STATE OF CALIFORNIA
STANDARD AGREEMENT AMENDMENT
STD 213A_CDPH (12/08)

EXHIBIT A

☒ Check here if additional pages are added: 1 Page(s)

Agreement Number	Amendment Number
07-65571	A01
Registration Number:	

1. This Agreement is entered into between the State Agency and Contractor named below:

State Agency's Name (Also known as CDPH or the State)
California Department of Public Health

Contractor's Name (Also referred to as Contractor)
California Department of Health Care Services

2. The term of this Agreement is: July 1, 2007 through 06/30/12

3. The maximum amount of this Agreement after this amendment is: $ 44,760,106 Forty four million, seven hundred sixty thousand, one hundred and six dollars

4. The parties mutually agree to this amendment as follows. All actions noted below are by this reference made a part of the Agreement and incorporated herein:

I. **Amendment effective date:** May 1, 2009

II. **Purpose of amendment:** This amendment increases the budget for Year 2, 3, 4, and 5 due to the increase of eligible refugees being resettled in California. The contractor will continue to provide refugee medical assistance benefits to all eligible persons who are admitted to the United States as refugees, asylees, parolees, and victims of trafficking resettling in California.

III. Certain changes made in this amendment are shown as: Text additions are displayed in **bold and underline**. Text deletions are displayed as strike through text (i.e., ~~Strike~~).

IV. Paragraph 3 (maximum amount payable) on the face of the original STD 213 is increased by **$6,517.286** and is amended to read: ~~$38,242,820 (Thirty eight million, two hundred forty two thousand, eight hundred twenty dollars)~~ **$44,760,106 (Forty four million, seven hundred sixty thousand, one hundred and six dollars).**

V. Paragraph 4 (incorporated exhibits) on the face of the original STD 213 is amended to add the following revised exhibit.

(Continued on next page)

All other terms and conditions shall remain the same.

IN WITNESS WHEREOF, this Agreement has been executed by the parties hereto.

CONTRACTOR

Contractor's Name *(If other than an individual, state whether a corporation, partnership, etc.)*
California Department of Health Care Services

By *(Authorized Signature)* ✍ | Date Signed *(Do not type)*

Printed Name and Title of Person Signing
Jayna Querin, Chief, Contract Management Unit

Address
1501 Capitol Avenue, Suite 71.5195
MS 1403, P.O. Box 997413, Sacramento, CA 95899-7413

STATE OF CALIFORNIA

Agency Name
California Department of Public Health

By *(Authorized Signature)* ✍ | Date Signed *(Do not type)*

Printed Name and Title of Person Signing
Sandra Winters, Chief, Contracts and Purchasing Services Section

Address
1501 Capitol Avenue, Suite 71.5178, MS 1802, P.O. Box 997377,
Sacramento, CA 95899-7377

CALIFORNIA
Department of General Services
Use Only

☐ Exempt per:

Exhibit A A1 – Scope of Work (4 pages)

All references to Exhibit A – Scope of Work in any exhibit incorporated into this agreement shall hereinafter be deemed to read Exhibit A A1 – Scope of Work. Exhibit A is hereby replaced in its entirety by the attached revised exhibit.

VI. Paragraph 4 (incorporated exhibits) on the face of the original STD 213 is amended to add the following revised exhibit:

Exhibit B, Attachment II, A1 – Budget (Year 2); Exhibit B, Attachment III, A1 – Budget (Year 3); Exhibit B, Attachment IV, A1 – Budget (Year 4); Exhibit B, Attachment V A1 – Budget (Year 5)

All references to Exhibit B, Attachment I, II, III, IV, and V in any exhibit incorporated into this agreement shall hereinafter be deemed to read Exhibit B, Attachment I, II A1, III A1, IV A1, and V A1.

VII. Provision 4 (Amounts Payable) of Exhibit B – Budget Detail and Payment Provisions is amended to read as follows:

4. Amounts Payable

A. The amounts payable under this agreement shall not exceed:

1) $6,921,000 for the budget period of 07/01/07 through 06/30/08
2) ~~$7,267,051~~ **9,267,051** for the budget period of 07/01/08 through 06/30/09
3) ~~$7,630,404~~ **9,135,887** for the budget period of 07/01/09 through 06/30/10
4) ~~$8,011,885~~ **9,517,643** for the budget period of 07/01/10 through 06/30/11
5) ~~$8,412,480~~ **9,918,525** for the budget period of 07/01/11 through 06/30/12

B. Reimbursement shall be made for allowable expenses up to the amount annually encumbered commensurate with the state fiscal year in which services are performed and/or goods are received.

VIII. All other terms and conditions shall remain the same.

Exhibit A A1
Scope of Work

1. Service Overview

The California Department of Health Care Services (CDHCS), agrees to provide the following services for the California Department of Public Health (CDPH).

Provide Refugee Medical Assistance (RMA) benefits (same as for a Medi-Cal eligible), to all eligible persons who are admitted to the United States as refugees, asylees, parolees, and victims of trafficking (henceforth referred to as "eligible new entrants") who are resettled in California.

2. Projects Representatives

A. The project representatives during the term of this agreement will be:

California Department of Public Health	California Department of Health Care Services
~~Laura Hardcastle~~ **Carlos Zavala** Telephone: (916) 552-8252 Fax: (916) 552-8260 Email: ~~lhardcas@dhs.ca.gov~~ **Carlos.Zavala@cdph.ca.gov**	John Zapata, Contract Officer Telephone: (916) 552-9451 Fax: (916) 552-9477 Email: ~~Jzapata@dhs.ca.gov~~ **John.Zapata@dhcs.ca.gov**

B. Direct all inquiries to:

California Department of Public Health	California Department of Health Care Services
Refugee Health Section Attention: Beatrice Avis Mail Stop 5204 ~~1501 Capitol Avenue~~,**1616 Capitol Avenue** P.O. Box ~~997413~~ **997377** Sacramento, CA 95899-~~7413~~**7377** Telephone: (916) 552-8009 Fax: (916) 552-8260 Email: ~~bavis@dhs.ca.gov~~ **Beatrice.Avis@cdph.ca.gov**	Medi-Cal Policy Division Administrative Support Unit Attention: Dalia Gouveia 1501 Capitol Avenue, MS 4600 P.O. Box 997413 Sacramento, CA 95899-7413 Telephone: (916) 552-9599 Fax: (916) 552-9477 Email: ~~DGouveia@dhs.ca.gov~~ **Dalia.Gouveia@dhcs.ca.gov**

C. Either party may make changes to the information above by giving written notice to the other party. Said changes shall not require an amendment to this agreement.

