y completarla.

POR FAVOR ESCRIBA CON TINTA EN LETRAS DE IMPRENTA

1. Nombre: _____

   Nombre del Cónyuge: _____

2. Dirección: _____
   Calle

   _____
   Ciudad Código del Area

   _____
   Condado

3. Número Telefónico: (____) _____ Teléfono para Dejar Mensajes: (____) _____

4. Número de su Seguro Social: ____/____/____

   Número del Seguro Social de su Actual Cónyuge: ____/____/____

5. ¿Es Ud. casado(a) y vive con su cónyuge: ☐ Sí ☐ No

6. ¿Recibió Ud. alguna vez los beneficios del SSI (un cheque dorado)? ☐ Sí ☐ No

   Si su respuesta es sí, ¿cuándo fue la última vez que recibió los beneficios del SSI? _____
   Mes Año

7. Alguna vez su cónyuge actual recibió los beneficios del SSI (un cheque dorado)? ☐ Sí ☐ No

   Si su respuesta es sí, ¿cuándo fue la última vez que él/ella recibió los beneficios SSI? _____
   Mes Año

8. En alguna oportunidad, desde abril de 1977, ¿recibió Ud. en el mismo mes los beneficios del SSI (un cheque dorado) y los beneficios del Seguro Social (un cheque verde)? ☐ Sí ☐ No

9. En alguna oportunidad, desde abril de 1977, ¿recibió su cónyuge actual en el mismo mes los beneficios del SSI (un cheque dorado) y los beneficios del Seguro Social (un cheque verde)? ☐ Sí ☐ No

10. ¿Vive Ud. ahora en un hospital para convalecientes? ☐ Sí ☐ No

Si su respuesta es sí, ¿cuando es que Ud. entró en ese hospital? _____
Mes Año

11. ¿Vive ahora su cónyuge en un hospital para convalecientes? ☐ Sí ☐ No

Si su respuesta es sí, ¿cuándo es que su cónyuge entró en ese hospital? _____
Mes Año

12. En algún momento desde abril de 1980 ¿vivió Ud. con un cónyuge diferente al que menciona en la pregunta No. 1? ☐ Sí ☐ No

Si su respuesta es sí, dé el(los) nombre(s) de ese cónyuge y el(los) número(s) del Seguro Social (si los sabe) y las fechas durante las cuales vivió con ese cónyuge.

Nombre del Cónyuge	Número del Seguro Social	Fechas en que Vivieron Juntos

13. Desde abril de 1980 Ud. o su cónyuge con quien vivía, ¿solicitaron Medi-Cal en algún condado? ☐ Sí ☐ No

Si su respuesta es sí, ¿en qué condado(s) Ud. ó su cónyuge los solicitaron y cuándo?

Nombre del Solicitante	Año	Nombre del Condado

14. Indique la suma y origen de *su* ingreso que recibió en julio de cada año. Si Ud. está casado(a) y estuvo viviendo con un cónyuge en algún momento desde el 1° de abril de 1980, indique también el ingreso de ese cónyuge y mencione que es él(ella) quien lo ha recibido.

	Suma	Fuente de Ingreso	Nombre de la Persona que lo Recibió
[illegible] 1980	$_____	_____	_____
	$_____	_____	_____
	$_____	_____	_____
Julio 1981	$_____	_____	_____
	$_____	_____	_____
	$_____	_____	_____
Julio 1982	$_____	_____	_____
	$_____	_____	_____
	$_____	_____	_____
Julio 1983	$_____	_____	_____
	$_____	_____	_____
	$_____	_____	_____
Julio 1984	$_____	_____	_____
	$_____	_____	_____
	$_____	_____	_____

15. Indique la suma y origen de *su* ingreso en enero 1°, 1985. Si Ud. estuvo casado(a) y viviendo con su cónyuge en alguna época desde el 1° de abril de 1980, enumere también el ingreso de ese cónyuge y mencione que fue recibido por él(ella).

	Suma	Fuente de Ingreso	Persona que lo Recibió
Enero 1°, 1985	$_____	_____	_____
	$_____	_____	_____
	$_____	_____	_____

16. ¿Han tenido Ud. o su cónyuge algún ingreso adicional que no está indicado en las respuestas Nos. 14 y 15 en algún mes desde julio 1980 hasta enero 1985? ☐ Sí ☐ No

Si su respuesta es sí, indique la fecha, suma y fuente de ese ingreso e identifique a la persona que lo recibió.

