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

August 27, 1987

TO: All County Welfare Directors
All County Administrative Officers

Letter: 87 - 51

SUBJECT: LYNCH V RANK RETROACTIVE REIMBURSEMENT - ADDITIONAL APPLICANTS

REFERENCE: All County Welfare Directors Letters 85-52, 85-60, and 85-67

The Department of Health Services (DHS) has recently identified an additional 446 persons who should have been sent the "Notice of Retroactive Reimbursement - Lynch v Rank" (Attachment 1) in July 1985. On September 15, 1987 this notice and instructions for obtaining reimbursement will be sent to each person's last known address.

In addition to the notice and instructions, each person will be sent a cover letter (Attachment 2) and a completed Response Form (DHS 7053) (Attachment 3) indicating the amount of the share of cost which DHS records show was met during the retroactive period. They will be instructed to sign the Response Form and return it to DHS in the self addressed, stamped envelope in order to receive reimbursement. CWDs will be sent a copy of each of the Response Forms with the claimant's home address and reimbursement amount completed. These are for information only. No action on the part of the CWD is necessary unless the claimant has questions or needs assistance with the process. At the time assistance is requested, we are requesting CWDs to provide assistance as outlined in All County Welfare Directors Letter (ACWD) 85-52.

For anyone having additional expenses in months when the share of cost was not met, the instructions to the claimant will be to contact the county welfare department to receive a Claim for Reimbursement form (DHS 7039). A stamped envelope addressed to the CWD Medi-Cal Policy Liaison will be provided to each of the 446 persons. The Notice is to be returned in this envelope and is to be considered as a request for a claim form. Upon receipt of a request for a Claim Form, the CWD is to follow the procedures in ACWD letters 85-52, 85-62, 85-67, including the 30 and 60 day personal contacts and any other assistance necessary to complete and file the Claim Form.

When the Claim Form is completed the CWD is to review it for accuracy and ensure that the required bills and/or receipts are attached prior to forwarding the Claim to DHS.

The Claim must be sent to:

Department of Health Services
Medi-Cal Eligibility Branch
Attention: Kristi Allen
714 P Street, Room 1650
Sacramento, CA 95814

Any CWD questions regarding this process should be directed to Kristi Allen at (916) 324-4961, ATSS 454-4961. Claimant questions are to be handled by the CWD and should not be referred directly to DHS.

Thank you for your cooperation.

Sincerely,

Original signed by

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Attachments

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

Expiration Date: August 27, 1988

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

IF YOU HAVE ANY QUESTIONS CONTACT:
SI USTED TIENE PREGUNTAS PONGASE EN CONTACTO CON:

MAKE ANY CORRECTIONS TO NAME AND ADDRESS AND INCLUDE PHONE NUMBER or MESSAGE NUMBER

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

_____

_____

ANSWER THE FOLLOWING QUESTIONS AND RETURN THIS ENTIRE NOTICE (RESPONDA A LAS PREGUNTAS SIGUIENTES Y DEVUELVA ESTA NOTICIA)

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

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?

TO RECEIVE AN APPLICATION FOR REIMBURSEMENT, RETURN THIS NOTICE BY OCTOBER 15, 1987. 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 PREGUNTAS ES "SI", ES POSIBLE QUE EL ESTADO LE DEBA DINERO POR GASTOS MEDICOS QUE USTED A 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 ESTA NOTICIA ANTES DEL 15 DE OCTUBRE DE 1987. SE ADJUNTA A ESTE PROPOSITO UN SOBRE CON SELLO YA IMPRESO 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) O UN(A) EMPLEADO(-A) DE UNA INSTITUCION PUEDE PRESENTAR UNA SOLICITUD SI USTED LE HA AUTORIZADO(-A) A HACERLO; O
3. UN(A) EJECUTOR(A) TESTAMENTARIO(-A), UN(A) ADMINISTRADOR(A), O PARIENTES MAS PROXIMOS PUEDEN PRESENTAR UNA SOLICITUD POR [illegible] CUENTA.

Debido a una decision de tribunal (Lynch v. Rank), se ha descubierto que usted es eligible a recibir un reembolso de la parte del costo que usted pagó por sus beneficios de Medi-Cal entre Abril de 1980 y Junio de 1985.

Para recibir el dinero que el estado le debe, usted tiene que firmar el Formulario de Respuesta (color amarillo) que se adjunta y devolverlo al Departamento de Servicios de Salud en el sobre con sello ya impreso con la dirección del remitente. Es preciso que usted lo devuelva antes del 15 de Noviembre de 1987. Se le mandará un cheque aproximadamente 60 días después de que usted devuelva el formulario.

Si usted tiene otros gastos médicos que no han sido pagados por Medi-Cal, devuelva la Solicitud de Reembolso Retroactivo (color blanco) adjunta al departamento de bienestar de su condado. Se adjunta también a este propósito un sobre con sello ya impreso con la dirección del remitente.

No olvide de:

1. Firmar el Formulario de Respuesta (color amarillo) y mandarlo al Departamento de Servicios de Salud en Sacramento.

2. Mandar la Solicitud de Reembolso Retroactivo (color blanco) al departamento de bienestar del condado solamente si usted tiene otros gastos médicos (no pagados por Medi-Cal) para los cuales usted tiene cuentas o recibos.

Si usted tiene preguntas sobre este proceso llame a la persona cuyo nombre y teléfono aparecen en la Solicitud de Reembolso Retroactivo (el formulario blanco).

As a result of a court decision (Lynch v Rank) you have been found to be eligible for reimbursement for your Medi-Cal share of cost that you paid between April 1980 and June 1985.

In order to receive the money that the state owes you, the attached yellow Response Form must be signed by you and returned in the stamped, self addressed envelope to the Department of Health Services. It must be returned no later than November 15, 1987. A check will be sent to you approximately 60 days after you return the form.

If you have other medical expenses that haven't been paid by Medi-Cal, please return the attached white Request for Retroactive Reimbursement to your county welfare department. There is a stamped, self addressed envelope enclosed for this purpose also.

Be sure to :

1. Sign the yellow Response Form and send it to the Department of Health Services in Sacramento.

2. Send the white Request for Retroactive Reimbursement form to your county welfare department only if you have other medical expenses (not paid by Medi-Cal) for which you have bills or receipts.

If you have questions about this process, please call the person whose name and telephone number are on the white Request for Retroactive Reimbursement form.

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

RESPONSE FORM

Claimant Name: _____

Claimant ID No.: _____

Worker Name: _____

Worker Phone No.: _____

☐ I (we) will accept $_____ as full reimbursement for the share of cost that I had during the month(s) listed on page 3 of the Notice of Action. (I understand that I can request a hearing if I think the county has made a mistake.)

Important: To receive payment, you must check one box and sign below (check only *one* box):

☐ I (we) declare under penalty of perjury that I (we) paid all medical bills used to meet my (our) share of cost.

☐ I (we) declare under penalty of perjury that I (we) paid some but not all of my (our) medical bills used to meet my (our) share of cost. I (we) paid bills in the amount of $_____ .

_____ _____
Your Signature Date

_____ _____
Your Spouse's (if any) Signature Date

Return immediately to: _____

_____

_____

_____

DHS 7053 (8/85)