3. Services to be Performed

A. CDHCS shall reimburse providers for services provided to beneficiaries eligible for Refugee Medical Assistance (RMA) pursuant to the policies and procedures contained in the Medi-Cal Provider Manual pertaining to RMA.

B. All new refugee entrants must be determined ineligible for California Opportunity and Responsibility to Kids (CalWORKS), Healthy Families, Supplemental Security Income/State Supplementary Payment-based Medi-Cal or Medi-Cal Only before they can be placed in RMA-based Medi-Cal. County welfare departments will determine eligibility based on guidelines provided by the Medi-Cal Eligibility Branch (MEB) within CDHCS. RMA benefits shall not exceed a period of eight months.

Exhibit A A1
Scope of Work

C. The CDHCS/MEB will:

1. Have oversight of the eligibility requirements of the Refugee Medical Assistance/Entrant Medical Assistance (RMA/EMA) Program.

2. Prepare All County Welfare Directors Letters as needed instructing counties in RMA/EMA eligibility requirements and procedures.

3. Prepare state regulations as needed.

4. Prepare any correspondence regarding RMA/EMA program eligibility requirements in response to inquiries from the federal Office of Refugee Resettlement (ORR), other states, etc., providing copies of such documents to the CDPH, Refugee Health Section (RHS) and the California Department of Social Services, Refugee Programs Bureau (CDSS/RPB).

5. Update the State Refugee Plan with regard to RMA/EMA eligibility rules as needed.

6. Respond to county calls or other phone inquiries regarding RMA/EMA eligibility requirements.

7. Conduct annual RMA case monitoring per ORR requirements and submit an Annual Report on RMA Case Monitoring to ~~ORR~~ **CDPH/RHS**, providing a copy to ~~CDPH/RHS and~~ CDSS/RPB.

8. Implement enhancements to the MEDS system that may become necessary due to changes in RMA eligibility requirements.

9. Notify and collaborate with CDPH/RHS to resolve eligible issues identified during RMA case reviews.

10. Provide training on RMA/EMA program eligibility requirements.

11. Participant in any pertinent meetings related to the Refugee Health Program.

D. The CDHCS will also:

1. Process and pay RMA-based claims through the Electronic Data Systems (EDS) check write process and Delta Dental process.

2. Pay EDS and Delta Dental administrative fees for claims processing for the RMA-based claims.

3. Provide technical assistance for problems relating to the RMA-based claims.

4. Process and pay RMA-based claims from Department of Mental Health and Department of Developmental Services.

5. Provide CDPH annual cost projections for all RMA claims and administrative charges for all entities listed under Section E.1, E.2 and E.3 below. This will be reported via the ORR-1 form by CDPH/RHS to CDSS/RPB.

6. Immediately notify CDPH/RHS of any anticipated increases in annual cost projections that will exceed what is reported in the ORR-1 process for any given federal fiscal year.

Exhibit A A1
Scope of Work

7. Provide to the CDPH/RHS RMA-related CORE reports and other financial data reports as required for preparation of quarterly and annual Financial Status Reports (STD 269) to be submitted to ORR by CDPH.

8. Provide CDPH and/or CDSS/RPB with quarterly RMA enrollee data for inclusion in the Quarterly Performance Report (ORR-6) prepared by CDSS/RPB for submission to ORR.

E. Funding Agency Responsibilities

The CDPH will:

1. Reimburse CDHCS for costs associated with the provision of health services to refugees and entrants that are eligible under RMA. These costs shall include costs for all RMA claims; and RMA-related claims from the Department of Mental Health and Department of Developmental Services.

2. Reimburse CDHCS Fiscal Intermediary costs for claims processing (Delta Dental and Electronic Data Systems).

3. Reimburse CDHCS/MEB for administrative costs associated with the oversight and maintenance of the eligibility requirements of the RMA/EMA Program.

The CDPH/RHS will also:

4. Process all claims received from CDHCS and submit to CDPH accounting for payment.

5. Coordinate with the CDHCS and CDPH accounting sections in the preparation of quarterly and annual Financial Status Reports (STD 269) ensuring accuracy of expenditures prior to timely submissions to ORR.

6. Inform CDHCS/MEB and Fiscal Forecasting about any significant unanticipated increases in caseload in a given federal fiscal year.

7. Inform the CDHCS/MEB about any pertinent meetings, information, publications, issues, legislation, and correspondence relating to the RMA/EMA program and/or refugees in California.

4. Information Sharing and Liaison

A. Each department shall appoint a liaison to act in a monitoring capacity throughout the term of this Agreement.

B. CDHCS/MEB and CDPH/RHS will share information and work together to assist each other in meeting the goals of the Refugee Resettlement Program and the Refugee Medical Assistance/Entrant Medical Assistance Program.

5. Allowable Informal Scope of Work Changes

Exhibit A A1
Scope of Work

A. The CDHCS or the CDPH may propose informal changes or revisions to the activities, tasks, deliverables and/or performance time frames specified in the Scope of Work (SOW), provided such changes do not alter the overall goals and basic purpose of the agreement.

B. Informal SOW changes may include the substitution of specified activities or tasks; the alteration or substitution of deliverables and modifications to anticipated completion/target dates.

C. Informal SOW changes processed hereunder, shall not require a formal amendment, provided the annual budget does not increase or decrease as a result of the informal SOW change.

D. Unless otherwise stipulated in this agreement, all informal SOW changes and revisions are subject to prior written approval by the CDPH.

E. In implementing this provision, the CDPH may provide a format for the CDHCS' use to request informal SOW changes. If no format is provided by the CDPH, the CDHCS may devise its own format for this purpose.