Fecha	Suma	Fuente de Ingreso	Persona que lo Recibió
_____	$ _____	_____	_____
_____	$ _____	_____	_____
_____	$ _____	_____	_____

17. En alguna época entre el 1° de abril de 1980 y el 1° de enero de 1985 Ud. (y su cónyuge si es que le corresponde) tuvieron propiedades cuyo valor fue superior a la siguiente suma: ☐ Sí ☐ No

Miembros en la Familia	Valor de la Propiedad
1 persona	$1,500
2 personas	$2,250

18. Si su respuesta es sí a la pregunta No. 17, indique más abajo el mes, año, valor y tipo de propiedad.

Mes	Año	Valor	Clase de Propiedad

19. Para julio de cada año, marque el tipo de vivienda que más se adeque a la suya:

	Casa/Apt. con Facilidades de Cocina	Casa/Apt. sin Facilidades de Cocina	Hogar de otra Persona	Casa de Hospedaje y Cuidado
Julio 1980				
Julio 1981				
Julio 1982				
Julio 1983				
Julio 1984				
Julio 1985				

20. ¿Es Ud. legalmente ciego(a)? ☐ Sí ☐ No

21. ¿Es su cónyuge legalmente ciego(a)? ☐ Sí ☐ No

DECLARO BAJO PENA DE PERJURIO QUE LO INDICADO EN ESTE FORMULARIO ES VERDADERO Y CORRECTO, Y LO LLENE EN _____, CALIFORNIA.
Ciudad

FECHA: _____ _____
Firma del (de la) Solicitante

SI ALGUNA OTRA PERSONA QUE EL(LA) RECLAMANTE LLENO O AYUDO CON ESTA SOLICITUD, ESA PERSONA DEBERA COMPLETAR ESTA PARTE:

Nombre: _____

Dirección: _____

_____

Número Telefónico: (____) _____

Su relación con el(la) reclamante: _____

Diga las razones por las que llenó o ayudó con esta solicitud:

_____

_____

_____

INSTRUCCIONES PARA LLENAR ESTA SOLICITUD

I. ¿Quién Puede Llenar la Solicitud?

A. Un amigo o familiar puede ayudarlo a llenar la solicitud. Usted debe firmarla cuando la complete o poner una "X" si no puede firmar su nombre.

B. Si el reclamante está imposibilitado para llenar esta solicitud, las siguientes personas pueden someterla a favor de él/ella:

1. un guardián
2. un familiar
3. un amigo
4. un empleado de una institución que cuida al reclamante

C. Si el reclamante ha fallecido, Ud. puede presentar y firmar una solicitud, si Ud. es:

1. un albacea o administrador
2. el cónyuge sobreviviente
3. un hijo o una hija
4. un pariente cercano

D. SI UD. ESTA CASADO(A) Y ESTA VIVIENDO CON SU ESPOSO(A), UD. SOLAMENTE TIENE QUE LLENAR UN FORMULARIO PARA LOS DOS

II. Como Llenar la Solicitud

Llene la solicitud lo más que pueda. Una solicitud incompleta puede demorar el reembolso de su reclamo.

Si Ud. necesita ayuda para conseguir información o no entiende las preguntas, marque el casillero al final de la solicitud y devuelva ésta en el sobre incluso. Un trabajador del condado se pondrá en contacto con Ud. para ayudarlo.

ESTE SEGURO DE ENVIAR LA SOLICITUD AUNQUE UD. NO PUEDA COMPLETARLA.

Pregunta No. 1:

Ponga el nombre de su cónyuge si él/ella ha vivido con Ud. cualquier mes desde abril de 1980.

Pregunta No. 4:

Ponga el número del Seguro Social de su cónyuge sólo si él/ella ha vivido con Ud. cualquier mes desde abril de 1980.

