

§ 50141. Application Process -General.

The county department shall receive and act upon all applications, reapplications, requests for restoration and redeterminations without delay and in accordance with the provisions of this article.

§ 50142. Screening.

(a) County departments that have established a procedure for screening potential applicants prior to application shall:

(1) Determine the Medi-Cal program under which the person or family should be processed.

(2) Provide information regarding Medi-Cal eligibility requirements to all persons being screened.

(3) Inform each person being screened of that person's rights under the Medi-Cal program, even if it appears that the person is ineligible. Rights of Persons Requesting Medi-Cal, MC 216, shall be explained to, and signed by, the person being screened.

(A) The original shall be retained by the county department. If the person being screened does not apply for Medi-Cal, the form shall be retained for at least 90 days.

(B) A copy shall be given to the person being screened.

§ 50143. Persons Who May File an Application for Medi-Cal.

(a) Any person who wishes to receive Medi-Cal may file an application. If the applicant for any reason is unable to apply on his own behalf, or is deceased, any of the following persons may file the application for the applicant.

(1) The applicant's guardian or conservator or executor.

(2) A person who knows of the applicant's need to apply.

(3) A public agency representative.

§ 50145. Medi-Cal Application for Persons Applying for a Cash Grant.

(a) A person or family applying and approved for any public assistance program as specified in Section 50227 shall not be required to submit a separate application for Medi-Cal. Medi-Cal eligibility is established automatically.

(b) A person or family specified in (a) may also apply for retroactive Medi-Cal in accordance with Section 50148.

§ 50146. Medi-Cal Application for Persons Applying for In-Home Supportive Services.
[Repealed]

§ 50147. Application for Medi-Cal Only.

(a) A person or family applying for Medi-Cal only shall submit a completed application form to the county department.

(b) The county department shall, within 30 days of receipt of a referral from the Department pursuant to 50183.5, contact an ABD person in a long-term care facility and assist the ABD person with the completion of an application form for Medi-Cal-only.

(1) An application for Medi-Cal-only shall be completed when:

(A) The ABD person has been in long-term care for more than the month of admission and is expected to remain in the facility for at least 30 days.

(B) The ABD person has nonexempt monthly gross income in excess of \$44.90.

(2) The county department shall advise the Department immediately that an inappropriate referral has been received when the conditions in (1) do not exist.

§ 50147.1. Child Applying for Medi-Cal.

(a) A child may apply for Medi-Cal without parental contact in order to receive minor consent services.

(b) A child applying on the basis of a need for minor consent services other than mental health care shall submit to the county welfare department a completed and signed form Request for Eligibility for Limited Services indicating the need for services related to one or more of these needs.

(c) A child applying for Medi-Cal solely on the basis of a need for mental health care shall submit to the county welfare department a statement from a mental health professional: licensed marriage, family and child counselor; licensed educational psychologist; credentialed school psychologist; clinical psychologist; or a licensed psychologist which states that the child needs mental health treatment or counseling and meets both of the following conditions:

(1) Is mature enough to participate intelligently in the mental health treatment or counseling on an outpatient basis.

(2) Is one of the following:

(A) In danger of causing serious physical or mental harm to self or others without mental health treatment or counseling.

(B) The alleged victim of incest or child abuse.

(d) The county department shall process the applications of children applying under (b) and (c) in accordance with the following:

(1) If a child refuses to complete or sign the form or provide a statement of need for mental health care the child's application shall be denied.

(2) If a child is not competent to complete or sign the form, the person completing the Statement of Facts in accordance with Section 50163(a)(2) and (3) may sign the form on the child's behalf.

(3) After submission of the completed and signed form or statement of need for mental health care, the county department shall:

(A) Deny the application if a child is under 12 years of age and applying for services related to drug abuse, alcohol abuse, venereal disease or a sexually transmitted disease or for mental health care.

(B) Issue POE labels under the child's existing Medi-Cal status if the child is currently included in a public assistance case or an MFBU which has no share of cost and is not enrolled in a PHP or PCCM plan. The child's separate application shall be denied.

(C) Deny the application if the child is currently eligible for Medi-Cal and enrolled in a PHP or PCCM plan and refer the child to the PHP or PCCM plan for care.

(D) Process the application and determine eligibility if the child is one of the following:

1. Currently included in an MFBU which has a share of cost.
2. Part of a family not currently receiving Medi-Cal.
3. Excluded from an MFBU.
4. An ineligible member of an MFBU.

(E) If the child is an unmarried minor parent, he/she shall be included in the MFBU with his/her child for minor consent services only.

(e) When a child is not living with the child's parents and county department determines that no person or agency accepts legal responsibility for the child, the county department shall process the child's application and determine his or her eligibility as an adult if the child appears to be competent.

(f) The parents of a child applying in accordance with (b) or (c) shall neither be contacted regarding the child's application nor informed that the application has occurred.

§ 50148. Application for Retroactive Medi-Cal.

(a) A person or family applying for retroactive Medi-Cal shall:

(1) Submit a completed application form to the county department, if the application is for retroactive coverage only.

(2) Request retroactive coverage in one of the following ways if the request for retroactive Medi-Cal is made in conjunction with, or after, an application for public assistance or Medi-Cal:

(A) On the application form.

(B) On the Statement of Facts.

(C) By submitting a written request.

(b) An application for retroactive coverage pursuant to (a)(2) must be submitted within one year of the month for which retroactive coverage is requested.

§ 50149. Application Form.

(a) An application for Public Social Services shall be used as the application form for all Medi-Cal applications.

(b) The original of the completed form shall be placed in the case file.

(c) A copy of the completed form shall be given to the applicant at the time of application.

(d) Only one person's signature shall be required on the application or any other forms necessary to complete the eligibility determination.

(e) A new application form shall not be required for:

(1) Requests for restoration of aid.

(2) Interprogram transfers.

(3) Interprogram status changes.

(4) Request to add a family member to the Medi-Cal case.

(5) Redeterminations.

(6) Infants meeting the criteria under the Continued Eligibility Program as described in Section 50262.3.

§ 50151. Date of the Application.

(a) The date of application for a person or family applying for Medi-Cal shall be the date the completed application form is received by the county department.

(b) The date of application for a person or family applying for Medi-Cal in a county other than the county of responsibility shall be the date the completed application form is received by the county department in which the application is being made.

§ 50153. Medi-Cal Application -Process for All Programs.

(a) An application for Medi-Cal under any program other than SSI/SSP shall be an application for Medi-Cal under all such programs for which the person or family may be eligible.

(b) When taking an application, the county department shall:

(1) Determine the program under which the person or family may be eligible.

(2) Process the application under the appropriate program. Applications by persons who appear to be eligible for SSI/SSP shall be processed in accordance with (3). Applications by persons who appear to be eligible for AFDC shall be processed in accordance with (4).

(3) Refer persons who may be eligible for SSI/SSP, and who do not refuse to apply for that program, to the Social Security Administration for a determination of SSI/SSP eligibility.

(A) The referral shall be documented in the case file.

(B) Pending the SSI/SSP determination, the county department shall determine eligibility under any other program for which the person may be eligible.

(4) Applicants who appear to be eligible for an AFDC cash grant shall be advised of their potential eligibility and the application shall be processed under the AFDC cash grant program if the applicant so desires. The fact that the applicant was advised of potential AFDC cash grant eligibility shall be documented in the case file.

(c) A person or family may choose to have their application processed under any program for which they are eligible even if such program is not the most advantageous.

§ 50155. Withdrawal of Application -Request for Discontinuance.

(a) An applicant or beneficiary may withdraw an application for or request discontinuance from Medi-Cal by any of the following methods:

(1) Completion of a Request for Withdrawal of Application or Discontinuance of Eligibility form.

(A) The original shall be placed in the case file.

(B) A copy shall be given to the applicant.

(2) Submission of a signed request for withdrawal or discontinuance. The request for withdrawal or discontinuance shall be placed in the case file.

(3) Failing to respond to a Notice of Action which requests that the beneficiary contact the county to indicate a desire to continue eligibility.

§ 50157. Face-to-Face Interview.

(a) A face-to-face interview with the applicant, or the person completing the Statement of Facts, is required only at the time of application, reapplication, restoration or as specified in (d). The interview shall be completed within 30 days of the date of application, reapplication or restoration.

(b) A face-to-face interview shall not be required at time of application, reapplication or restoration for persons who have a government representative, such as a public guardian, acting on their behalf.

(c) A face-to-face interview at restoration shall not be required, for beneficiaries who have been notified that eligibility will be discontinued, if the request for restoration is received before the effective date of discontinuance.

(d) A face-to-face interview shall be required at redetermination of eligibility for persons or families indicated in this paragraph. The interview shall be completed within the month in which redetermination is required. A face-to-face interview shall be completed once a year at time of redetermination for all MFBUs which contain at least one AFDC-MN or MI member, except for MFBUs consisting of any of the following:

(1) Persons who receive Medi-Cal through the Aid for Adoption of Children program.

(2) Persons who have a government representative, such as a public guardian, acting on their behalf.

(3) MI children who are not living with a parent or relative and for whom a public agency is assuming financial responsibility in whole or in part.

(e) The face-to-face interview shall be conducted by a representative of the county department unless, for good reason, a direct interview between the county department and the applicant or the person completing the Statement of Facts is not possible. In such a situation, the interview may be conducted by another public agency acting on behalf of the county department.

(f) The representative of the agency conducting the interview shall verbally advise the applicant, or the person completing the Statement of Facts, in detail of the:

(1) Eligibility requirements.

(2) Medi-Cal benefits available under the Medi-Cal program.

(3) Confidential nature of information received, including the fact that the parents will not be contacted, without the applicant's consent if the applicant is a child, requesting Medi-Cal for minor consent services in accordance with Section 50147.1.

(4) Exchange of income and eligibility information through IEVS, including the fact that tax information will be obtained and that IEVS information will be used to verify income and eligibility.

(5) Purposes, provisions and availability of social services, the Family Planning Program, Child Health Disability Prevention (CHDP) Program, Special Supplemental Food Program for Women, Infants and Children (WIC) and other public or private resources.

(A) If the applicant is a pregnant, breastfeeding or postpartum woman as defined in Title 42, United States Code, Section 1786(b), or a parent/guardian of a child under the age of five, the applicant shall be provided with a WIC brochure to inform them of the availability of benefits provided under WIC.

(B) An oral explanation of the Special Supplemental Food Program for WIC benefits shall be given to those individuals who are unable to read.

(C) Referrals shall be made to the WIC program for all such individuals as specified in (A).

(D) The representative of the agency conducting the interview shall document by a notation on the Statement of Facts that the requirements of the CHDP program, as specified in subsections (f)(5) and (k) and Section 50184(b), and of the Special Supplemental Food Program for Women, Infants and Children (WIC) program as specified in (f)(5) and Section 50184(c), have been met.

(6) Possibility of being included in a quality control sample.

(7) Availability of Medi-Cal prepaid health plans and PCCM plans in the area.

(8) Right to request a fair hearing.

(9) Responsibility to report to the county department and to any provider of health care services any existing contractual or other legal entitlement to other health care coverage; and, to fully utilize other health care coverage before using Medi-Cal benefits. The information to be reported shall include the name of the other health care coverage, policy and group numbers, and termination date, if available. Willful failure to comply with these requirements is a misdemeanor.