Exhibit B Attachment I
Budget
(Year 1)
(07/01/07 through 06/30/08)

Personnel		$ 83,911
Fringe Benefits (34.726% of Personnel)		$ 29,139
Operating Expenses		$ 16,295
Equipment		$ -0-
Travel		$ 11,655
Subcontracts		
Department of Mental Health	$ 118,000	
Department of Developmental Services	$ 966,000	
Total Subcontracts		$ 1,084,000
Other Costs (Estimated annual cost of claims paid to medical providers, including fees and administrative cost to process and pay all Refugee Medical Assistance-based claims.		$ 5,696,000
Indirect Costs (X% of Costs basis)		$ -0-
Total		$ 6,921,000

Exhibit B Attachment II A1
Budget
(Year 2)
(07/01/08 through 06/30/09)

Line Item	Original Budget	This Amendment	Amended Total
Personnel	$88,107	-0-	$ 88,107
Fringe Benefits (34.726% of Personnel)	$30,596	-0-	$ 30,596
Operating Expenses	$17,910	-0-	$ 17,910
Equipment	-0-	-0-	$ -0-
Travel	$12,238	-0-	$ 12,238
Subcontracts			
Department of Mental Health	$ 123,900		
Department of Developmental Services	$ 1,014,300		
Total Subcontracts	$1,138,200	-0-	$ 1,138,200
Other Costs (Annual cost of claims paid to providers, including fees and administrative cost to process and pay all RMA-based claims.	$5,980,000	$2,000,000	$ 7,980,000
Indirect Costs (X% of Costs basis)	-0-	-0-	$ -0-
Total	$7,267,051	$2,000,000	$ 9,267,051

Exhibit B Attachment III A1
Budget
(Year 3)
(07/01/09 through 06/30/10)

Line Item	Original Budget	This Amendment	Amended Total
Personnel	$92,512	-0-	$ 92,512
Fringe Benefits (40.653% of Personnel)	$32,126	5,483	$ 37,609
Operating Expenses	$17,966	-0-	$ 17,966
Equipment	-0-	-0-	$ -0-
Travel	$12,850	-0-	$ 12,850
Subcontracts			
Department of Mental Health	$ 130,095		
Department of Developmental Services	$ 1,065,015		
Total Subcontracts	$1,195,110	-0-	$ 1,195,110
Other Costs (Annual cost of claims paid to providers, including fees and administrative cost to process and pay all RMA-based claims.	$6,279,840	$1,500,000	$ 7,779,840
Indirect Costs (X% of Costs basis)	-0-	-0-	$ -0-
Total	$7,630,404	$1,505,483	$ 9,135,887

Exhibit B Attachment IV A1
Budget
(Year 4)
(07/01/10 through 06/30/11)

Line Item	Original Budget	This Amendment	Amended Total
Personnel	$ 97,138	-0-	$ 97,138
Fringe Benefits (40.653% of Personnel)	$ 33,732	5,758	$ 39,490
Operating Expenses	$ 18,864	-0-	$ 18,864
Equipment	-0-	-0-	$ -0-
Travel	$ 13,493	-0-	$ 13,493
Subcontracts			
Department of Mental Health	$ 136,560		
Department of Developmental Services	$ 1,118,266		
Total Subcontracts	$1,254,826	-0-	$ 1,254,826
Other Costs (Annual cost of claims paid to providers, including fees and administrative cost to process and pay all RMA-based claims.	$6,593,832	$1,500,000	$ 8,093,832
Indirect Costs (X% of Costs basis)	-0-	-0-	$ -0-
Total	$8,011,885	$1,505,758	$ 9,517,643

Exhibit B Attachment V A1
Budget
(Year 5)
(07/01/11 through 06/30/12)

Line Item	Original Budget	This Amendment	Amended Total
Personnel	$101,995	-0-	$ 101,995
Fringe Benefits (40.653% of Personnel)	$ 35,419	6,045	$ 41,464
Operating Expenses	$ 19,807	-0-	$ 19,807
Equipment	-0-	-0-	$ -0-
Travel	$ 14,168	-0-	$ 14,168
Subcontracts			
Department of Mental Health	$ 143,388		
Department of Developmental Services	$ 1,174,179		
Total Subcontracts	$1,317,567	-0-	$ 1,317,567
Other Costs (Annual cost of claims paid to providers, including fees and administrative cost to process and pay all RMA-based claims.	$6,923,524	$1,500,000	$ 8,423,524
Indirect Costs (X% of Costs basis)	-0-	-0-	$ -0-
Total	$8,412,480	$1,506,045	$ 9,918,525

CDPH Refugee Health Program

California Refugee Health Assessment

1. Identification

Alien Number or VOT HHS Tracking Number

Demographic Data

Case Number

County Medical Record Number

Last Name

First Name

☐ Male ☐ Female

Date of Birth (MM/DD/YYYY)

Age at Arrival

Email

Current Address

Street

Apartment #

City

ZIP Code

Contact Phone Numbers

Home

Cell

2. Arrival Data

Entry Status (select one) Copy of I-94 on file ☐

☐ Refugee

U.S. Arrival Date (I-94) (MM/DD/YYYY)

☐ Primary
☐ Secondary to State

Specify State

Date to CA (MM/DD/YYYY)

☐ Asylee

U.S. Arrival / Adjudication Date (MM/DD/YYYY)

☐ Inside U.S.
☐ Outside U.S.

☐ Parolee

Paroled Date (MM/DD/YYYY)

☐ Cuba
☐ Haiti

☐ Victim of trafficking

Certification Date (MM/DD/YYYY)

☐ Other

U.S. Arrival Date (MM/DD/YYYY)

☐ Special Immigrant Visa
☐ Amerasian
☐ Other

Voluntary Resettlement Agency Information

Voluntary Resettlement Agency Name

County

☐ No Voluntary Agency

City

State

ZIP Code

Medi-Cal

Has Medi-Cal? ☐ Yes **Medi-Cal Number** ☐ Pending Application Date (MM/DD/YYYY) ☐ No Reason

Interpreter

Was an interpreter used? ☐ Yes ☐ No If yes, what type ☐ In-Person ☐ Video ☐ Phone ☐ Other

3. Demographics

Country of Birth and Ethnicity

Country of Birth

Ethnicity

Languages

Primary

Secondary

Education and Occupation

Years of Education

Previous or Current Occupation

Residing Country Prior to U.S. (last 2 years)

☐ Not applicable

Country (most recent first)	Refugee Camp (if applicable)	Length of stay		
		Years	Months	Days

4. Assessment Disposition

Assessment Status

☐ Started

Date Started (MM/DD/YYYY) ___/___/___

Date of Final Visit (MM/DD/YYYY) ___/___/___

☐ Fully completed

☐ Partially completed

Reason:

- ☐ Used other provider
- ☐ Moved to _____
- ☐ Unable to locate
- ☐ Declined
- ☐ Medi-Cal eligibility issue _____
- ☐ Deceased
- ☐ Did not keep appointment
- ☐ Other _____

☐ Not started

Reason:

- ☐ Used other provider
- ☐ Moved to _____
- ☐ Unable to locate
- ☐ Declined
- ☐ Medi-Cal eligibility issue _____
- ☐ Deceased
- ☐ Did not keep appointment
- ☐ Other _____

