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

DEPARTMENT OF HEALTH SERVICES
744 P STREET
BOX 942732
SACRAMENTO, CA 94234-7320

October 4, 1989

TO: All County Welfare Directors
All County Administrative Officers

Letter No: 89-84

SUBJECT: PRUCOL POLICY AND PROCEDURES

Reference: ACWDLs 88-66 and 88-87

This letter is to explain the Permanent Residence Under Color of Law (PRUCOL) pilot recently conducted by the Immigration and Naturalization Service (INS), the counties of Los Angeles and Orange, the Departments of Health Services (DHS) and Social Services (Foster Care Bureau), and to give you direction for statewide implementation.

BACKGROUND:

Senate Bill (SB) 175, Chapter 1441, Statutes of 1988 mandated the DHS and the counties to continue to provide full Medi-Cal benefits to undocumented aliens receiving Medi-Cal long-term care (LTC) or renal dialysis (RD) services on October 1, 1988. Eventually all counties aiding such aliens would have to seek a PRUCOL response for them from INS. The bill also provided that if PRUCOL could not be applied to these undocumented aliens, they would continue receiving LTC or RD at state-only expense. We told you of this in All County Welfare Directors Letter (ACWDL) 88-66.

In October 1988, the Ruiz vs. Kizer and Crespin vs. Kizer court injunctions expanded the application of PRUCOL to aliens receiving LTC or RD services who applied for full Medi-Cal benefits after October 1, 1988. We explained this in ACWDL 88-87.

From March through May of this year, we developed and tested procedures to find out whether certain aliens were PRUCOL or not. No actions were taken on the benefits of individuals who were determined to not have PRUCOL status as a result of this pilot. Thirteen LTC/RD cases were submitted to INS for PRUCOL determination. Of them, eleven were LTC patients found to be PRUCOL. The remaining two were RD patients who were not PRUCOL.

PRUCOL POLICY:

A PRUCOL response from INS is for entitlement purposes only. INS does not recognize PRUCOL as a real or implied legal alien status, so no immigration benefits result from it. INS uses SAVE secondary verification to process PRUCOL requests, with three variations:

1. INS agents, rather than status verifiers, review and act on PRUCOL requests.

2. INS does not discuss the reasons for particular determinations.

3. INS requires additional information with INS Form G-845, Document Verification Request. To provide it, we have devised Form MC 845. (Attachment 1).

INS will not deport aliens on the basis that they claim PRUCOL or that they apply for or receive Medi-Cal. INS has told us that PRUCOL aliens are nonetheless subject to deportation when their case warrants it for reasons unrelated to Medi-Cal, such as when an alien fraudulently supplies INS false information or has an open warrant for his/her arrest.

PRUCOL PROCEDURES:

Submission of PRUCOL Requests to INS

Start submitting PRUCOL requests to INS on October 1, 1989 for undocumented aliens receiving LTC/RD services who apply for or receive full or restricted Medi-Cal benefits. These aliens must claim SIS on the basis that INS knows they are in the U.S. but does not intend to deport them, either because of their status category or individual circumstances. To claim this status, they must check the last PRUCOL box on Form MC 13. Do not seek a PRUCOL determination when another kind of PRUCOL is claimed, i.e. when one of the boxes from 1 through 15 is checked on Form MC 13.

PRUCOL need not be sought for undocumented alien applicants or existing beneficiaries who are not receiving LTC or RD services at the time of application or when they report a change in their status to you and now request full benefits. This includes any patient currently on a waiting list for dialysis. They are not entitled to full Medi-Cal benefits.

FOR MEDI-CAL APPLICATIONS filed after receipt of this letter, submit complete PRUCOL requests to INS before granting the application, although you do not have to wait for INS' PRUCOL response to grant full benefits. Give the applicant thirty days to submit a completed MC 845 to you. If the applicant submits the MC 845 within the thirty days but you are not ready to grant until after the thirty days, grant full benefits when all of the eligibility factors have been evaluated. Again, you do not have to wait for INS' PRUCOL response to grant full benefits.

If you have granted restricted benefits for failure to submit a MC 845 and you receive it sometime later, increase benefits to full effective the first of the month in which the completed MC 845 was returned to you and submit to INS.

FOR EXISTING BENEFICIARIES WHO ARE RECEIVING FULL MEDI-CAL BENEFITS AND WHO ARE IN LTC OR ON RD SERVICES, submit complete PRUCOL requests to INS no later than the next annual redetermination. After that, submit them at least once a year, preferably at redetermination time.

FOR EXISTING BENEFICIARIES WHO ARE RECEIVING RESTRICTED MEDI-CAL BENEFITS AND WHO ARE IN LTC OR ON RD SERVICES who now claim to have SIS based on PRUCOL, increase benefits to full effective the first of the month in which he/she notifies you of his/her change in status. Follow the same procedures for seeking PRUCOL as you would for new applicants wanting full Medi-Cal benefits.