(10) Responsibility to report to the county department the availability of any option to obtain other health care coverage through, but not limited to, the beneficiary's employer, labor union, trust fund, spouse or parent and to provide information requested by the Department which is necessary to determine if it would be cost effective for the Department to pay the premium to obtain or continue other health care coverage.

(11) Responsibility to apply for, and/or retain any available other health care coverage when there is no premium cost to the beneficiary. Compliance with this requirement shall be a condition of coverage for Medi-Cal covered benefits to the party responsible for the acquisition or continuance of such health care coverage, and shall not interfere with Medi-Cal benefits provided to the remaining family unit.

(12) Assignment of Rights Requirements as follows:

(A) Assignment to the state by an applicant, beneficiary, caretaker relative, or individual applying on behalf of an applicant, of all rights to medical support and to payments for medical care from a third party is a condition of eligibility.

(B) Receipts of Medi-Cal benefits shall constitute an assignment by operation of law except as provided below. This means that receipt of Medi-Cal benefits shall constitute automatic assignment of these rights that the individual may assign on his/her behalf, or on behalf of any other family member for whom he/she has the legal authority to assign such rights, as required in Section 50185.

(C) The county shall advise the individual that he/she has the right to refuse to assign these rights on behalf of himself/herself or the child on whose behalf application is made.

(D) An applicant, beneficiary, parent, or caretaker relative who does not wish to assign his/her rights or the rights of a person for whom he/she can legally assign rights to medical support and payments shall be given the opportunity to withdraw his/her Medi-Cal application, as specified in Section 50155.

(E) Refusal of the individual to assign these rights shall result in his/her denial or discontinuance of Medi-Cal eligibility.

(13) Responsibility of the applicant, beneficiary, parent, caretaker relative, or individual applying on behalf of the applicant, to cooperate in:

(A) Identifying and locating the absent parent.

(B) Establishing paternity for a child born out of wedlock for whom Medi-Cal is requested.

(C) Obtaining medical support and payments.

(D) Identifying and providing information concerning any third party who is or may be liable for medical care and services.

Failure of the applicant, beneficiary, parent, caretaker relative, or individual acting on behalf of an applicant to comply with the above shall result in denial or discontinuance of his/her eligibility unless good cause exists for not cooperating, as specified in Section 50771.5. If the applicant/beneficiary is a pregnant woman, cooperation with Sections (A), (B), and (C) above is waived until the end of the 60-day postpartum period.

(14) Applicant's or beneficiary's responsibilities as specified in Sections 50185 and 50187 which include but are not limited to:

(A) Responsibility to report to the county department when Medi-Cal may be billed for health care services received by the beneficiary as a result of an accident or injury caused by some other person's action or failure to act.

(B) Responsibility to report any changes in circumstances which may affect eligibility or share of cost within 10 calendar days following the date the change occurred.

(C) Responsibility to furnish Social Security account numbers for all persons for whom Medi-Cal is requested.

(D) Responsibility to apply for Medicare, if eligible, and furnish the Health Insurance Claim Number.

(g) During the interview, the representative of the agency conducting the interview shall complete and explain the contents of the following forms if the forms were not completed during screening:

(1) Important Information for Persons Requesting Medi-Cal (MC 210 Coversheet (9/91))

(2) Statement of Facts (Medi-Cal (MC 210 (3/92))

(3) Child Support Questionnaire (CA 2.1 Q Support Questionnaire (3/93)) and the Child/Spousal and Medical Support Notice and Agreement (CA 2.1 Notice of Agreement (12/89));

(4) Child Support Enforcement Program Notice (CS 196 (12/92)); and

(h) The applicant shall sign and date the forms referenced in subsection (g).

(i) The original of the Important Information for Persons Requesting Medi-Cal (MC 210 Coversheet (9/91)), and a copy of the Child Support Questionnaire (CA 2.1 Q Support Questionnaire (3/93)), and the Child/Spousal and Medical Support Notice and Agreement (CA 2.1 Notice of Agreement (12/89)) shall be placed in the case file.

(j) A copy of each relevant form referenced in i shall be given to the persons being interviewed and the originals of the Child Support Questionnaire (CA 2.1 Q (3/93)) and the Child/Spousal and Medical Support Notice and Agreement (CA 2.1 Notice of Agreement (12/89)) shall be forwarded, within two working days, to the district attorney.

(k) An informational pamphlet on the CHDP program shall be given to the applicant, if there are persons under 21 years of age in the family,

§ 50159. Statement of Facts.

(a) Following completion of the application form, a Statement of Facts shall be completed, signed and filed with the county department.

(b) The Statement of Facts shall be used by the county department in the determination of the applicant's:

(1) Eligibility.

(2) Share of cost.

(3) Other health care coverage.

§ 50161. Statement of Facts Form.

(a) A Statement of Facts is not required in determining Medi-Cal eligibility for a child receiving aid under the Aid for Adoption of Children program.

(b) A public agency, applying on behalf of a child who may be eligible as an MI child who is not living with a parent or relative and for whom a public agency is assuming financial responsibility in whole or in part, shall complete the Application and Statement of Facts for Child in Foster Care Supported by Public Funds, MC 250.

(c) An applicant applying for Medi-Cal under any other program shall complete the Statement of Facts, form MC 210.

(d) A person applying for Medi-Cal and requesting retroactive coverage shall complete the appropriate Statement of Facts for the current month and the Supplement to Statement of Facts for Retroactive Coverage/Restoration, MC 213, for the retroactive months. If only retroactive coverage is requested, a Statement of Facts, MC 210, shall be completed for one retroactive month for which Medi-Cal is requested and the MC 213 shall be completed for each additional retroactive month.

(e) An applicant or beneficiary who has a form CA 2 which has been completed within the last 12 months and which is on file with the county department need not complete the MC 210, unless the county department determines that the applicant's or beneficiary's circumstances have changed to such a degree as to require a new Statement of Facts.

(f) Any person requesting a restoration of Medi-Cal-only eligibility shall complete the Supplement to Statement of Facts for Retroactive Coverage/Restoration, form MC 213, unless the county department determines that the applicant's circumstances have changed to such a degree as to require a new MC 210, or unless a new MC 210 is required as part of redetermination of eligibility under Section 50189.

§ 50163. Persons Who May Complete and Sign the Statement of Facts .

(a) The applicant or spouse of the applicant shall complete and sign the Statement of Facts, unless:

(1) The applicant is a child. Generally, the person or agency having legal responsibility for the child shall complete and sign the Statement of Facts. The child shall complete and sign the Statement of Facts if the child is competent and either of the following applies:

(A) The child is not living with the child's parents or caretaker relatives and the county has determined that no person or agency accepts legal responsibility for the child.

(B) The child is applying on his or her own behalf in accordance with Section 50147.1 (a).

(2) The applicant has a conservator, guardian or executor. In this case, the conservator, guardian or executor shall complete and sign the Statement of Facts.

(3) The applicant is incompetent, in a comatose condition or suffering from amnesia, and there is no spouse, conservator, guardian or executor. In this case:

(A) The county department shall evaluate the applicant's circumstances and determine whether or not there is a need for protective services.

(B) The Statement of Facts may be completed and signed on the applicant's behalf by a relative, a person who has knowledge of the applicant's circumstances, or a representative of a public agency or the county department.

(C) The person completing the Statement of Facts on behalf of the applicant shall provide all available information required on the Statement of Facts regarding the applicant's circumstances.

(D) If a county department representative completes and signs the Statement of Facts, another representative of that county department shall:

1. Confirm, by personal contact, the applicant's inability to act on his own behalf.
2. Countersign and approve any recommendations for eligibility.

§ 50165. Filing the Statement of Facts.

(a) At the time the Statement of Facts is given or mailed to an applicant, the county department shall:

(1) Set a reasonable deadline for returning the Statement of Facts to the county department.

(2) Inform the applicant of the deadline.

(b) If the Statement of Facts is not returned personally or by mail by the deadline specified in (a), the county department shall:

(1) Attempt to contact the applicant or beneficiary to determine the reason for the delay.

(2) Extend the deadline for returning the Statement of Facts if a valid reason for the delay, such as incapacity, is found.

(3) Deny the application or discontinue eligibility if a valid reason for the delay cannot be established.

(c) A copy of the completed Statement of Facts shall be provided to the individual who signed it, at the request of that individual.

§ 50166. Obtaining Information for the Completion of the Statement of Facts.

(a) The county department or the representative of a public agency completing the Statement of Facts in accordance with Section 50163(a)(3) shall:

(1) Perform a diligent search to obtain available information regarding the applicant's circumstances applicable to Medi-Cal eligibility determination.

(2) Complete the Statement of Facts based upon the findings of the diligent search.

(3) Establish disability in accordance with Section 50167(a)(1).

§ 50167. Verification-Prior to Approval.

(a) With regard to information on the Statement of Facts, the county department shall obtain verification of the following items in the manner specified below, prior to approval of eligibility:

(1) Blindness, as determined in accordance with Section 50219, and federal disability, as determined in accordance with Section 50223 (a)(1) or (b), shall be verified by any of the following methods:

(A) By determining that the person was eligible as an MN person on the basis of blindness or disability in December 1973, and that there has been continuing eligibility since that time.

(B) By obtaining verification that a prior determination of blindness or disability is still valid. Verification shall be documented by viewing any of the following or similar items and noting in the case record the date of the award letter or notification and the disability onset and reexamination dates:

1. A Social Security Administration Title II award letter indicating receipt of disability benefits provided the reexamination date has not passed or a reexamination date is not indicated and the applicant is still receiving those benefits.

2. A Social Security Administration notification that Title II disability benefits have been increased or decreased provided the applicant is still receiving those benefits.

3. A Railroad Retirement Board notification of a total and permanent disability award provided the applicant is still receiving those benefits.

4. A signed statement from the Social Security Administration that states that the person is eligible for Title II benefits on the basis of a disability.

5. Documentation of a prior determination of disability under the MN program, if the determination was performed within the last 12 months unless:

a. The reexamination date has passed.

b. The applicant indicates his/her physical or mental condition has improved.

6. Data on the SDX or a signed statement from the Social Security Administration indicating that a person was discontinued from SSI/SSP for reasons other than cessation of disability provided the procedures specified in (D) are followed within twelve months of the SSI/SSP discontinuance date.

(C) By obtaining a letter from a physician verifying any of the physical or mental impairments meeting the federal definition of presumptive disability or blindness contained in Title 20, Code of Federal Regulations, Section 416.934, provided the procedures specified in (D) are followed after eligibility is determined.

(D) By following procedures established by the California Department of Social Services, Disability Evaluation Division. All necessary information shall be submitted to that division not later than 10 days after the receipt of the Statement of Facts by the county, except in the event of a delay due to circumstances beyond the control of the county.

(2) Incapacity, as defined in Section 50211, shall be verified by viewing one of the following:

(A) A current Medical Report form or written statement signed by a physician, licensed or certified psychologist or authorized member of their staff which documents that incapacity exists and gives the expected duration of the condition.

(B) A current Certificate of Disability form.

(C) Documentation of current receipt of Title II or Railroad Retirement disability benefits.

(D) Documentation of current receipt of SSI/SSP benefits based on disability or blindness.

(E) Documentation of current receipt of State Disability Insurance (SDI) or Worker's Compensation.

