STATE OF CALIFORNIA--HEALTH AND WELFARE AGENCY PETE WILSON, Governor

DEPARTMENT OF HEALTH SERVICES
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June 24, 1996

Letter No.: 96-33

TO: All County Welfare Directors
All County Administrative Officers
All County Medi-Cal Program Specialists/Liaisons

IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL (MC 219)
IMPORTANT INFORMATION ABOUT RESIDENCY (MC 214)

The purpose of this letter is to transmit a sample copy of the newly revised and reformatted MC 219. As of September 1, 1996, the 5/96 version of the MC 219 obsoletes all previously issued versions of the following Rights and Responsibilities forms:

- MC 216: Rights of Persons Requesting Medi-Cal;
- MC 217: Medi-Cal Responsibility Checklist;
- MC 218: Privacy and Confidentiality Notification; and
- MC 219 (11/93): Important Information For Persons Requesting Medi-Cal.

All pertinent information on the MC 216, MC 217, and the MC 218 was incorporated into the 11/93 version of the MC 219 when it was released as a single informing notice. The 5/96 revisions to the MC 219 include:

- Informing language which reflects the Department's implementation of the Appellate Court ruling in the Crespin case;
- Technical changes in the discussion of third party liability, recovery, other health insurance coverage information, and Managed Care health plan options;
- Overall simplified wording;
- An interpreter signature and telephone number line; and
- ~~Removal of pages 5~~ ("Important Information About Residency") and 6 ("Citizenship/Immigration Status Information For Applicants and Beneficiaries of Medi-Cal") which were previously included in the 11/93 version.

Pages removed from the MC 219 (11/93)

Due to the infrequent use of the "Important Information About Residency" page and escalating printing costs, the Medi-Cal Eligibility Branch (MEB), after consulting with the Medi-Cal Forms Committee, made the decision to detach the "Important Information About Residency" page from the new MC 219. The "Important Information About Residency" page is now a separate form and is numbered as the MC 214. The MC 214 must be completed by the applicant/beneficiary whenever evidence of residency is required and the applicant/beneficiary does not have one of the items listed on that form. Persons who sign the MC 214 are still required to provide some evidence of California residency in accordance with established policies for verification of residency. A sample copy of the new MC 214 is enclosed for your information. The MC 214 is available through the Department of Health Services' warehouse beginning August 1, 1996.

Information in the "Citizenship/Immigration Status Information For Applicants and Beneficiaries of Medi-Cal" page of the previous version of the MC 219 has been updated to reflect the State Appellate Court ruling in the Crespin case and incorporated into the May 1996 version of the MC 13. The revised MC 13 and a description of the requirements for implementing the Appellate Court decision have been sent to the counties in a separate All County Welfare Directors Letter.

Completing the MC 219 (5/96)

County staff are reminded that the MC 219 must be reviewed with the applicant/beneficiary or his/her representative. SAWS/ISAWS counties must manually issue the MC 219 because the SAWS generated SAWS 2A currently does not contain adequate information for Medi-Cal only cases. County staff is to file the original signature page in the case record and give the complete informing notice to the applicant/beneficiary or his/her representative.

Counties are instructed to begin using the new MC 214 and the revised MC 219 on September 1, 1996, and to discard all previous versions of these forms on that date. A three-month supply of the revised MC 219 forms will be shipped to counties by August 1, 1996. Questions regarding the MC 214 or residency may be directed to John Zapata at (916) 657-0725 and questions regarding the MC 219 may be directed to Alice Mak at (916) 654-0573.

