§ 50601. Maintenance Need -General.

(a) The amount of income a person or family is allowed to retain for living expenses shall be determined by adding the following:

(1) The maintenance need for the members of the MFBU living in the home as determined in accordance with Section 50603.

(2) The maintenance need for the members of the MFBU in long-term care as determined in accordance with Section 50605.

§ 50603. Maintenance Need -Persons Living in the Home.

(a) The maintenance need for members of the MFBU living in the home shall be determined in the following manner with amounts of 1 cent or more rounded to the next highest dollar.

(1) The maintenance need for an MFBU consisting of one individual shall equal 80 percent of the AFDC payment level for a family of two persons multiplied by 133 1/3 percent.

(2) The maintenance need for an MFBU consisting of two adults shall equal the AFDC payment level for a family of three persons multiplied by 133 1/3 percent.

(3) The maintenance need for an MFBU consisting of two persons when one or both persons are not adults and for an MFBU consisting of three through ten persons shall equal 133 1/3 percent of the AFDC payment level for a family group of corresponding size.

(4) The monthly maintenance need determined in accordance with (1) through (3) shall be calculated on an annual basis, rounded to the next higher multiple of $100, and then prorated.

(5) The maintenance need for an MFBU consisting of 11 or more persons shall equal the maintenance need level for a family group of 10 established in accordance with (3) and (4) plus an amount equal to the AFDC MBSAC increase level for additional persons in excess of 10 for each MFBU member in excess of 10.

§ 50604. Maintenance Need -Family Members Maintaining Separate Residences with E

(a) An MFBU which includes a child who maintains a separate residence from his/her parent(s) in accordance with Section 50351(c) shall be assigned a combined maintenance need to be calculated according to (1) through (3).

(1) In accordance with Section 50603, determine the maintenance need for the separate household of the child as follows:

(A) For one child living alone or one child sharing a residence with other persons not financially responsible for the child, use the maintenance need level for one person established in accordance with Section 50603(a).

(B) For two or more children who are living together and who are claimed as dependents by the parent(s) for tax purposes, use the maintenance need level for the corresponding number of persons established in accordance with Section 50603(a).

(C) For two or more children who live alone in separate residences, use the maintenance need level for one for each child established in accordance with Section 50603(a).

(D) For a married child living with his/her spouse, use the maintenance need level for two established in accordance with Section 50603(a).

(2) Determine the maintenance need for the parent's household in accordance with Section 50603.

(3) Combine the maintenance need determined in (1) and (2). This is the total maintenance need for the entire MFBU.

§ 50605. Maintenance Need - Persons in Long-Term Care.

(a) The maintenance need for a member of the MFBU in long-term care shall be either of the following:

(1) Thirty-five dollars for personal and incidental needs, when the beneficiary will remain in long-term care for the entire calendar month.

(2) For individuals with therapeutic wages, thirty-five dollars plus an additional amount equal to either a) 70 percent of the gross therapeutic earnings; or, b) 70 percent of the maintenance need level allowed for a noninstitutionalized person or family of corresponding size, as described in Section 50603, whichever is less.

(A) The provisions of subsection (a)(2) of this regulation also apply to eligibility determinations or redeterminations made retroactively to October 1, 1984.

(3) The appropriate maintenance need determined in accordance with Section 50603, if the person will be in long-term care for only a portion of the month.

(b) An LTC patient shall retain an amount of income for upkeep of a home in addition to the amount specified for personal and incidental needs in (a) (1) if all of the following conditions are met.

(1) The LTC patient's spouse or a family member of the LTC patient is not living in the home.

(2) The home, whether rented or owned by the LTC patient, is actually being maintained for the return of the LTC patient.

(3) There is a verified medical determination that the LTC patient, or when both spouses are in LTC, either spouse, is likely to return home within six months of the date LTC patient status was established.

(4) The income is deducted for not more than the six-month period referenced in (3).

(c) The amount allowed for upkeep of the home, if the conditions specified in (b) are met, shall be:

(1) One hundred thirty-three and one-third percent of the income in kind value of housing for one person pursuant to Section 50511(a) and (b), if the applicant or beneficiary has been living alone in the home.

(2) One hundred thirty-three and one-third percent of the income in kind value of housing for 2 persons pursuant to Section 50511(a) and (b) divided by 2, if the home is shared with persons for whom the applicant or beneficiary has no legal responsibility for support.

(3) One hundred thirty-three and one-third percent of the income in kind value of housing for 2 persons pursuant to Section 50511(a) and (b) divided by 2 for each spouse, if the beneficiary and spouse were living together at the time either or both became inpatients and both have become LTC patients and either is likely to return home within six months of the date LTC status was established.

