ParaReg Headnotes
400-599 Medi-Cal Paraphrased Regulations

Section 400-410

400-1 Medi-Cal regulations are in Title 22, California Code of Regulations (CCR), and cites are to the CCR (50005)

400-1A W&IC is the abbreviation for the Welfare & Institutions Code

400-1B Hearings are governed by provisions in the Welfare and Institutions Code (W&IC) (50951(b))

400-1C Right to hearing on any action relating to Medi-Cal eligibility or benefits; exceptions (50951(a))

400-2 Reference to DSS regulations on hearing procedures (50953)

400-3 DHS has sole authority for Medi-Cal decisions (50953(c))

400-5 Medi-Cal Program administration (50004)

400-6 Federal rules at Medicaid hearings (42 CFR 431.242)

400-7 Federal rules regarding hearing decisions (42 CFR 431.244)

400-8 State must specify a single State agency to administer Medicaid program, and that agency must not delegate to others outside agency authority to exercise administrative discretion, or issue policies, rules, and regulations on program matters (42 CFR 431.10(b),(c))

400-9 DHS representative and Managed Care representative can make stipulations and agreements at hearing (MPP 22-073.37)

401-1 After NOA denying Medi-Cal eligibility due to excess property, applicant may still establish eligibility up to three years later, and county must rescind and issue benefits including NOA if necessary (ACWDL 97-41)

404-1 Requirements for denial NOA (ACWDL 97-48)

404-2 Required language on NOAs denying due to excess property (ACWDL 97-41)

404-3 Required county actions, and required NOA language, after approval of retroactive Principe benefits (ACWDL 97-41)

404-4 When an NOA must be sent in regard to “medical services” (51014.1(a))

404-4A Contents of the required NOA for reduction or termination of "medical services" (51014.1(c), (i))

404-4B APP requirements when there is a timely filing after proposed reduction or termination of "medical services" (51014.2(a),(b))

404-5 NOA requirements when a CalWORKs discontinuance occurs 7/1/01 and following (ACWDL 01-17; SB 87)

404-6 BICs have replaced Medi-Cal cards and MC 177 forms as of 6/1/97; NOA is required before discontinuance can occur (ACWDL 96-06; Denti-Cal Bulletin, Vol. 13, No. 13; *Bowman* v. *Belshé*)

404-7 Notice of Action must include a statement of the action that the county intends to take. (ACWDL 13-13)

404-8 Requirements for notice of action regarding Medi-Cal application (ACWDL 13-13)

404-9 Conditional notices do not meet notice of action requirements (50179(f))

404-10 Time frames for mailing notices of action (50179(d))

404-11 Required elements of notices of action (50179(c))

404-11A Notices of Action regarding failure to supply information must specify the information required in order to be adequate. Notice must also indicate 90 day period for curing the failure (ACWDL 15-27)

404-12 Notice to use prescribed form, have contact information, and be added to case file (50179(b) and ACWDL 13-13)

404-13 When notice of action required (50179(a))

404-14 Notice of Action provisions in Medi-Cal Eligibility Procedures Manual (MEPM 4-4U)

406-1 State hearing appeal for Low Income Health Plan must follow an internal county level appeal. (42 CFR 438.402)

406-2 Actions subject to appeal for Low Income Health Program (LIHP) applicants and recipients. (DHS Document, April 23, 2011)

406-3 No right to hearing on Healthy Families Program administered by Managed Risk Medical Insurance Board prior to January 1, 2013. (Insurance Code 12693.20) Healthy Families participants became Medi-Cal beneficiaries by operation of law on January 1, 2013. (ACWDL 12-30; ACWDL 12-33)

406-4 Processing of appeals regarding Low Income Health Program (LIHP) (22-004.2)

410-1 Time period for processing applications; reasons for extension of such limits (50177(a))

410-1A County must refer disability application to DED within 10 days (ACWDL 93-50; *Radcliffe v. Cahill*)

410-1C After NOA denying Medi-Cal eligibility due to excess property, applicant may still establish eligibility up to three years later, and county must rescind and issue benefits including NOA if necessary (ACWDL 97-41)

410-2 Circumstances under which persons other than applicant or spouse may complete application documents (50163(a))

410-2A Definition of "applicant" (50021)

410-2B Definition of "competent" (50032)

410-2C Application defined; county duty to complete SAWS I when applicant calls in to apply for Medi-Cal (50022; ACWDL 00-31)

410-2D Medi-Cal form 210 available in English and 10 other languages (ACWDL 01-68)

410-3 Face-to-face interview necessary only at time of application and not required when adding adults to MFBU; totally eliminated effective July 1, 2000 (50157(a); ACWDL 99-36, ACWDL 00-17, ACWDL 00-31)

410-3A Elimination of face-to-face interview except when good cause or fraud exist (ACWDL 00-31)

410-3B Beneficiary is a person determined eligible for Medi-Cal (50024)

410-3C Requirement for simplified application process, face to face interview only for good cause or fraud (W&IC 14011.15)

410-4 Procedure for withdrawal of Medi-Cal application (50155)

410-5 Persons who may file an application (50143(a))

410-6 County duty to accept and promptly act on applications; who may file applications (50141, 50143)

410-7 Application as a basis for determination, applicant's duty to provide necessary additional information; county's duty to assist in this process (50171)

410-8 County welfare department the agent of CDHS (50004(c))

410-9 Requirements to protect applicants' right to apply when welfare offices closed on normal working days (*Blanco v. Anderson and Belshé*)

410-9A Requirement to provide for filing applications on normal working days implemented (*Blanco v. Anderson*; ACL 94-108, ACL 95-08)

410-10 Medi-Cal must continue for beneficiaries discontinued from Title II or SSI at least for 65 days, and if appeal is filed and is subject to federal review, until "FINAL" decision (i.e., no more appeals can be filed) is rendered (ACWDL 97-28)

410-11 SSI former recipients are PA recipients until appeal rights are terminated, even if they transfer to AFDC/TANF and then are discontinued from AFDC/TANF (ACWDL 97-28)

410-12 No longer disabled SSI/SSP recipients to be treated akin to *Edwards* discontinuances (ACWDL 97-28)

410-12A Formerly Healthy Families recipients to be transitioned to Medi-Cal and temporary eligibility provided without a new application. (ACWDL 12-30)

410-13 County of responsibility when eligibility is not based on being part of a family or on family income (50125)

410-13A County which accepts application, but is not county of responsibility, may still process application with consent of applicant, and initiate ICT (50135)

410-14 Requirement to outstation EWs at Disproportionate Share Hospitals and Federally Qualified Health Centers (ACWDL 98-13)

410-15 Required county actions, and required NOA language, after approval of retroactive Principe benefits (ACWDL 97-41)

410-16 Notice to be sent when re-evaluation of Medi-Cal eligibility occurs (W&IC 14005.31(b))

410-17 What happens when Medi-Cal benefits are transferred from one program to another, and required notice (W&IC 14005.32(a))

410-17A Written TMC notice must be given to CalWORKs and 1931(b) recipients when Medi- Cal eligibility is determined and six months thereafter, or when they are terminated due to failure to meet reporting responsibilities (ACWDL 01-45)

410-18 When re-evaluation shall not re-occur after loss of Medi-Cal eligibility; continuation of benefits when evaluation is occurring; required notices (W&IC 14005.37)

410-18A County requirements after denying or discontinuing CalWORKs/1931(b) benefits, including ex parte responsibilities (ACWDL 01-36)

410-18B Specific mandate to use Form MC 355 as request for information form, contents of the form, time limits, county requirements (ACWDL 01-39)

410-18C Required SB 87 procedures for counties evaluating Medi-Cal eligibility (ACWDL 02-59, ACWDL 07-24)

410-18D Required MC355 process (ACWDL 07-24)

410-18E County must reevaluate eligibility under other Medi-Cal categories if eligibility ceases

under one category; aid pending continues, effective 7/1/01 (50183(a); MEPM 4-0-3; W&IC 14005.31, W&IC14005.32, W&IC14005.37; ACWDL 02-59)

410-18F Medi-Cal beneficiary may continue to receive Medi-Cal after SSI/SSP discontinuance based on "no longer disabled" if he/she alleges a new disability (ACWDL 04-31)

410-18G Steps county must follow in different circumstances regarding annual redetermination form (ACWDL 06-16)

410-18H County must follow SB 87 process if annual redetermination packet is returned as undeliverable (ACWDL 06-16)

410-18I If person who no longer has linkage to Medi-Cal program but alleges disability on MC210 RV, county must continue Medi-Cal (ACWDL 06-17)

410-19 If county is sure that there is no need to transfer eligibility to another Medi-Cal program, no redetermination necessary but documentation must occur and notice must be sent (W&IC 14005.39)

410-20 County requirements for evaluation of non-MAGI eligibility when MAGI eligibility ceases. (ACWDL 14-18)

410-21 County requirements for evaluation of MAGI eligibility when non-MAGI eligibility ceases. (ACWDL 14-18)

Section 411-419

411-1 Purpose of Medi-Cal Program is to provide, to the extent practicable, health care benefits to eligible persons (W&IC 14000)

411-2 County must act with courtesy, consideration, and respect (W&IC 10500)

413-1 DHCS policy on LEP clarifying county responsibility to provide efficient language services (ACWDL 10-03)

413-1A Guideposts for counties in providing effective language services to Limited English Proficient (LEP) individuals (ACWDL 10-03)

413-1B Counties must use translated forms/NOAs provided by DHCS and not English version for those preferring non-English version; counties must provide interpretation services to LEP individuals upon request to regardless of whether DHCS has translated notices/forms (ACWDL 10-03)

413-1C Counties required to ask applicants/beneficiaries their preferred language for oral and written communication (ACWDL 10-03)

413-4 Medi-Cal form 210 available in English and 10 other languages (ACWDL 01-68)

413-5 At application and renewal counties to provide multilingual notification and if necessary

provide notice of interpretive services (MEDIL I-14-54)

414-1 Duties of counties which have a procedure for screening applicants (50142)

414-2 IHSS and AFDC applicants not required to submit separate application. If AFDC or IHSS is approved, Medi-Cal is automatic (50145)

414-3 Persons or families denied Medi-Cal under any program other than SSI/SSP shall be reviewed for any other type of eligibility (50180)

414-4 County shall set reasonable deadline for returning the Statement of Facts, inform applicant of the deadline, and attempt to contact applicant if Statement is not submitted by deadline (50165)

414-4A Requirements for two contacts, then specific NOA, if county is to deny applications for failure to provide information; discontinuance actions governed by SB 87 (ACWDL 90-07, ACWDL 97-48, ACWDL 02-59)

414-5 Legislative intent to process nursing facility applications timely, and to encourage nursing facility participation (SB 635)

414-5A County may not deny application of LTC person due to non-cooperation of representative, but must do diligent search (ACWDL 94-62)

414-6 Nursing facility applicants shall be assisted in applying and have applications processed timely (W&IC 14110.05)

414-7 Requirement to outstation EWs at Disproportionate Share Hospitals and Federally Qualified Health Centers (ACWDL 98-13)

414-8 Two contacts mandated, and must be documented, when county is proposing to discontinue on redetermination and beneficiary fails to provide information/verification (ACWDL 97-48)