5. Overseas Medical Exam (DS-2053 or DS-2054)

Form DS-2053 or DS-2054

DS-2053 or DS-2054 Reviewed? ☐ Yes ☐ Not available ☐ Not applicable

Classifications

☐ No apparent defect, disease, or disability

Class A Conditions (Check all that apply)

- ☐ TB, active, infectious
- ☐ Syphilis, untreated
- ☐ Chancroid, untreated
- ☐ Gonorrhea, untreated
- ☐ Granuloma inguinale, untreated
- ☐ Lymphogranuloma venereum, untreated
- ☐ Hansen's disease, lepromatous or multibacilliary
- ☐ Addiction or abuse of specific substance without harmful behavior
- ☐ Any physical or mental disorder with harmful behavior or history of such behavior likely to recur

Class B Conditions (Check all that apply)

- ☐ TB, active, noninfectious
- ☐ TB, inactive
- ☐ Syphilis (with residual deficit), treated within the last year
- ☐ Other sexually transmitted infections, treated within last year
- ☐ Current pregnancy
- ☐ Hansen's disease, prior treatment
- ☐ Hansen's disease, tuberculoid, borderline, or paucibacillary
- ☐ Sustained, full remission of addiction or abuse of specific substances
- ☐ Any physical or mental disorder with harmful behavior or history of such behavior likely to recur
- ☐ Other _____

6. Immunizations

	Overseas Immunization Status					Updated in RHAP Clinic				Referred Out	
	Completed	Not started	Series started	No records provided	Not applicable	Yes	No	Declined	Not applicable	Yes*	Not applicable
Diphtheria, Tetanus, and Pertussis (DPT/DTaP/DT/Tdap)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Tetanus (Td)	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
Haemophilus influenzae type b (Hib)	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
Polio (IPV/OPV)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hepatitis B (HBV)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hepatitis A	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Measles, Mumps, Rubella (MMR)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Varicella	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Rotavirus	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Meningococcal	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
Influenza	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
Pneumococcal	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other _____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

*If referred out, where? _____

7. Tuberculosis

Overseas Chest X-Ray Findings

____/____/____ X-Ray Date (MM/DD/YYYY)

☐ Normal ☐ Abnormal ☐ Not Available ☐ Not Applicable

U.S. TST

☐ TST Placed

____/____/____ Date Placed (MM/DD/YYYY)

____/____/____ Date Read (MM/DD/YYYY)

Results: ☐ + ☐ - _____ mm Induration

☐ Did not return for reading

☐ No TST

Reason:

☐ Moved to _____ ☐ Declined

☐ Lost to follow-up ☐ Deceased

☐ Did not keep appointment ☐ Other _____

☐ IGRA performed

Tuberculosis (continued)

U.S. IGRA

☐ IGRA

___/___/_____
Date Drawn (MM/DD/YYYY)

☐ Results: ☐ + ☐ - ☐ Indeterminate
QFT _____IU

☐ Results: ☐ + ☐ - ☐ Borderline
TSpot _____Spots

☐ No IGRA

Reason:
☐ Moved to _____
☐ Lost to follow-up
☐ Did not keep appointment
☐ Declined
☐ Deceased
☐ TST Performed
☐ Insufficient blood draw
☐ Other _____

U.S. Chest X-Ray

☐ U.S. Chest X-Ray Performed

___/___/_____
Date (MM/DD/YYYY)

Result:
☐ Normal
☐ Abnormal (consistent with TB)
☐ Abnormal (NOT consistent with TB)
☐ Unavailable, reason _____

☐ No U.S. Chest X-Ray Performed

Reason:
☐ Moved to _____
☐ Lost to follow-up
☐ Did not keep appointment
☐ Declined
☐ Deceased
☐ Pregnancy
☐ Other _____

Disposition

☐ Completed

Result:
☐ TB Class 0 (No TB exposure, not infected)
☐ TB Class I (TB exposure, no infection)
☐ TB Class II (TB infection, no disease)
☐ TB Class III (TB, clinically active)
☐ TB Class IV (TB, not clinically active)
☐ TB Class V (TB suspected, pending final diagnosis)

Reason for retaining TB V classification:
☐ Moved to _____
☐ Lost to follow-up
☐ Work-up in progress
☐ Deceased
☐ Other _____

☐ Not Completed

Reason:
☐ Moved to _____
☐ Lost to follow-up
☐ Did not keep appointment
☐ Declined
☐ Deceased
☐ Other _____

LTBI Treatment

☐ LTBI Treatment

___/___/_____
Started Date (MM/DD/YYYY)

___/___/_____
Stopped Date (MM/DD/YYYY)

Reason LTBI treatment stopped:
☐ Treatment completed
☐ Moved to _____
☐ Lost to follow-up
☐ Did not keep appointment
☐ Declined
☐ Deceased
☐ Active TB developed
☐ Changed to outside provider
☐ Adverse effect of medicine
☐ Other _____

☐ No LTBI Treatment

Reason:
☐ Moved to _____
☐ Lost to follow-up
☐ Did not keep appointment
☐ Declined
☐ Deceased
☐ Pregnancy
☐ Changed to outside provider
☐ Patient's age
☐ Medical contraindication
☐ Prior adequate treatment
☐ Other _____

Comments

8. Laboratory Tests (Refer to RHAP protocol for specific guidelines)

CBC with Differential	Hemoglobin	☐ Normal	☐ Abnormal	Value _____	
	Hematocrit	☐ Normal	☐ Abnormal	Value _____	
	Absolute Eosinophil Count	☐ Normal	☐ Abnormal	Value _____	
Lipid Panel	Total Cholesterol	☐ Elevated	☐ Not elevated	☐ Not applicable	Value _____
	HDL	☐ Elevated	☐ Not elevated	☐ Not applicable	Value _____
	LDL	☐ Elevated	☐ Not elevated	☐ Not applicable	Value _____
	Triglycerides	☐ Elevated	☐ Not elevated	☐ Not applicable	Value _____
Hepatitis B - HBsAg		☐ Reactive	☐ Non-reactive	☐ Not applicable	
Hepatitis C - Anti HCV		☐ Reactive	☐ Non-reactive	☐ Not applicable	
Serum Glucose (random)		☐ Elevated	☐ Not elevated	☐ Not applicable	Value _____
Serum Lead		☐ Elevated	☐ Not elevated	☐ Not applicable	Value _____
Malaria		☐ Positive	☐ Negative	☐ Not applicable	
HIV		☐ Positive ☐ Type I ☐ Type II	☐ Negative	☐ Declined	
Syphilis VDRL or RPR		☐ Reactive*	☐ Nonreactive	☐ Not applicable	
*If Reactive, which test ☐ FTA-ABS ☐ TPPA ☐ TP-MHA		☐ Positive	☐ Negative	☐ Not applicable	
Chlamydia		☐ Positive	☐ Negative	☐ Not applicable	
Gonorrhea		☐ Positive	☐ Negative	☐ Not applicable	
Pregnancy Test ☐ Urine ☐ Serum		☐ Positive	☐ Negative	☐ Not applicable	