(4) The amount allowed for upkeep of the home as determined according to (1) through (3) shall be calculated on an annual basis, rounded to the next higher multiple of $100, and then prorated.

(d) The LTC patient shall also retain an amount of income to pay for the support of a disabled relative if all of the following conditions are met.

(1) The disabled relative is not the LTC patient's:

(A) Spouse.

(B) Child, as defined in Section 50030.

(2) The LTC patient has contributed and will continue to contribute to the support of the disabled relative on a regular basis.

(e) The amount allowed for the support of a disabled relative, if the conditions specified in (d) are met, shall be the lesser of:

(1) The actual amount contributed.

(2) The maintenance need level for one person established in accordance with Section 50603(a)(1), minus the disabled relative's net income.

§ 50651. Share of Cost -General.

Share of cost shall be determined and processed in accordance with the requirements of this article.

§ 50652. Share of Cost Period. [Repealed]

§ 50653. Determination of Share of Cost.

(a) The share of cost shall cover a one month period and be determined as follows:

(1) For MFBUs which do not include a person in LTC:

(A) Determine the net nonexempt income available to the members of the MFBU.

(B) Round the total net nonexempt income determined in (A) to the nearest dollar, with amounts ending in 50 cents or more rounded to the next higher dollar.

(C) Determine the appropriate maintenance need for the MFBU in accordance with Section 50603.

(D) Subtract the combined maintenance need from the total rounded net nonexempt income. The remainder, if any, is the share of cost.

(2) For MFBUs which include a person in LTC:

(A) Determine the total countable income available to the MFBU in the month.

(B) Add to the total countable income any amounts previously deducted in accordance with Sections 50547 through 50554.

(C) Subtract from the amount determined in (B) the deductions and allocations specified in Sections 50555.1 through 50555.4 and 50563. This is the net nonexempt income available to the MFBU.

(D) Round the total net nonexempt income determined in (C) to the nearest dollar, with amounts ending in 50 cents or more to the next highest dollar.

(E) Determine the appropriate maintenance need in accordance with Section 50601.

(F) Subtract the amount determined in (E) from the amount determined in (D). This amount, if any, is the share of the cost.

(b) The share of cost shall be determined:

(1) At the time of application, reapplication or restoration.

(2) When there is a change in income, family composition or any other factor affecting the share of cost. In these instances the share of cost shall be determined in accordance with Sections 50653.3 and 50655.5.

§ 50653.3. Changes Which Decrease the Share of Cost.

(a) In situations where a change in income or other circumstances, which results in a decrease in the share of cost is reported by the beneficiary in a timely manner, as specified in Section 50185, the county department shall:

(1) Make the necessary changes in the ongoing share of cost by the first of the month following the month in which the change was reported.

(2) Determine what the share of cost should have been for the month in which the change occurred.

(3) Implement the beneficiary's choice of either of the following:

(A) Having an adjustment made in future months in accordance with (c) for the months in which income in excess of the correct share of cost was paid or obligated toward medical bills.

(B) Having the correct Form MC 177S or Medi-Cal card with a share of cost issued and processed for the months in which the share of cost should have been lower.

(b) In situations where a change in income or other circumstances, which results in a decrease in the share of cost, is not reported by the beneficiary in a timely manner, as specified in Section 50185, the county department shall:

(1) Make the necessary changes in the ongoing share of cost by the first of the month following the month in which the change was reported.

(2) Not make an adjustment for the excess income the beneficiary may have paid or obligated prior to county action specified in (b)(1) unless the county department determines that there was good cause for failure to report in a timely manner. Good cause shall be determined in accordance with Section 50175.

(c) When it is determined in accordance with (a) or (b) that there has been a decrease in the share of cost which is to be adjusted, the adjustment shall be made in accordance with the following:

(1) The period of adjustment shall begin with the month the county department takes action in accordance with (a) or (b), and shall terminate when the total adjustment has been made.

(2) The amount of the adjustment is the difference between the original share of cost and the corrected share of cost.

(3) The amount of the adjustment or a portion of the adjustment equal to the share of cost shall be subtracted from the share of cost each month until the adjustment is completed.

§ 50653.5. Changes Which Increase the Share of Cost.

(a) Except as described in Section 50262.3, in situations where a change in income or other circumstances, which result in an increase in the share of cost, is reported by the beneficiary in a timely manner, as specified in Section 50185, the county department shall make necessary changes effective:

(1) Immediately, if the increase is due to the voluntary inclusion of a family member who has income. The share of cost to be met shall be either of the following:

(A) The total increased share of cost shall be met by all members of the MFBU providing Medi-Cal cards have not been issued to the MFBU for the share-of-cost month and form MC 177S has not been submitted to the Department in accordance with Section 50658(c).