414-8A Implementation of two contact requirement applies to mail-in applications (ACWDL 08-07)

414-8B Clarification on what constitutes contact (ACWDL 08-07)

414-8C Application process reminders (ACWDL 08-07)

414-8D Two contact requirement applies to applicants; SB87 process applies to beneficiaries (ACWDL 08-07)

414-10 Income maintenance responsibility to make and record eligibility and grant determinations for PA cases, and for MN share of cost cases (MPP 11-501.1)

414-11 State law eliminated the requirement that pregnant women and children complete a face-to-face interview (W&IC 14011.1; ACWDL 98-42)

414-11A Elimination of face-to-face interview except when good cause or fraud exist (ACWDL 00-31)

414-12 County must send informing brochures and forms with redetermination notice, and provide such information to beneficiaries on request (ACWDL 99-36)

414-13 Application defined; county duty to complete SAWS I when applicant calls in to apply for Medi-Cal (50022; ACWDL 00-31)

414-13A Protecting the date of application in mail-in or walk-in situations; county duty to assist; when applicant need not sign application for Medi-Cal, but must still sign for CalWORKs and CalFresh (ACWDL 01-06)

414-13B Information which must be included when an application is mailed to, or handed to, an applicant (ACWDL 01-06)

414-13C If application is by voicemail, the date of the call is the date of application. (MEDIL I 16-01)

414-14 Counties must provide DHCS 0001 form to applicants and DHCS 0002 form to beneficiaries (ACWDL 07-12)

415-1 Denial of application for failure to cooperate (50175(a))

415-1A Notices of Action regarding failure to supply information must specify the information required in order to be adequate. Notice must also indicate 90 day period for curing the failure (ACWDL 15-27)

415-1B Denial/discontinuance for noncooperation applies only to individual who fails to cooperate and those for whom he/she is responsible (ACWDL 92-09)

415-1C Annual Medi-Cal redetermination required by state and federal law (ACWDL 06-16)

415-1D Informing beneficiary of annual redetermination requirements (ACWDL 06-16)

415-1E Counties must mail only MC 210 RV form along with mandated program information; no need for *ex parte* review prior to sending redetermination packet (ACWDL 06-16)

415-1F County must allow beneficiary at least 20 days to complete and return required forms; may not require face-to-face interview unless SB 87 process will not resolve all issues (ACWDL 06-16)

415-1G If good cause for failing to return forms within 30 days after Medi-Cal termination, Medi-Cal is reinstated without break in benefits; if no good cause, beneficiary must reapply (ACWDL 06-16)

415-1H If annual form returned complete with verification within 30 days of termination, county must determine eligibility as though submitted timely (ACWDL 06-16)

415-1I County must evaluate eligibility annually and whenever information is presented. (W&IC 14005.37(a), in pertinent part; W&IC 14005.39(a))

415-2 General duty of applicant or beneficiary to cooperate (50185(a))

415-2A DA decides whether person has cooperated in identifying the absent parent, securing medical support, and determining paternity, but the county makes the good cause determination (ACWDL 97-64; MEPM 23E-1)

415-2B Good cause claim for cooperation re paternity, medical support results in eligibility for Medi-Cal if other conditions are met, and once granted, shall continue until or unless the county decides at redetermination that circumstances have changed (MEPM 23E-1)

415-2C Criteria for establishing if good cause for noncooperation with the FSD/DA exists, and evidence which can support claim; good cause determination made by county (MEPM 23E-2, 3)

415-2D FSD/DA makes determination of noncooperation in establishing paternity, medical support; necessity to have staff persons readily available; cooperation requirements and factors to consider as to whether cooperation exists (MEPM 23E-1)

415-3 Denial or discontinuance due to noncooperation can be rescinded if good cause established (50175(b)(2))

415-3A Termination to be rescinded if information submitted prior to termination date. (MEDIL I 15-22E)

415-4 Good cause for failure to cooperate (50175(c))

415-5 Duty to report changes within 10 days (50185(a)(4))

415-5A Statutory requirement to report significant changes within 10 days. (W&IC 14005.31(b)(4))

415-6 Applicant or recipient must take action to accept unconditionally available income as a condition of eligibility (50186)

415-7 Applicant must attempt to obtain Social Security Number (50187)

415-8 Parent, not child, disqualified for parent's failure to cooperate with medical support or identifying an absent parent or determining paternity (ACWDL 93-56, ACWDL 97-64; 50175(a)(7); MEPM 23E-1, 2; W&IC 14008.7)

415-8A Good cause requirements for failure to cooperate in paternity, medical, or child support, or third-party payments (50771.5(a)-(c))

415-9 Serious physical or emotional harm defined; burden on applicant (50771.5(d)-(f))

415-10 Claims for good cause for medical support required only once per situation (ACWDL 93-56)

415-11 Documentation of U.S. citizenship and identity required (ACWDL 07-04)

415-11A Federal law requires CDHS to implement federal citizenship/identity documentation requirements with as much flexibility as allowed (ACWDL 07-04)

416-1A Recipients must still report changes of items affecting Medi-Cal eligibility within 10 days (ACWDL 00-64)

416-3 Midyear status report requirement and exemptions from that requirement; children under 19 now required to complete MSR (W&IC 14011.16; ACWDL 03-41; ACWDL 08-56)

416-4 Groups exempt from MSR requirements (ACWDL 08-56; W&IC 14011.17)

416-4A Groups exempt from MSR requirements in addition to the mandated group of exempt beneficiaries (ACWDL 08-56, W&IC 14011.16)

416-4B Children under the age 19 must comply with MSR requirements; CEC reduction from 12 months to 6 months suspended from 10/08 through 12/10 (ACWDL 08-56; ACWDL 09-15)

416-4C Fact that a beneficiary is exempt from MSR does not affect any other reporting obligations (ACWDL 08-56)

416-4D Qualifying for MSR exemption based on pregnancy includes reporting the pregnancy before or during MSR process (ACWDL 08-56)

416-4E Counties must Bridge children to the Healthy Families when the MSR documents increased income that would result in a child no longer being eligible for $0 share of cost Medi-Cal (ACWDL 08-56)

416-4F Counties must implement the new MSR requirements effective January 1, 2009; CEC reduction from 12 months to six months suspended from 10/08 through 12/10 (ACWDL 08-56; ACWDL 09-15)

416-4G CalWORKs beneficiary who is discontinued from CalWORKs for failure to submit a QR7 is subject to MSR reporting unless otherwise exempt (ACWDL 08-56)

416-4H Counties shall continue the current policy to mail the MSR to the non-exempt beneficiary in the sixth month (ACWDL 08-56)

416-4I When the beneficiary submits an incomplete MSR, the county must follow the SB 87 process before initiating any discontinuance action (ACWDL 08-56)

416-4J MSRs received after discontinuance date (ACWDL 08-56)

416-4K When the MSR, or other mail, is returned to the county as undeliverable, the county is

required to follow the three-step SB 87 process (ACWDL 08-56)

416-4L When sending county has sent beneficiary a MSR in the mail, beneficiary has responsibility to submit MSR and sending county continues to be the county of responsibility (ACWDL 08-56)

417-1 *Edwards* v. *Myers* relating to continuing Medi-Cal following the discontinuance of AFDC-related Medi-Cal; re-evaluation for all programs required as of 7/1/01 (MEPM 40; W&IC 14005.31, W&IC 14005.32, W&IC 14005.37)

417-1A Refugees are eligible for Medi-Cal for eight months only under RMA/ECA; county must determine eligibility and send application 60 days before eight month period ends (ACWDL 08-43)

417-2 All Medi-Cal discontinuances are now subject to the provisions of Senate Bill 87, which requires evaluation of eligibility under all possible Medi-Cal programs (W&IC 14005.31, W&IC 14005.32, W&IC 14005.37)

417-2A When recipient of Medi-Cal benefits is no longer eligible for benefits, re-evaluation of eligibility must occur (W&IC 14005.31(a))

417-2B Notice to be sent when re-evaluation of Medi-Cal eligibility occurs (W&IC 14005.31(b))

417-2C What happens when Medi-Cal benefits are transferred from one program to another, and required notice (W&IC 14005.32(a))

417-2D When re-evaluation shall not re-occur after loss of Medi-Cal eligibility; continuation of benefits when evaluation is occurring; required notices (W&IC 14005.37)

417-2E If county is sure that there is no need to transfer eligibility to another Medi-Cal program, no redetermination necessary but documentation must occur and notice must be sent (W&IC 14005.39)

417-2F Required SB 87 procedures for counties evaluating Medi-Cal eligibility (ACWDL 02-59)

417-3 Four-month continuing Medi-Cal benefits for AFDC families terminated because of increased child/spousal support (50243; ACWDL 90-32, ACWDL 90-33, ACWDL 90-66)

417-6 TMC eligibility (MEPM 5B-3, 4)

417-6A CalWORKs, 1931(b) and *Edwards* benefits count towards TMC eligibility period (MEPM 5B-11)

417-6B Receipt of CalWORKs plus 1931(b) in 3 of last 6 months meets TMC eligibility test (MEPM 5B-12)

417-6C TMC requirements (ACWDL 90-66, ACWDL 90-77, ACWDL 95-85, ACWDL 98-43)

417-6D Persons who are not eligible for TMC, even if the family lost CalWORKs or 1931(b)

benefits due to increased hours of employment or earned income (MEPM 5B-6)

417-6E What constitutes “because of” hours of employment or earnings for purposes of potential TMC eligibility (MEPM 5B-6, 7)

417-6F Persons receiving TMC are ineligible members of the MFBU of those persons who are not eligible for TMC; the ineligible TMC members may be, e.g., 1931(b) or MI eligible (MEPM 5B-10)

417-7 When TMC may be discontinued after initial six-month period (ACWDL 90-66; MEPM 5B-4, 5)

417-7A Written TMC notice must be given to CalWORKs and 1931(b) recipients when Medi- Cal eligibility is determined and six months thereafter, or when they are terminated due to failure to meet reporting responsibilities (ACWDL 01-45)

417-8A Second year of TMC eliminated (ACWDL 03-45)

417-9 County should process case for TMC even if flyer returned late (ACWDL 99-20)

417-10 TMC beneficiaries not required to complete annual redetermination (ACWDL 06-16)

417-11 CEC program protects zero share of cost children under 19 from discontinuance or an share of cost until the next redetermination, or until they turn 19, whichever is earlier; CEC period reduced from 12 months to six months effective January 1, 2009; Reduction of CEC from 12 months to six is suspended until December 2010 (ACWDL 01-01; AB 2900, ACWDL 08-55; ACWDL 09-15)

417-12 Statutory provisions for CEC program (W&IC 14005.25(a))

417-13 Child's eligibility under CEC continues through guaranteed period, but may not follow another zero share of cost continuous eligibility program (ACWDL 01-40)

417-13A New State law reduced the CEC program period from 12 months to 6 months effective January 1, 2009; Reduction of CEC from 12 months to six is suspended until December 2010 (ACWDL 08-55; ACWDL 09-15)

417-13B CEC continues for up to six months from initial eligibility to MSR or from MSR to annual redetermination: Reduction of CEC from 12 months to six is suspended until December 2010 (ACWDL 08-55; ACWDL 09-15)

417-14 CEC answers regarding MFBU composition, redeterminations, and SSI/SSP discontinuances (ACWDL 02-14)