Sincerely,

ORIGINAL SIGNED BY

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Enclosure

Enclosure 1-A

IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL

PRIVACY AND CONFIDENTIALITY NOTIFICATION

Sections 14011 and 14012 of the Welfare and Institutions Code allow county welfare departments to get certain facts from you to decide if you, or the persons you represent, can get Medi-Cal benefits. You must provide these facts to get Medi-Cal benefits. The information will be used:

1. By the county welfare department to establish first time and ongoing Medi-Cal eligibility.
2. By Electronic Data Systems (EDS) to process claims and make Benefits Identification Cards (BICs).
3. By the United States (U.S.) Department of Health and Human Services to make audit and quality control reviews and verify Medicare Buy-In and Social Security Numbers (SSNs).
4. To verify alien status with the U.S. Immigration and Naturalization Service (INS) only for aliens who claim to be lawfully admitted for permanent residence or Permanently Residing in the U.S. Under Color of Law (PRUCOL) or Amnesty Aliens with a valid and current I-688 card. The information the INS receives can only be used to determine the Medi-Cal eligibility, and cannot be used for immigration enforcement unless you are committing fraud.
5. By medical services providers and health maintenance organizations to certify eligibility.
6. To identify health insurance coverage and take recovery actions.

MEDI-CAL APPLICANT/BENEFICIARY RIGHTS, RESPONSIBILITIES, AND UNDERSTANDINGS

I HAVE THE RIGHT TO:

1. Ask for an interpreter to help me in applying for Medi-Cal if I have difficulty in speaking or understanding the English language.
2. Be treated fairly and equally regardless of my race, color, religion, national origin, sex, age, or political beliefs.
3. Apply as a disabled person if I think I am disabled.
4. Be told about the rules for retroactive Medi-Cal eligibility.
5. Apply for Medi-Cal and to be told **in writing** whether I qualify for any Medi-Cal program, even if the county representative tells me during the interview that it appears I am not eligible.
6. Review Medi-Cal program rules and regulation manuals if I want to question the basis on which my eligibility is approved or denied.
7. Have all facts that I give to the county welfare department kept in the strictest confidence and to look at those facts during regularly scheduled office hours.
8. Receive an immediate need card, **when possible and eligible**, if I have a medical emergency or I am pregnant.
9. Receive Medi-Cal, as authorized, while my satisfactory immigration status is being documented and verified, if I am otherwise eligible. **Aliens who are lawfully admitted for permanent residence or PRUCOL or Amnesty Aliens with a valid and current I-688 card are in a satisfactory immigration status.**
10. Be told about the Child Health and Disability Prevention Program and the Special Supplemental Food Program for Women, Infants, and Children, and to ask for help in receiving those services.
11. Ask for and receive information about the Family Planning Program and be told if I am eligible for those services.
12. Speak to a social worker about other public or private services or resources that I can get.
13. Be told about Medi-Cal Health Care Plans that my family and I can join to get a doctor and other medical care, and to choose the option I prefer.

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IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL (Continued)

14. Lower my share of cost by providing past unpaid medical bills (that I still owe).
15. Reduce my property reserve to within the Medi-Cal property limit by the last day of a month for which I want Medi-Cal including the month I apply and to be told how I may spend my excess property.
16. Divide countable (nonexempt) community (MY SPOUSE's AND MY) property by written agreement into equal shares of separate property if either of us entered a long-term care (LTC) facility before September 30, 1989.
17. Keep a certain amount of countable separate and community property if I enter an LTC facility on or after January 1, 1990. My spouse and I have the right to be told the amount.
18. Have a state hearing if I am dissatisfied with an action taken (or not taken) by the county welfare department or the State Department of Health Services, except actions relating to the Health Insurance Premium Payment (HIPP) and Employer Group Health Plan (EGHP) programs. If I want a state hearing to appeal the decision, I must ask for it within **90 days** of the date the Notice of Action (NOA) was mailed to me. If I do not receive a NOA, I must request a hearing within **90 days** from the date I discover the action (or inaction) with which I am dissatisfied. The date of discovery is the date I know, or should have known, of the action. The best way to ask for a hearing is to contact the nearest county welfare department.