____ / ____ / ____
EDC Date
(MM/DD/YYYY)

Parasitic Infection	Value	Treated
Stool Sample 1	☐ Positive ☐ Negative Parasite 1 _____ Parasite 5 _____ Parasite 2 _____ Parasite 6 _____ Parasite 3 _____ Parasite 7 _____ Parasite 4 _____ Parasite 8 _____	☐ Yes ☐ No - Reason: _____
Stool Sample 2	☐ Positive ☐ Negative Parasite 1 _____ Parasite 5 _____ Parasite 2 _____ Parasite 6 _____ Parasite 3 _____ Parasite 7 _____ Parasite 4 _____ Parasite 8 _____	☐ Yes ☐ No - Reason: _____
Serum Strongyloides	☐ Positive ☐ Negative ☐ Not applicable	☐ Yes ☐ No - Reason: _____
Serum Schistosomiasis	☐ Positive ☐ Negative ☐ Not applicable	☐ Yes ☐ No - Reason: _____

9. Patient Medical History

Medical Condition	No History	Check All that Apply TIf applicable, what type(s)	Taking Medications for Condition
Allergies	☐	☐ Current ☐ Past	☐ Yes, specify ☐ No
Anemia	☐	☐ Current ☐ Past	☐ Yes, specify ☐ No
Cancer	☐	☐ Current ☐ Past	☐ Yes, specify ☐ No
Cardiovascular Dz	☐	☐ Current ☐ Past	☐ Yes, specify ☐ No
Diabetes Mellitus	☐	☐ Current ☐ Past	☐ Yes, specify ☐ No
Epilepsy	☐	☐ Current ☐ Past	☐ Yes, specify ☐ No
Hepatitis	☐	☐ Current ☐ Past	☐ Yes, specify ☐ No
High Cholesterol	☐	☐ Current ☐ Past	☐ Yes, specify ☐ No
Hypertension	☐	☐ Current ☐ Past	☐ Yes, specify ☐ No
Kidney Dz	☐	☐ Current ☐ Past	☐ Yes, specify ☐ No
Liver Dz	☐	☐ Current ☐ Past	☐ Yes, specify ☐ No
Lung Dz	☐	☐ Current ☐ Past	☐ Yes, specify ☐ No
Mental/Emotional	☐	☐ Current ☐ Past	☐ Yes, specify ☐ No
Stroke	☐	☐ Current ☐ Past	☐ Yes, specify ☐ No
Surgery(ies)	☐	☐ Current ☐ Past	☐ Yes, specify ☐ No
Tuberculosis	☐	☐ Current ☐ Past	☐ Yes, specify ☐ No
Thyroid Dz	☐	☐ Current ☐ Past	☐ Yes, specify ☐ No
Other (specify)	☐	☐ Current ☐ Past	☐ Yes, specify ☐ No
Other (specify)	☐	☐ Current ☐ Past	☐ Yes, specify ☐ No

Supplements (Vitamins, Herbs, Etc.)

Are you taking supplements? ☐ Yes ☐ No

_____
If yes, supplements taken

Menstrual History

Not applicable (pre-puberty) ☐

☐ Menstruating _____ / _____ / _____
Date of LMP (MM/DD/YYYY)

☐ Menopausal _____
Age stopped menstruating

Pregnancy History

Not applicable (pre-puberty) ☐

Gravida	Para	SAB	TAB

Female Genital Cutting

Declined ☐

Female genital cutting ☐ Yes ☐ No

☐ Clitoridectomy ☐ Infibulation
☐ Excision ☐ Other _____

10. Family Medical History

Medical Condition	If applicable, what type(s)
Cancer ☐ No history ☐ Mother ☐ Father ☐ Maternal grandmother ☐ Maternal grandfather ☐ Paternal grandmother ☐ Paternal grandfather ☐ Sibling(s)	Kidney Dz ☐ No history ☐ Mother ☐ Father ☐ Maternal grandmother ☐ Maternal grandfather ☐ Paternal grandmother ☐ Paternal grandfather ☐ Sibling(s)
Cardiovascular Dz ☐ No history ☐ Mother ☐ Father ☐ Maternal grandmother ☐ Maternal grandfather ☐ Paternal grandmother ☐ Paternal grandfather ☐ Sibling(s)	Lung Dz ☐ No history ☐ Mother ☐ Father ☐ Maternal grandmother ☐ Maternal grandfather ☐ Paternal grandmother ☐ Paternal grandfather ☐ Sibling(s)
Diabetes Mellitus ☐ No history ☐ Mother ☐ Father ☐ Maternal grandmother ☐ Maternal grandfather ☐ Paternal grandmother ☐ Paternal grandfather ☐ Sibling(s)	Mental/Emotional ☐ No history ☐ Mother ☐ Father ☐ Maternal grandmother ☐ Maternal grandfather ☐ Paternal grandmother ☐ Paternal grandfather ☐ Sibling(s)
Hepatitis ☐ No history ☐ Mother ☐ Father ☐ Maternal grandmother ☐ Maternal grandfather ☐ Paternal grandmother ☐ Paternal grandfather ☐ Sibling(s)	Stroke ☐ No history ☐ Mother ☐ Father ☐ Maternal grandmother ☐ Maternal grandfather ☐ Paternal grandmother ☐ Paternal grandfather ☐ Sibling(s)
High Cholesterol ☐ No history ☐ Mother ☐ Father ☐ Maternal grandmother ☐ Maternal grandfather ☐ Paternal grandmother ☐ Paternal grandfather ☐ Sibling(s)	Thyroid Dz ☐ No history ☐ Mother ☐ Father ☐ Maternal grandmother ☐ Maternal grandfather ☐ Paternal grandmother ☐ Paternal grandfather ☐ Sibling(s)
Hypertension ☐ No history ☐ Mother ☐ Father ☐ Maternal grandmother ☐ Maternal grandfather ☐ Paternal grandmother ☐ Paternal grandfather ☐ Sibling(s)	Tuberculosis ☐ No history ☐ Mother ☐ Father ☐ Maternal grandmother ☐ Maternal grandfather ☐ Paternal grandmother ☐ Paternal grandfather ☐ Sibling(s)

11. Lifestyle Assessment (13 years of age and older)

Health Behaviors Declined to answer ☐ Not applicable ☐

Exercise

During the last 30 days, did you exercise?