417-14A Children who are eligible for CEC when added to an existing MFBU continue to retain $0 share of cost for initial 12-month period even if rest of MFBU has share of cost after annual redetermination (42 USC 1396a (e)(4), ACWDL 11-33)

417-14B Infant receiving benefits during continuous eligibility (deemed eligibility) remain eligible

until one year old if DE requirements met (ACWDL 06-16)

417-15 CEC applies to children discontinued from SSI/SSP (ACWDL 07-11)

417-15A SB 87 process modified for children discontinued from SSI/SSP (ACWDL 07-11)

417-16 "Bridging" program provides one month zero share of cost to children losing full- scope, no-cost Medi-Cal and who are apparently eligible for Healthy Families (ACWDL 01-57)

417-16A Bridging" program provides one month zero share of cost to children losing full-scope, no-cost Medi-Cal and who are apparently eligible for Healthy Families (ACWDL 07-03)

418-1 County which accepts application, but is not county of responsibility, may still process application with consent of applicant, and initiate ICT (50135)

418-2 ICT rules (ACWDL 03-12)

Section 420-429

420-1 Person must be citizen or eligible alien. Definition of eligible alien (50301(b))

420-1A MC 13 form used to process eligible citizen/immigrant status (ACWDL 96-34)

420-2A Unnecessary to obtain MC 13 from persons who claim to be born in the U.S. (ACWDL 03-14)

420-2B Citizens who need not complete Medi-Cal 13 form (MEDIL I-14-21)

420-2C Self attestation of citizenship sufficient (MEDIL I-14-21)

420-3 Persons automatically U.S. Citizens or nationals if born in specified locations (ACWDL 03-14)

421-1 Documentation of U.S. citizenship and identity required (ACWDL 07-12)

421-1A Federal law requires CDHS to implement federal citizenship/identity documentation requirements with as much flexibility as allowed (ACWDL 07-12)

421-1B County duty to assist in obtaining evidence of citizenship/identity; if otherwise eligible for Medi-Cal, but ineligible for full-scope Medi-Cal for lack of citizenship/identity verification, applicants/beneficiaries eligible for restricted Medi-Cal (ACWDL 07-12)

421-1C Documentation of citizenship and identity is a **one-time activity** (ACWDL 07-12)

421-1D New applicants are treated differently from ongoing beneficiaries (ACWDL 07-12)

421-2 Applicants and beneficiaries who are exempt from citizenship/identity verification (ACWDL 07-12; ACWDL 08-29)

421-2A Former SSI or Medicare recipients are not exempt from citizenship/identity requirements (ACWDL 08-29)

421-3 Requirement to document citizenship/national status does not apply when presumptive eligibility/accelerated enrollment is established, although is required when ongoing eligibility is determined (ACWDL 07-12)

421-4 Counties must provide DHCS 0001 form to applicants and DHCS 0002 form to beneficiaries (ACWDL 07-12)

421-4A Five-tier hierarchy of acceptable evidence of citizenship and identity (ACWDL 07-12)

421-4B Documentation establishing U.S. citizenship (ACWDL 07-12)

421-4C Documentation of identity required if Tier 1 evidence of citizenship is not available (ACWDL 07-12)

421-4D Acceptable evidence of identity (tier 5) (ACWDL 07-12)

421-4E New documents added as acceptable evidence of identity (ACWDL 08-29)

421-4F Clarification related to acceptable evidence of identity (ACWDL 08-29)

421-5 County must obtain evidence of citizenship/identity for applicants within prescribed time limit that may be extended for "good faith" effort to obtain documentation (ACWDL 07-12)

421-5A At redetermination, county must allow beneficiaries time to provide evidence of citizenship/identity as long as beneficiary is making "good faith" effort to obtain documentation (ACWDL 07-12)

421-5B Definition of "good faith" effort to obtain documentation of citizenship/identity (ACWDL 07-12)

421-5C Examples of "good faith" effort to obtain documentation of citizenship/identity (ACWDL 07-12)

421-5D County must provide reasonable assistance to persons incapable of obtaining required documents (ACWDL 07-12)

422-1 Non-citizen who is PRUCOL is eligible (50301)

422-1A MC 13 form used to process eligible immigrant status (ACWDL 96-34)

422-1B Definition of "permanently residing under color of law" (W&IC 14007.5)

422-2 Children under 19 without satisfactory immigration status entitled to full scope Medi- Cal benefits effective May 2016 (W&IC 14007.8, ACWDL 16-12)

422-4A Aliens who do not meet eligible alien requirements but are otherwise ineligible for Medi-Cal, may be entitled to medically necessary pregnancy-related services (W&IC 14007.7)

422-4B Definition of "emergency services" pertaining to non-PRUCOL alien eligibility (W&IC 14007.7)

422-4C Duration and nature of emergency services pertaining to non-PRUCOL alien eligibility (W&IC 14007.7)

422-7A Counties no longer required to verify the immigration status of immigrants who claim the last PRUCOL category on MC 13 (ACWDL 09-40)

422-7B For applicants who claim last PRUCOL category on MC13, there is no duty to complete G-845 or MC845 form; no county duty to verify PRUCOL at annual redetermination for those claiming last PRUCOL category on MC13 (ACWDL 09-40)

422-7C Process for reviewing immigrant status through SAVE (MEDIL I-14-21)

422-8 Spouses and unmarred children of IRCA alien immigrants eligible for Medi-Cal (ACWDL 93-14, ACWDL 93-49)

423-2 California residence continues until residence in another state or country is established (50320(e))

423-3 California residency requirements effective 5/17/93 (50320(a))

423-3A Children's residence generally follows parents, with one exception (50320(c))

423-4 Verification and declarations required to establish residency (50320.1(a))

423-5 ALJ decides, based on preponderance of evidence, that California residency exists because of intent to remain indefinitely, or because of Medi-Cal regulations (50320.2(f))

423-6 Weighing California residency when there is evidence to the contrary that such residency exists (50320(f); ACWDL 96-27)

423-6C State law requirements as how ALJs shall determine residency (W&IC 14007.1(b))

423-7 Determining residency of persons incapable of forming intent. (W&IC 14007.1)

423-8 Person who is out of state and unresponsive for two months is to be terminated (W&IC 14007.6)

425-1 Persons in public institutions are ineligible for Medi-Cal; certain persons in jails or prisons, or minors in detention centers or correctional facilities, are specified as ineligible (50273(a)1-8)

425-2 Regulations make IMD residents between 21 and 65 ineligible for Medi-Cal (50273(a)(9))

425-2A Under state law, persons from 21-64 in IMDs are not eligible for Medi-Cal unless there is FFP (W&IC 14053)

425-2B State law allowed persons 21-64 in MDs to receive ancillary services, even without FFP until 7/1/01 (W&IC 14053.1, repealed 7/1/01)

425-3 Persons ineligible for Medi-Cal due to institutional status (set forth in 50273(a)) are ineligible only while actually in that status (50273(b))

426-1 Background to Affordable Care Act and MAGI Medi-Cal (42 USC 1396a(a)(10)(A)(i)(VIII), (e)(14)(C); 42 CFR 435.119, 42 CFR 435.603(d)(44), (g)(1); 45 CFR 155.305; Gov't Code §§ 100500-100503; Short Doyle Aid Code Master Chart)

426-1A Description of Insurance Affordability Program (IAP) (42 CFR 435.4; W&IC 14057; 42 USC 1396a(a)(10)(A)(ii)(XIV); 42 USC 1396a(r)(2); 42 USC 1396d(u)(2)(B); 42 USC 1397jj(b); W&IC 14005.26; CA State Plan Amendment 13-005)

426-1B Individual is ineligible for APTC and CSR if eligible for MAGI Medi-Cal (26 USC 36B(b)(1), (c)(2)(B); 26 CFR §§ 1.36B-2(a)(2), 45 CFR 155.305(f)(1)(ii)(B); 10 CCR 6474(c)(1)(B))

426-1C MAGI Med-Cal recipients must enroll in available managed care (W&IC 14005.60Z(c); 22 CCR 53887, 22 CCR 53923.5)

426-2A MAGI Medi-Cal eligibility for adults 19 to 64 (42 USC 1396a(a)(10)(A)(i)(VIII); 42 CFR 435.119; 45 CFR 155.305(c); ACWDL 14-15)

426-2B MAGI Medi-Cal eligibility for children (including OTLIC) (42 USC 1396a(a)(10)(A)(ii)(XIV); 42 USC 1396a(r)(2); 42 USC 1396d(u)(2)(B); 42 USC 1397jj(b); 45 CFR 155.305(c); W&IC 14005.26; CA State Plan Amendment 13-005; ACWDL 14-15; ACWDL 14-21; State Medicaid & CHIP Policies 2014)

426-2C Eligibility of parent/caretaker relatives (42 USC 1396a(a)(10)(A)(i)(VIII); 42 CFR 435.110, 42 CFR 435.119; 42 CFR 435.603(d)(4); 45 CFR 155.305(c); W&IC14055; ACWDL14-15; ACWDL 14-21)

426-2D Definition of a caretaker relative (42 CFR 435.4; W&IC 14055)

426-2E Eligibility of pregnant women (42 USC 1396a(a)(10)(A)(i)(IV); 42 USC 1396a(a)(10)(A)(ii)(IX); 42 USC 1396a(l)(1)(A); 26 CFR 1.5000A-2(b)(2)(iii); 42 CFR 435.116; 42 CFR 435.119; 45 CFR 155.305(c); W&IC 14005.22,.225; MEDIL I-14-05; MEDIL I-14-31; ACWDL 14-15; MEDIL I-15-25)

426-2F Limited-Scope Medi-Cal for pregnant women do not constitute minimum essential coverage (26 CFR 1.5000A-2(b)(2)(iii); W&IC 14005.37; ACWDL14-18; CMS, Minimum Essential Coverage, SHO #14–002)

426-2G Women who report pregnancy as a change in circumstance (MEDIL I-14-31)

426-2H Individuals not evaluated using MAGI methods (42 CFR 435.603(j))

426-2I Former Foster Care Children, not Evaluated Using MAGI Methods (42 USC 1396a(a)(10)(A)(i)(IX); MEDIL I-14-05)

426-3A Applications processed using CalHEERS (W&IC 14015.5(f)(2); 10 CCR 6410)

426-3B One application to collect information and determine eligibility (42 USC 18083(a)(b); 42 CFR 435.907(b); 45 CFR 155.405(a)(b); W&IC 15926(c); 10 CCR 6470(a); MEDIL I-13-12; ACL 14-14)

426-3C Applicants who seek any IAPs must be evaluated for all IAPs (42 USC 18083(a); 45 CFR 155.310(b); 10 CCR 6476(b))

426-3D County duty to perform other evaluations if applicant not eligible for MAGI Medi-Cal California Department of Healthcare Services (26 USC 5000A(a)(b)(c); 26 CFR 1.5000A-2(b)(2)(v); 45 CFR 155.605(g)(1)(iii); MEDIL I-13-03; MEDIL I-13-12; ACWDL 14-18; W&IC 14005.32, W&IC 14005.37; Section 5000A Transition Relief for Individuals with Certain Government-Sponsored Limited-Benefit Health Coverage, Notice 2014-10, Internal Revenue Bulletin 2014-9 pp. 605-06; CMS - Minimum Essential Coverage, SHO No. 14–002, pp. 6-7 & 10-11; CMS Guidance on Hardship Exemptions for Persons Meeting Certain Criteria)