I HAVE THE RESPONSIBILITY TO TELL MY COUNTY REPRESENTATIVE WITHIN TEN (10) DAYS WHENEVER:

1. Income received by me or any member of my family increases, decreases, starts, or stops. This includes income from Social Security Administration (SSA), loans, settlements, or any other source.
2. I plan to change or have already changed my place of residence or mailing address.
3. A person, including a newborn child, whether or not related to me or my family, moves into or out of my home.
4. An absent parent returns to the home.
5. I or a member of my family gives birth, becomes pregnant, or ends a pregnancy.
6. I, my spouse, or any member of my family enters or leaves a nursing home or an LTC facility.
7. I receive, transfer, give away, or sell real or personal property (including money) or when someone gives me or a member of my family such things as a car, house, insurance payments, etc.
8. I have any expenses that are paid for by someone other than myself.
9. I or a member of my family gets a job, changes jobs, or no longer has a job.
10. I have a change in expenses related to my job or education. (For example: child care, transportation, etc.)
11. I or a member of my family becomes physically or mentally impaired so that I/he/she cannot get or keep a job (this would include a child in the family who may not be able to get a job in the future due to the impairment).
12. I or a member of my family applies for disability benefits with the SSA, Veterans Administration, or Railroad Retirement.
13. One of my children drops out of school or returns to school.
14. There is a change in the citizenship/immigration status of any family member applying for or receiving Medi-Cal.
15. Health insurance coverage for me or a member of my family changes.

I HAVE THE RESPONSIBILITY TO:

1. Complete and return a status report by the date required when requested by the county.
2. Give proof that I am a resident of California.
3. Make a declaration about my citizenship/immigration status.

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IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL (Continued)

4. Provide an SSN for myself and/or for any member of my family who has an SSN and wants Medi-Cal benefits. If I am a U.S. citizen, a U.S. national, or an alien in a satisfactory immigration status, I must apply for an SSN and provide it to the county if I do not already have one. If I need to apply for an SSN, I can get help from my eligibility worker, but I must work with the SSA to clear up any questions or my Medi-Cal will be denied or stopped. (Aliens who are not in a satisfactory immigration status and do not have an SSN can get ***restricted*** Medi-Cal without applying for an SSN if they meet all the rules.)
5. Apply for any income that may be available to me or any member of my family.
6. Apply for Medicare benefits if I am blind, disabled, have End Stage Renal Disease, or am 64 years and 9 months of age or older and eligible. I am responsible for telling my providers that I have both Medi-Cal and Medicare coverage.
7. Apply for and enroll in any health insurance if that is available to me and my family at no cost. I have the responsibility to remain enrolled in the health plan when Medi-Cal approves payment of plan premiums by the State of California.
8. Report to the county department, and to the health care provider, any health care coverage/insurance I carry or am entitled to use, including Medicare. If I willfully fail to give this fact, I may be guilty of a criminal offense, or may be billed by my provider.
9. Go to my health care plan (such as Kaiser, CHAMPUS, or a Medicare HMO) for medical care. (Medi-Cal will not pay for any services covered by the plan.)
10. Give any insurance payments I receive to the State if Medi-Cal has already paid for my care.
11. Go to a presentation, if presentations are given, and make a written choice, or answer if received by mail, about how I want to get my Medi-Cal benefits. If I do not go and make a choice, or choose by mail, my eligible family members and I may be signed up in a Medi-Cal Health Care Plan near my home.
12. Sign and date my BIC when I get it and ensure it is used only to get necessary health care for myself or eligible family members.
13. Take my BIC to my medical provider when I am sick or have an appointment. In emergencies when the BIC is not in hand, I must get the BIC to the medical provider when possible.
14. Report to the county department when I receive health care services because of an accident or injury caused by another person's action or failure to act, for which Medi-Cal has been, or may be billed.
15. Cooperate with the State or county in establishing paternity and identifying any possible medical coverage I or my family may be entitled to through an absent parent.
16. Cooperate with the State of California if my case is selected for review by the quality control review team. If I refuse to cooperate, my Medi-Cal benefits will be stopped.