☐ Yes – Days per week _____ Minutes per day _____
☐ No

Smoking

1. Have you ever smoked?
   ☐ Yes, age started _____
   ☐ No (skip to question 4)

2. Do you now smoke?
   ☐ Everyday
   ☐ Some days
   ☐ No, age stopped _____

3. On average, how many do/did you smoke a day?
   # of Cigarettes _____
   # of Pipes _____
   # of Cigars _____
   # of Other Tobacco _____

4. Is smoking ever allowed inside your home?
   ☐ Yes, # of hours per day _____
   ☐ No

Alcohol

1. During the past 30 days, have you had at least one alcoholic drink?
   ☐ Yes
   ☐ No (skip questions 2 and 3)

2. During the past 30 days, how many days per month did you have at least one alcoholic drink?
   # of Days/Month _____

3. During the past 30 days, on the days when you drank, about how many drinks did you drink on the average?
   # of Wine Drinks _____ (3-5 oz)
   # of Beer Drinks _____ (10-12 oz or 1 bottle)
   # of Hard Liquor Drinks _____ (1-1.5 oz)

Health Education

Was health education provided on health behaviors (exercise, diet/nutrition, smoking, and alcohol)?

☐ Yes – ☐ Written ☐ Verbal
☐ No

12. Mental Health (16 years of age and older)

PTSD Screening Declined to answer ☐ Not applicable ☐

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

	Yes	No
1. Have had nightmares about it or thought about it when you did not want to?	☐	☐
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	☐	☐
3. Were constantly on guard, watchful, or easily startled?	☐	☐
4. Felt numb or detached from others, activities, or your surroundings?	☐	☐

Generalized Anxiety Disorder Screening Declined to answer ☐ Not applicable ☐

Over the past 2 weeks, how often have you been bothered by the following problems?

	Not at all (0)	Several days (1)	More than half of the days (2)	Nearly every day (3)
1. Feeling nervous, anxious or on edge.	☐	☐	☐	☐
2. Not being able to stop or control worrying.	☐	☐	☐	☐

Depression Declined to answer ☐ Not applicable ☐

Over the past 2 weeks, how often have you been bothered by the following problems?

	Not at all (0)	Several days (1)	More than half of the days (2)	Nearly every day (3)
1. Little interest or pleasure doing things.	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless.	☐	☐	☐	☐

13. Traumatic Events (16 years of age and older)

Trauma Declined to answer ☐ Not applicable ☐

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event tell me if: a) it *happened to you* personally, b) you *witnessed it* happen to someone else, c) you *learned about it* happening to someone close to you, d) it *doesn't apply* to you. Be sure to consider your entire life (growing up as well as adulthood) as I go through the list of events.

	Happened to me	Witnessed it	Learned about it	Doesn't apply
1. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)	☐	☐	☐	☐
2. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb, land mine)	☐	☐	☐	☐
3. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)	☐	☐	☐	☐
4. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war, forced labor)	☐	☐	☐	☐
5. Sudden, violent death of a family member (for example, homicide, suicide)	☐	☐	☐	☐
6. Serious injury, harm, or death you caused to someone else	☐	☐	☐	☐
7. Any other very stressful event or experience which caused you to experience intense fear	☐	☐	☐	☐
8. Sudden move or loss of home and possessions	☐	☐	☐	☐

Persecution Declined to answer ☐ Not applicable ☐

Have you experienced any type of persecution? ☐ Yes ☐ No

If yes, check all that apply: ☐ Religious ☐ Political ☐ Ethnic ☐ Reproductive choices ☐ Military service escapee ☐ Other _____

14. Vital Signs / Measurements

Vital Signs

Temperature _____ ☐ °F ☐ °C Pulse _____

B/P (6 years +) **1.** _____ / _____ (systolic / diastolic) **2.** _____ / _____ (systolic / diastolic) **3.** _____ / _____ (systolic / diastolic)

Measurements

Height _____ ☐ inches ☐ cm Weight _____ ☐ lbs ☐ kg Head circumference _____ ☐ inches ☐ cm (2 years and under)

Vision (6 years +) Glasses/contact lenses worn ☐ Yes ☐ No

_____ Left _____ Right _____ Both

Difficulty hearing (6 years +) ☐ Yes ☐ No

15. Physical Exam

Physical Exam Not Completed

☐ Declined ☐ Other _____

Findings						Comments
Abdomen	☐ Normal	☐ Abnormal	☐ Declined	☐ Deferred	☐ Not appropriate	
Breast	☐ Normal	☐ Abnormal	☐ Declined	☐ Deferred	☐ Not appropriate	
Ears	☐ Normal	☐ Abnormal	☐ Declined	☐ Deferred	☐ Not appropriate	
Extremities	☐ Normal	☐ Abnormal	☐ Declined	☐ Deferred	☐ Not appropriate	
Eyes	☐ Normal	☐ Abnormal	☐ Declined	☐ Deferred	☐ Not appropriate	
Genital	☐ Normal	☐ Abnormal	☐ Declined	☐ Deferred	☐ Not appropriate	
Head	☐ Normal	☐ Abnormal	☐ Declined	☐ Deferred	☐ Not appropriate	
Heart	☐ Normal	☐ Abnormal	☐ Declined	☐ Deferred	☐ Not appropriate	
Lungs	☐ Normal	☐ Abnormal	☐ Declined	☐ Deferred	☐ Not appropriate	
Lymph Nodes	☐ Normal	☐ Abnormal	☐ Declined	☐ Deferred	☐ Not appropriate	
Mouth	☐ Normal	☐ Abnormal	☐ Declined	☐ Deferred	☐ Not appropriate	
Neurologic	☐ Normal	☐ Abnormal	☐ Declined	☐ Deferred	☐ Not appropriate	
Nose	☐ Normal	☐ Abnormal	☐ Declined	☐ Deferred	☐ Not appropriate	
Rectal	☐ Normal	☐ Abnormal	☐ Declined	☐ Deferred	☐ Not appropriate	
Skin	☐ Normal	☐ Abnormal	☐ Declined	☐ Deferred	☐ Not appropriate	
Throat	☐ Normal	☐ Abnormal	☐ Declined	☐ Deferred	☐ Not appropriate	
Other	☐ Normal	☐ Abnormal	☐ Declined	☐ Deferred	☐ Not appropriate	

16. Diagnosis

Findings

☐ No overseas findings, and no U.S. findings. ☐ VOLAG follow-up assistance needed.