426-3E Covered California to transmit applications to counties in three days (45 CFR 155310(d)(3); W&IC 14015.5(c); 10 CCR 6476(e), (f))

426-3F Applications that Covered California must forward to counties (W&IC 15926(h)(2), MEDIL I-13-12)

426-4A Multiple methods must be allowed for applications (10 CCR 6470(j), 42 USC 18083(b)(1); 45 CFR 155.405(c)(2); W&IC 15926(b); MEDIL I-13-12)

426-4B Continued use of certain existing applications until January 1, 2016 (W&IC 15926(c)(4)(G); MEDIL I-13-12)

426-4C Content required in application (42 USC 18083(b)(2); 42 CFR 435.907(e),(f); W&IC 15926(h)(1); 10 CCR 6470(b))

426-4D Requirement to provide social security number (42 USC 1320b-7(a)(1); 42 CFR 435.910(a), (h); W&IC 14007.5(d), W&IC 15926(c)(4)(B); 22 CCR 50187(a), (b))

426-4E County duty to assist applicants who cannot recall, or do not have, social security numbers (42 CFR 435.910(e))

426-4F Requests for social security numbers from non-applicants (42 CFR 435.907(e))

426-4G No face-to-face interview required (42 CFR 435.907(d); W&IC 14011.1(d), W&IC 14011.15(e))

426-4H Timeline to determine eligibility (42 USC 1396a(a)(8); 42 CFR 435.912(a); W&IC 15926(e); 22 CCR 50177)

426-5A MAGI Medi-Cal effective date of eligibility (22 CCR 50193; 42 USC 1396a(a)(10)(A)(i)(VIII))

426-5B Retroactive Medi-Cal Eligibility (22 CCR 50148; 22 CCR 50197(a); 42 USC 1396(a)(10)(A)(i)(VIII))

426-5C Applicants must move between programs without any breaks in coverage (W&IC 15926(h)(1))

426-5D Determining county of responsibility (22 CCR 50120, 22 CCR 50123; 22 CCR 50125)

426-5E Application in county other than county of responsibility (22 CCR 50135)

426-6A Inter-County transfers (ICTs), ongoing eligibility with no interruption in benefits (ACWDL 03-12)

426-6B Inter-County transfers, duties of sending county (ACWDL 03-12)

426-6C Inter-County transfers, duties of receiving county (ACWDL 03-12)

426-6D Inter-County Transfers, sending county termination date and receiving county effective date (ACWDL 03-12)

427-1A Requirement for citizenship or satisfactory immigration status (8 USC 1641; 42 USC 1396b(v)(1); 42 CFR 435.406; W&IC 14007.5; 22 CCR 50301(b))

427-1B California residence required for eligibility (42 CFR 435.403(a); W&IC 14007; W&IC 14007.15(a))

427-1C A recipient maintaining residence out of state for two months not eligible, subject to rebuttal (W&IC 14007.6(a))

427-1D Reapplication by out-of-state recipient after reestablishing residency (W&IC 14007.6(b); W&IC 14007.15)

427-1E Instructions on individual eligibility determinations, appropriate county action on data errors. (ACWDL 16-16)

427-1F Procedures for determining children's conditional eligibility when loss of contact or other changes (ACWDL 16-16)

427-1G Procedures for children provided with presumptive eligibility through Accelerated Enrollment (ACWDL 16-16)

427-1H Procedures for individuals determined conditionally eligible by CalHEERS (ACWDL 16-16)

427-1I Individuals considered eligible by CalHEERS are considered eligible for Medi-Cal even if eligibility pending for other family members (ACWDL 16-16)

427-2A Financial eligibility overview for MAGI-Based Medi-Cal (42 CFR 435.603)

427-2B MAGI Medi-Cal household composition (42 CFR 435.603(b), (f))

427-2C Household with pregnant woman includes unborn child or children (42 CFR 435.603(b); CA State Plan Amendment 13-0023 p. 5.)

427-2D Married Couples living together, each spouse's household includes the other spouse (42 CFR § 435.603(f)(4).)

427-3A Basic rule for individual taxpayers not claimed as tax dependents (42 CFR 453.603(f)(1), (3), (4); CA State Plan Amendment 13-0023 p.6)

427-3B Basic rule for child of any age claimed as dependent by taxpayer(s) who is (are) child's parent (42 CFR 435.603(f)(2))

427-3C Individuals other than a spouse or child claimed as dependents by taxpayers (42 42 CFR 435.603(f)(2)(i), (f)(3); CA State Plan Amendment 13-0023 p. 6)

427-3D Child claimed as tax dependent by only one parent and living with both parents who do not file a joint tax return (42 CFR 435.603(f)(2)(iii), (f)(3); CA State Plan Amendment 13-0023 p. 6)

427-3E Child claimed as tax dependent by non-custodial parent (§42 CFR 435.603(f)(2)(iii), (f)(3); CA State Plan Amendment 13-0023 p.6.)

427-3F Individuals who do not file taxes and who are not claimed as dependents (42 CFR 435.603(f)(3))

427-3G Who taxpayers may claim as dependents (26 USC 151, 152)

427-3H Definition of a qualifying child (26 USC 152(a), (b), (c); 26 CFR 1.152-1, 1.152-2(a))

427-3I Special qualifying child rule for individuals with disability (26 USC 152(c)(3)(B))

427-3J Parent and non-parent taxpayers that can claim the qualifying child (26 USC 152(c)(4)(A))

427-3K Two parent taxpayers that can claim the qualifying child (26 USC 152(c)(4)(B); 26 CFR 1.152-4(a))

427-3L Custodial parent's release of claim to exemption (26 USC 152(e); 26 CFR 1.152-4(b))

427-3M Definition of a qualifying relative (26 USC 152(a), (b), (d); 26 CFR 1.152-1, 26 CFR 1.152-2(a))

427-3N Qualifying relative – household determination steps (42 CFR 435.603(d), (e))

427-4A Household income determination overview (42 CFR 435.603(d); 435.603(f)(i); IRS Publication 501 (2014), Table 2)

427-4B Determining whose income is included (42 CFR 435.603(d), 42 CFR 435.603(f)(i); IRS Publication 501 (2014) Table 2)

427-4C Tax filing thresholds – individuals claimed as dependents (26 USC 6012; 26 CFR 1.1-1; IRS Publication 501 (2014), Table 2; see also 26 USC 86 (rules for determining whether social security benefits are taxable)

427-4D 2014 Tax filing thresholds – individuals claimed as tax dependents (26 USC 6012; 26 CFR 1.1-1; IRS Publication 501 (2014), Table 2; see also 26 USC 86 (rules for determining whether social security benefits are taxable)

427-4E Modified adjusted gross income, general definition (26 USC 36B(d)(2)(B); 26 CFR 1.36B-1(e)(2); 42 CFR 435.603(e))

427-4F Adjusted Gross Income (AGI), general definition (26 USC 62, 162(l), 164(f); 26 CFR 1.62-1(c); IRS Form 1040 Instructions (2014), pp. 30-37)

427-4G General definition of gross income (26 USC 61, 22 USC 85; 26 CFR 1.61-1; *Hyde v. Commission* (2011) Tax Court Memo 2011-104, 101 T.C.M. (CCH) 1502; IRS Publication 501, Table. 1 (2013)

427-4G1 Gross income – self-employment income (26 USC 1402(a); IRS Form 1040, Schedule C (2015); IRS Form 1040 Instructions (2015))

427-4H Gross income - Social Security benefits (26 USC 86; *Maki v. Commissioner* (1996) Tax Court Memo 1996-209, RIA TC Memo P 96209, 71 T.C.M. (CCH) 2933)

427-4I Gross Income does not include workers' compensation (26 USC § 104; 26 CFR § 1.104-1(b); IRS Publication 17 (2013) p. 53; IRS Publication 525 (2013), pp. 18-19)

427-4J Gross Income does not include Veteran's Benefits (26 USC 104; 26 USC 122; 26 USC 134; IRS Publication 17 (2014) pp. 51-53; IRS Publication 525 (2014), pp. 15-16)

427-4K Gross Income does not include child support (26 USC 71(c))

427-4L IHSS wages included; exception for WPCS wages when provider in home with service recipient (26 USC 36B(d)(2)(B); 26 USC 131; Internal Revenue Bulletin: 2014-4, (January, 2014);IRS Notice 2014-7(August, 2015); MEDIL 15-03)

427-4M Income considered available if taxpayer has access to it in the taxable year (26 CFR 1.451-2(a))

427-4N Conversion of weekly or biweekly income to monthly income (22 CCR 50517)

427-4O Deductions permitted when calculating Adjusted Gross Income (AGI) (26 USC 62; 26 USC 162(l); 26 USC 164(f); 26 CFR 1.62-1(c); IRS Form 1040 Instructions (2014) pp. 30-37; IRS Publication 970 (2014) pp. 37-43)

427-4P Conditions where taxpayer can deduct moving expenses (26 USC 62(a)(15); 26 CFR 1.62-1(c))

427-4Q Five-Percent income disregard allowed in determining whether income is under the MAGI limit (42 USC §§ 1396a(e)(14)(C), 1396(e)(l)(1); 42 CFR § 435.603(d)(4),(g)(2); W&IC 14005.64(b))

427-4R No assets or resource test for MAGI eligibility (42 CFR 435.603(g)(1))

427-5A Applicants use current monthly income and family size, which may be prorated (42 CFR 435.603(h)(1), (h)(3); W&IC 14005.65; CA State Plan Amendment 13-0023, p. 5)

427-5B Beneficiaries may use projected annual income and family size, remainder of calendar year (42 CFR 435.603(h)(2), (h)(3), (h)(3); W&IC 14005.65; CA State Plan Amendment 13-0023, p. 5.)

427-5C MAGI Medi-Cal, 2015 Federal Poverty Level applicable beginning January 1, 2015 (42 USC § 9902(2); 42 CFR § 435.4; ACWDL 15-14)

427-5D MAGI Medi-Cal, 2014 Federal Poverty Level applicable April 1, 2014 through December 31, 2014 (42 USC 9902(2); 42 CFR 435.4; ACWDL 14-04)

427-5E MAGI Medi-Cal, 2013 Federal Poverty Level applicable Jan. 1, 2014 through March 31, 2014 (42 USC 9902(2); 42 CFR 435.4; ACWDL 13-09)

427-5F Medi-Cal process if applicant is initially found ineligible for both Medi-Cal and APTC (42 CFR 435.603(i))

427-6A MAGI Medi-Cal annual redetermination requirement (42 CFR 435.916(a); W&IC §14005.37(a); ACWDL 14-32)

427-6B Annual redetermination, county and CalHEERS ex parte review of records (42 CFR 435.916(a); W&IC 14005.37(e); ACWDL 14-32)

427-6C Annual redetermination, ex parte review confirms eligibility (42 CFR 435.916(a); W&IC 14005.37(e); ACWDL 14-32)

427-6D Annual redetermination, request information if CalHEERS cannot confirm eligibility (42 CFR § 435.916(a); W&IC 14005.37(f); ACWDL 14-32)

427-6E Annual redetermination, Medi-Cal discontinued if beneficiary does not provide information (W&IC 14005.37(f); ACWDL 14-32; *Korean Community Center of the East Bay v. Kent* (Super. Ct. Alameda County, No. RG14748387).)