Pregunta No. 6:

Si Ud. no está recibiendo Medi-Cal o tiene que pagar una parte del costo, debe dar esta información para que se procese su solicitud. Si Ud. no puede recordar cuándo fue la última vez que recibió los beneficios del SSI, Ud. puede obtener esta información de su oficina local del Seguro Social. Si Ud. tiene un problema, su representante del condado indicado en la página uno de esta solicitud puede ayudarlo.

Pregunta No. 7:

Esta pregunta concierne a Ud. solamente si es casado(a) *y* vive con su esposo(a).

Si su esposo(a) no está recibiendo Medi-Cal o si él/ella tiene que pagar una parte del costo, esta información debe ser dada. Si Ud. no puede recordar cuándo fue la última vez que él/ella recibió los beneficios del SSI, Ud. puede obtener esta información de su oficina local del Seguro Social. Si Ud. tiene un problema, su representante del condado indicado en la página uno de esta solicitud puede ayudarlo.

Preguntas No. 10 y No. 11:

"Residencia de Cuidado Médico" significa un hospital para convalecientes. No incluye hospedaje ni una casa de cuidado de la comunidad.

Pregunta No. 13:

Si Ud. (y/o su cónyuge) solicitaron Medi-Cal en más de un condado durante el mismo año, indique todos los condados.

Pregunta No. 14:

Ingreso incluye el dinero de ciertas fuentes tales como el Seguro Social, los beneficios de los veteranos y las pensiones. Indique la suma de su(s) cheque(s) y/o el de su cónyuge en forma separada. Indique el ingreso de su cónyuge si él/ella estuvo viviendo con Ud. en julio de ese año.

Si alguno de Uds. estuvo trabajando, indique la suma *total* de su salario mensual *antes de las deducciones.*

Pregunta No. 15:

Ingreso incluye el dinero de ciertas fuentes tales como Seguro Social, beneficios de los veteranos y las pensiones. Indique la suma de su(s) cheque(s) y/o el de su cónyuge en forma separada. Indique el ingreso de su cónyuge sólo si él/ella estuvo viviendo con Ud. el 1° de enero de 1985 y si él/ella todavía está viviendo con usted.

Pregunta No. 16:

No conteste esta pregunta si Ud. ya ha enumerado su ingreso (y el de su cónyuge) en las preguntas 14 y 15.

Pregunta No. 18:

Propiedad incluye, pero no está limitada, a lo siguiente:

- Cuentas Bancarias
- Dinero en Efectivo de Pólizas de Seguro
- Hipotecas Y Fideicomisos
- Botes, Vehículos de Recreo
- Acciones y Bonos
- Pagarés
- Bienes Raíces *Diferentes* a la Casa Donde Vive
- Cualquier Artículo del Hogar Individual o Personal cuyo Valor es más de $500.

Date: _____

Applicant Name: _____

INFORMATION NOTICE – No. 1 (30 days)

Applicant SSN: _____

Worker Name: _____

Worker Phone No.:_____

On _____ (Date) , _____ (County) received your response to the Request for Retroactive Reimbursement (*Lynch* v. *Rank*) Notice sent by the State Department of Health Services.

On _____ , this Department sent you an Application for Retroactive Reimbursement, (DHS 7038), with a request to return the completed application as soon as possible.

To date we have not received your completed application. We have not been able to reach you by telephone, please call us for assistance.

NOTICE OF ACTION – No. 3

Lynch v. *Rank*
Denial of Benefits

Date: _____
Beneficiary ID No.: _____
Worker Name: _____
Worker Phone No.: _____

Your application for retroactive Medi-Cal coverage under the court's decision in *Lynch* v. *Rank* has been denied:

☐ You did not identify yourself as a potential class member within 45 days from the date the court-ordered notice was sent to you.

☐ You did not return the Pickle application.

☐ You are not eligible because you:

- ☐ Received no share-of-cost Medi-Cal cards during the entire retroactive period.
- ☐ Have never received SSI/SSP benefits.
- ☐ Have not received SSI/SSP benefits since April 1977.
- ☐ Have failed to provide sufficient information.
- ☐ Had excess income during the entire retroactive period.
- ☐ Had excess resources during the entire retroactive period.
- ☐ Received no Social Security benefits (green checks) during the entire retroactive period.
- ☐ Did not receive both SSI/SSP and RSDI, Social Security (green checks), in the same month at any time during retroactive period.
- ☐ Were in a long-term care facility during the entire retroactive period.
- ☐ Other (state specific reason(s)): _____

_____

_____

This action does not affect any application you may have submitted for current and continuing Medi-Cal. If you have any questions about this action or if there are additional facts relating to your circumstances which you have not reported to us, please write or telephone. We will answer your questions or make an appointment to see you in person.