A PRUCOL response is good for one year from the date INS determines PRUCOL applies to the beneficiary. If a PRUCOL beneficiary is in LTC and leaves the facility within that year, the PRUCOL status remains in effect. This beneficiary should remain on full benefits for the remainder of that year if he/she is otherwise eligible for Medi-Cal.

FOR BENEFICIARIES IN LTC/RD

Send the beneficiary/representative the Beneficiary PRUCOL Notification Letter (See Attachment 2) to request him/her to complete and return Form MC 845. When the beneficiary is incapable of acting in his/her own behalf and no friend, relative or guardian is acting as his/her representative, a nursing home administrator can appoint a representative.

FOR APPLICANTS IN LTC/RD

Follow these procedures also for applicants who:

1. Are in LTC or receiving RD services at the time they apply for Medi-Cal (RD services are verified by a doctor's statement regarding the plan of care) and;

2. Declare on the MC 13 that they want full benefits and have SIS on the basis that INS knows they are in the U.S. but does not intend to deport them, either because of their status category or individual circumstances; and

3. Have not had 30 days to provide you documentation of SIS by the time you approve their application.

4. Are existing beneficiaries on restricted benefits and are in LTC or on RD services who now claim to have PRUCOL-based SIS and request full benefits.

An Applicant Notification Letter must be given to the applicant/beneficiary at the time the MC 13 is completed. (See Attachment 3)

If The MC 845 Is Not Returned:

1. Notify the beneficiary/representative again that the MC 845 must be completed and returned to the eligibility worker or full benefits will be reduced. You may call him/her by telephone. If you do, explain the benefits of cooperating and that the MC 845 information is confidential. Note in the case file whether you wrote or called, whom, and when.

2. If you do not receive the MC 845 as requested, repeat the previous step. If after this attempt the form is not returned, send one Notice of Action each to the beneficiary and representative reducing benefits to restricted Medi-Cal benefits (Aid Code 58). State-only nonemergency LTC benefits cannot be granted when there is a failure to cooperate without good cause.

If The MC 845 Is Returned:

Review it to ensure that the beneficiary/representative supplied the information and documents you requested.

If The MC 845 Is Incomplete:

1. If the information missing from the MC 845 is available to you from other means, supply it in the appropriate box within the MC 845 noted with an asterisk. If you call the beneficiary/representative and he/she indicates that the information is not known, is not available, etc. write the response in the appropriate box and note with an asterisk. Explain your actions in the Remarks section, Line 21, Page 4.

   Otherwise return the MC 845 to the beneficiary/representative for completion. Explain orally or in writing that a complete form must be returned or else benefits will be reduced to restricted Medi-Cal benefits. Note in the case file whether you wrote or called, whom and when.

   INS must have a completed form to respond to any PRUCOL request. No sections can be left blank. A response of "information unknown" or "information not available" is better than leaving it blank. Please keep in mind that INS considers all sections equally important.

2. If the beneficiary/representative does not return a completed MC 845 by the deadline you gave him/her, give a second extension. After another failure to cooperate without good cause, send one Notice of Action each to the beneficiary and representative reducing benefits to restricted Medi-Cal benefits.

If The MC 845 Is Complete:

1. Complete a G-845, Document Verification Request, check "Other" in Box #8 and write "PRUCOL Request" in the open space. Do not check any other square within Box #8.

2. Place a copy of the G-845, MC 845 and documents, if any, in the case file. Submit the originals to the appropriate INS district office using standard SAVE procedures.

INS COMPLETION OF THE G-845:

1. INS will list in Box #8 the INS case number (e.g. LOS-89-0123). The middle digits indicate the current year.

2. INS will check Box # 14 if it cannot respond from the information submitted. INS will ask you to provide additional information, and to resubmit the G-845.

3. Upon a PRUCOL determination, INS will check Box #17 or #18.

4. The "Stamp" box at the bottom of Page 1 will have the date, location and signature of the INS verifier.

If Box #17 Is Checked:

The statement "INS actively pursues the expulsion of an alien in this class/category" means that the beneficiary is not PRUCOL. Send one Notice of Action each to the beneficiary and the representative. For LTC patients reduce benefits to State-only nonemergency LTC plus restricted Medi-Cal benefits (but wait until we develop the necessary card and system). For RD patients, reduce them to restricted Medi-Cal benefits, which include RD. The basis for this action is the lack of satisfactory immigration status (SIS) as reported by INS.

If Box #18 Is Checked:

The statement "INS is not actively pursuing the expulsion of an alien in this class/category at this time" means that the beneficiary is PRUCOL. The beneficiary is entitled to full Medi-Cal benefits as long as he/she is otherwise eligible. Place the returned G-845 in the case file as evidence of the beneficiary's PRUCOL-based SIS.

Notify the beneficiary and the representative in writing that PRUCOL applies to the beneficiary for one year for purposes of entitlement to full Medi-Cal benefits.