427-6F Annual redetermination, further evaluation if beneficiary provides requested information (W&IC 14005.37(f); ACWDL 14-32)

427-6G Annual redetermination, benefits renewed if CalHEERS confirms beneficiary's information (September ACWDL 14-32)

427-6H Annual redetermination, CalHEERS determines beneficiary not eligible for MAGI Medi-Cal (26 USC 5000A(a)(b)(c); 26 CFR 1.5000A-2(b)(2)(v); 45 CFR 155.605(g)(1)(iii); W&IC 14005.37 & W&IC 15926(h)(1); ACWDL 14-18; ACWDL 14-32; *Korean Community Center of the East Bay v. Kent* (Super. Ct. Alameda County, No. RG14748387); IRS Bulletin 2014-9, pp. 605-06; CMS Guidance on Hardship Exemptions)

427-6I Beneficiary must report changes in circumstances affecting Medi-Cal Eligibility within 10 days (42 CFR 435.916(c); W&IC 14005.37(h))

427-6J County duty to redetermine when beneficiary reports change in circumstances (42 CFR 435.916(d); W&IC 14005.37(a), (e), (g))

427-6K Change of circumstances, county and CalHEERS ex parte review of records (42 CFR 435.916(a); W&IC 14005.37(e))

427-6L Change of circumstances, ex parte review confirms eligibility (W&IC 14005.37(e)(4))

427-6M Change of circumstances, request information if CalHEERS cannot confirm eligibility (W&IC 14005.37(g))

427-6N Change of circumstances, Medi-Cal discontinued if beneficiary does not provide information (W&IC 14005.37(g)(3); *Korean Community Center of the East Bay v. Kent* (Super. Ct. Alameda County, No. RG14748387))

427-6O Change of circumstances, further evaluation if beneficiary provides requested information (W&IC 14005.37(g)(3); ACWDL 14-18; ACWDL 14-32)

427-6P Change of circumstances, beneficiary no longer eligible for MAGI Medi-Cal (26 USC 5000A-2(b)(2)(v); 26 CFR § 1.5000A-2(b)(2)(v); 42 CFR 435.916(d); 45 CFR 155.605(g)(1)(iii); W&IC 14005.37;W&IC 15926(h)(1); ACWDL 14-18; ACWDL 14-32 ; *Korean Community Center of the East Bay v. Kent* (Super. Ct. Alameda County, No. RG14748387); IRS Notice 2014-10, IRS Bulletin 2014-9 pp. 605-06; CMS Minimum Essential Coverage, SHO #14–002 (Nov. 7, 2014) at pp. 6-7 & 10-11)

427-6Q Termination to be rescinded if beneficiary submits information within 90 days (W&IC 14005.37(i), (j); California Department of Healthcare Services, ACWDL 14-18 pp. 6-9)

427-6R Notification of Process to Cure (22 CCR 50179 (c)(7); W&IC 14005.37(i); ACWDL 14-18, pp. 6-9; *Korean Community Center of the East Bay v. Kent* (Super. Ct. Alameda County, No. RG14748387))

427-7A Verification of U.S. citizenship or satisfactory immigration status (42 USC 1396A(ee); 42 USC 1396b(x); 42 CFR 435.407, 42 CFR 435.945(b); 42 CFR 435.952; MEDIL I-14-21)

427-7B Immigration status may not be used to determine state residency (42 CFR 435.956(c)(2))

427-7C Indefinite suspension of paper verification requirements for residency; verify with attestation (42 CFR 435.945(a); 42 CFR 435.952, 42 CFR 435.956(c); MEDIL I-14-44)

427-7D Self-Attestation of Age, Date of Birth and Household Size (42 CFR 435.945(a); 42 CFR 435.956(f); 42 CFR 435.952)

427-7E Electronic income verification (42 CFR 435.948; W&IC 14013.3(a), (b))

427-7F Reasonably compatible information, definition (W&IC 14013.3(c)(3))

427-7G Information accepted if reasonably compatible (W&IC 14013.3(c)(1))

427-7H Verification process if income information is not reasonably compatible (W&IC 14013.3(c)(2); MEDIL I-14-16 p. 1.; MEDIL I-4-23)

427-7I County should accept attestation of pregnancy unless in possession of contrary information (W&IC 14013.3(d); 42 CFR 435.952; 42 CFR 435.956(e))

427-7J General verification requirement, other than for income and pregnancy (42 CFR § 435.952; W&IC 14013.3(e))

427-7K Limitation on situations when county should require additional information or documentation (42 CFR 435.952(c))

427-7L No negative action without seeking additional information or documentation, and providing notice and hearing rights (42 CFR 435.952(c))

428-1A Notice of Action; when required (42 CFR 435.913; 42 CFR 431.206(b)(1), 42 CFR 431.210; 22 CCR 50179(c); ACWDL No. 13-13)

428-1B Conditional notices are not considered a notice of action (22 CCR 50179(a), (f))

428-1C Required notice of hearing procedures (42 CFR 431.206(b); 22 CFR 431.210(e); 22 CCR 50179(c)(5), (6); ACWDL 13-13)

428-1D Notice of action must be timely and adequate (42 CFR 435.919(a); ACWDL 13-13)

428-1E Adverse action notice of action must be mailed at least 10 days prior to effective date (42 CFR 211; 22 CCR 50179(d)(1); ACWDL 13-13)

428-1F No 10-day notice requirement for non-adverse action notice of action (42 CFR 431.213; 22 CCR 50179(d)(2); ACWDL13-13)

428-1G Five-day notice if probable fraud (42 CFR § 431.214; ACWDL 13-13)

428-1H Notice of action must be in the case file (22 CCR 50179(b); ACWDL 13-13)

428-2A Appeals may be submitted by multiple methods (ACL 14-14) Appeals regarding Covered California or MAGI Medi-Cal conducted by CDSS SHD (10 CCR 6600; 10 CCR 6602; ACL 14-14 pp. 6-8)

428-2B Right to appeal if no eligibility decision within 45 days of application (*Rivera v. Douglas (DHCS)Douglas*, Alameda County Superior Court, Case No. RG1474091, Order Granting Petitioners' Motion for Preliminary Injunction (Jan. 20, 2015) p. 25; MEDIL I-15-11)

428-2C An appeal decision may have retroactive effect if appellant is otherwise eligible (22 USC 100506.4(i))

428-2D Eligibility for aid paid pending appeal hearing (42 CFR 431.230, 42 USC 431.231(c), (d); 51014.2(a))

428-2E Due process rights, MAGI Medi-Cal appeals (ACL 14-14, p. 8)

428-2F Counties' role in MAGI Medi-Cal appeal hearings (ACL 14-14, p. 8)

428-2G Hearings can involve both MAGI Medi-Cal and Covered California, known as "dual cases" (ACL 14-14)

428-2H Agency representative must contact appellant and attempt informal resolution (Govt. Code 100506.4(g)(1), (4))

428-2I Agency responsibility to contact other agency if it is determined to be a dual case (Govt. Code 100506.4(g)(1), (8)(c))

428-2J Dual cases, role of county and Covered California representatives, presentation of evidence (ACL 14-14, p. 18)

428-2K Mixed Coverage household involves member(s) receiving Covered California and member(s) receiving MAGI Medi-Cal (ACWDL 14-38)

428-2L Counties to notify state hearings if informal resolution obtained (ACL 14-14 ,pp. 12-13)

428-2M Appellant can request reopening of administrative dismissal if good cause shown (ACL 14-14, pp. 12-13)

428-2N Expedited appeal process available if there is immediate need (10 CCR 6616(a); 45 CFR 155.540(a); ACL 14-14, pp. 14-15.)

428-2O Expedited appeal decisions to be issued no later than 5 business days after close of record (10 CCR 6618(b)(2); ACL 14-14)

428-2P Conditional or unconditional withdrawals result in dismissal of appeal (10 CCR 6610(A)(1); ACL 14-14, p. 11.)

428-2Q Conditional withdrawal procedure; agreement required; action to be completed in 30 days (10 CCR 6610(a)(1)(C), ACL 14-14, pp. 11-12)

428-2R Verbal unconditional withdrawals to be followed with written notification to appellant, dismissal after 15 days (10 CCR 6610(a)(1)(C); ACL 14-14, p. 12)

428-2S Dismissal due to failure to appear/abandonment (10 CCR 6610(a)(2); 22-054.22)

428-2T Dismissal if appeal is not valid (10 CCR 6610(a)(3))

428-2U Dismissal if claimant/appellant dies while appeal pending; exceptions (10 CCR 6610(a)(4))

428-2V Written notice of dismissal to be sent to appellants; content of notice (10 CCR 6610(c))

428-2W Dismissal vacated for good cause (10 CCR 6610(d)(2); ACL 14-14, p. 13.)

428-2X Denial of request to vacate appeal - notice to claimant/appellant (10 CCR 6610(d)(2); ACL 14-14, p. 13)

428-3A Evidence to be considered during the appeals process (10 CCR 6614(e), (f); ACL 14-14, p. 18)

428-3B Covered California and County representatives have authority to issue stipulations during hearing process (22-073.37; ACL 14-14, p. 11-12)

428-3C Appellant entitled to appoint authorized representative (42 CFR 435.907(a); 42 CFR 435.923(a), (f); Govt. Code 100506.4(f); 10 CCR 6508(a), (b))

Section 430-439

430-1 Pregnant woman and postpartum eligibility (50260)

430-1A Beneficiaries of the Presumptive Eligibility for Pregnant Women (PE) program may require retroactive Medi-Cal; county duty to advise of retroactive coverage (ACWDL 08-27)

430-1B "Deemed" eligibility for infant born to mother receiving Medi-Cal regardless of infant's current living arrangements (ACWDL 09-17)

430-2 Eligibility to 200% program, pregnant women and infants (50262(a); ACWDL 94-91, ACWDL 95-28, ACWDL 95-52)

430-2A Period of eligibility and benefits available to pregnant women and infants in 185%, 200% programs (ACWDL 92-23; 50262(b) and (c))

430-2B Retroactive eligibility under property waiver program (50262(b); ACWDL 95-28)

430-2C Income of parents living with pregnant minor is exempt for 200% disregard program purposes (ACWDL 03-34)

430-3 Children one to six years of age eligible if family income does not exceed 133% of federal poverty level, and such children are automatically property eligible (ACWDL 90-34; ACWDL 98-06; 50262.5, W&IC 14148.75)

430-4 All FPL programs except QWDI shall disregard Title II COLAs until FPL charts are adjusted 4/1/01 (ACWDL 00-65)

430-5 In general, in Sneede situations, use net income of child plus parents to determine total income, and compare to MFBU standard, for percent program eligibility (MEPM 8G-6)

430-9 EGHP and HIPP are considered non-hearable issues by CDHS (ACWDL 95-71; ACWDL 95-82)

430-10 Children six to 19 years of age eligible for zero share of cost if family income does not exceed 100% of FPL and such children are automatically property eligible (ACWDL 92-23, ACWDL 98-06; 50262.6; W&IC 14148.75)