If you disagree and want to appeal this decision, you may request a state hearing by following the instructions on the back of this notice.. You must request a hearing within 90 days of the date of this notice.

Lynch v. *Rank* **(Pickle Amendment)**

Instructions for Pickle NOA No. 3 — DENIAL

This NOA is to be used in the following situations:

(1) Person(s) did not respond within 45 days to DHS notice of July 1, 1985.

(2) Person(s) did not return retroactive Pickle application after *all* allowable extensions.

(3) After review of the retroactive Pickle application, the person(s) is denied for the entire retroactive period.

Date: _____

Applicant Name: _____

INFORMATION NOTICE – No. 2 (60 days)

Applicant SSN: _____

Worker Name: _____

Worker Phone No.: _____

On _____ (Date), _____ (County) sent you a notice requesting you complete and return your Application for Retroactive Benefits within 30 days from the above date. To date, we have still not received your application.

If you are still interested in applying for *Lynch* v. *Rank* retroactive benefits, please answer questions 1–5 and 13 on the application and return it to the above address or contact this Department at the above phone number.

Failure to indicate interest in pursuing your application for *Lynch* v. *Rank* retroactive benefits by October 30, 1985 will result in ineligibility for these benefits.

DECLARATION OF RIGHT TO PROPERTY
(PROBATE CODE SECTION 630)

The undersigned declares:

That he/she is the (state relationship) of (name of decedent), decedent; who died on (date); that said decedent left no real property, nor interest therein or lien thereon, in this state and the total value of the decedent's property in this state, excluding any motor vehicle, mobile home or commercial coach registered under the provisions of Part 2 (commencing with Section 18000) of Division 13 of the Health and Safety Code, of which the decedent was the owner or legal owner, over and above the amounts due to the decedent for services in the armed forces of the United States, and over and above the amount of salary not exceeding five thousand dollars ($5,000).

Declarant is an heir of the decedent who died intestate, the other heir being (name and relationship of other heirs). Declarant as such (relationship) has a right to succeed to said decedent's personal property and asks that the property, described as decedent's claim in the sum of (amount of claim) against the State of California pursuant to the Court order entered in the case of Lynch v. Rank, be transferred and delivered to declarant.

I declare under penalty of perjury that the foregoing is true and correct.

Executed at _____, California on _____, 1985.

_____
Signature

Name: _____
Address: _____
Telephone No. _____

Alameda

Pollie Vandiver
Alameda Co. Soc. Svcs. Agency
4501 Broadway
Oakland, CA 94611

(415) 874-7877

Alpine

George Vasquez
Alpine County Welfare Dept.
P. O. Box 277
Markleeville, CA 96120

(916) 694-2235

Amador

Emily Daniels
Amador Co. Dept. of Soc. Svcs.
108 Court Street
Jackson, CA 95642

(209) 223-3230 ext. 550

Butte

Mary Ellen Laswell
Butte County Dept. of Social Welfare
P. O. Box 1649
Oroville, CA 95965

(916) 534-4598

Calaveras

Connie McClain
Calaveras Co. Dept. of Soc. Svcs.
Government Ctr.
San Andreas, CA 95249

(209)754-4225

Colusa

Jim Fouch
Colusa County Welfare Dept.
P. O. Box 370
Colusa, CA 95932

(916) 458-4985

Contra Costa

Arlyce Siino
Contra Costa County Soc. Svcs. Dept.
P. O. Box 5488, Court Order Unit
Concord, CA 94524

(415) 671-4164

Del Norte

Carmen Hollinsead
Del Norte County Welfare Dept.
981 H Street
Crescent City, CA 95531

(707) 464-3191

El Dorado

Ron Merrill
El Dorado County Welfare Dept.
2929 Grandview St.
Placerville, CA 95667