I UNDERSTAND THAT:

1. Failure to give necessary facts or deliberately giving false facts can result in Medi-Cal benefits being denied or stopped. My case may also be investigated for suspected fraud.
2. The facts I give will be checked by computer with facts given by employers, banks, SSA, Franchise Tax Board, welfare, and other agencies. I will have the right to give proof to correct any facts which are found to be wrong.
3. Aliens who are not in a satisfactory immigration status and do not have an SSN can get ***restricted*** Medi-Cal without applying for an SSN if they meet all the rules.
4. Immigration status data given as part of the Medi-Cal application is confidential.
5. Based on my income, I will have to pay or be billed for part of my medical expenses before I can get Medi-Cal.
6. If I do not report changes promptly, and because of this, receive Medi-Cal benefits that I am not eligible for, I may have to repay the State Department of Health Services.

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IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL (Continued)

7. If I am receiving Medi-Cal based on disability and I apply for disability benefits from the SSA, and the SSA denies my disability claim, my Medi-Cal may be stopped. If I appeal my SSA denial right away, my Medi-Cal will continue until the SSA makes a final decision. If the SSA reverses the denial decision and approves my SSA disability claim, my Medi-Cal will not stop.
8. As a condition of Medi-Cal eligibility, all rights to medical support and/or payment for medical services for myself and any eligible persons that I have legal responsibility for, are automatically assigned to the State.
9. If medical support is court-ordered from an absent parent for my children, the insurance carrier must allow me to enroll and provide benefits to my children without the absent parent's consent.
10. If I don't apply for or keep no-cost health coverage or state-paid coverage, my Medi-Cal benefits and/or eligibility will be denied or stopped.
11. When I apply for Medi-Cal, I will be evaluated for potential eligibility under other medical assistance programs, including the HIPP and EGHP programs.
12. If I ask a Medi-Cal provider for any services not covered by my **non-Medi-Cal** health insurance plan, I must give the medical provider a written statement from my health plan saying it does not offer the Medi-Cal-covered services.
13. Medi-Cal providers cannot collect insurance copayment, coinsurance, or deductibles from me unless the payment is used to meet my Medi-Cal share of cost and/or copayment.
14. If I am admitted to a nursing facility and I have no intention of returning to my home, the State may impose a lien against my property.
15. After my death, the State has the right to seek reimbursement from my estate for all Medi-Cal benefits I received after age 55 unless I have a surviving spouse (during his or her lifetime), minor children, blind or permanently and totally disabled children, or it would create a hardship for my heirs.
16. After the death of my surviving spouse, the State has the right to claim from the part of his or her estate received from me, all Medi-Cal benefits I received after age 55 up to the amount of property my spouse received from my estate.

I, _____, am applying for Medi-Cal benefits from _____ County Welfare Department (on behalf of _____).

I hereby state that I have reviewed the information on this form with the county representative and that I fully understand my **RIGHTS AND RESPONSIBILITIES** to have my eligibility determined for Medi-Cal and to maintain that eligibility.

Applicant/Representative Signature	Telephone Number	Date
Interpreter's Signature	Telephone Number	Date

I have explained to the applicant the rights, responsibilities, and other information listed on this form.

Eligibility Worker's Signature	Telephone Number	Date

"IMPORTANT INFORMATION ABOUT RESIDENCY"

Medi-Cal applicants who have one of the items listed below **MUST** provide it as evidence of residency. Medi-Cal applicants who **DO NOT** have one of the items listed below must sign this page **AND** provide other evidence of residency. ***DO NOT SIGN THIS PAGE IF YOU HAVE ONE OF THE ITEMS LISTED BELOW.***

I UNDERSTAND that the welfare department will only consider evidence other than the items listed below if I do not have one of the following items:

- A recent California rent or mortgage receipt or utility bill in my name.
- A current and valid California Motor Vehicle Driver's License or California Identification Card issued by the California Department of Motor Vehicles.
- A current and valid California motor vehicle registration in my name.
- A document showing that I am employed in this State.
- A document showing that I have registered with a public or private employment service in this State.
- Evidence that I have enrolled myself or my children in a school in this State.
- Evidence that I am receiving public assistance other than Medi-Cal in this State.
- Evidence that I have registered to vote in this State.

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT I DO NOT POSSESS ANY OF THE ITEMS LISTED ABOVE.

Applicant Signature	Date
Person Acting for Applicant (Signature)	Date