(F) If a current Medical Report form or a written statement cannot be obtained without delay, and no other verification of incapacity exists, a verbal statement from one of the persons specified in (A) shall be accepted as verification for up to 60 days pending receipt of written verification.

(3) Alien status shall be verified in accordance with the alienage verification and documentation procedures described in Article 7.

(4) The fact that the parents and a public or private agency will not accept legal responsibility for a child shall be verified by documented verbal or written communication with the parents and agencies, if the child is applying alone on the basis that neither the parents nor an agency will accept legal responsibility.

(5) SGA disability, as determined in accordance with Section 50223 (a) (2), shall be verified by following procedures established by the Department of Social Services, Disability Evaluation Division. All necessary information shall be submitted to the Department of Social Services by the county not later than 10 days after the receipt of the Statement of Facts by the county, except in the event of a delay due to circumstances beyond the control of the county.

(6) Identity of all persons other than those listed in (D). Identity shall be verified by viewing one of the following:

(A) California driver's license.

(B) Identification card issued by the Department of Motor Vehicles.

(C) Any other document which appears to be valid and establishes identity.

(D) Persons who are:

1. In an institution and contact is made with the facility to verify presence in the institution.
2. Receiving Medi-Cal through the Aid for Adoption of Children program.
3. Children in a family, if identity of one parent has been verified
4. Children requesting Medi-Cal for minor consent services in accordance with Section 50147.1.
5. MI children who are not living with a parent or relative and for whom a public agency is assuming financial responsibility in whole or in part.
6. Not acting on their own behalf and a government representative, such as a public guardian, is acting for them.
7. The spouse of a person whose identity has been verified.

(7) The following income and resources:

(A) Unearned income, which shall be verified by viewing any of the following:

1. Data from the IEVS which confirms information on the Statement of Facts.
2. Checks or copies of checks. County departments shall not require copies of checks issued by the United States Government.
3. Award letters.
4. Signed statements from persons or organizations providing the income.
5. Check stubs.
6. Statements from checking, savings or trust fund accounts which indicate that the income is directly deposited for the applicant or beneficiary by the persons or organizations providing the income.
7. The statement of the person completing the Statement of Facts, for income received from the United States Government. This statement shall constitute verification pending

receipt by the county department of verification from appropriate government agency, when the verification in 1 through 6 cannot be provided.

(B) Income in kind, which shall be verified by a written statement from the provider of the items of need. Verification shall be limited to those items which the applicant is claiming have a lower value than the values established in accordance with Section 50511 (b).

(C) Earned income, which shall be verified by viewing paycheck stubs. If paycheck stubs are not available, a signed statement from the employer verifying the amount and frequency of the payments shall be obtained. If an individual is self-employed, records kept by such individual for tax purposes shall be viewed.

1. Therapeutic Wages as defined in Section 50095.5 shall be verified by obtaining all of the following:

a. A statement from the individual's physician which provides that he/she has no financial interest in the LTC facility in which the individual resides and that the work has been prescribed as therapy for the individual.

b. A statement from the facility in which the individual resides verifying the individual's employment by that facility and that such employment does not displace any existing employees.

c. A statement(s) from the facility(ies) verifying that the individual has been an LTC resident for a continuous period commencing at least five years prior to September, 1984.

d. The provisions of this regulation also apply to eligibility determination or redeterminations made retroactively to October 1, 1984.

(D) Fluctuating income, which shall be verified by viewing check stubs or a copy of the checks that show the amount of income. If these are not available a signed statement from the person or organization making the payments verifying the amount and frequency of the payments shall be obtained.

(E) Child care costs, which shall be verified by viewing receipts and/or canceled checks.

(F) Cost of care for an incapacitated person while someone else is employed, which shall be verified by viewing receipts and/or canceled checks.

(G) Deductible expenses for maintenance or improvement of income-producing property, as defined in Section 50508, which shall be verified by viewing actual receipts for such services or a signed statement from the person providing the service or goods verifying the nature and cost of the service or goods.

(H) The market value of real property, other than the principal residence, which shall be verified by viewing any of the following:

1. A current incorporated tax statement from the county Tax Assessor's Office.

2. Records maintained by the County Tax Assessor.

3. A written statement from a qualified real estate appraiser which gives the appraisal value of the property, when the applicant chooses to meet the conditions of Section 50412(a)(3).

(I) Checking or savings account balances, which shall be verified by viewing either of the following:

1. A current account statement from the institutions holding the funds.
2. Signed correspondence from the institution holding the funds.

(J) The value of stocks, bonds and mutual funds, which shall be verified by both:

1. Viewing the certificate or a signed statement from the issuing institution stating a description of the investment, including the number of shares owned.
2. Taking one of the following actions:
 - a. Telephone contact with a recognized stock exchange broker to establish at the current selling price of the property.
 - b. Establishment of the current selling price of the property through listings in a current newspaper.

(K) U.S. Savings Bonds values, which shall be verified by viewing the bond and by contacting any bank or institution where such bonds may be liquidated.

(L) The value of deeds of trusts, mortgages and other promissory notes, which shall be verified by both:

1. Viewing documents which state a description of the item.
2. Taking one of the following actions:
 - a. Viewing documents from the lender which establish the principal amount remaining on the note.
 - b. Viewing an appraisal obtained from a party qualified to appraise mortgages and notes as described in Section 50441 (c)(2).
 - c. Making a telephone contact with a recognized broker who buys, sells or appraises such items.

(M) The value of nonexempt motor vehicles, boats, campers or trailers, which shall be verified by viewing the appropriate document as follows:

1. Vehicle registration.
2. Appraisal statements when obtained pursuant to Sections 50461 and 50463.

(N) The cash surrender value of nonexempt life insurance policies, which shall be verified by viewing either of the following:

1. The value tables included in the policy.
2. Signed correspondence from the carrier indicating the current value.

(O) The value of nonexempt jewelry, which shall be verified by reviewing the appraisal statements.

(P) The value of burial trusts or prepaid burial contracts, which shall be verified by viewing the actual trust or contract or by viewing signed correspondence from the trustor or contractor which details its value.

(Q) The value of nonexempt property held in trust, which shall be verified by viewing either of the following:

1. A document indicating the trust's current value, executed by the trustor or executor.
2. An appraisal of the property obtained by the applicant from an agent qualified to appraise such property.

(R) Encumbrances of record on any item of property subject to verification, which shall be verified by either of the following:

1. A payment book issued by the institution or person holding the encumbrance which indicates the current amount of the encumbrance.
2. Written correspondence stating the amount of the encumbrance obtained by the applicant from the institution or person holding the encumbrance.

(S) The value of oil leases or mineral rights which shall be verified by one of the following:

1. Written or telephone contact with a member of a recognized professional appraisal society which establishes the current market value of the lease or right.
2. Viewing records maintained by the county tax assessor where the lease or right is located.
3. Written or telephone contact with the company/organization developing the natural resource which establishes the current market value.

(T) Health care benefits available through employment, retirement or military service which shall be verified by viewing those insurance policies which specifically name the applicant, health benefit identification cards, or letters from health care benefit providers. Health care benefits available through work related injuries or settlements from prior injuries shall be verified by viewing letters from the Workmen's Compensation Board, employers, or insurance companies.

(U) Application for unconditionally available income as determined in accordance with Section 50186, which shall be verified by viewing:

1. A Veterans Benefit Referral form, referral for veterans benefits.
2. Application printouts for disability insurance benefits.
3. Application printouts for unemployment insurance benefits.
4. Application receipts for OASDI benefits.
5. Application receipts for any other unconditionally available income source.

(V) Employee retirement contributions and other employee benefit contributions which shall be verified by viewing a statement from the employer.

(8) Except for women applying for minor consent services under Section 50147.1, a woman whose eligibility or share of cost is based on pregnancy shall provide a letter of verification from either a physician or a person certified as a nurse practitioner, midwife or physician's assistant.

(9) Property as defined in Section 50425 (a)(7) is listed for sale with a licensed real estate broker at its fair market value and a bona fide attempt is being made to sell such property. This shall be verified by viewing a listing contract and appraisal from a qualified real estate appraiser.

(10) California residency shall be verified in accordance with Sections 50320.1 and 50320.2.

(b) The provisions of this section apply to all items listed in(a) at:

- (1) Initial application and reapplication.
- (2) The time a change is reported or at redetermination for items not previously verified.
- (3) Redetermination for items which the county determines could have appreciated in value since the last verification.

(c) The applicant or the county shall make a diligent search to obtain documentation necessary to verify items (a)(7)(A) through (a)(7)(V) and (a)(9) above. Such a search shall include at a minimum, one contact with the appropriate person/organization from which this documentation could be obtained. When the county determines that such documentation cannot be obtained either by the applicant or by county within the promptness requirements listed in Section 50177, the county shall:

- (1) List and retain in the case record all actions taken to obtain documentation required for verification.
- (2) Obtain from the applicant, and retain in the case record, an affidavit dated and signed by the applicant under penalty of perjury which lists a description and value of any item for which documentation for verification purposes was determined not available.

(3) Obtain a signed and dated affidavit from the applicant under penalty of perjury which lists the amounts of any earned or unearned income received and retain this document in the case record.

§ 50167.2. Verification of Income -IEVS Requirements.

(a) In administering the Medi-Cal program, the county department shall adhere to the requirements in Division 20.006, Manual of Policy and Procedures, Department of Social Services, governing:

(1) Submission of information to IEVS on applicants, beneficiaries and any other family member whose income and resources are considered in establishing eligibility and share of cost, for persons in long-term care status except as provided in (c).

(2) Use of matched IEVS information received from the Departments of Health Services and Social Services.

(3) Time requirements for completing case action based on IEVS information.

(4) Maintenance of records.

(5) Submission of reports.

(b) The county department shall review and compare the IEVS information against information contained in the case file and shall verify that IEVS information pertains to the applicant, beneficiary or other family member and is applicable to case circumstances in accordance with procedures established by the Department prior to taking case action based upon IEVS information alone.

(c) The county department shall submit information on persons in Long-Term Care status only at application and at the annual redetermination.

(d) In addition to the requirements of (a) the county department shall submit to the Department for submittal to the State Wage Information Collection Agency, the name and Social Security Number of the absent parent of any child in the MFBU to the extent such information is available in order to identify employers of the absent parent and any third party liability.

§ 50167.5. Verification of Unearned Income Information from Internal Revenue Service (IRS) or Franchise Tax Board (FTB) -IEVS Requirements.

(a) The county department shall not deny or terminate benefits to an applicant or beneficiary or increase the share of cost based on unearned income information from IRS or FTB until it has:

(1) Verified the amount of the income and the value of the property involved.

(2) Established whether the income or property was available to the individual.

(3) Determined the period or periods when the individual actually had the income or property.

(b) The county department shall verify the IRS or FTB information by either:

(1) Contacting the individual by a letter, written in a neutral, nonaccusatory manner, which advises of the:

(A) Information received from IEVS.

(B) Potential impact on eligibility or share of cost.

(C) Requirement to respond within 10 days.

(D) Consequences of failure to respond to the inquiry, as specified in Section 50175.

(2) Referring the case to the Department for investigation in accordance with procedures established by the Department.

§ 50168. Verification -Within 60 Days.