(B) The difference between the increased share of cost and the former share of cost shall be met by the newly included family member(s) when Medi-Cal cards have been issued to the MFBU for the share-of-cost month or form MC 177S has been submitted to the Department in accordance with Section 50658(c).

(2) In accordance with the following, in all other instances:

(A) The first of the month following the month in which the change was reported, if a 10 day notice can be given.

(B) The first of the second month following the month in which the change was reported, if the change cannot be made in accordance with (A).

(b) In situations where a change in income or other circumstances, which results in an increase in the share of cost determination, is not reported by the beneficiary in a timely manner, as specified in Section 50185, the county department shall:

(1) Make the changes to the ongoing share of cost in accordance with (a).

(2) Determine what the share of cost should have been for the months in which the beneficiary should have had a share of cost or an increased share of cost.

(3) Report a potential overpayment in accordance with Section 50783 which incorporates 50781, if the beneficiary:

(A) Received a Medi-Cal card and should have had a share of cost.

(B) Met a share of cost which was less than the corrected share of cost.

§ 50653.7. Changes in Share of Cost Determination Due to Administrative Error.

(a) An administrative error which causes the share of cost amount to be in excess of the correct share of cost amount shall be adjusted in accordance with Section 50653.3(a).

(b) If the county fails to take action on an increase in income within the time frames specified in Section 50653.5, excess income received after the time the county department should have taken action shall not be reported as a potential overpayment.

§ 50655. Record of Health Care Costs -Share of Cost.

(a) The Record of Health Care Costs -Share of Cost, form MC 177S, shall be used to verify that health care costs have been obligated or paid by the beneficiary in an amount equal to the share of cost. The form shall be used for all beneficiaries who have a share of cost, except as specified in (b).

(b) Form MC 177S shall not be used for beneficiaries who meet both of the following conditions:

(1) Are in long-term care.

(2) Have a share of cost which is less than or equal to the monthly cost of care at the Medi-Cal reimbursement rate for the long-term care facility.

§ 50657. Completion of Form MC 177S.

(a) Form MC 177S shall be completed as follows:

(1) The identifying information shall be completed by the county department. The only persons who shall be listed on form MC 177S as eligible to have the cost of their health services used to meet the share of cost are those:

(A) Eligible members of the MFBU in accordance with Sections 50373, 50375 and 50377.

(B) Ineligible members of the MFBU in accordance with Section 50379.

(2) Form MC 177S shall be issued to the beneficiary for each month during which the beneficiary must meet a share of cost.

(A) For continuing beneficiaries, form MC 177S shall be issued prior to the first day of the month of eligibility.

(B) For new and restored beneficiaries, form MC 177S shall be issued at the time the approval notice of action is issued.

(3) The beneficiary shall present form MC 177S to each provider when the cost of services provided will be used to meet the share of cost.

(4) The provider will list on the form MC 177S health services which have been provided and meet all of the following criteria.

(A) Were provided in the month specified on form MC 177S. Services are considered to have been provided in the month if the date of service is within the month. The date of service for:

1. Health services provided under a Global Billing Agreement is the date the last service under the agreement is rendered or the date of delivery, if the global billing is for pregnancy and delivery.

2. Dental prosthesis, prosthetic and orthotic appliances, and eye appliances is the date the item is actually ordered from the fabricating laboratory.

3. Prescription drugs is the date the item was actually received .

4. All other health services is the date the service was actually rendered.

(B) Have not been submitted as a claim against the Medi-Cal program.

(C) Have not been paid by Medicare, other health coverage, or any other party, and the provider for the amounts listed on form MC 177S.

(5) For each service listed the provider shall include:

(A) The date of service, in accordance with (a) (4) (A).

(B) The total cost of the service provided.

(C) The amount billed to the patient.

(D) The patient Medi-Cal identification number.

(E) Either of the following:

1. For Medi-Cal program covered services, the procedure/drug code for the service provided.

2. For other services, a description of the service provided, such as inpatient, drug or dental.

(F) The Medi-Cal provider number or provider license number.

(6) The provider shall sign a declaration under penalty of perjury that:

(A) Each service listed on form MC 177S was provided to the person listed on the date specified.

(B) Payment for the amount listed in the Billed Patient column will be sought from the patient and not from the Medi-Cal program or a third-party payor.

(7) When the amount in the Billed Patient column of form MC 177S equals or exceeds the share of cost, the beneficiary or the beneficiary's representative shall:

(A) Sign the form indicating that the beneficiary has assumed legal responsibility for the amount shown in the Billed Patient column.