INS should send its response to the PRUCOL request within thirty days. If a response is not received by that time, please contact the appropriate INS officer listed below:

Los Angeles	Don Looney
San Francisco	Dick Schumert
San Diego	Ray Putnam

If INS determines that they did not receive the PRUCOL request, complete a new G-845, attach a copy of the MC 845 and re-submit to INS.

BENEFIT REDUCTION:

Failure To Cooperate:

Reduce to restricted Medi-Cal benefits the benefits of LTC/RD patients failing without good cause to cooperate in the PRUCOL process despite repeated county attempts to encourage such cooperation.

PRUCOL Not Obtained:

When we develop State-only LTC cards, reduce to restricted Medi-Cal benefits and State-only non-emergency LTC services the benefits of LTC patients who complete the MC 845 but for whom, according to INS, PRUCOL cannot be applied. We expect to have such cards and the accompanying system changes ready in the near future. Please track these cases until then.

For RD patients who are not found to be PRUCOL, reduce benefits to restricted Medi-Cal benefits. All RD services are covered by this restricted card.

PRUCOL REDETERMINATION:

If the PRUCOL beneficiary continues to be otherwise eligible, to claim SIS on the basis of PRUCOL, and to receive LTC/RD, start the cycle again within one year of your first step, i.e. of sending the beneficiary or representative a Beneficiary PRUCOL Notification Letter and a MC 845. For administrative ease, we recommend doing so at the time of annual redetermination. A copy of the previous MC 845 can be sent to the beneficiary and submitted for a redetermination as long as the beneficiary indicates on the form that his/her information has not changed. However, a new medical statement must be completed for every redetermination.

AID PAID PENDING AND HEARING RIGHTS:

Follow standard hearing and aid paid pending rules when reducing benefits of prospective PRUCOL aliens. This applies whether you propose to reduce the benefits of INS-determined non-PRUCOL aliens or those of aliens failing to cooperate in the PRUCOL determination without good cause. In either case, use a timely Notice of Action, and suspend the reduction for aliens who appeal it timely.

Decisions upholding your proposed action should result in reduced benefits: Restricted Medi-Cal benefits for uncooperative beneficiaries; restricted plus LTC benefits for cooperative but non-PRUCOL LTC aliens; and restricted benefits (which cover RD) for non-PRUCOL RD aliens. Let us know about decisions deviating from the policy set forth in this letter and ask for a rehearing.

NOTICES OF ACTION:

Existing Notices of Action are applicable to all PRUCOL cases. We are developing a new notice to reduce full Medi-Cal benefits to State-only nonemergency LTC and restricted Medi-Cal benefits. We will transmit it to you by ACWDL when it becomes available after review by the CWDA Medi-Cal Forms Subcommittee.

ANNUAL REPORT TO THE LEGISLATURE:

DHS must complete an annual report to the Legislature for all PRUCOL applicants. To assist us, please complete the attached form (See Attachment 4) by February 1, 1990. From it, we hope to determine the number of beneficiaries receiving LTC or RD whose benefits are reduced because they have not been designated PRUCOL by INS. This form is to be completed for the previous calendar year. It applies to PRUCOL determinations for both existing and new beneficiaries.

Please send your completed logs to Sandra Bierer, DHS, 714 P Street, Room 1692, Sacramento, CA 95814.

REGULATIONS AND PROCEDURES MANUALS:

We intend to incorporate these rules into the regulations and procedures manual.

If you have questions about PRUCOL policy or procedures, contact Linda Hayes at (916) 323-6954, ATSS 8-473-6954. Regarding data collection for our annual report, call Sandra Bierer at (916) 324-4971, ATSS 8-454-4971.

Sincerely,

ORIGINAL SIGNED BY
Sandra Duveneck for

Frank Martucci, Chief
Medi-Cal Eligibility Branch

Attachments

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

Expiration Date: October 4, 1990

G-845 SUPPLEMENT-PRUCOL
(For Entitlement Purposes Only)

PLEASE READ THE FOLLOWING CAREFULLY BEFORE COMPLETING THIS FORM:

All applicants for PRUCOL (Long-Term Care [LTC], Renal Dialysis [RD], and Foster Care) should complete Part A, sign on Page 6, and provide the supplemental statements as specified. Part B is completed by LTC and RD applicants only; Part C is completed by Foster Care applicants only. If you are completing this form on someone else's behalf, "you" and "your" apply to the person named in SECTION I – IDENTITY. Please explain in the REMARKS section (number 21) why this form is not being completed by that person. *Also, use the REMARKS SECTION if more space is needed to answer individual questions.* Make a note, i.e., Continued to number 21, so the form reviewer knows additional information is included.

The Immigration and Naturalization Service (INS) provides a PRUCOL response for *entitlement purposes only* based on the information provided on this form. INS does not recognize PRUCOL as a legal immigration status; however, unless fraudulent information is knowingly supplied, or the applicant has an open felony criminal warrant, INS cannot use the information from this form for detention or deportation purposes.