(a) With regard to information on the Statement of Facts, the county department shall obtain verification of the following items in the manner specified below, within 60 days of the date of initial application, but not necessarily prior to approval of eligibility:

(1) Social Security Numbers (SSNs) shall be submitted through the IEVS to the Social Security Administration for verification in accordance with procedures established by the Department.

(A) SSN(s) shall be confirmed by viewing Social Security cards, Social Security Administration form series OA-702. Any one of the following shall be acceptable if the Social Security card is not available:

1. An award letter, Medicare card or a check from the Social Security Administration showing the applicant's name and SSN with letters A, HA, J, T or M following the SSN.

2. Other documentation from the Social Security Administration upon approval by the Department.

(B) Application for an SSN or evidence of an SSN shall be confirmed by viewing Social Security Administration district office notification that application for an SSN or evidence of an SSN has been made.

(b) Medicare eligibility shall be verified by viewing a Health Insurance Card, form SSA-1966, an award letter showing the individual's Health Insurance Claim number (HIC), an Explanation of Medicare Benefits (EOMB) issued by the Medicare fiscal intermediary, or a bill for Premium Part A or Part B, form SSA 1545 or 1545A.

(c) If a person or family receives a Medi-Cal card prior to verification of an HIC number, SSN, application for an SSN or evidence of an SSN, and that verification is not completed within the time limit for reasons within the beneficiary's control:

(1) Eligibility no longer exists and the person shall be discontinued. In family situations only the person or persons whose number is not verified shall be discontinued.

(2) Eligibility shall not be reapproved until the required evidence is submitted.

§ 50169. Additional Verification Requirements.

(a) The county department shall not require verification of information, other than the verification specified in these regulations, unless the county department considers the verification necessary to ensure a correct eligibility determination in the specific case.

(b) The need for in-home supportive services as determined under the IHSS program pursuant to the standards and procedures established for that program, DSS Manual of Policies and Procedures, division 30, sections 30-700 through 30-775, shall be verified prior to the application of the deduction specified in section 50551.6. Such determination and verification shall be limited to the type and amount of services needed. The payment for IHSS services shall be verified by viewing cancelled checks, or receipts signed by the provider of service.

(c) The county department shall document in the case file the type of verification obtained when verification is required under (a) or (b) or under sections 50167 and 50168.

(d) The following items shall be verified at each redetermination, restoration or reapplication.

(1) Incapacity.

(2) Legal responsibility for a child applying alone.

(3) Refusal of the parent to apply for an 18 to 21 year old child.

(4) Income, except income received from the United States government which has previously been verified in accordance with the provisions of sections 50167(a)(7)(A)1. through 5. or for which verification has been obtained from the appropriate government agency.

(5) Status and value of nonexempt property.

(6) The continuing need for IHSS services.

(7) Immigration status; provided, however, that the county department shall not require or request an applicant for or a beneficiary of restricted Medi-cal benefits to disclose their citizenship or immigration status, birthplace, country of citizenship, alien registration number and/or alien admission number, date of first entry into the United States, or name upon first entry into the United States.

(e) County departments shall verify the immigration status of all alien applicants for full Medi-Cal benefits and of persons applying for restricted Medi-Cal benefits who indicate they are amnesty aliens.

(f) The following items shall be verified whenever there is a change:

(1) Blindness.

(2) Disability.

(3) Immigration status; provided, however, that the county department shall not require or request an applicant for or a beneficiary of restricted Medi-cal benefits to disclose their citizenship or immigration status, birthplace, country of citizenship, alien registration number and/or alien admission number, date of first entry into the United States, or name upon first entry into the United States.

(4) SSN; provided, however, that the county department shall not require or request an applicant for or a beneficiary of restricted Medi-cal benefits to disclose whether they have a Social Security Number or what that number is.

(5) HIC number.

(6) A change in residency shall be verified whenever one of the following conditions exists:

(A) The applicant or beneficiary is absent from the state for less than 60 days and claims to be a resident of California, and the county has evidence to the contrary pursuant to Section 50321(a).

(B) The applicant or beneficiary is absent from the state for more than 60 days and claims to meet the conditions of Section 50323 for maintaining California residency.

(g) The following procedures shall apply, for persons who were determined eligible prior to the effective date of this subsection and who have not submitted an SSN, at the time of the next redetermination, restoration or reapplication:

(1) Section 50168(a)(1) shall apply when a face-to-face interview is required.

(2) Persons for whom a face-to-face interview is not required shall submit an SSN, or evidence of application for an SSN, within 60 days.

(h) Certification for Medi-Cal shall not be delayed or discontinued pending receipt of verification from a person who is currently eligible unless the beneficiary refuses to cooperate.

§ 50171. Clarification of Statement of Facts.

(a) All information provided on the Statement of Facts other than that verified in accordance with Sections 50167, 50168 and 50169 shall be accepted as a basis for

determination of eligibility and share of cost, unless the Statement of Facts is unclear or inconsistent.

(b) If additional clarification is needed, the county department shall inform the person who signed the Statement of Facts of the information needed and the reason for the request. Such persons shall be responsible for securing the additional information.

(c) If the person who signed the Statement of Facts has difficulty in securing the necessary information, the county department shall, with the person's written consent, obtain the information. The Applicant Authorization for Release of Information form shall identify persons to be contacted and the specific information to be requested.

§ 50172. Verification by Signature.

(a) The signature on the Statement of Facts shall be accepted as verification of the facts if both of the following conditions are met, except as specified in (c):

(1) The information required for establishing eligibility under these regulations is not available.

(2) The county department determines that the information provided on the Statement of Facts is sufficient to determine eligibility. If the information on the Statement of Facts is insufficient, the county department shall accept a signed statement, from the person completing the Statement of Facts, providing the necessary supplemental information.

(b) The county department shall state on the Statement of Facts that this is the only method of verification available, if this method of verification is used.

(c) The signature on the Statement of Facts shall not be accepted as verification of a person's SSN, application for an SSN or for evidence of an SSN.

§ 50173. Eligibility Determination.

(a) The county department shall determine the person's or family's eligibility and share of cost after the applicant for Medi-Cal has applied, completed the Statement of Facts, and provided all essential information. The eligibility and share of cost determination shall be completed in the following manner:

(1) Those persons whose eligibility is being determined as Other PA recipients shall have their eligibility determined in accordance with the regulations and procedures governing the program to which they are linked and any other requirements applicable to their aid category, as specified in sections 50237 through 50247.

(2) Those persons whose eligibility is being determined as MN or MI shall have their eligibility and share of cost determined in accordance with articles 4 through 13 (commencing with section 50141).

(b) A determination based on the results of a county search for information under section 50166 shall be completed in the same manner as any other determination.

(1) Only the income and resources discovered through the search shall be considered available.

§ 50175. Denial or Discontinuance Due to Lack of Information, Noncooperation or Loss of Contact.

(a) The application shall be denied or eligibility shall be discontinued under any of the following circumstances:

(1) There is insufficient information available to make an eligibility determination, after the county department has made a reasonable effort to obtain the necessary information.

(2) The applicant or person completing the Statement of Facts fails, without good cause, to provide necessary verification or to cooperate with the county department in resolving incomplete, inconsistent or unclear information on the Statement of Facts.

(3) The beneficiary fails, without good cause, to return a status report required under Section 50191 (a) or (b).

(4) The applicant or beneficiary fails, without good cause, to participate in the face-to-face interview in accordance with Section 50157.

(5) The applicant or beneficiary fails, without good cause, to respond within 10 days to a letter from the county department identifying information received from the IEVS and requesting further information.

(6) The county department, after reasonable attempts to contact the applicant or beneficiary, determines that there is loss of contact.

(7) The applicant or beneficiary;

(A) Refuses to assign to the state all rights to medical support and payments as specified in Section 50185(a)(11).

(B) Fails to cooperate with the state, county department, and the district attorney's office, without good cause, as specified in Section 50771.5 in:

1. Providing information to establish paternity for a child under eighteen years of age born out of wedlock for whom Medi-Cal is requested;

2. Obtaining medical support and payments; and

3. Identifying and providing information to assist the state, county, or district attorney in pursuing any third party who is or may be liable to pay for medical care, services, or support.

In the case of a refusal to assign rights or to cooperate in (B) above, the parent or caretaker relative will be given the opportunity to withdraw his/her application. Refusal to withdraw the application shall result in his/her ineligibility as specified in Section 50379.

(b) A person or family whose eligibility is denied or discontinued for any of the reasons specified in (a) may:

(1) Reapply at any time, including the original month of application.

(2) Have the denial or discontinuance rescinded by providing evidence that the person or family had good cause for not meeting the conditions specified by the county department.

(c) For purposes of this section good cause includes, but is not limited to:

(1) Failure of the county to provide the beneficiary with the required status report form or with the information that failure to complete and return the form may result in discontinuance.

(2) Failure of the postal system to deliver the required status report forms in a timely manner.

(3) Physical or mental illness or incapacity of the beneficiary and the authorized representative which precludes their completion or return of the completed status report form in a timely manner, or which precludes their participation in the face-to-face interview.

(4) A level of literacy of the beneficiary and the authorized representative which, in conjunction with other social or language barriers, precludes the beneficiary and the authorized representative from completing the status report.

(5) Failure of the county to process properly the submitted Statement of Facts or status report form.

(6) Unavailability of transportation to the county department for the face-to-face interview.

(7) A determination by the county department that the applicant or beneficiary (1) failed to cooperate in obtaining medical support and payments for himself/herself and for any other individual for whom he/she is applying; in identifying and providing information to assist the state, county, and/or district attorney in pursuing any third party who is or may be liable to pay for medical care, services, and support; and in establishing paternity, but (2) met the good cause criteria specified in Section 50771.5.

§ 50176. Discontinuance Due to Death.

Eligibility, shall be discontinued at the end of the month in which a person dies.

§ 50177. Promptness Requirement.

(a) The county department shall complete the determination of eligibility and share of cost as quickly as possible but not later than any of the following:

(1) Forty-five days following the date the application, reapplication or request for restoration is filed.

(2) Ninety days following the date the application, reapplication or request for restoration is filed when eligibility depends on establishing disability or blindness.

(b) The 45- and 90-day periods may be extended for any of the following reasons:

(1) The applicant, the applicant's guardian, or other person acting on the applicant's behalf, has for good cause, been unable to return the completed Statement of Facts, Supplement to Statement of Facts for Retroactive Coverage/Restoration, or necessary verification in time for the county department to meet the promptness requirement.

(2) There has been a delay in the receipt of reports and information necessary to determine eligibility and the delay is beyond the control of either the applicant or the county department.

(c) The determination of eligibility shall be considered complete on the date the Notice of Action is mailed to the applicant .

§ 50179. Notice of Action -Medi-Cal-Only Determinations or Redeterminations.

(a) County departments shall notify beneficiaries in writing of their Medi-Cal-only eligibility or ineligibility, and of any changes made in their eligibility status or share of cost. This notification shall be called the "Notice of Action."

(b) The Notice of Action shall be on a form prescribed by the Department and shall include the name and telephone number of the eligibility worker who completed the eligibility determination, and the date the form was completed. A copy of the Notice of Action shall be placed in the case file.

(c) The Notice of Action shall include the following:

(1) The approval, denial or discontinuance of eligibility, the rescission of a denial or discontinuance, or the change in the share of cost and the effective date of the action.