(B) Return the form to the county department.

(b) For purposes of this section, the following definitions shall apply:

(1) Provider means the person or entity which provides health services to the persons listed on form MC 177S and which is a Medi-Cal provider or a licensed practitioner meeting the criteria of a Medi-Cal provider in accordance with Article 3, Chapter 3.

(2) Health services means the medical services, social services, supplies, devices, drugs and any other medical care provided to a person listed on form MC 177S by a provider as defined in (b)(1).

§ 50658. Form MC 177S Processing.

(a) When the share of cost has been met, the beneficiary shall return the signed form MC 177S to the county department. The county department shall review form MC 177S to ensure that:

(1) The case description portion of the form is complete.

(2) The services listed were provided to persons listed on form MC 177S.

(3) The providers have completed the form in accordance with Section 50657(a)(4) through (6).

(4) The beneficiary or the beneficiary's representative has signed the form.

(b) If the items specified above are not completed correctly, the following action shall be taken:

(1) The county department shall attempt to obtain the information necessary for completion of form MC 177S verbally from either of the following:

(A) The beneficiary.

(B) The provider.

(2) If the information necessary to correct form MC 177S cannot be obtained verbally the county department shall:

(A) Identify the information needed.

(B) Return the form to the beneficiary.

(3) When the amount shown in the Billed Patient column is in excess of the share of cost amount, the county department shall:

(A) Explain to the beneficiary that the amount shown in the Billed Patient column is the amount for which he has assumed legal responsibility.

(B) Attempt to correct the error in accordance with (b) (1) and (2) if the beneficiary states that the assumption of legal responsibility for the cost of services in excess of the share of cost was not intentional.

(c) After form MC 177S has been determined to be correct and complete, the following action shall be taken, unless the conditions specified in (d) are met.

(1) The first two pages of form MC 177S shall be submitted to Department of Health Services, Key Data Entry Unit. In addition a copy of form MC 176M shall be submitted with form MC 177S if an adjustment to the share of cost is being made pursuant to Section 50653.3.

(2) Key Data Entry Unit will certify that the share of cost has been met.

(3) The Department will issue Medi-Cal cards to the persons included in the MFBU.

(d) If the beneficiary signs a Certification of Medical Need/Request for Medi-Cal Card, MC 113, which indicates a need for medical services prior to normal anticipated receipt of a Department issued Medi-Cal card, the county department shall:

(1) Enter the date of certification for claims clearance on form MC 177S.

(2) Issue a Medi-Cal card to each person who has been listed on form MC 113 as having an immediate need. Card issuance procedures specified in Article 14 shall be followed.

(3) Indicate on form MC 177S and form MC 176M, if required, the persons who have been issued a card.

(4) Forward form MC 177S and form MC 176M, if required, to the Key Data Entry Unit.

§ 50659. Long-Term Care Patients with a Share of Cost.

(a) Form MC 177S shall not be required for a person or family with a share of cost when all the following conditions are met:

(1) One or more members of the MFBU are LTC patients.

(2) The share of cost is less than or equal to the monthly cost of care at the Medi-Cal reimbursement rate for the long-term care facility.

(b) If the conditions listed in (a) are met:

(1) All members of the MFBU who are not LTC patients shall be issued Medi-Cal cards with no share of cost listed.

(2) The LTC patient shall be issued a Medi-Cal card that shows the share of cost.

(3) If there is more than one LTC patient in the MFBU, the MFBU share of cost shall be divided equally among the LTC patients.

(c) If an MFBU includes LTC patients and the share of cost is in excess of the cost of care at the Medi-Cal rate, the MFBU shall meet its share of cost by using form MC 177S procedures described in this article.

§ 50660. MFBUs Which Include a Title II Disregard Person.

(a) Form MC 177S shall not be required for an aged, blind or disabled person who meets the conditions specified in Section 50564. Each Title II disregard person shall be issued a Medi-Cal card with no share of cost.

(b) The remaining MFBU members with a share of cost shall have their case processed in accordance with Section 50655. Those services received by the aged, blind or disabled MN person meeting the conditions of Section 50564 shall not be used to meet the remaining MFBU members' share of cost.

(c) A person meeting the conditions of Section 50564 shall be identified in the case file by the notation “Title II Disregard Person” beside the person's name on the applicable MC 176.

§ 50701. Beginning Date of Eligibility. [Renumbered]

§ 50703. Period of Eligibility. [Renumbered]

§ 50710. Retroactive Eligibility. [Renumbered]

§ 50715. Certification for Medi-Cal - Completion. [Renumbered]