430-10A Adults under 19 also covered under 100% program (ACWDL 98-16)

430-21 Hierarchy of Medi-Cal programs for both aged/blind disabled MFBUs and non-aged/nondisabled MFBUs (ACWDL 06-41)

430-28 Safe Aims for Newborns eligibility (ACWDL 03-26; W&IC 14005.24)

430-29 Targeted Low Income Program (ACWDL 12-33)

431-1 MCCA, general instructions (ACWDL 90-01, ACWDL 90-03)

431-2 Definitions, institutionalized and community spouse (42 USC 1396r-5(h); ACWDL 91-55)

431-2A "Spouse" for MCCA purposes includes same sex marriages and registered domestic partners. (ACWDL 12-36, W&IC 14015.12)

431-3 Transfers, CSRA (42 USC 42 USC 1396r-5(f); ACWDL 08-49; ACWDL 09-53)

431-3A CSRA is combined separate property and community property of institutionalized and community spouses (ACWDL 90-01; 50031.7)

431-3B Property of institutionalized and community spouses treated in accord with 50490.1 through .7, supersedes any other sections inconsistent with those sections (ACWDL 90-01, draft regulation 50490)

431-3C Net market value of all available net non-exempt income of institutional or community spouse is available to the institutionalized spouse (ACWDL 90-01, draft 50490.3)

431-4 MMMNA, basic plus adjustments for indexing, at state hearing (42 USC 1396r-5(d), (e), (g); ACWDL 08-49; ACWDL 09-53)

431-5 CSRA, adjustments to raise CSRA to provide for minimum income (42 USC 1396r-5(e)(2), (f)(2))

431-6 Deposits into joint account by LTC spouse treated as transfer of income to spouse at home (ACWDL 90-89)

431-7 Determination of income of institutionalized spouse (42 USC 1396r-5(d)(1))

431-8 State proposed regulations governing MCCA income, including exceptional circumstance rules and allocation to other family members (ACWDL 90-03)

431-8A MMMNA may be increased if there are exceptional circumstances resulting in financial duress. Determination made by hearing or court. Criteria used for determination. (42 USC 1396r-5(e)(2), proposed §50605.5(c) set forth in ACWDL 90-03)

431-8A1 Family member maximum base allocation for current and prior years (ACWDL 09-37; ACWDL 10-15)

431-8B Allocation methodology for parent in LTC to children in home with no community spouse; or where person is in board and care or an MIA in LTC with spouse and/or children in home (ACWDL 90-03)

431-8C If person in LTC status has and will contribute to the support of a disabled non- spouse, non-child relative, the LTC person may allocate income to that disabled relative (ACWDL 90-03 draft regulation 50605(d),(e))

432-1 QMB, general instructions; BDOA, income and resource limits (50258)

432-2 QMB, federal definition and state participation (42 USC 1396d-p; ACWDL 90-02, ACWDL 91-09; MEPM 5F)

432-3 Payment of premiums, deductibles, and coinsurance for QMBs (W&IC 14005.11)

432-4 QMB requirements, including property and income limits (ACWDL 97-34; ACWDL 09-52)

432-5 SLMB eligibility criteria; period of eligibility; payment of Medicare Part B premiums (50258.1)

432-6 SLMB eligibility criteria and income forms reference (ACWDL 92-61; PL 101-508; 50258.1, MEPM 5J-1)

432-7 SLMB limitations in payment, eligibility criteria, and what Medicare Part B covers (MEPM 5J-1; ACWDL 09-52)

432-8 Net non-exempt income for the QMB, SLMB or QI program computed without allowance of health insurance deduction. (§50570)

433-1 Establishment of QI program, and interim procedures; QI-2 program discontinued 12/31/02; QI-1 program discontinues 9/30/03 (ACWDL 97-45, ACWDL 98-15, ACWDL 98-47, ACWDL 03-02; ACWDL 09-52)

433-2 County duty to evaluate MN applicants for QMB, SLMB and QI, to see if state can be reimbursed for Part B Medicare premiums (ACWDL 99-61)

433-3 QI-1 program payments and eligibility criteria; program discontinued 9/30/03 (MEPM 5J-55J-5; ACWDL 03-20)

433-4 QI-1 program sunset extended to December 30, 2012 (ACWDL 12-18)

433-4A QI-1 program sunset extended to March 31, 2015 (ACWDL 14-25)

433-4A TB program eligibility requirements (MEPM 5N; ACWDL 95-12, ACWDL 95-39, ACWDL 95-73, ACWDL 98-02,ACWDL 99-62, ACWDL 01-03)

434-1 TB program net income determinations and exceptions (MEPM 5N; ACWDL 01-03, ACWDL 01-66, ACWDL 02-01)

434-2 TB program property determinations (MEPM 5N; ACWDL 95-12, ACWDL 95-39; 20 CFR 416.1207)

434-3 Coverage for TB eligible individuals limited to TB related services; no share of cost for those services (MEPM 5N; ACWDL 95-12)

435-1 Definition of EPSDT supplemental services (51184(c))

435-2 Information to be included with EPSDT supplemental service request (51340(d))

435-3 EPSDT exceptions to general orthodontic coverage (51340.1(a)(2))

435-4 Background of EPSDT, medical necessity under EPSDT (ACL 00-83)

435-5 Required notification of EPSDT mental health services (*Emily Q.* v. *Bontá*; ACWDL 01-47)

435-50 Low Income Health Program (LIHP) generally (W&IC 15909.1)

435-51 Implementation of Low Income Health Program (LIHP) (W&IC 15910(a))

436-1 Health care includes mental health services provided by county or city, Short-Doyle, Alcohol and Drug, in IMD, or for diagnostic, screening or remedial rehabilitative services (W&IC 14021)

436-2 Case management services are a benefit under the Short-Doyle Medi-Cal program (W&IC 14021.3)

436-3 Community health services defined, and covered by Medi-Cal when provided by Short-

Doyle Medi-Cal (51341)

436-4 Short-Doyle coverage for substance abuse services (51341.1(a)-(d))

437-1 250% program for working disabled established effective 4/1/00 (ACWDL 99-67; AB 155)

437-2 Program description of the 250% WD program (MEPM 5R-1)

437-2A Disability income received after age 65 or person's retirement age is not exempt for purposes of determining maximum amount allowed or premium payment (ACWDL 09-33)

437-3 Beneficiaries of 250% program who don't pay monthly premiums may be discontinued (ACWDL 99-67)

437-3A Persons who do not pay premiums for two consecutive months will be discontinued from the 250% WD program for six months (MEPM 5R-1)

437-4 "Work" undefined in 250% program, but examples of "work" are given (ACWDL 00-51; MEPM 5R-2)

437-5 MFBU composition in 250% WD program (MEPM 5R-1, 2)

437-6 Determination of net nonexempt income in 250% WD program (MEPM 5R-2, 3)

437-6A Net income limits, 250% WD program (MEPM 5R-3)

437-7 Net nonexempt property limits, 250% WD program (MEPM 5R-3)

437-8 Restricted service Medi-Cal recipients not eligible for 250% WD program (MEPM 5R-3, 4)

437-9 Premium payments for 250% WD program (MEPM 5R-5)

437-10 Person with earned income under 250% of FPL may qualify for Medi-Cal as disabled person even if income exceeds SGA limit (ACWDL 02-40)

437-11 250% Working Disabled Recipient remains eligible during temporary periods of unemployment if premiums continue to be paid. (W&IC 14007.9, ACWDL 11-38)

437-12 250% Working Disabled Recipient can retain exempt earned income if account is separate; (W&IC14007.9, ACDWL 11-38)

437-13 250% Working Disabled participant's Social Security disability income remains exempt if it has been converted to Social Security retirement income. (W&IC 14007.9, ACWDL 11-38)

437-14 250% recipients retirement arrangements remain exempt for those who leave the 250%

program for other Medi-Cal programs that serve aged, blind and disabled individuals. (Welfare and Institutions Code (W&IC 14007.9, ACWDL 11-38)

438-1 General provisions governing the A&D FPL program (ACWDL 00-57, ACWDL 00-68, ACWDL 02-38)

438-2 Count parent's income in determining child's eligibility for A&D FPL program; if parent and child tentatively eligible, they are in separate units (ACWDL 01-18)

438-3 Statutory provisions for A&D FPL program (W&IC 14005.40)

438-3A Current A&D FPL program income limits. (ACWDL 12-08)

438-4 IHSS payments are not allowable deductions for A&D FPL purposes (ACWDL 02-22, ACWDL 02-22E; 50551.6, 50245)

438-4A MN deductions, other than IHSS, are allowable in A&D FPL (ACWDL 02-38)

438-5 Couples income standard can be no less than SSI/SSP couple payment standard (W&IC 14005.40(c)(1); ACWDL 02-24, ACWDL 02-24E)

438-6 A&D FPL program is neither PA nor other PA (ACWDL 02-38)

438-7 Person cannot qualify for A&D FPL by paying Medicare Part B premium once state "buys in" (ACWDL 02-38)

438-8 One spouse can receive A&D FPL, while the other spouse receives MN benefits, or declines Medi-Cal (ACWDL 02-38)

438-8A Deduction from income of an aged or disabled person as allocation to ineligible family members. Allocation equals the maintenance need level for ineligible family members. (ACWDL 00-57)

438-9 A&D FPL program rules follow the Medically Needy rules including property and income deductions, allocations and exemptions.(ACWDL 08-42)

438-10 New Federal Poverty Level Program for the Blind (FPLB) will be effective July 1, 2009 that has same eligibility criteria as A&D FPL program (ACWDL 09-28)

439-1 CSRA amount past two years and current (ACWDL 07-22, ACWDL 08-49; ACWDL 09-53)

439-1A MMMNA amount past two years and current (ACWDL 07-22, ACWDL 08-49; ACWDL 09-53)

439-1B Insert CSRA/MMMNA amounts (ACWDL_____)

439-1D Insert family member base allocation amount (ACWDL_____)

439-3 Current and prior year TB income standard, resource limit, standard allocation and federal benefit rate (ACWDL 07-31, ACWDL 08-60)

439-3A Insert for TB income standard, resource limit, standard allocation and federal benefit rate (ACWDL_____)

439-4 Current and prior two years Medicare Part B premiums (ACWDL 06-35, ACWDL 07-26, ACWDL 08-57)

439-4A Insert Medicare Part B premium (ACWDL____)

439-5 Effective A&D FPL limit for individual and couples in current and prior year (ACWDL 08-13; ACWDL 08-24, ACWDL 08-40, ACWDL 08-52; ACWDL 09-08;47 ACWDL 09-20)

439-5A Insert effective A&D FPL limit for individual and couples in 20_____(ACWDL_____)

439-6A QMB income limit is 100% of FPL (ACWDL 97-34)

439-7 FPL and SLMB levels effective April for current and prior year (ACWDL 08-05; ACWDL 09-06)

439-7A Insert FPL (ACWDL____)

439-7B Effective dates for new FPLs in 2007 (ACWDL 07-04)

Section 440-449

440-1 SSI recipients are eligible, but their eligibility is determined by SSA (50179.7)

440-1A Medi-Cal to be terminated if eligibility clearly ends due to death or lack of residence. (W&IC 14005.39(a))