(2) The amount of the share of cost, if any, and the amount of the net nonexempt income used to determine the share of cost.

(3) The reason an action is being taken and the law or regulation that requires the action, if the action is a denial, discontinuance or increase in share of cost.

(4) The right to request a State hearing if dissatisfied with:

(A) Any action or inaction by the county department that affects the applicant's or beneficiary's Medi-Cal eligibility or share of cost, except as limited in Section 50951(a).

(B) Any action taken by, or on behalf of, the Department that affects the applicant's or beneficiary's Medi-Cal benefits.

(5) The procedures for requesting a State hearing and the time limits within which a state hearing must be requested.

(6) The circumstances under which aid will be continued if a hearing is requested.

(7) A statement, when appropriate, regarding the information or action necessary to reestablish eligibility or determine a correct share of cost.

(d) The Notice of Action shall be mailed for:

(1) Adverse actions, at least 10 calendar days prior to the first of the month in which the action becomes effective, excluding the date of mailing.

(2) Discontinuances or increases in the share of cost which are not adverse actions, in sufficient time to reach the beneficiary by the effective date of the action.

(3) All other instances, no later than the date the county department takes the action.

(e) Duplicate Notices of Action shall be mailed to the administrator of the long-term care facility in which the applicant or beneficiary resides, if the applicant or beneficiary or person acting on their behalf has made such a request.

(f) Conditional notices, which advise applicants or beneficiaries that eligibility will be denied or discontinued unless specified actions are taken by the applicants or beneficiaries, shall not be considered to meet the Notice of Action requirements of (a).

§ 50179.5. Notice of Action - County Cash Assistance Determinations or Redeterminations Which Affect County Cash-Based Medi-Cal Eligibility.

(a) Persons who are granted, denied or discontinued from county cash-based programs shall be notified by the county department, in writing, of their eligibility or ineligibility for county cash-based Medi-Cal. Additionally, persons who are discontinued shall be notified of their continued Medi-Cal eligibility status in accordance with (c).

(b) The form of notification shall be one of the following:

(1) The appropriate Notice of Action prescribed by the Department of Social Services, if the notification regarding Medi-Cal eligibility does not affect the adequacy of timeliness of the cash assistance.

(2) A Medi-Cal Notice of Action, if the notification regarding Medi-Cal eligibility would affect the adequacy of timeliness of the cash assistance.

(c) A Notice of Action of discontinuance of county cash-based Medi-Cal shall include notice that one of the following actions has been taken:

(1) A referral for determination of Medi-Cal eligibility under another program is being made and notification of that determination will follow.

(2) A Medi-Cal-only determination has been made and the specific results of that determination.

(3) County cash-based Medi-Cal is being discontinued for one of the reasons stated in Section 50183 and a determination of Medi-Cal-only eligibility will require a separate application.

(4) A cash grant is being discontinued due to failure of the recipient to submit data on current status, via Monthly AFDC Eligibility and Income Report form or another approved method. An automatic reevaluation of Medi-Cal eligibility under any program will be done only if the data is provided by the effective date of the notice.

(5) Additional information is required to permit completion of a Medi-Cal-only determination. The information required may include the person's wishes concerning continued Medi-Cal eligibility. The county department may require that the person provide the information by a specific date.

§ 50179.7. Notice of Action - Medi-Cal Eligibility of SSI/SSP Recipients.

(a) The Department of Health Services shall notify persons determined to be eligible for SSI/SSP by the Social Security Administration that they are also eligible for Medi-Cal.

(b) The Department of Health Services shall notify persons whose Medi-Cal eligibility has been discontinued by the Department pursuant to Section 50183.5 that their public assistance Medi-Cal eligibility has been discontinued and that the county department will contact them to assist them with the completion of a Medi-Cal-only application.

§ 50180. Action Prior to Denial of Application.

Persons or families denied Medi-Cal eligibility under any program other than SSI/SSP shall have their circumstances evaluated by the county department prior to denial. If it appears that eligibility would exist under any program other than SSI/SSP, the application shall be processed under that program. The date of application shall be the date of the original application.

§ 50181. Action Following Denial of an SSI/SSP Application.

(a) Persons denied SSI/SSP eligibility, who then apply for Medi-Cal at the county department, shall have their application processed under the appropriate program. The date of application shall be:

(1) The date of the original application for SSI/SSP for those persons who apply at the county department within 30 days of receipt of a written notice of denial of SSI/SSP benefits.

(2) The date the person's completed application form is received by the county department for those persons who do not apply at the county department within the 30-day period specified in (1).

§ 50182. Corrective Action on Denied Applications.

(a) A denial of an application shall be rescinded in either of the following situations:

(1) A fair hearing decision orders such action.

(2) The county department determines that the denial was in error.

(b) Medi-Cal eligibility that results from corrective action taken on a denied application shall be approved based on the date of the application that was denied.

§ 50183. Transfer Between Programs.

(a) A person or family who has been receiving Medi-Cal under any program other than SSI/SSP and whose eligibility is discontinued shall be evaluated by the county department to determine if Medi-Cal eligibility exists under any other program. If it appears that eligibility would exist for:

(1) AFDC, regulations pertaining to the appropriate AFDC program shall be followed in transferring the case and establishing eligibility.

(2) SSI/SSP, the person shall be referred to the Social Security Administration. This referral shall be documented in the case file. Pending the SSI/SSP determination, the county department shall determine eligibility under any other program for which the person may be eligible.

(3) Only Medi-Cal-only, the county department shall initiate an intraprogram status change or interprogram transfer to the appropriate aid category and shall determine eligibility under that aid category. A new application form is not required.

(b) The county shall not be required to evaluate Medi-Cal eligibility under another program when a beneficiary has:

(1) Been discontinued due to any of the following:

(A) A move out of state.

(B) A move with loss of contact.

(C) Death.

(2) Established Medi-Cal eligibility simultaneously in two or more different counties or under two or more different programs or identities, and eligibility was discontinued in all but one county or under all but one program or identity.

(3) Been discontinued from the program due to noncooperation in supplying information needed to meet cash grant eligibility requirements, and those same requirements exist for all Medi-Cal-only programs for which the person may be eligible.

(c) Persons whose SSI/SSP eligibility has been discontinued may apply for Medi-Cal at the county department.

(1) A new application shall be completed, unless the family of the person discontinued from SSI/SSP is currently receiving Medi-Cal. In this case, the request for aid shall then be treated as a request to add a family member to the Medi-Cal case.

(2) The date of the application shall be the date the completed application form is received by the county department.

§ 50183.5. Action Following Medi-Cal Discontinuance by the Department.

(a) The Department shall inform the county department of any ABD person whose Medi-Cal eligibility as an SSI/SSP PA recipient has been discontinued because the conditions in (1)(A) and (B) exist.

(1) The county department shall contact the person and assist the person with the completion of an application for Medi-Cal-only pursuant to Section 50147 when the following conditions exist.

(A) The person has been in long-term care for more than the month of admission and is expected to remain in the facility for at least 30 days.

(B) The person has nonexempt monthly gross income in excess of \$44.90.

(2) The county department shall advise the Department immediately that an inappropriate referral has been received when the conditions in (1) do not exist.

§ 50184. Referral for Social Services.

(a) The county department shall refer a person or family for social services in accordance with Department procedures if it appears that there is a need for such services.

(b) A referral for social services shall also be made for the following needs related to the CHDP Program unless other arrangements have been made with the local CHDP Program:

(1) Assistance in:

(A) Arranging for screening services for persons under 21 years of age under the CHDP Program.

(B) Overcoming fears of medical treatment.

(C) Understanding the importance of preventive health.

(2) Arranging for transportation, child care or other services to enable the individual to take advantage of CHDP benefits.

(c) The county department shall notify all applicants who are pregnant, breastfeeding or postpartum women as defined in Section 50157(f)(5)(A) or parents/guardians of children under the age of five of the availability of benefits provided by the Special Supplemental Food Program for Women, Infants and Children (WIC) program by giving the applicant a WIC brochure.

(1) An oral explanation of WIC benefits shall be given to those individuals who are unable to read.

(2) Referral shall be made to the WIC program if there appears to be a need for such services for all such individuals, as specified in subsection (c) above.

(d) The Department of Health Services, no less frequently than annually, shall provide written notification concerning the WIC program to all Medi-Cal beneficiaries who might be pregnant, breastfeeding, or postpartum as defined in Section 50157(f)(5)(A), or a parent/guardian of a child under the age of five.

§ 50185. Applicants' and Beneficiaries' General Responsibilities.

(a) As a condition of eligibility, applicants and beneficiaries, and persons acting on behalf of such applicants or beneficiaries, shall:

(1) Complete and participate in the completion of all documents required in the application process or in the determination of continuing eligibility.

(2) Make available to the county department all documents needed to determine eligibility and share of cost, as specified in Sections 50167 through 50172.

(3) Report all facts that are pertinent to the determination of eligibility and share of cost.

(4) Report the following facts to the county department that may affect the determination of eligibility and share of cost within 10 calendar days following the date the change occurred:

(A) Change of address.

(B) Change in property or income.

(C) Change in family composition.

(D) Change in other health care coverage.

(5) The requirement to report to the county department and to any provider of health care services any existing contractual or other legal entitlement to other health care coverage; and, to fully utilize other health care coverage before using Medi-Cal benefits.

The information to be reported shall include the name of the other health care coverage, policy and group numbers, and termination date, if available.

(6) Responsibility to report to the county department the availability of any option to obtain other health care coverage through, but not limited to, the beneficiary's employer, labor union, trust fund, spouse or parent and to provide information necessary for the Department to determine if it would be cost effective for the Department to pay the premium to obtain or continue other health coverage.

(7) The requirement to apply for, and/or retain any available other health care coverage when there is no premium cost to the beneficiary. Compliance with this requirement shall be a condition of coverage for Medi-Cal covered benefits to the party responsible for the acquisition or continuance of such health care coverage, and shall not interfere with Medi-Cal benefits provided to the remaining family unit.

(8) Cooperate fully in any investigation that may be required for quality control.

(9) Report, apply for, and utilize all other health care coverage available to the individual or family group in accordance with Section 50763.

(10) Complete Medi-Cal status reports in accordance with Section 50191 (a) or (b).

(11) Promptly notify the county department which initially established Medi-Cal eligibility of any changes in residence from one county to another within the state and apply for a redetermination of eligibility within the new county of residence. "Apply for a redetermination of eligibility," as used in this section, is defined as any clear expression to the county department, whether verbal or written, that the beneficiary is living in the county and wishes to continue receiving Medi-Cal.

(12) Cooperate with the state, county department, and the district attorney's office in all of the following:

(A) Establishing paternity for a child under eighteen years of age born out of wedlock for whom Medi-Cal is requested.

(B) Obtaining medical support and payments; and

(C) Providing all of the information requested by the state, county department, and district attorney's office, which is necessary to identify, locate, and pursue any third party, including an absent parent, who is or may be liable for medical care and services or support.

(13) In the case of a woman who is pregnant, or a child who was born out of wedlock or whose parent is absent from the home, at the conclusion of the 60-day postpartum period:

(A) Complete the Child Support Questionnaire (CA 2.1 Q Support Questionnaire, Revised 3/93), the Child/Spousal and Medical Support Notice and Agreement (CA 2.1 Notice and Agreement, Revised 12/92), and any additional forms specified in the district attorney and approved by the Department of Health Services;

(B) Appear at the county department and at the office of the district attorney to provide information, when requested;

(C) Provide to the county department and to the district attorney all information which is relevant to the case.