ICD10	Diagnosis	Findings	Follow-up	Date Seen by Outside Provider (optional)
		☐ Overseas findings ☐ New, U.S. findings	☐ Problem addressed or treated at refugee clinic ☐ Problem referred to primary care ☐ Problem referred to specialty clinic ☐ Follow-up for this problem not currently available under current medical insurance (such as optometry, dental, etc.)	/ / Date (MM/DD/YYYY) ☐ Lost to follow-up ☐ Declined follow-up
		☐ Overseas findings ☐ New, U.S. findings	☐ Problem addressed or treated at refugee clinic ☐ Problem referred to primary care ☐ Problem referred to specialty clinic ☐ Follow-up for this problem not currently available under current medical insurance (such as optometry, dental, etc.)	/ / Date (MM/DD/YYYY) ☐ Lost to follow-up ☐ Declined follow-up
		☐ Overseas findings ☐ New, U.S. findings	☐ Problem addressed or treated at refugee clinic ☐ Problem referred to primary care ☐ Problem referred to specialty clinic ☐ Follow-up for this problem not currently available under current medical insurance (such as optometry, dental, etc.)	/ / Date (MM/DD/YYYY) ☐ Lost to follow-up ☐ Declined follow-up
		☐ Overseas findings ☐ New, U.S. findings	☐ Problem addressed or treated at refugee clinic ☐ Problem referred to primary care ☐ Problem referred to specialty clinic ☐ Follow-up for this problem not currently available under current medical insurance (such as optometry, dental, etc.)	/ / Date (MM/DD/YYYY) ☐ Lost to follow-up ☐ Declined follow-up
		☐ Overseas findings ☐ New, U.S. findings	☐ Problem addressed or treated at refugee clinic ☐ Problem referred to primary care ☐ Problem referred to specialty clinic ☐ Follow-up for this problem not currently available under current medical insurance (such as optometry, dental, etc.)	/ / Date (MM/DD/YYYY) ☐ Lost to follow-up ☐ Declined follow-up
		☐ Overseas findings ☐ New, U.S. findings	☐ Problem addressed or treated at refugee clinic ☐ Problem referred to primary care ☐ Problem referred to specialty clinic ☐ Follow-up for this problem not currently available under current medical insurance (such as optometry, dental, etc.)	/ / Date (MM/DD/YYYY) ☐ Lost to follow-up ☐ Declined follow-up
		☐ Overseas findings ☐ New, U.S. findings	☐ Problem addressed or treated at refugee clinic ☐ Problem referred to primary care ☐ Problem referred to specialty clinic ☐ Follow-up for this problem not currently available under current medical insurance (such as optometry, dental, etc.)	/ / Date (MM/DD/YYYY) ☐ Lost to follow-up ☐ Declined follow-up

17. Signatures

Physical Exam Performed By

Name (print) _____ Signature _____ Date (MM/DD/YYYY) ___/___/___

Physical Exam Reviewed By

☐ Same as above

Name (print) _____ Signature _____ Date (MM/DD/YYYY) ___/___/___

Intake Interviewer 1

Name (print) _____ Signature _____ Date (MM/DD/YYYY) ___/___/___

Intake Interviewer 2

Name (print) _____ Signature _____ Date (MM/DD/YYYY) ___/___/___

Other Provider

Name (print) _____ Signature _____ Date (MM/DD/YYYY) ___/___/___

Role _____

EXHIBIT C

2009/2010 California State Plan for Refugee/Entrant Assistance and Services
California Department of Social Services
Manual of Policies and Procedures (MPP) Section Reference

SUBJECT	MPP SECTION
State will use the hearings standards and procedures as set forth in 45 CFR Section 400.83(b)	69-210 – Notices and Hearings
Describe the elements of the TANF program which will be used in the RCA program. Determination of initial and on-going eligibility treatment of income and resources, budgeting methods, need standards. (45 CFR Section 400.66(a)(1)) Determination of benefit amounts/payment levels based on size of the assistance unit, income disregards. (45 CFR Section 400.66(a)(2)) Proration of shelter, utilities, and similar needs. (45 CFR Section 400.66(a)(3)) Any other State TANF rules relating to financial eligibility and payments. (45 CFR Section 400.66(a)(4))	69-206 – Refugee Resettlement Program, Income and Resources 42-200 – Property 44-100 - Income 44-200 – Assistance Unit Composition and Need 44-300 – Aid Payments
Will not consider resources remaining in the applicant's country of origin. (45 CFR Section 400.66(b))	69-206.21
Will not consider a sponsor's income and resources as accessible to the refugee solely because the person is serving as a sponsor. (45 CFR Section 400.66(c))	69-206.2
Will not consider any cash grant received by the applicant under the DOS or DOJ R and P program (45 CFR Section 400.66(d))	69-206.11
Will use date of application as the date RCA begins. (45 CFR Section 400.66(e))	69-205.211
Implementation date must be implemented by 3/21/2002	69-200 Regulations became effective 2/1/02
Describes the criteria for exemption from registration for employment services, participation in employability service programs, and acceptance of appropriate offers of employment.	69-207.3 – Refugees Exempt from Registration, Employment and Employment-Directed Education/Training Requirements
State will notify promptly local resettlement agency whenever refugee applies for RCA. (45 CFR Section 400.68(a))	69-203.2 – County Responsibilities
State will contact applicant's sponsor or local resettlement agency at time of application for RCA concerning offers of employment, etc. (45 CFR Section 400.68(b))	69-203.2 – County Responsibilities
Describes safeguards for limited English proficient persons as required by 45 CFR Section 400.55	21-115 – Provisions for Services to Applicants and Recipients who Are Non-English speaking or who Have Disabilities

CALIFORNIA STATE PLAN FOR REFUGEE/ENTRANT
ASSISTANCE AND SERVICES
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
MEDI-CAL ELIGIBILITY PROCEDURES MANUAL ARTICLE 24