PART A—ALL APPLICANTS—SECTION I—IDENTITY

1. Name Currently Used

   Last | First | Middle

2. Other Names (Include maiden name/alias/double surnames):

   Last | First | Middle

   Last | First | Middle

3. Name of Father

   Last | First | Middle

   Name of Mother (Maiden name)

   Last | First | Middle

4. Birthplace

   City/Town | State/Province | Country

5. Birthdate Year _____ Month _____ Day _____ Age: _____

   Birth Certificate Attached? (Attach if available) ☐ Yes ☐ No

6. County of Citizenship _____

7. Nationality _____

8. Were you ever in the U.S. military? ☐ Yes ☐ No

   If yes, complete the following and attach a copy of your discharge papers.

   Branch of Service | Date | Type of Discharge

COUNTY/INS USE ONLY

Case Name:

Case Number:

Worker Number:

ATTACHMENT 1

PART A ALL APPLICANTS–SECTION I–IDENTITY (Continued)

COUNTY/INS USE ONLY

9. Do you have a passport, visa, or other papers from your country of citizenship? ☐ Yes ☐ No
If yes, attach copies.

Name of Document(s)

Issuance Date(s) Expiration Date(s)

10. **Have you** ever been granted lawful permanent residence status in the U.S.? ☐ Yes ☐ No ☐ Unknown

Do you have INS documentation? If yes, attach a copy. ☐ Yes ☐ No

11. Give dates of your first and last entry into U.S.

First: _____ Last: _____

City/State of First and last entry into U.S.

First: _____ Last: _____

How did you enter each time?

First: ☐ With INS Inspection ☐ Without INS Inspection

Last: ☐ With INS Inspection ☐ Without INS Inspection

Did you receive entry document(s)? ☐ Yes ☐ No

If yes, list the document(s) you received:

12. Were you ever deported from the U.S.? ☐ Yes ☐ No
If yes, list date(s) of deportation and the city/state where deportation occurred.

PART A–SECTION II–ALL APPLICANTS–RESIDENCE

13. Please enter current and previous addresses for past ten (10) years both in and out of the U.S. Enter your current address first, the next most recent, etc., with the oldest address listed last.

Number/Street	City/Province	State/Country	ZIP	From	To
Number/Street	City/Province	State/Country	ZIP	From	To
Number/Street	City/Province	State/Country	ZIP	From	To
Number/Street	City/Province	State/Country	ZIP	From	To
Number/Street	City/Province	State/Country	ZIP	From	To
Number/Street	City/Province	State/Country	ZIP	From	To
Number/Street	City/Province	State/Country	ZIP	From	To
Number/Street	City/Province	State/Country	ZIP	From	To
Number/Street	City/Province	State/Country	ZIP	From	To
Number/Street	City/Province	State/Country	ZIP	From	To

PART A—SECTION II—ALL APPLICANTS—RESIDENCE (Continued)

COUNTY/INS USE ONLY

14. Do you live:

☐ With a relative/guardian? ☐ In a long-term care facility? ☐ In a Group Home?
☐ With an unrelated person? ☐ In a Foster Home/Certified Home? ☐ Other ______

Name of Person or Facility: ______

PART A—SECTION III—ALL APPLICANTS—SUPPORT/DEPENDENCY

15. Do you have any immediate relatives (spouse, mother, father, son, daughter, sister, brother) living in or out of the U.S.? If yes, please list below. ☐ Yes ☐ No

Name of Spouse		Birthdate	Age
Address of Spouse			
Date of Marriage	Spouse's Citizenship/Immigration Status ☐ U.S. Citizen ☐ Lawful U.S. Resident ☐ Unknown/Other		

Name		Relationship
Address		
Birthdate	Age	Citizenship/Immigration Status ☐ U.S. Citizen ☐ Lawful U.S. Resident ☐ Unknown/Other

Name		Relationship
Address		
Birthdate	Age	Citizenship/Immigration Status ☐ U.S. Citizen ☐ Lawful U.S. Resident ☐ Unknown/Other

Name		Relationship
Address		
Birthdate	Age	Citizenship/Immigration Status ☐ U.S. Citizen ☐ Lawful U.S. Resident ☐ Unknown/Other

Name		Relationship
Address		
Birthdate	Age	Citizenship/Immigration Status ☐ U.S. Citizen ☐ Lawful U.S. Resident ☐ Unknown/Other

Name		Relationship
Address		
Birthdate	Age	Citizenship/Immigration Status ☐ U.S. Citizen ☐ Lawful U.S. Resident ☐ Unknown/Other

16. Do you provide financial support to any relative(s) listed in number 15, above? If yes, please list below. ☐ Yes ☐ No ☐ Unknown

Name	Amount/Value	How Often Paid
Name	Amount/Value	How Often Paid

PART A–SECTION III–ALL APPLICANTS–SUPPORT/DEPENDENCY (Continued)

COUNTY/INS USE ONLY

17. Do you receive financial support from any relative(s) listed in number 15? ☐ Yes ☐ No ☐ Unknown
If yes, please list.

Name	Amount/Value	How Often Received
Name	Amount/Value	How Often Received

18. Do you receive income/money from any source not listed above (stocks, pension plans, employment, public assistance, SSI, Social Security, etc.)? ☐ Yes ☐ No ☐ Unknown
If yes, please list

Source	Amount	How Often Received
Source	Amount	How Often Received
Source	Amount	How Often Received

19. Have you ever been arrested in or outside the U.S.? ☐ Yes ☐ No ☐ Unknown
If yes, please list

Date(s) of Arrest(s)	City/State/Country

Reason(s) for Arrest(s)

Outcome(s) (Conviction, Parole, Suspension, etc.)