(916) 626-2298

Fresno

Ann Schmidt #HF20
Fresno Co. Dept. of Soc. Svcs.
P. O. Box 1912
Fresno, CA 93750

(209) 453-6467

Glenn

Patti Blakeman
Glenn County Welfare Dept.
P. O. Box 611
Willows, CA 95988

(916) 934-7714

Humboldt

Rosella Jacobson
Humboldt County Welfare Dept.
929 Koster Street
Eureka, CA 95501

(707) 445-6137

Imperial

Carolyn Benton
Imperial County Welfare Dept.
P. O. Box 930
El Centro, CA 92244

(619) 353-1400 ext. 13

Invo

Darlene Landis
Inyo County Welfare Dept.
Drawer A
Independence, CA 93526

(619) 878-2411

Kern

Leslie Brown
Kern County Welfare Dept.
P. O. Box 511
Bakersfield, CA 93302

(805) 861-3496

Kings

Betty Holden
Kings County Welfare Dept.
1200 South Drive
Hanford, CA 93230

(209) 582-3241

Lake

Elizabeth Burritt
Lake County Welfare Dept.
P. O. Box G
Lakeport, CA 95453

(707) 263-2202

Lassen

Peggy Crosby
Lassen County Welfare Dept.
P. O. Box 1359
Susanville, CA 96130

(916) 257-8311 ext. 153

Los Angeles

Charles Dill
Los Angeles Co. Dept. of Pub. Soc. Svcs.
P. O. Box 5493
El Monte, CA 91731

(818) 572-5851

Madera

Jim Wood
Madera Co. Dept. of Pub. Welfare
P. O. Box 569
Madera, CA 93639

(209) 675-7837

Marin

Linn Rand
Marin Co. Dept. of Health and Human Svcs
P. O. Box 4160, Civic Center
San Rafael, CA 94913

(415) 499-7084

Mariposa

Elaine Livengood
Mariposa Co. Dept. of Soc. Svcs.
P. O. Box 7
Mariposa, CA 95338

(209) 966-3609

Mendocino

Sandi Brown
Mendocino Dept. of Soc. Svcs.
P. O. Box 1060
Ukiah, CA 95482

(707) 463-2437

Merced

JoAnn Cartagena
Merced Co. Dept. of Human Res.
P. O. Box 112
Merced, CA 95341

(209) 385-7439

Modoc

Patricia Wood
Modoc Co. Dept. of Soc. Svcs.
Courthouse Annex
Alturas, CA 96101

(916) 233-4395

Mono

Chuck Spresser
Mono County Dept. of Soc. Svcs.
P. O. Box 576
Bridgeport, CA 93517

(619) 934-3411

Monterey

Felipe Velazquez
Monterey Co. Dept. of Soc. Svcs.
P. O. Box 299
Salinas, CA 95902

(408) 449-8101

Napa

Juanita Rackley
Napa Co. Dept. of Soc. Svcs.
P. O. Box 329
Napa, CA 94559

(707) 253-4511

Nevada

Suzanne Nobles
Nevada Co. Dept. of Pub. Soc. Svcs
P. O. Box 1210
Nevada City, CA 95959

(916) 265-1340

Orange

Liz Oster
Orange Co. Soc. Svcs. Agency
P.O. Box 1999
Santa Ana, CA 92701

(714) 834-7959

Placer

Ruthe Hotchkiss
Placer County Welfare Dept.
11519 B Avenue
Auburn, CA 95603

(916) 823-4488

Plumas

Kathy Kiener
Plumas Co. Dept. of Soc. Svcs.
P. O. Box 360
Quincey, CA 95971

(916) 283-2250

Riverside

Ann Logan
Riverside Co. Dept. of Pub. Soc. Svcs.
4129 Main Street
Riverside, CA 92501

(714) 369-4248

Sacramento

Fran Snyder
Sacramento Co. Dept. of Soc. Welfare
P. O. Box 487
Sacramento, CA 95803

(916) 732-3290

San Benito

Maria Hernandez
San Benito County Welfare
419 Fourth Street
Hollister, CA 95023

(408) 637-5336

San Bernardino

D. Clausen
San Bernardino DPSS, MCH Unit
494 North E Street
San Bernardino, CA 92401

(714) 383-3925

San Diego

E. T. Peterson
San Diego Dept. of Soc. Svcs.
7949 Mission Center Ct, W-401-X
San Diego, CA 92108

(619) 560-3716

San Francisco

Juan Galvan
San Francisco Co. DSS/Medi-Cal Div.
P. O. Box 7988
San Francisco, CA 94120