(D) Appear as a witness in court or in other hearings and proceedings relating to (9) and (10) above.

(14) Assign to the state all rights to any medical support and to payments for medical care from any third party, as specified in Section 50157.

(b) Applicants and recipients whose eligibility is determined by the Social Security Administration shall, as a condition of eligibility, comply with subsections (a)(9), (a)(10), and (a)(11) above, and report to the Department and utilize all other health care coverage available to them in accordance with Section 50763.

(c) If the Statement of Facts has been completed and signed by someone other than the applicant or beneficiary, the responsibilities stated in (a) and (b) shall rest with that person as well as with the applicant or beneficiary.

(d) The county shall assist the applicant or beneficiary as necessary in meeting the requirements of this section.

§ 50185.5. Medi-Cal Managed Care Plan Assigned Enrollment Prior to Two-Plan Model Implementation or for Geographic Areas Not Designated for Two-Plan Model Implementation.

(a) This section applies to geographic areas specified by the director, which may include geographic areas designated for implementation of the two-plan model as defined in section 53810(n) prior to implementation of the two-plan model, and geographic areas not designated for two-plan model implementation. This section applies to aid categories specified by the director, pursuant to Welfare and Institutions Code Section 14016.5 and 14087.305.

(b) The following definitions apply to this section:

(1) Affiliate means an existing Medi-Cal managed care plan that has a written agreement to become a subcontractor to the local initiative or the commercial plan when the local initiative or commercial plan commences operation, or an entity that has been awarded the local initiative or commercial plan contract under the Two-Plan Model and is an existing Medi-Cal prepaid health plan contractor that is authorized under its Medi-Cal prepaid health plan contract to operate in the service area to which the plan has been awarded the commercial plan or local initiative contract under the Two-Plan Model.

(2) Assignment means the action taken by the health care options contractor to enroll an eligible beneficiary or an eligible family group into a Medi-Cal managed care plan when the beneficiary fails to select a managed care plan and does not provide a written certification of an established patient-provider relationship.

(3) Authorized affiliate means any existing Medi-Cal prepaid health plan that has been awarded the local initiative or commercial plan contract under the Two-Plan Model, or is an affiliate that has been authorized by the department to receive assignments after a local initiative or commercial plan has submitted a written request to the department that assignments be made to that affiliate.

(4) Commercial plan means a prepaid health plan in a designated geographic area awarded a contract by the department pursuant to sections 53800(b)(1).

(5) Commercial plan enrollment maximum means the enrollment level established by the department pursuant to section 53820(b).

(6) Confirmed conditional start date means the date established by the department on which a local initiative or commercial plan is authorized to begin operation under the Two Plan Model, subject to the local initiative or commercial plan fulfilling the conditions specified by the department at the time the confirmed conditional start date is given by the department.

(7) CP/LI ratio means the total enrollment of the commercial plan, or if the commercial plan is not operational, the combined total enrollment of the commercial plan affiliates, DIVIDED by the combined total enrollment of the local initiative affiliates. The source of the enrollment totals is the department's monthly Medi-Cal managed care capitation report.

(8) Fee-for-service managed care program means a program operated in a designated geographic area by an entity contracting with the Department under which services continue to be provided on a fee-for-service basis, but each Medi-Cal beneficiary is provided with a primary care provider who coordinates the beneficiary's Medi-Cal health care.

(9) Health care options contractor means the entity contracting with the department to provide applicants and beneficiaries with information on the available options to receive Medi-Cal benefits and to process applicant and beneficiary enrollment choices or assignments in designated geographic areas.

(10) Health care options presentation means a presentation in-person or by mail to Medi-Cal applicants and beneficiaries which provides information on the Medi-Cal managed care plans and fee-for-service options available within the designated geographic area in which the applicant or beneficiary resides.

(11) Local initiative means a prepaid health plan awarded a contract by the department pursuant to sections 53800(b)(2) and 53810(h).

(12) Local initiative enrollment minimum means the total number of Medi-Cal beneficiaries in the mandatory aid categories in the designated geographic area less the maximum enrollment level established pursuant to section 53820 of the commercial plan.

(13) Operational means a managed care plan is providing covered services to enrolled Medi-Cal beneficiaries and is entitled to receive capitation payments from the department.

(c) Applicants and beneficiaries shall be informed by the county welfare department of the availability of health care options presentations which explain the options for receiving Medi-Cal benefits and the obligation of the applicants and beneficiaries to attend a presentation. For beneficiaries who do not attend a health care options presentation, the department shall mail information explaining the beneficiary's health care options.

(1) The county welfare department shall inform applicants and beneficiaries of the availability of health care options presentations at the time of their initial eligibility and annual redetermination in the following geographic areas:

(A) Areas designated for the two-plan model, when:

1. only the commercial plan is operational; or
2. only the local initiative is operational; or
3. the department intends to award two commercial plan contracts and no local initiative contract, and only one commercial plan is operational.

(B) Areas not designated for the two-plan model.

(2) If, within the same geographical area, the local initiative is scheduled to become operational prior to the date the commercial plan is expected to become operational, the local initiative may submit a written request to the department that the department include all existing beneficiaries in the mandatory aid categories in the health care options notification process.

(d) At the health care options presentation or by mail, the department shall provide to the applicant or beneficiary information on Medi-Cal managed care plans operating within the geographic area in which the applicant or beneficiary resides.

(e) Each applicant or beneficiary shall submit in writing to the health care options contractor a choice to enroll in a Medi-Cal managed care plan or shall certify in writing that he or she has an established patient-provider relationship either:

(1) within 30 days of the applicant's or beneficiary's attendance at a health care options presentation; or,

(2) if the applicant or beneficiary does not attend a health care options presentation prior to the postmark date on which the health care options materials were mailed to the applicant or beneficiary, within 30 days of the postmark date of the mailed health care options materials.

(f) The health care options contractor shall assign beneficiaries failing to comply with the requirements of subsection (e) to an available Medi-Cal managed care plan that has capacity to accept new beneficiaries and that has a primary care service site serving the postal ZIP code area in which the beneficiary resides. To the extent possible, a beneficiary shall not be assigned to a different Medi-Cal managed care plan than other members of the same family group.

(g) In geographic areas designated for health care to be provided under the two-plan model, if more than one Medi-Cal managed care plan meets the conditions in (f), assignments shall be made as follows:

(1) If the local initiative is operational, all assignments will be directed to the local initiative until it reaches the local initiative enrollment minimum.

(2) If the local initiative is operational and has attained its enrollment minimum and the commercial plan is not operational but has authorized affiliates, one of every two assignments will be directed to the local initiative and one will be directed to an authorized affiliate of the commercial plan. Assignments to the commercial plan's affiliates will be evenly distributed among all authorized affiliates of the commercial plan. Assignments to the authorized commercial plan affiliates will continue until their combined enrollment total reaches the commercial plan enrollment maximum, at which time assignments to authorized commercial plan affiliates will be discontinued. Enrollment in the local initiative and commercial plan affiliates will be reviewed on a monthly basis. If the local initiative's enrollment falls below the local initiative's enrollment minimum, all assignments will be directed to the local initiative as needed to restore it to its enrollment minimum. After the local initiative has been restored to its enrollment minimum, assignments to the authorized commercial plan affiliates will be resumed as provided above until the commercial plan affiliates' combined enrollment total reaches the commercial plan enrollment maximum, at which time assignments to authorized commercial plan affiliates will be discontinued. If the commercial plan does not have any authorized affiliates, all assignments will be directed to the local initiative.

(3) If the commercial plan is operational and the local initiative is not operational but has authorized affiliates, and the combined total enrollment of the local initiative affiliates is less than the total enrollment of the commercial plan, assignments will be made as follows:

(A) If the CP/LI ratio is 1.0 or less, one of every two assignments will be directed to an authorized affiliate of the local initiative and one assignment will be directed to the commercial plan.

(B) If the CP/LI ratio is greater than 1.0 but less than or equal to 2.0, two of every three assignments will be directed to the authorized affiliates of the local initiative and one assignment will be directed to the commercial plan.

(C) If the CP/LI ratio is greater than 2.0 but less than or equal to 3.0, three of every four assignments will be directed to the authorized affiliates of the local initiative and one assignment will be directed to the commercial plan.

(D) If the CP/LI ratio is greater than 3.0, four of every five assignments will be directed to the authorized affiliates of the local initiative and one assignment will be directed to the commercial plan.

(E) For (g)(3)(A), (B), (C) and (D), assignments to the authorized local initiative affiliates will be evenly distributed among all authorized affiliates of the local initiative.

(F) Once (g)(3)(B), (C), or (D) have been applied, and the CP/LI ratio reaches 1.0 or less, until 90 days prior to the Local Initiative's confirmed conditional start date, one of every two assignments will be directed to an authorized affiliate of the local initiative and one assignment will be directed to the commercial plan. No further use of the CP/LI ratio will be made to determine assignments. When the commercial plan reaches its enrollment maximum, further assignments to the commercial plan will be discontinued. Enrollment totals in the commercial plan and the combined enrollment total for the local initiative affiliates will be reviewed on a monthly basis. If enrollment falls below the commercial plan enrollment maximum, assignments to the commercial plan will be resumed with the commercial plan receiving one of every two assignments until the commercial plan reaches the commercial plan enrollment maximum.

(G) Beginning 90 days prior to a local initiative's confirmed conditional start date, all assignments will be made to the authorized affiliates of the local initiative. These assignments will be evenly distributed among all authorized affiliates of the local initiative. When enrollment in the affiliates of the local initiative reaches the local initiative's minimum enrollment, one of every two assignments will be directed to an authorized affiliate of the local initiative and one assignment will be directed to the commercial plan. Assignments to the authorized affiliates of the local initiative will be evenly distributed among all authorized affiliates of the local initiative. Assignments to the commercial plan will continue until the enrollment total of the commercial plan equals the commercial plan enrollment maximum, at which time assignments to the commercial plan will be discontinued. The enrollment total of the commercial plan and the combined enrollment total for the affiliates of the local initiative will be reviewed on a monthly basis. If the combined enrollment of the affiliates of the local initiative falls below the local initiative's enrollment minimum, all assignments will be directed to the authorized affiliates of the local initiative as needed to restore the combined enrollment in affiliates of the local initiative to the local initiative enrollment minimum. After enrollment in the affiliates of the local initiative has been restored to its enrollment minimum, assignments to the commercial plan will be resumed as provided above until the commercial plan's enrollment reaches the commercial plan enrollment maximum, at which time assignments to the commercial plan will be discontinued.

(4) If the commercial plan is operational, and the local initiative is not operational but has authorized affiliates, and the combined enrollment of the local initiative affiliates is equal to or greater than the enrollment in the commercial plan, one of every two assignments will be directed to an authorized affiliate of the local initiative and one assignment will be directed to the commercial plan. When the commercial plan reaches its enrollment maximum, further assignments to the commercial plan will be discontinued. Enrollment totals in the commercial plan and the combined enrollment total for the local initiative affiliates will be reviewed on a monthly basis. If enrollment falls below the commercial plan enrollment maximum, assignments to the commercial plan will be resumed with the commercial plan receiving one of every two assignments until the commercial plan reaches the commercial plan enrollment maximum.