Length of Time Served In Jail, Each Offense

Have you ever sold, distributed or otherwise trafficked in illegal narcotics? ☐ Yes ☐ No

PART A–SECTION V–ALL APPLICANTS–REMARKS/ADDITIONAL INFORMATION

21. List additional information or remarks in this section. Please be sure to list the question number to which the information pertains. Attach additional pages if needed.

PART B—LTC/RD APPLICANTS ONLY—MEDICAL INFORMATION

COUNTY/INS USE ONLY

1. *Date illness began:* _____

Have you received treatment for your illness in another country? ☐ Yes ☐ No ☐ Unknown
If yes, please list the country(ies)

Country(ies) _____

2. Do you have a guardian, conservator, or other caretaker? ☐ Yes ☐ No ☐ Unknown
If yes, please list.

Name | Telephone Number

Address

Reason a Caretaker Is Needed

4. List your doctor's name and address.

Physician's Name | Telephone Number

Address

5. PROVIDE STATEMENT FROM ATTENDING PHYSICIAN, NURSING HOME ADMINISTRATOR, OR HEAD NURSE on Attachment 1 of this form. Attachment 1A is a sample of the kind of information which is expected. This STATEMENT must be provided, or the request for PRUCOL will not be processed.

PART C—FOSTER CARE APPLICANTS ONLY

1. PROVIDE CASE SUMMARY ON ATTACHMENT 2 OF THIS FORM—COMPLETED BY SOCIAL WORKER most familiar with child's history. Attachment 2A is a sample of the kind of information expected. This SUMMARY must be provided, or the request for PRUCOL will not be processed.

2. Has the child been or is it possible he/she will be referred for adoption? ☐ Yes ☐ No
If yes, please explain in Case Summary, Attachment 2.

3. Are there current plans to return this child to the parent(s) or person(s) from whom the child was removed? If yes, please indicate date ☐ Yes ☐ No

Planned date of return

4. Expected duration of court ordered foster placement:

From: _____ To: _____

5. Has child ever received medical or psychological/psychiatric treatment? ☐ Yes ☐ No
If yes, please indicate whether medical or psychological/psychiatric and explain in the Case Summary, Attachment 2. ☐ Medical ☐ Psychological/Psychiatric

6. Is the treatment indicated in number 5, above, generally available in the child's country of origin? ☐ Yes ☐ No ☐ Unknown

7. What attempts were made for suitable placement in the child's country of origin? If no attempt was made, explain why not.

What were the results of the above mentioned attempt(s)?

PART C—FOSTER CARE APPLICANTS ONLY (Continued)	*COUNTY/INS USE ONLY*
8. What would happen to to the child if he/she were removed from the U.S. in the next 12 months? ☐ Can be removed with no detrimental effects. ☐ Removal would be detrimental for the following reason(s): ☐ No immediate relatives to return child to. Child would be unaccompanied/endangered. ☐ Child can only communicate in English and the transition would be difficult. ☐ No means of income/support for the child. ☐ Child would be separated from his/her siblings or relatives legally in the U.S. ☐ Child would not have the financial resources to receive essential medical treatment. ☐ Other (explain): _____	

BE SURE YOU HAVE READ EVERY ITEM ABOVE AND ANSWERED ALL QUESTIONS. PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING.

I UNDERSTAND THAT THIS APPLICATION IS CONFIDENTIAL AND WILL BE USED FOR ENTITLEMENT PURPOSES ONLY. I DECLARE UNDER PENALTY OF PERJURY THAT THE ANSWERS I HAVE GIVEN ARE COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE.

Signature of Applicant or Person Acting on Applicant's Behalf	Relationship
Print Name of Signer	Date
Signature of Witness (if signed with a mark) or Person Helping Applicant	Relationship
Print Name of Signer	Date

Beneficiary PRUCOL Notification Letter (LTC/RD)

Case Name _____
Case Number _____

Dear Medi-Cal Beneficiary or Authorized Representative:

READ THIS BEFORE you complete the attached Form MC 845, the G-845 Supplement - PRUCOL.