ORR REQUIREMENT	MEPM SECTION
The state will base RMA/EMA on the applicant's income and resources on the date of application.	Article 24B-4, Section 2. RMA/EMA Eligibility Requirements, a.(4)
The state will use the 200 percent poverty option as an eligibility standard for RMA/EMA.	Article 24B-3, Section 2. RMA/EMA Eligibility Requirements, a.(2) and (3)
The state will allow refugees who do not meet the financial eligibility standards for RMA/EMA to spend down as is done for Medi-Cal.	Article 24B-4, Section 2. RMA/EMA Eligibility Requirements, a.(6)
The state will determine eligibility for RMA/EMA applicants as individuals and not as a family or assistance unit.	Article 24B-3, Section 2. RMA/EMA Eligibility Requirements, a.(1)
The state will not count the Reception and Placement grant, matching grant, or RCA when determining RMA/EMA eligibility on the date of application.	Article 24B-4, Section 2. RMA/EMA Eligibility Requirements, a.(5)
The state will not count any property remaining in the refugee's country of origin.	Article 24B-4, Section 2. RMA/EMA Eligibility Requirements, a.(5)
The state will not county any income earned after the date of application.	Article 24B-4, Section 2. RMA/EMA Eligibility Requirements, a.(4)
The state will not consider in-kind services and shelter provided by a sponsor or local resettlement agency when determining eligibility for RMA/EMA.	Article 24B-4, Section 2. RMA/EMA Eligibility Requirements, a.(5)
The state must comply with regulations governing applications, determination of eligibility and furnishing Medicaid (including opportunity for fair hearings).	Title 22, California Code of Regulations, Section 50257(b)(2);Article 24B-11, Section 9. Notice of Action
Notify the agency which provided for the initial resettlement of a refugee whenever the refugee applies for medical assistance.	Article 24B-5, Section 4. Resettlement Agency Identification
The state will transfer clients who lose eligibility for Medi-Cal due to employment during their first 8 months in the U.S. to RMA/EMA without an eligibility determination.	Article 24B-4, Section 2. RMA/EMA Eligibility Requirements, a.(9) and (10)
The state will not use denial or termination from RCA as criterion for eligibility for RMA/EMA.	Article 24B-4, Section 2. RMA/EMA Eligibility Requirements, a.(9)

EXHIBIT E

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
WELFARE TO WORK DIVISION

Continuity of Government/Continuity of Operations (COG/COOP) Plan
Disaster Management Procedures – Pandemic Flu Preparation

Task-Event/Activity	Responsib Team Mem	Detail or Reference
Maintain telephone trees	WTW Management Team	Each manager responsible for his/her staff
Conference Call Capability	WTW Management Team	Obtain conference call lines to be used as needed
Dial-Up Access	WTW Branch Chiefs	If Dial-Up PC access becomes necessary, Branch Chiefs would work with managers to determine wh needs access. ISD would then be requested to se accounts.
Communication Plan for Stakeholders	WTW Deputy Branch Chiefs	Inform stakeholders to refer to website for daily updates on issues. Branch Chiefs would review w content prior to posting.
Contact with Federal Governmer	WTW Deputy Branch Chiefs	Keep federal officials informed of limitations by program and geographic area.
Request Waivers	WTW Management Team	If mandated program activities can not be perform e.g. face-to-face interviews, then waivers would be requested from federal entities.
Seek Executive Order	WTW Deputy Director	If State mandates can not be carried out, e.g., fingerprint imaging, request an Executive Order to suspend mandate.
Alternative Operational Guidelin	WTW Management Team	Develop alternative program procedures for mand activities that can not be performed.

REFERENCES

Information by Government – U.S. Department of Health and Human Services
http://www.pandemicflu.org.

Pandemic Influenza Fact Sheet
http://cdc.gov/flu/avian/gen-info/pandemics.htm

California Department of Health Services
http://www.dhs.ca.gov

Governor's Office of Emergency Services
http://www.oes.ca.gov

World Health Organization
http://www.who.org

EXHIBIT F

ACRONYMNS

ACIN -- All County Information Notice

ACL -- All County Letter

AREERA -- Agricultural Research, Extension and Education Reform Act

Cal EMA – California Emergency Management Agency

CalWORKs -- California Work Opportunity and Responsibility to Kids

CAPI -- Cash Assistance Program for Immigrants

CBO – Community-Based Organization

CDA -- California Department of Aging

CDDS -- California Department of Developmental Services

CDE -- California Department of Education

CDHCS – California Department of Health Care Services

CDMH -- California Department of Mental Health

CDPH – California Department of Public Health

CDSS – California Department of Social Services

CFR -- Code of Federal Regulations

COG – Continuity of Government

COOP – Continuity of Operations Plan

CRC – County Refugee Coordinator

CRHC – County Refugee Health Coordinator

CWD -- County Welfare Department

CWDA -- County Welfare Directors Association

DCDC – Division of Communicable Disease Control

DOJ -- Department of Justice

DOS -- Department of State

ECA -- Entrant Cash Assistance

EPO – Office of Emergency Preparedness

ESL -- English-as-a-Second Language

FFP -- Federal Financial Participation

FFY -- Federal Fiscal Year

FSP – Food Stamps Program

GA/GR -- General Assistance/General Relief

HFP -- Healthy Families Program

HHSA -- Health and Human Services Agency

JVCC -- Joint Voluntary Agencies Committee of California

LEP -- Limited English Proficient

MAA – Mutual Assistance Association

MAP -- Maximum Aid Payment

MBSAC -- Minimum Basic Standard of Adequate Care

MEB -- Medical Eligibility Branch

MEDS – Medi-Cal Eligibility Data System

MPP -- Manual of Policies and Procedures

OES – Office of Emergency Services

ORR – Office of Refugee Resettlement

PIPRP – Pandemic Influenza Preparedness and Response Plan

PIWG – Pandemic Influenza Work Group

PRWORA -- Personal Responsibility and Work Opportunity Reconciliation Act

R&P -- Reception and Placement

RCA -- Refugee Cash Assistance

RHA -- Refugee Health Assessment

RHEIS – Refugee Health Electronic Information System

RHS – Refugee Health Section

RMA -- Refugee Medical Assistance

RPHDG -- Refugee Preventive Health Discretionary Grant

RPB – Refugee Programs Bureau

RRP -- Refugee Resettlement Program

RSS -- Refugee Social Services

SAC – State Advisory Council on Refugee Assistance and Services

SNAP – Supplemental Nutrition Assistance Program

SSA - Social Security Act

SSI/SSP -- Supplemental Security Income/State Supplementary Payment

TA -- Targeted Assistance

TANF -- Temporary Assistance to Needy Families

TB -- Tuberculosis

URM -- Unaccompanied Refugee Minors Program

U.S. -- United States

VOLAG – Voluntary Agency

W&I Code -- Welfare and Institutions Code

WTW – Welfare to Work