440-1B Former Foster Youth eligible for Medi-Cal until age 26 without further application (W&IC 14005.28 , ACIN I-31-15)

440-2 General description of Medi-Cal categories (50201)

440-2A Definition of “linked” (50055)

440-3 SSI and AFDC applicants not required to submit separate application. If AFDC or SSI is approved, Medi-Cal is automatic (50145)

440-3A When Medi-Cal eligibility is established for new members of the assistance unit (ACL 03-18)

440-3B Effect of person moving into the home with income that causes assistance unit/household to be financially ineligible. New person ineligible for Medi-Cal. (ACL 03-18)

440-3C Pregnant women eligible to full scope Medi-Cal if income less than 138% of FPL (ACWDL 15-35)

440-4 County must reevaluate eligibility under other Medi-Cal categories if eligibility ceases under one category; aid pending continues, effective 7/1/01 (50183(a); MEPM 4-0-3; W&IC 14005.31, W&IC 14005.32, W&IC 14005.37; ACWDL 02-59)

440-5 Basic Medi-Cal beginning date of aid rule (50193(c)); 50197(a)),

440-6 Person is to be given option of Medi-Cal programs (50153(c))

440-7 Basis of AFDC deprivation (50205)

440-7A Deprivation not a requirement for MAGI or Medically Needy eligibility effective January 1, 2014 (ACWDL 14-28)

440-8 Parent may choose basis of deprivation under which he/she will receive linked AFDC-MN benefits (MEPM 5C-14)

441-1 Basic definition of "continued absence" (50213(c)(1))

441-2 Basic rules in joint custody situations (50374)

442-1 Definition of incapacity (50211)

442-1A U-parent deprivation can be established when the PWE is working under 100 hours in a month, or over 100 hours in the month but the family's net earned income does not exceed 100% of the FPL (AB 1107; MEPM 5C-13, 14)

443-2 Requirements under CDHS policy for U-deprivation (ACWDL 97-37; 50215 , MEPM 5C-11 through 14)

443-3 PWE is based on which parent had greater earnings in 24 months prior to determination of U eligibility; if equal earnings, parents may choose who is to be PWE (50215(c); MEPM 5C-11)

444-1 Medi-Cal eligibility for persons who meet 7/16/96 AFDC requirements, but U- deprivation requires only that PWE work fewer than 100 hours; effective 3/1/00, the PWE may work more than 100 hours if net earnings are at or below the FPL (ACWDL 98-43, ACWDL 00-04; SSA 1931(b); PL 104-193; AB 1107; MEPM 5S-3(d))

444-1A 1931(b)-Only Program--persons must first meet nonfinancial, then financial requirements (ACWDL 98-43; MEPM 5S-2)

444-1B Definition of applicant for 1931(b) purposes (ACWDL 98-43, Attachment 1)

444-1C Importance of determining 1931(b) eligibility to establish potential eligibility for TMC, because there are no time limits, because of AFDC type deductions, etc. (MEPM 5S-1)

444-1E 1931(b) person can choose aid under, e.g., Pickle or QMB, but not under optimal federal programs (MEPM 8G-4)

444-1F Procedure for evaluating Medi-Cal eligibility for a potential 1931(b) family (ACWDL 99-02E)

444-2 Age requirements for 1931(b) eligibility; child must be deprived and have 0 share of cost for parent(s) to be eligible for 1931(b) (ACWDL 98-43; MEPM 5S-3, 4, 8G-2)

444-2A Example of how a parent can establish 1931(b) eligibility when the only child is eligible for a zero share of cost under a percent program, here the 200% program (MEPM 8G-9)

444-4 MFBU is basic 1931(b) unit, but if there is an share of cost and a *Sneede*/*Gamma* situation, modified *Sneede* rules must be followed to see if zero (0) share of cost eligibility can be established for any MBU (ACWDL 98-43)

444-4A Persons ineligible for CalWORKs (e.g., fleeing felons, work sanctioned, aliens without SIS) may still be 1931(b) eligible (MEPM 8G-2, 5S-4)

444-4B Pregnant women in last trimester, without other children, may be 1931(b) eligible, but father of the unborn is not; if other deprived children are 1931(b) eligible, unborn may be used to increase family size from date pregnancy is established (MEPM 5S-3, MEPM 8G-2)

444-4C Stepparent may be aided as an essential person for 1931(b) purposes (MEPM 5S-4)

444-4D Parent, child, and caretaker relative of child can all receive 1931(b) benefits, but parent is financially responsible (MEPM 5S-4, MEPM 8D-3)

444-4E All persons in the family who are living in the home are included in the MFBU except those receiving cash benefits, e.g., SSI, CalWORKs, IHSS, and certain PA or other PA Persons (MEPM 8G-2)

444-4F Sanctioned WTW persons and CalWORKs AUs discontinued for failure to provide a monthly or annual income report are still 1931(b) eligible (ACWDL 02-59)

444-5 Income must be less than limit for family size; to determine income eligibility, use CalWORKs or AFDC rules as of 7/16/96, whichever is more liberal (ACWDL 98-43; MEPM 5S-5)

444-5A 1931(b) income eligibility tests for applicants and recipients (MEPM 8G-5)

444-5B Determining net nonexempt income and income eligibility for the 1931(b) recipient or recipient family (ACWDL 98-43, Attachment 1)

444-5C Determining net nonexempt income and income eligibility for the 1931(b) applicant or applicant family (ACWDL 98-43, Attachment I, 02-44)

444-5D 1931(b) “Test A” income standards increase effective December 2004 (ACWDL 04-35)

444-5E Rules for determining net income in 1931(b) cases are based on modified Title 22 regulations in draft form, new draft regulations, and Title 22 unmodified regulations, as amended by previous draft regulations (ACWDL 98-43, Attachment 1 and Exhibit B)

444-5F Social Security COLAs are not to be applied until new FPLs are issued (ACWDL 00-53)

444-6 Property is generally determined under CalFresh rules for personal property and under 7/16/96 AFDC rules for real property, but exceptions exist in, e.g., automobile evaluation, and because certain Medi-Cal property rules and court cases are used in evaluating eligibility (ACWDL 98-43, Attachment 2; W&IC 11155(b),(c))

444-6A Property limit for one in 1931(b) is $3000, and for two and more is MN limit (ACWDL 98-43; MEPM 5S-5)

444-6B Motor vehicles with equity value of $1500 or less are exempt in 1931(b) (ACWDL 01-62, eff. 6/1/01)

444-6C Partial list of personal property exemptions in 1931(b) (ACWDL 99-02E)

444-7 Procedure for evaluating Medi-Cal eligibility for a potential 1931(b) family (ACWDL 99-02E)

444-10 *Sneede* methodology in 1931(b) (MEPM 5S-6)

444-11 TMC eligibility in 1931(b) (MEPM 5S-7)

445-1 Disability may be verified in accordance with procedures established by DDSD formerly known as DAPD, and previously known as DED (50167(a)(1)(D); ACWDL 97-54, ACWDL 06-28E)

445-2 Disability may be verified through signed statement from SSA (50167(a)(1)(B))

445-3 If applicant does not have good reason for failing to attend consultative examination, he/she is subject to a determination of no disability (20 CFR 416.918)

445-4 SSI/SSP is a PA program, and retroactive coverage may be available for one year prior to request month (50148, 50078; ACWDL 95-81)

445-5 Presumptive disability criteria (MEPM 22C-3.6, revised 3/9/07)

445-5A SP-DAPD (formerly DED) can grant Presumptive Disability, but neither SP-DAPD nor county can grant retroactively; aid pending appropriate if timely filing (MEPM 22C-3.1, 3.2; ACWDL 97-54)

445-6 Disability determinations by other private or public groups not binding on SSA (POMS DI 24515.011)

445-9 County must refer disability application to DED within 10 days (ACWDL 93-50; Radcliffe v. Cahill)

445-10 Medi-Cal must continue for beneficiaries discontinued from Title II or SSI at least for 65 days, and if appeal is filed and is subject to federal review, until "FINAL" decision (i.e., no more appeals can be filed) is rendered (ACWDL 97-28)

445-12 No longer disabled SSI/SSP recipients to be treated akin to Edwards discontinuances (ACWDL 97-28)

445-13 SSI former recipients are PA recipients until appeal rights are terminated, even if they transfer to AFDC/TANF and then are discontinued from AFDC/TANF (ACWDL 97-28)

445-14 Social Security Administration disability decision binding for 12 months, exceptions (42 CFR 435.541)

446-2 Eligibility requirements for RMA (50257)

446-3 Refugees are eligible for Medi-Cal for eight months only under RMA/ECA; county must determine eligibility and send application 60 days before eight-month period ends. (ACWDL 08-43)

446-3A County must determine eligibility and send application 60 days before eight-month period ends. (ACWDL 08-43)

446-4 RMA individuals are eligible for three-month retroactive Medi-Cal (ACWDL 09-40)

447-4 Pickle eligibility (Pickle Handbook, 15; *Lynch* v. *Rank*)

447-4A Actual receipt of SSI/SSP required, but only entitlement to RSDI required, for potential Pickle Eligibility (Pickle Handbook, 2)

447-4B Persons who are long term care are not evaluated for potential Pickle Eligibility. (Pickle Handbook, Section 7, Page 7-1)

447-5 Resource eligibility for Pickle persons (Pickle Handbook, 15)

447-6 Pickle person disregard multiplier (Pickle Handbook, 15; ACWDL 05-35)

447-6A No changes on July 1, 2009, to SSI/SSP payment standards used to establish eligibility for the Pickle, Disabled Adult Children, Disabled Widow(er)s and 250 Percent Working Disabled Programs; Counties should use May 1, 2009 levels (ACWDL 09-28)

447-7 Pickle income is established on a monthly basis (Pickle Handbook, 15)

447-8A SSI payment levels to determine if Pickle eligibility exists (ACWDL__)

447-9 Method for computing Pickle income eligibility (Pickle Handbook, 18)

447-10 How to determine ISM from VTR or PMV (Pickle Handbook, 14, ACWDL 04-37; ACWDL 05-35, ACWDL 06-29)

447-11 Disabled widow(er) eligibility under Pickle (Pickle Handbook §5-1 through-5-4)

447-12 Determining eligibility for Pickle couples (Pickle Handbook §15-9)

447-14 DAC eligibility under Pickle (Pickle Handbook, 6)

447-15 Disabled adult children who lose SSI/SSP eligibility due to Social Security increase treated similar to Pickle (ACWDL 87-49)

448-1 IHSS recipients are eligible for Medi-Cal as long as net nonexempt income in excess of SSI/SSP level is applied to share of cost (MPP 30-755.31; 50245)

448-2 Eligibility for Medi-Cal for severely impaired working individuals (Social Security Act, Title XVI, 1619(b); ACWDL 97-27)

448-4 Definition of MI persons under age 21 (50251(a))

448-5 Breast and Cervical Cancer Treatment Program authorized eff. 1/1/02(W&IC 14007.71; H&S 104160-104163)

448-5A Criteria for federal BCCTP (ACWDL 06-09)

448-5B Criteria for state-funded BCCTP (ACWDL 06-09)

448-5C Toll-free number for persons applying at county for, or apparently eligible for BCCTP (ACWDL 06-09)

448-5D SB 87 process applies to discontinuances of federal BCCTP (ACWDL 06-25)

448-5E If person declares she has breast or cervical cancer at initial application or redetermination, county must make BCCTP referral (ACWDL 09-42)

448-5F When an individual applies for Medi-Cal, she must be evaluated for eligibility under all Medi-Cal programs, including BCCTP (ACWDL 09-42)

448-5G County must contact BCCTP before presentation at hearing and receive statement why person was not eligible for federal BCCTP (ACWDL 09-42)

448—6 Dialysis Program, generally (§50801 et. seq.)