The attached Form MC 845 must be completed and returned to your eligibility worker by _____ or your full Medi-Cal benefits may be in jeopardy. Failure to complete and return this form is considered failure to cooperate. Therefore, your benefits will be reduced to restricted emergency and pregnancy-related services only if you do not complete the MC 845. If problems occur which may delay the return of this form, or if you have questions, **call your eligibility worker for assistance** at (___)_____. The following explains the reasons why this form must be completed:

ATTACHMENT 2

You are an alien who by federal law, should receive only restricted (emergency and pregnancy-related) Medi-Cal benefits. However, you are currently receiving full Medi-Cal benefits to cover long term care (LTC) and/or renal dialysis services. So that you may continue to receive full Medi-Cal benefits, the Immigration and Naturalization Service (INS) must provide us a "permanently residing under color of law" (PRUCOL) response. This PRUCOL response provides absolutely <u>no</u> immigration benefit; it only allows you to continue to receive full Medi-Cal benefits. (See Notes 1 and 2 on Page 2 of this letter).

If it is determined that PRUCOL can be applied to you, full Medi-Cal benefits will continue so long as you remain eligible for the Medi-Cal program. This PRUCOL entitlement must be re-evaluated annually.

To determine whether PRUCOL applies to you, you (or the person helping you) must complete the attached Form MC 845. Provide as much information as you can. If you cannot answer a particular question, explain why. Be sure that your physician, nursing home administrator or chief nurse completes the medical summary attached to the form. If the medical summary is not completed, we cannot submit the form to the INS for a PRUCOL response.

If PRUCOL cannot be applied to you, your Medi-Cal benefits will be reduced to LTC services only and restricted emergency and pregnancy-related services if you are in a LTC status and restricted emergency and pregnancy-related services if you are a renal dialysis patient.

There are some medical services provided under full Medi-Cal benefits which you will not receive when your benefits are reduced. If you receive notice that your benefits are to be reduced, you have the right within a certain period of time, to request a State Hearing to appeal the decision. Instructions on how to appeal would appear on the back of the notice informing you of the reduced benefits.

Again, if you have questions or need more time to complete the MC 845, call your eligibility worker. REMEMBER, FAILURE TO RETURN A COMPLETED MC 845 TO YOUR ELIGIBILITY WORKER BY THE DATE WRITTEN ABOVE COULD RESULT IN THE LOSS OF YOUR FULL MEDI-CAL BENEFITS.

County Signature

cc: (if any)

NOTE 1: Under federal and state law, aliens may receive full Medi-Cal benefits only if they are one of the following: lawful permanent residents; conditional resident aliens; aliens permanently residing in the U.S. under color of law (PRUCOL); aliens who have been granted amnesty who are also aged (65 or older), blind, disabled, or children under 18 years of age.

The following aliens may receive only restricted (emergency and pregnancy-related) benefits: undocumented aliens; aliens granted amnesty but who are between the ages of 18 and 65, not blind or disabled; nonimmigrants with unexpired visas (students, visitors, etc.), or on unexpired parole status.

NOTE 2: The INS is prohibited by law from using the information on the MC 845 against you or any of your relatives for administrative purposes. This means the INS may not detain or deport you or any of your relatives based on the information you provide. In addition, this information is kept confidential. However, if it is determined that there is an open felony criminal warrant for your arrest, law enforcement agencies may be

provided information regarding your whereabouts. Also, if you knowingly provide fraudulent information, you are open to criminal investigation and the loss of all Medi-Cal benefits.

SAMPLE–ATTACHMENT 2A

SAMPLE CASE SUMMARY–FOSTER CARE

Child's Name: XXXX | Sex: FEMALE

Name of Current Placement: YZY

Address of Current Placement: 999 ANYWHERE, TOWNSHIP, STATE ZIP

Court Case Number: 99999 | Court Name: ZZZZ

Suitable Placement Order Date: 6-6-89

The following elements should be included in the Summary: (1) Date and reason for protective services referral; (2) date of entry to the U.S.; (3) brief historical background of child's family life; (4) family reunification efforts (parents, relatives); (5) adoption prospects; (6) current level of functioning (social, academic, medical, etc.); and (7) summary/prognosis. *A sample Summary is attached for reference.*

CASE SUMMARY: (Attach additional pages, if necessary)

Minor XXXX, age 13 years and 8 months, was born in Honduras and entered the United States in July 1982. On August 22, minor XXXX was placed in protective custody due to a severe conflict between the mother and the child. On August 29, 1988 a petition was filed on behalf of the minor. The sustained petition states that the minor has severe emotional problems and the mother has a limited capacity to deal with those problems. On October 13, 1988 the ZZZZ Juvenile Court declared the minor a Dependent child and ordered suitable foster home placement.

Approximately two years ago, the mother and the child began having conflicts in their relationship. The origins of these conflicts are not clear, but the mother acknowledges that her daughter feels a strong hatred for her and she does not have the time to supervise her daughter adequately. Therefore, there is no likelihood of family reunification.

The Minor's father, OOOO, resides in Ontario, Canada. On November 18, 1988 an attempt to contact him was unsuccessful. On January 19, 1989 the Family Services Department of Ontario informed this agency that Mr. OOOO's son, (XXXX's sibling) is under their custody due to father leaving the child unattended for a long period of time on a consistent basis. Consequently, there is no likelihood of reunification between minor XXXX and her father.