(415) 557-6160

San Joaquin

Patricia Armstrong
Dept. of Pub. Assistance
Drawer F
Stockton, CA 95201

(209) 944-2708

San Luis Obispo

Shirley Hazen
San Luis Obispo Co. DSS
P. O. Box T
San Luis Obispo, CA 93406

(805) 549-4000

San Mateo

Laura McCormick
San Mateo County DSS
225 37th Ave
San Mateo, CA 94403

(415) 573-2399

Santa Barbara

Lorna Baker
Santa Barbara Co. Welfare Dept.
509 W. Morrison
Santa Maria, CA 93454

(805) 925-0911 ext. 287

Santa Clara County

Michael Finstead
Santa Clara County DSS
55 West Younger
San Jose, CA 95110

(408) 299-2188

Santa Cruz County

Louise Heath-Wilson
Santa Cruz County DSS
P. O. Box 1320
Santa Cruz, CA 95061

(408) 425-2521

Shasta County

Mrs. Overton or Mrs. Clark
Shasta County Welfare Dept.
P.O. Box 6005
Redding, CA 96099

(916) 225-5553 or (916) 225-5738

Sierra

Martha Ortiz
Sierra County Welfare Dept.
P. O. Box 568
Loyalton, CA 96118

(916) 993-4742

Siskiyou

Nadine Belladitta
Siskiyou Co. Welfare Dept.
Courthouse, Room 4
Yreka, CA 96097

(916) 842-4471

Solano

Pauline Crews
Solano Co. Public Welfare Dept.
355 Tuolumne Street
Vallejo, CA 94590

(707) 553-5451

Sonoma

Nancy Crowe
Sonoma County Dept. of Soc. Svcs.
P. O. Box 1539
Santa Rosa, CA 95402

(707) 527-2269

Stanislaus

Beth McCoy
Stanislaus County Welfare Dept.
P. O. Box 42
Modesto, CA 95353

(209) 571-6752

Sutter

Eugene P. Bryan
Sutter County Welfare Dept.
P. O. Box 1535
Yuba City, CA 95991

(916) 674-2160 ext. 67

Tehama

Bonnie Davis
Tehama County Depart. of Soc. Welfare
1135 Lincoln St.
Red Bluff, CA 96080

(916) 527-1911

Trinity

Chris Talkington
Trinity County Welfare Dept.
P. O. Box 218
Weaverville, CA 96093

(916) 623-4000 ext. 114

Tulare

Fern Haller
Tulare County Welfare Dept.
P. O. Box 671
Visalia, CA 93279

(209) 733-6142

Tuolumne

Sharon Minor
Tuolumne County Welfare Dept.
105 East Hospital Road
Sonora, CA 95370

(209) 533-5734

Ventura

Elia Magallanes
Ventura Co. Pub. Soc. Svcs. Agency
3161 Loma Vista Road
Ventura, CA 93009

(805) 652-6418

Yolo

Irene Cooley
Yolo Co. Dept. of Soc. Svcs.
922 Sacramento Ave.
Broderick, CA 95605

(916) 372-2000

Yuba

Pat Wildberger
Yuba County Welfare Dept.
935 14th Street, P.O. Box 2320
Marysville, CA 95901

(916) 741-6311

ATTACHMENT 8

State of California—Health and Welfare Agency

Department of Health Service

LYNCH v. RANK RETRO MONITORING SYSTEM

County: _____

PART I:

A. Applicant's Name: _____

B. Applicant's Social Security Number: _____

C. Applicant's Address: _____

_____ Zip Code

D. Applicant's Phone Number: ( ) _____

E. Date Application Mailed by County Welfare Department (CWD): _____

PART II:

A. 30-Day Personal Contact (If Applicable): Date: _____ Telephone ☐ Letter ☐

Results: _____

_____

B. 60-Day Personal Contact (If Applicable): Date: _____ Telephone ☐ Letter ☐

Results: _____

_____

C. 60-Day Claim Form Follow-Up (If Applicable): Date: _____ Telephone ☐ Letter ☐

Results: _____

_____

PART III:

A. Date Application Received by CWD: _____

B. Disposition of Case: ☐ Total Approved ☐ Totally Denied

Reason(s): _____ Number of Reason(s) _____

☐ Partially Approved/Denied

Denial Reason(s): _____ Number of Reason(s) _____

C. Response Form and Appropriate Notice of Action (NOA) Mailed? Yes ☐ No ☐ Date Mailed: _____

D. Date Completed and Signed Response Form Received by CWD: _____

E. Date Claim Form and NOA Number 6 Mailed (If Applicable): _____

F. Date Completed Claim Form Received by CWD: _____

G. Date Claim Form Submitted to DHS: _____

PART IV:

Date Completed Form Sent to DHS: _____

Completed by: _____

Title: _____

Telephone Number: ( ) _____

DHS 7042 (6/85)

INSTRUCTIONS FOR COMPLETION OF RETRO PICKLE MONITORING SYSTEM FORM

This form must be completed for each person requesting an application. For situations involving married persons, one form must be completed for each spouse. Completed forms must be sent monthly with the *Lynch* v. *Rank* Retro Activity Report to:

Department of Health Services
Medi-Cal Eligibility Branch
714 P Street, Room 1692
Sacramento, CA 95814
Attention: Kristi Allen

PART I.

A. through E. This section is to be completed at the time the applicant requests a Retro Pickle Application. Person completing form must print legibly.

PART II.

A., B., and/or C. Enter date *all* personal contacts (30- and 60-day follow-up on application, any follow-up necessary to complete application, and 60-day follow-up on claim) were made. Check box indicating if contact was made by telephone or letter. Enter the results of the personal contacts (e.g., left message with spouse, applicant no longer interested, telephone disconnected, applicant will forward necessary information within ten days, etc.).

Example: Mr. Adams has not returned his application within 30 days. CWD phones him to determine if he still wants to apply for retro benefits under *Lynch* v. *Rank*. Mr. Adams states he has not returned form to CWD because he forgot to mail it. At this time CWD completes the Screening Worksheet (DHS 7020), with applicant. Document the reason why Mr. Adams has not returned the application ~~form~~ under "Results."

If Mr. Adams answers "yes" to all questions on the DHS 7020, allow another 30 days to return application. If Mr. Adams answers "no" to any question on the DHS 7020, send Notice #3 and forward this form to DHS.

If personal contact is done by letter send DHS 7020 and Information Notice #1 and follow up in 30 days.

PART III.

A. Enter date application received. If application is not complete, refer to Part II. Personal contact must be made if application is incomplete.

B. Check whether case was totally or partially approved/denied. If case has been totally or partially denied, the appropriate code(s) must be entered. If case has been totally denied this form should immediately be sent to DHS.

Code	Reason
a.	Failure to provide sufficient information.
b.	Failure to cooperate (other than Code "a.")
c.	Application untimely.
d.	Claimant in long-term care during entire retroactive reimbursement period.
e.	Claimant received SSI in all months since April 1, 1980.
f.	Claimant ineligible due to excess resources.
g.	Claimant ineligible due to excess income.
h.	Not Pickle eligible at any time since April 1, 1980 (for reasons *other* than Codes "d" through "g") specify reason.

Example: Applicant is denied for some months because he/she received SSI in those months (Code "h"). Same applicant was denied for other months due to excess resources (Code "f"). Codes "h" and "f" and the notation "received SSI/SSP" must be entered after Reasons in Part III. Number of reasons would be "2."

C. Check appropriate box if Response form and appropriate NOA were mailed and enter date mailed.

D. Enter date completed and signed Response form is received by the CWD.

E. Enter date claim form mailed (if applicant requests a claim form). Claim form and NOA #6 must be sent within 15 days after applicant requests claim form.

F. Enter date completed claim form is received by CWD. (Applicant has 60 days to return claim form. Time limit may be extended for good cause per Section 50175.)

G. Enter date claim form submitted to DHS. (This must be done without delay.)

PART IV.

Complete this section after entire process has been completed. Original of form is sent to DHS. Retain remaining copy with applicant's complete Retro Pickle application package.