(5) If the commercial plan is operational, and the local initiative is not operational and the local initiative does not have any authorized affiliates, all assignments will be directed to the commercial plan. When the commercial plan reaches its enrollment maximum, further assignment to the commercial plan will be discontinued. Enrollment in the commercial plan will be reviewed on a monthly basis. If enrollment falls below the commercial plan enrollment maximum, assignments to the commercial plan will be

resumed with the commercial plan receiving all assignments until the commercial plan reaches its enrollment maximum.

(6) If neither the local initiative nor commercial plan is operational, but either one or both has authorized affiliates, assignment shall be as follows:

(A) If the local initiative does not have any authorized affiliates and the commercial plan has authorized affiliates, all assignments will be directed to the commercial plan's authorized affiliates. When the combined total enrollment of the commercial plan's affiliates reaches the commercial plan maximum, further assignments to the commercial plan's authorized affiliates will be discontinued. Enrollment in the commercial plan's affiliates will be reviewed on a monthly basis. If the combined total enrollment of the commercial plan's affiliates falls below the commercial plan maximum, assignments will be resumed until the combined enrollment in the commercial plan's affiliates reaches the commercial plan maximum.

(B) If the local initiative has authorized affiliates and the commercial plan does not have authorized affiliates, all assignments will be directed to the authorized affiliates of the local initiative.

(C) If the local initiative has not been given a confirmed conditional start date by the department, and the combined total enrollment of the local initiative affiliates is less than the combined total enrollment of the commercial plan affiliates, until the combined total enrollment of the local initiative affiliates is equal to or greater than the combined total enrollment of the commercial plan affiliates, assignments will be made as follows:

1. If the CP/LI ratio is 1.0 or less, one of every two assignments will be directed to the authorized affiliates of the local initiative and one assignment will be directed to an authorized affiliate of the commercial plan.
2. If the CP/LI ratio is greater than 1.0 but less than or equal to 2.0, two of every three assignments will be directed to the authorized affiliates of the local initiative and one assignment will be directed to an authorized affiliate of the commercial plan.
3. If the CP/LI ratio is greater than 2.0 but less than or equal to 3.0, three of every four assignments will be directed to the authorized affiliates of the local initiative and one assignment will be directed to an authorized affiliate of the commercial plan.
4. If the CP/LI ratio is greater than 3.0, four of every five assignments will be directed to the authorized affiliates of the local initiative and one assignment will be directed to an authorized affiliate of the commercial plan.
5. For (g)(6)(C)(1), (2), (3) and (4), assignments to the authorized affiliates of the local initiative will be evenly distributed among all authorized affiliates of the local initiative and assignments to authorized affiliates of the commercial plan will be evenly distributed among all authorized affiliates of the commercial plan.
6. Once (g)(6)(C), (2), (3) or (4) have been applied, and the CP/LI ratio reaches 1.0 or less, until 90 days prior to the local initiative's confirmed conditional start date, one of every two assignments will be directed to an authorized affiliate of the local initiative and one assignment will be directed to an authorized affiliate of the commercial plan. No

further use of the CP/LI ratio will be made to determine assignments. Assignments to the authorized affiliates of the local initiative will be evenly distributed among all authorized affiliates of the local initiative and assignments to the authorized affiliates of the commercial plan will be evenly distributed among all authorized affiliates of the commercial plan. Assignments to the authorized affiliates of the commercial plan will continue until the combined enrollment total of the affiliates of the commercial plan equals the commercial plan enrollment maximum, at which time assignments to authorized affiliates of the commercial plan will be discontinued. In the case of an affiliate that has affiliated with both the local initiative and the commercial plan, the total enrollment of that affiliate will be included in the combined commercial plan enrollment totals to determine if the commercial plan enrollment maximum has been reached. The combined enrollment total for the affiliates of the commercial plan and combined total for the affiliates of the local initiative will be reviewed on a monthly basis. If the local initiative's enrollment falls below the local initiative's enrollment minimum, all assignments will be directed to the local initiative as needed to restore it to its enrollment minimum. After the local initiative has been restored to its enrollment minimum, assignments to the authorized affiliates of the commercial plan will be resumed as provided above until the combined enrollment of the authorized affiliates of the commercial plan reaches the commercial plan enrollment maximum, at which time assignments to the authorized affiliates of the commercial plan will be discontinued.

(D) If the combined enrollment of the affiliates of the local initiative is equal to or greater than the combined enrollment of the affiliates of the commercial plan, one of every two assignments will be directed to an authorized affiliate of the local initiative and one assignment will be directed to an authorized affiliate of the commercial plan. Assignments to the authorized affiliates of the local initiative will be evenly distributed among all authorized affiliates of the local initiative, and assignments to the authorized affiliates of the commercial plan will be evenly distributed among all authorized affiliates of the commercial plan. Assignments to the authorized affiliates of the commercial plan will continue until the combined enrollment total of affiliates of the commercial plan equals the commercial plan enrollment maximum, at which time assignments to the authorized affiliates of the commercial plan will be discontinued. In the case of an affiliate that has affiliated with both the local initiative and the commercial plan, the total enrollment of that affiliate will be included in the combined commercial plan enrollment totals to determine if the commercial plan enrollment maximum has been reached. The combined enrollment total for the affiliates of the commercial plan and combined total for the affiliates of the local initiative will be reviewed on a monthly basis. If enrollment falls below the commercial plan enrollment maximum, assignments to the authorized affiliates of the commercial plan will be resumed with the commercial plan receiving one of every two assignments until the combined enrollment of the affiliates of the commercial plan reaches the commercial plan enrollment maximum.

(E) Beginning 90 days prior to a local initiative's confirmed conditional start date, all assignments will be made to the authorized affiliates of the local initiative. These assignments will be evenly distributed among all authorized affiliates of the local initiative. When enrollment in the affiliates of the local initiative reaches the local initiative's minimum enrollment, one of every two assignments will be directed to an authorized affiliate of the local initiative and one assignment will be directed to an authorized affiliate of the commercial plan. Assignments to the authorized affiliates of the local initiative will be evenly distributed among all authorized affiliates of the local initiative and assignments to the authorized affiliates of the commercial plan will be

evenly distributed among all authorized affiliates of the commercial plan. Assignments to the authorized affiliates of the commercial plan will continue until the combined enrollment total of the affiliates of the commercial plan equals the commercial plan enrollment maximum, at which time assignments to authorized affiliates of the commercial plan will be discontinued. In the case of an affiliate that has affiliated with both the local initiative and the commercial plan, the total enrollment of that affiliate will be included in the commercial plan's enrollment totals to determine if the commercial plan enrollment maximum has been reached. The combined enrollment total of the affiliates of the commercial plan and combined enrollment total for the affiliates of the local initiative will be reviewed on a monthly basis. If enrollment falls below the commercial plan enrollment maximum, assignments to the authorized affiliates of the commercial plan will be resumed with one of every two assignments directed to the authorized affiliates of the commercial plan until the combined enrollment of the affiliates of the commercial plan reaches its enrollment maximum. If the commercial plan does not have any authorized affiliates, all assignments will be directed to the authorized affiliates of the local initiative.

(7) Where the department awards two commercial plan contracts and no local initiative contract, assignment shall be as follows:

(A) If neither commercial plan is operational, assignments will be evenly distributed among authorized affiliates of the two commercial plans. When the combined total enrollment of a commercial plan's affiliates totals one-half of the mandatory enrollment population, assignments will cease for the authorized affiliates of that plan. In the case of an affiliate that has affiliated with both commercial plans, the total enrollment of this affiliate will be equally divided for purposes of computation of the enrollment total to determine when assignments will cease.

(B) If a single commercial plan is operational, assignments will be evenly distributed among the operational commercial plan and the authorized affiliates of the nonoperational commercial plan. Assignments to the authorized affiliates of the nonoperational commercial plan will be evenly distributed. When the total enrollment of the single operational commercial plan or the combined total enrollment of the authorized affiliates of the nonoperational commercial plan equals one-half of the mandatory enrollment in the designated geographic area, assignments will cease for that plan. In the case of an affiliate that has affiliated with both the operational and nonoperational commercial plan, the total enrollment of that affiliate will be equally divided for purposes of computation of the enrollment total to determine when assignments will cease.

(8) If both the local initiative and the commercial plan become operational in a geographic area prior to the implementation of mandatory enrollment of beneficiaries in the two plan model, assignments will be directed to the local initiative until it reaches its enrollment minimum, then assignments will be evenly distributed between the local initiative and the commercial plan. No assignments will be made to other Medi-Cal managed care plans. When the commercial plan reaches its enrollment maximum, further assignment to the commercial plan will be discontinued. Enrollment in the local initiative and commercial plan will be reviewed on a monthly basis. If the local initiative's enrollment falls below the local initiative's enrollment minimum, all assignments will be directed to the local initiative as needed to restore it to its enrollment minimum. After the local initiative has been restored to its enrollment minimum, assignments to the

commercial plan will be resumed as provided above until the commercial plan's enrollment reaches the commercial plan enrollment maximum, at which time assignments to the commercial plan will be discontinued.

(9) This is a graphic presentation that illustrates the requirements set forth in sections (g)(1), (g)(2), (g)(3), (g)(4), (g)(5), (g)(6) and (g)(8):

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(h) In geographic areas not designated for two-plan model implementation, if the department contracts for a fee-for-service managed care program, assignments will be directed to the fee-for-service managed care contractor as long as the contractor has an available capacity. In other geographic areas, assignments will be evenly distributed among Medi-Cal managed care plans which have been approved by the department to participate in the assignment process and have available enrollment capacity consistent with the growth limits pursuant to section 53830.

(i) The health care options contractor shall notify the beneficiary in writing of the beneficiary's assignment to a Medi-Cal managed care plan at least ten working days prior to the submission of the assignment documents to the department for processing. The notice shall contain the name of the Medi-Cal managed care plan to which the beneficiary is assigned; the conditions defined in subdivisions (j)(1), (2) and (3); and the time frame for advising the health care options contractor if the assignment is not appropriate or if the beneficiary wishes to enroll in a different Medi-Cal managed care plan or certify to a patient-provider relationship.

(j) An assignment is not appropriate when:

(1) The time and distance a beneficiary is required to travel to obtain primary care services from his or her residence exceeds the normal practice for the community or 30 minutes or 10 miles, whichever is greater.

(2) Public transportation is not available to the primary care site, unless the managed care plan to which the beneficiary is assigned provides transportation for outpatient services. This criteria will not apply to the designated fee-for-service managed care program geographic areas where public transportation to Medi-Cal services has not historically been available to the beneficiary.

(3) Culturally and linguistically appropriate services are not available to the beneficiary.

(k) The beneficiary may notify the health care options contractor that the assignment meets one or more of the conditions in subdivisions (j)(1), (2), or (3) or the beneficiary requests enrollment in another Medi-Cal managed care plan. The beneficiary may also certify to a patient-provider relationship. The notice from the beneficiary shall be in writing and state, if applicable, the specific condition(s) making the assignment inappropriate and the desired action by the health care options contractor.