The minor suffers from serious depression and has a history of suicide attempts. She was hospitalized at the XYZ Hospital from April 13, 1988 to July 29, 1988. She was also hospitalized a second time from August 4, 1988 to August 22, 1988 after threatening to kill herself.

Minor presently resides at YZY Group Home and attends school at the same facility. XXXX has improved her grades and according to the teachers statements "it is a pleasure to work with her." Minor is also under psychiatric care.

Minor currently is taking an antidepressant medication. Minor is also receiving individual therapy and significant progress has been made. The minor has not made any suicidal threats and she is more coorperative with the group home staff.

Continued on Second Page

Signature of Social Worker | Date

Print Name of Person Signing

County Agency | Telephone Number

Due to the age of this minor (13), the prospects for adoption are slim.

In spite of minor's history of severe depression, she has made remarkable improvement in all areas of her life. XXXX will remain a Dependent child of the ZZZZ Juvenile Court until she reaches the age of majority.

CASE SUMMARY—FOSTER CARE

Child's Name:	Sex:

Name of Current Placement:

Address of Current Placement:

Court Case Number:	Court Name:

Suitable Placement Order Date:

The following elements should be included in the Summary: (1) Date and reason for protective services referral; (2) date of entry to the U.S.; (3) brief historical background of child's family life; (4) family reunification efforts (parents, relatives); (5) adoption prospects; (6) current level of functioning (social, academic, medical, etc.); and (7) summary/prognosis. *A sample Summary is attached for reference.*

CASE SUMMARY: (Attach additional pages, if necessary)

Signature of Social Worker	Date

Print Name of Person Signing

County Agency	Telephone Number

SAMPLE—ATTACHMENT 1A
MEDICAL STATEMENT
LONG-TERM CARE AND/OR RENAL DIALYSIS PATIENTS

Patient's Name	Patient's Sex
PATIENT'S NAME	FEMALE

This form must be completed by the attending physician for renal dialysis patients. For long-term care patients, the form may be completed by either the attending physician, the nursing home administrator, or the chief nurse of the nursing home. Attach additional pages, if necessary.

We are requesting a brief medical summary which will be submitted to the Immigration and Naturalization Service (INS). This information will assist INS in providing a response which would entitle your patient to be known as a Permanent Resident Under Color of Law (PRUCOL) solely to obtain full scope Medi-Cal benefits. The medical information you provide is essential to receive that response. It is better to provide too much information than not enough. If a favorable PRUCOL designation is not made, your patient may receive reduced Medi-Cal benefits.

This summary must address at least the following: (1) The patient's diagnosis and prognosis; (2) Whether to your knowledge, treatment generally would be available in the patient's country of citizenship; and (3) If in your opinion, the patient would be medically affected if deported from the U.S. within the next 12 months. *A sample summary is attached for reference.*

MEDICAL SUMMARY: (Attach additional pages, if necessary)

I, [name of person completing the summary], am [title, i.e., attending physician, nursing home administrator, etc.] at [name of facility] in [name of city], California. [Name of patient] is one of our patients. [Name of patient] entered [name of facility] on [date entered]. She was admitted in a comatose state, dehydrated, with a decreased level of consciousness. A few weeks earlier, she suffered a head injury from a fall.

[Name of patient] requires complete and total skilled care. She is in a vegetative state and is completely noncommunicative. She is fed through a nasal gastric tube and requires suctioning. She must be turned every two hours. She is incontinent in bladder and bowel and requires frequent changes.

[Name of patient] requires complete and total skilled nursing care. Although she has a family in [location of family], it would not be possible for them to care for her at home. She needs the care of trained nursing personnel at all times.

[Name of patient] suffered a severe cranial injury, resulting in extensive damage to the [specify*] part of the brain, while visiting her family here, as a tourist from [name of country]. It is doubtful that she would survive a trip back to her home even if medical care were available there. Any change in her surroundings or circumstances could be extremely disruptive to her medical condition, and could have serious, even fatal, consequences.

* Use layman's terms rather than medical terms whenever possible.

[Brackets should not be used, only indicated language.]

This is only one possible format. Your summary may vary due to the patient's circumstances.

Signature of Physician, Nursing Home Administrator, or Chief Nurse of Nursing Home		Date
Print Name of Person Signing	**Facility Name**	**Telephone Number**

MEDICAL STATEMENT
LONG-TERM CARE AND/OR RENAL DIALYSIS PATIENTS

Patient's Name	Patient's Sex

This form must be completed by the attending physician for renal dialysis patients. For long-term care patients, the form may be completed by either the attending physician, the nursing home administrator, or the chief nurse of the nursing home. Attach additional pages, if necessary.

We are requesting a brief medical summary which will be submitted to the Immigration and Naturalization Service (INS). This information will assist INS in providing a response which would entitle your patient to be known as a Permanent Resident Under Color of Law (PRUCOL) solely to obtain full scope Medi-Cal benefits. The medical information you provide is essential to receive that response. It is better to provide too much information than not enough. If a favorable PRUCOL designation is not made, your patient may receive reduced Medi-Cal benefits.

This summary must address at least the following: (1) The patient's diagnosis and prognosis; (2) Whether to your knowledge, treatment generally would be available in the patient's country of citizenship; and (3) If in your opinion, the patient would be medically affected if deported from the U.S. within the next 12 months. *A sample summary is attached for reference.*

MEDICAL SUMMARY: (Attach additional pages, if necessary)

Signature of Physician, Nursing Home Administrator, or Chief Nurse of Nursing Home		Date
Print Name of Person Signing	**Facility Name**	**Telephone Number**

Applicant PRUCOL Notification Letter (LTC/RD)

Case Name_____
Case Number _____

Dear Medi-Cal Applicant:

READ THIS BEFORE you complete the attached Form MC 845, the G-845 Supplement - PRUCOL.

The attached Form MC 845 must be completed and returned to your eligibility worker by _____ or you may not receive full Medi-Cal benefits. Failure to complete and return this form is considered failure to cooperate. Therefore, if you do not complete the MC 845 as requested, you will be entitled only to restricted emergency and pregnancy-related services. If problems occur which may delay the return of this form, or if you have questions, **call your eligibility worker for assistance** at (___)_____. The following explains the reasons why this form must be completed:

You are an alien who by federal law should receive only restricted (emergency and pregnancy- related) Medi-Cal benefits because you have no documentation of your immigration status. However, because you are in a long term care (LTC) status and/or receiving renal dialysis services, and claim to have satisfactory immigration status, you may request a "permanently residing under color of law" (PRUCOL) response from the Immigration and Naturalization Service (INS). A response which indicates you have PRUCOL will allow you to receive full Medi-Cal benefits. This PRUCOL response provides absolutely no immigration benefit; it only allows you to receive full Medi-Cal benefits. (See Notes 1 and 2 on Page 2 of this letter).

If it is determined that PRUCOL can be applied to you, full Medi-Cal benefits will continue so long as you remain eligible for the Medi-Cal program. This PRUCOL entitlement must be re-evaluated annually.

To determine whether PRUCOL applies to you, you (or the person helping you), must complete the attached Form MC 845. Provide as much information as you can. If you cannot answer a particular question, explain why. Be sure that your physician, nursing home administrator, or chief nurse completes the

ATTACHMENT 3

medical summary attached to the form. If the medical summary is not completed, we cannot submit the form to the INS for a PRUCOL response.

If PRUCOL applies to you, you will receive full Medi-Cal benefits so long as you remain otherwise eligible for the Medi-Cal program.

If PRUCOL cannot be applied to you and you are in LTC status, you will be eligible to LTC services only and restricted emergency and pregnancy-related services. If you are a renal dialysis patient, you will only be entitled to restricted emergency and pregnancy-related services.

There are some medical services provided under full Medi-Cal benefits which you will not receive with these reduced benefits. If you receive notice that you are entitled only to restricted benefits or, in some circumstances, that your benefits are to be reduced, you have the right within a certain period of time, to request a State Hearing to appeal the decision. Instructions on how to appeal would appear on the back of the notice informing you of the reduced benefits.

Again, if you have questions or need more time to complete the MC 845, call your eligibility worker. REMEMBER, FULL MEDI-CAL BENEFITS MAY NOT BE GRANTED TO YOU IF YOU FAIL TO RETURN A COMPLETED MC 845 TO YOUR ELIGIBILITY WORKER BY THE DATE WRITTEN ABOVE.

County Signature

cc: (if any)

NOTE 1: Under federal law, aliens may receive full Medi-Cal benefits only if they are one of the following: lawful permanent residents; conditional resident aliens; aliens permanently residing in the U.S. under color of law (PRUCOL); aliens who have been granted amnesty who are also aged (65 or older), blind, disabled, or children under 18 years of age.

The following aliens may receive only restricted (emergency and pregnancy-related) benefits: undocumented aliens; aliens granted amnesty but who are between the ages of 18 and 65, not blind or disabled; nonimmigrants with unexpired visas (students, visitors, etc.), or on unexpired parole status.

NOTE 2: The INS is prohibited from using the information on the MC 845 against you or any of your relatives for administrative purposes. This means the INS may <u>not</u> detain or deport you or any of your relatives based on the information you provide. In addition, this information is kept confidential. However, if it is determined that there is an open felony criminal warrant for your arrest, law enforcement agencies may be provided information regarding your whereabouts. Also, if you knowingly provide fraudulent information, you are open to criminal investigation and the loss of all Medi- Cal benefits.

PRUCOL LOG

County _____

Ending December 31, 19_____

CASE NAME	TYPE (LTC or RD)	INS DISPOSITION (Approved or Denied)

By February 1, 1990, send to: Department of Health Services
Attn: Sandra Bierer
714 P Street, Room 1692
Sacramento, CA 95814

ATTACHMENT 4