(1) For such notices from beneficiaries received within ten working days of the postmark date of the notice of assignment from the health care options contractor, the health care options contractor shall respond by accepting the patient-provider certification, if

provided, or by enrolling the beneficiary in another Medi-Cal managed care plan of his or her choice.

(2) For such notices from beneficiaries received after the tenth working day from the postmark date of the notice of assignment from the health care options contractor, the health care options contractor shall assist the beneficiary to disenroll from the assigned Medi-Cal managed care plan and then either accept the patient-provider certification or enroll the beneficiary in another Medi-Cal managed care plan of his or her choice.

(3) If the beneficiary notifies the health care options contractor that the assignment is inappropriate because one or more of the conditions described in subdivisions (j)(1), (2), and (3) exist, and if another Medi-Cal managed care plan within the geographic area cannot provide for an appropriate assignment in relation to the conditions in (j)(1), (2) and (3), or if another Medi-Cal managed care plan within the geographic area can provide for appropriate assignment in relation to the conditions in (j)(1), (2) and (3), but does not have available capacity, the beneficiary may elect to obtain benefits by receiving a fee-for-service card whether or not the beneficiary has certified to a patient-provider relationship.

§ 50186. Unconditionally Available Income.

(a) An applicant or beneficiary shall, as a condition of Medi-Cal eligibility, take all actions necessary to obtain unconditionally available income. This includes applying for such income and cooperating in supplying the information requested by the agency making the award determination.

(b) Income shall be considered unconditionally available if the applicant or beneficiary has only to claim or accept the income. Such income includes, but is not limited to:

(1) Disability insurance benefits.

(2) Benefits available to veterans of military service.

(3) OASDI benefits.

(4) Unemployment insurance benefits.

(c) Public assistance benefits shall not be considered unconditionally available income.

(d) Only the person who refuses to apply for and accept unconditionally available income shall be rendered ineligible by such refusal.

§ 50187. Social Security Numbers and Health Insurance Claim Numbers.

(a) Each applicant or beneficiary shall, as a condition of eligibility for full Medi-Cal benefits, obtain and provide to the county department a Social Security Number (SSN) and, if eligible, a Social Security Health Insurance Claim (HIC) Number. In addition, amnesty aliens eligible for restricted Medi-Cal benefits pursuant to section 50302(b)(3) must possess or have applied for an SSN and, if eligible, a HIC number.

(b) The SSN shall be provided at the time of application unless the applicant must apply for the number. If application for an SSN must be made, the number will be provided to the county department by the Department or by the Social Security Administration.

(c) The HIC number shall be provided by the applicant or beneficiary in accordance with section 50777.

(d) Medi-Cal shall not be denied, delayed or discontinued for an applicant or beneficiary because of these requirements unless the applicant or beneficiary refuses to cooperate.

(1) Eligibility of an applicant or beneficiary who refuses to apply for or provide a number shall be denied or discontinued.

(2) Eligibility of a child who is not applying on the child's own behalf shall be denied or discontinued if a parent or caretaker relative living with the child refuses to apply for or provide a number for the child.

(3) Persons ineligible for Medi-Cal in accordance with (1) or (2) shall be ineligible members of the MFBU in accordance with section 50379.

(e) The county department shall assist the applicant or beneficiary by explaining how to apply for an SSN or HIC number and by providing an SSA Referral Notice, form MC 194.

(f) The county shall notify the beneficiary if the information provided by that beneficiary does not result in verification of the SSN by SSA. Medi-Cal eligibility shall be discontinued if the beneficiary fails, without good cause, to respond to the notice within 60 days.

§ 50189. Redetermination -Frequency and Process.

(a) Persons or families determined to be eligible for Medi-Cal shall have their eligibility redetermined at least once every 12 months.

(b) At the time of the redetermination, the beneficiary shall complete a new Statement of Facts.

(c) The county department shall:

(1) Complete the redetermination within 12 months of the most recent of the following:

(A) Approval of eligibility on any application, reapplication or restoration which required a Statement of Facts form.

(B) Last redetermination.

(2) Inform beneficiaries in writing that income and eligibility information, including tax information, will be obtained through the IEVS.

(3) Verify information on the Statement of Facts in accordance with Section 50169 (d).

(4) Send a Notice of Action if there is a change in the beneficiary's eligibility status or share of cost.

(5) Provide an informational pamphlet on the CHDP program to the beneficiary which describes the CHDP benefits available, and how and where the benefits are provided in the county, if there are persons under 21 years of age in the family.

(d) A face-to-face interview shall be required at the time of redetermination for all MFBU's which contain at least one AFDC-MN or MI member, except for MFBU's consisting of any of the following:

(1) Persons who receive Medi-Cal through the Aid for Adoption of Children program.

(2) Persons who have a government representative, such as a public guardian, acting on their behalf.

(3) MI children who are not living with a parent or relative and for whom a public agency is assuming financial responsibility in whole or in part.

§ 50191. Status Reports.

(a) The county department shall require the completion of a Medi-Cal Status Report form at three month intervals for all MFBU's which contain at least one AFDC-MN or MI person. The requirement to complete status reports shall not apply to the following:

(1) Persons who receive Medi-Cal through the Aid for Adoption of Children program.

(2) Persons who have a government representative, such as a public guardian, acting on their behalf.

(3) MI children who are not living with a parent or relative and for whom a public agency is assuming financial responsibility in whole or in part.

(4) Children who are requesting Medi-Cal in accordance with Section 50147.1.

(5) Persons who receive county General Assistance Benefits and whose Medi-Cal eligibility factors are monitored at least quarterly by the county Department under its general assistance program.

(6) MFBU's consisting solely of an eligible pregnant woman and/or infant under one year of age.

(b) In addition to the status reports required in accordance with (a), the county department, consistent with Article 2, may require persons or families to complete status reports at more frequent intervals.

§ 50192. Testing Techniques for Redeterminations, Status Reporting and Verification.

(a) Notwithstanding Sections 50169, 50189 and 50191, the Director may, in counties selected by the Director, establish requirements for redeterminations, status reporting, and verification of information on the Statement of Facts for the purpose of testing the effectiveness of the different administrative requirements.

(b) Selection criteria may include, but shall not be limited to:

(1) Caseload size.

(2) Past county administrative requirements.

(3) Population characteristics.

§ 50193. Beginning Date of Eligibility.

(a) The beginning date of eligibility for Medi-Cal for persons who apply under any public assistance program shall be the first day of the month of application, providing the person meets the citizenship, residency, linkage and financial eligibility criteria of the appropriate program, notwithstanding the beginning date of the cash grant. For persons who do not meet these eligibility criteria during the month of application, the beginning date of eligibility shall be the first day of the first month in which the above specified eligibility criteria of the appropriate program are met.

(b) The beginning date of eligibility for Medi-Cal specified in (a) shall also apply to:

(1) Persons who apply for AFDC and meet eligibility criteria in the month of application but whose eligibility is denied because they no longer meet eligibility criteria at the time eligibility for AFDC is determined.

(2) Persons who apply for SSI/SSP and meet the eligibility criteria but are denied because they die before the application can be processed and an application is filed on their behalf at the county department within 30 days of receipt of a written notice of denial.

(c) The beginning date of eligibility for persons applying only for Medi-Cal shall be: the first day of the month of application, if all eligibility criteria of the appropriate Medi-Cal program are met. If the eligibility criteria are not met during the month of application, the beginning date of eligibility shall be the first day of the month, subsequent to the month of application, during which the eligibility criteria of the appropriate Medi-Cal program are met.

(d) For the purposes of (c), eligibility criteria are considered to be met throughout the month if they are met at any time during the month, except for persons specified in Section 50273(a).

§ 50195. Period of Eligibility.

(a) The period of eligibility for Medi-Cal for persons eligible for AFDC or SSI/SSP shall begin with the date specified in Section 50701 (a) and (b), and shall continue through each successive month during which the person is determined to be eligible.

(b) The period of eligibility for Medi-Cal for persons eligible as Other PA recipients shall begin with the date specified in Section 50701 (c), and shall continue through each successive month during which the person meets all eligibility requirements of the appropriate Other PA category.

(c) The period of eligibility for Medi-Cal for persons eligible as MN or MI, except as specified in (d), shall begin with the date specified in Section 50701 (c), and shall continue through each successive month during which the beneficiary meets the appropriate basic program requirements in Article 5 of this chapter and all of the following conditions:

(1) Has cooperated with the county department to the extent required by Sections 50185 and 50187.

(2) Has met the property requirements specified in Article 9 at some time during the month.

(3) Has met the citizenship, residence and institutional status requirements specified in Articles 6 and 7 at some time during the month.

(d) The period of eligibility for Medi-Cal for a child applying on his or her own behalf in accordance with Section 50147.1 (a) shall begin with the date specified in Section 50701 (c), and shall continue through each successive month during which the child meets both of the following conditions:

(1) Has met the conditions specified in (c).

(2) Has submitted a completed and signed form MC 4026 to the county department during the month in question which states that the child has a need for services related to sexual assault, drug or alcohol abuse, pregnancy, family planning or venereal disease.

(e) The period of eligibility shall be modified for any portion of a month in which a person is ineligible due to institutional status, as described in Section 50273.

(f) A final date of eligibility shall be established when the county department determines that the person or family will no longer meet all eligibility requirements as of the first of the following month. The final date shall be the last day of the:

(1) Current month, if the discontinuance is not an adverse action as defined in Section 50015.

(2) Current month, if the discontinuance is an adverse action and the 10-day advance notice requirements of Section 50179(e) will be met in the current month.

(3) Following month, if the discontinuance is an adverse action and the 10-day advance notice requirements will not be met in the current month.

§ 50197. Retroactive Eligibility.

(a) In addition to the period of eligibility specified in Section 50703, an applicant shall be eligible for Medi-Cal in any of the three months immediately preceding the month of application or reapplication if all of the following requirements are met in that month:

(1) The county department determines that the applicant would have been eligible for one of the programs specified in Section 50201, except as specified in (c), had an application been made.

(2) The applicant received health services.

(3) The applicant was not previously denied Medi-Cal for the month in question, unless the application was denied for one of the following reasons:

(A) County error.

(B) The applicant's failure to cooperate, when that failure, or the applicant's subsequent failure to reapply, was due to circumstances beyond the control of the applicant.

(b) The request for retroactive eligibility shall be made in accordance with Section 50148 and shall be treated as any other application, except that persons applying on the basis of disability shall have their disability determined prior to determining retroactive eligibility.

(c) A person 21 years of age or older shall not be retroactively eligible as a medically indigent person unless either of the following conditions exist.

(1) The person was residing in a skilled nursing or intermediate care facility during any part of both:

(A) The month of application.

(B) The month for which retroactive eligibility is requested.

(2) The person is a woman with a confirmed pregnancy.

§ 50199. Certification for Medi-Cal -Completion.

(a) A person or family determined to be eligible for Medi-Cal shall not receive a Medi-Cal card until certified for Medi-Cal.

(b) Certification for Medi-Cal shall be completed by:

(1) The county department for:

(A) Persons who have no share of cost or who have a share of cost for long-term care which is less than the cost of care.

(B) Persons who have a share of cost, other than those specified in (A), and who complete form MC 113, in accordance with Section 50658 (d).

(2) The Department for persons who have a share of cost, other than those specified in (1)(A) and (B).