448-7 Targeted Low Income Program (ACWDL 12-33)

449-1 Persons discontinued from SSI must reapply; Craig v Bonta and SB 87 apply to discontinuance of SSI/SSP based Medi-Cal (50183, .5; ACWDL 07-24)

449-3 SSI discontinued individuals receive continued benefits effective June 30, 2002, until CDHS issues new instructions; new instructions issued (ACWDL 02-45, ACWDL 02-54, ACWDL 03-24; *Craig* v. *Bontá*)

449-3A SB 87 procedures to be applied to Craig (discontinued SSI persons) beneficiaries (ACWDL 03-24)

449-3B Ongoing eligibility for persons discontinued from SSI/SSP until county completes eligibility redetermination (ACWDL 04-31)

449-4 Individuals discontinued from SSI/SSP due to reduction in SSI/SSP payment standard effective July 1, 2009 continue to receive $0 share of cost Medi-Cal pending Craig v Bonta evaluation (ACWDL 09-28)

Section 450-459

450-1 How to treat persons under age 21, living away from their parent's home (MEPM 8C-1, 2, 3)

450-1A Definition of "child" (50030)

450-1B Definition of MFBU (50060)

450-2 Current definition of "adult" (50014)

451-1 All family members living in the home shall be included in the MFBU (50373)

451-1A MFBU Determination full provisions (50373)

451-2 Definition of "family member" (50041)

451-3 Married couples living in the same home, even if legally separated, must be in the same MFBU (ACWDL 95-07; 50351, 50373)

452-1 Persons in LTC are in own MFBU; exceptions (50377(a); ACWDL 91-28)

452-2 Aged, blind, disabled person in LTC is usually in own MFBU (50377)

452-3 Definition of "Long-Term Care Status" (ACWDL 90-01, draft regulation 50056; W&IC 14050.3)

452-4 Certain inmates not eligible for Medi-Cal (ACWDL 93-42, 42 CFR 435.1009; 50273(a))

452-4A Persons in public institutions are ineligible for Medi-Cal; certain persons in jails or prisons, or minors in detention centers or correctional facilities, are specified as ineligible (50273(a)(1)-(a)(8))

452-4B Regulations make IMD residents between 21 and 65 ineligible for Medi-Cal (50273(a)(9))

452-4C Under state law, persons from 21-64 in IMDs are not eligible for Medi-Cal unless there is FFP (W&IC 14053)

452-5 Caretaker relative of FC child may receive Medi-Cal (ACWDL 95-07)

452-6 Unmarried father of unborn does not have to be in MFBU (ACWDL 95-07)

452-7 Noncaretaker relatives who are not parents may establish linkage to a child when the parent is absent from the home, but only one caretaker can be linked to each child; if independently linked, the caretaker may be in separate MFBU (MEPM 8D-3)

452-8 Child may be excluded, and eligibility and share of cost and health care costs shall be determined based on remaining MFBU members (50381(a))

453-1 Determination of persons living in the home; temporary absence of child (50071; ACWDL 90-55)

453-2 College students under 21 still in parents MFBU even if living elsewhere, must choose health plan where they are residing (MEDIL I-15-32)

454-1 Nonresponsible individuals may be in separate MFBUs (*Sneede* v. *Kizer*; ACWDL 90-76)

454-1A Relative responsibility is limited to parent to child and spouse for spouse with special provisions for a spouse in long term care. (50351)

454-3 MBU's income compared to family size of MFBU in determining FPL eligibility (MEPM 8F-17, replacing ACWDL 92-09, ACWDL 92-23)

454-4 Child's income for *Sneede* purposes includes child support payments, prorated unearned in-kind income, and interest income (ACWDL 92-09 replaced by MEPM 8F-10, 11)

454-5 Person with nonexempt income is *Sneede* person, even if there is no net income (ACWDL 92-09, replaced by MEPM 8F-13)

454-6 General rule regarding splitting into MBUs (ACWDL 92-09, replaced by MEPM 8F-3, 4)

454-6A MBU defined, and determination of share of cost for the MBU (MEPM 8F-3, 6, 7, 8)

454-7 Equal allocation of income/property to spouse and child(ren) under *Sneede* (ACWDL 90-91) modified by *Gamma* to allow a parent a $600 income deduction (MEPM 8F-4)

454-8 *Sneede* procedures apply to property first, and then income; if property eligible, *Sneede* applies only to income *Sneede* proration rules modified by Gamma (ACWDL 90-91; MEPM 8F)

454-9 No allocation to unborn under *Sneede* (MEPM 8F-5, replacing ACWDL 90-91)

454-10 *Principé* property exemption can apply to MFBU or MBU at person's choice (ACWDL 97-41)

456-1 In *Sneede* situation, parent is allowed $600 to meet needs, and remainder of income is equally allocated to persons for whom parent is responsible (*Gamma* v. *Belshé*; ACWDL 96-29)

456-2 General rules for establishing MBUs, and requirement to apply *Sneede* if financial ineligibility or share of cost in nonresponsible relative situation (MEPM 8F-1, 2)

456-3 MBU defined, and determination of share of cost for the MBU (MEPM 8F-3, 6, 7, 8)

456-4 MBUs which are property ineligible may not be used to establish AFDC-MN linkage, but property ineligibility is not established until a child is determined ineligible for a percent program (MEPM 8F-5)

456-7 "Name on the check" creates presumption of ownership, but if benefits are on behalf of designated persons, those persons are owners of income (MEPM 8F-10)

Section 460-470

461-1 Net income from property (50508(a))

461-2 Unearned income examples (50507(a))

461-2A SDI is earned income for AFDC-MN and MI (ACWDL 96-09; *Tinoco* v. *Belshé;* AB1542)

461-2B SDI verification required (ACWDL 96-09)

461-2C Veteran's Aid and Attendance excluded as income . (Medical Eligibility Procedures Manual § 10-JA)

461-3 Title IV and BIA assistance is exempt for income and property purposes (ACWDL 94-06; PL 102-325; 20 USC 1087uu)

461-4 Determinations of August 11, 1993 and following for value of annuities, payments from annuities, and county duty to advise applicant/beneficiary when annuity is improperly annuitized, after having considered whether restructuring annuity will cause undue hardship (MEPM 9J-13, 14)

461-5 The $25 weekly increase must not be considered income for purposes of determining eligibility or share-of-cost for all Medi-Cal programs. (ACWDL 10-10)

462-1 Earnings includes wages, salaries, bonuses, commissions, tips, self-employment (50503(a))

462-2 SDI is earned income for AFDC-MN and MI (ACWDL 96-09; *Tinoco* v. *Belshé*)

462-2A SDI verification required (ACWDL 96-09)

462-3 TWC is earned income for AFDC-MN and MI (ACWDL 95-63; *Sawyer* v. *Belshé;* AB1542))

463-1 Determination of net profit from self-employment (50505)

463-2 Factors to be considered in determining whether a person is an employee, or self-employed (MEPM 10M-1, 2)

463-3 Allowable and nonallowable self-employment deductions (MEPM 10M-2; 50505)

464-1 Treatment of fluctuating income (50518)

464-2 Conversion of weekly or biweekly income to monthly income (50517)

465-1 Responsible relatives are spouse for spouse and parent for child (50351(a))

465-2 Income and resources of parents living with child to be used; also income of absent parent if parent claims child as dependent for tax purposes (50351)

466-1 Only available income shall be used in determining a person's or family's share of cost (50513(a), 50515(a))

466-2 Unavailable income includes deductions from benefit payments for purposes of collecting overpayments (ACWDL 92-39)

466-3 MN person in board and care has unavailable income if income is paid to facility for care and support, and exceeds maintenance need level; after 4/1/00 there is a $315 deduction allowable (50515(a)(3)); *Pettit* v. *Bontá*; ACWDL 00-56)

466-3A Persons living in licensed board and care facility, even if facility is characterized as an assisted living arrangement, receives income exclusion (50515(a)(3)); ACWDL 99-31)

466-4 "Name on the check" creates presumption of ownership, but if benefits are on behalf of designated persons, those persons are owners of income (MEPM 8F-10)

466-7 Garnished income properly held to be available for SSI purposes. *Cervantez* v. *Sullivan*

466-8 Medicaid case law regarding availability of involuntarily withheld monies. *Mulder* v. *South Dakota Department of Social Services*, *Peura by and through Herman* v. *Mala*, *Emerson* v. *Steffen*, *Himes* v. *Sullivan*

467-1 Income in kind is only for housing, utilities, food, and clothing, and only is income if entire item of need is provided (50509)

467-1A In-kind income amounts for clothing are eliminated from Medically Needy rules, but not for purposes of 1931(b) Medi-Cal (ACWDL 09-64)

468-1 $90 deduction from earned income (AFDC/MN/MI persons) (50553.1)

468-2 Deduction from earned income for child care or incapacitated person expenses (50553.5)

468-3 Deduction of court ordered alimony or child support (50554)

468-4 Dependent care deduction from earned income, $30 plus 1/3 deduction from earned income; deductions no longer available as of 5/1/98 (50553.3; AB 1542)

468-5 To determine AFDC-MN income, deduct amounts appropriate under State AFDC plan (42 CFR 435.831(b)(2))

468-6 SDI is earned income for AFDC-MN and MI (ACWDL 96-09; *Tinoco* v. *Belshé;* AB1542))

468-7 TWC is earned income for AFDC-MN and MI (ACWDL 95-63; *Sawyer* v. *Belshé;* AB1542))

468-8 AFDC-MN or MI student exemption (50543)

469-1 $20 deduction from unearned income of ABD-MN persons or their spouse or parent; unused portion is subtracted from earnings (50549.2)

469-2 Reduction for court-ordered child support or alimony for ABD recipients (*Gibbins* v.*Rank*; ACWDL 87-77; 50554)

469-3 To determine ABD income, deduct amounts as appropriate under SSI, plus optimal state supplemental plan amounts (42 CFR 435.831(b)(3))

469-4 $65 (plus any unused portion of the $20 deduction) plus 1/2 earnings deduction for ABD persons, and spouses or parents of those persons (50551.3)

469-5 Additional actual work expenses allowed for blind earners (50551.4)

469-6 Net non-exempt income for the QMB, SLMB or QI program computed without allowance of health insurance deduction.50570)

469-7 Student deduction (50551, ACWDL 14-17)

469-8 Student exemption extended to all working students (ACWDL 14-17)

470-1 General reference to deductions and exemptions (50519)

470-4 Medical insurance deduction (50555.2)

470-4A Medicare Part D deductions (ACWDL 05-23)

470-4B Medicare Part B Buy-in 50773)

470-4C DHCS will stop paying Medicare Part B premiums for Medicare eligible Medi-Cal applicants and beneficiaries who have a SOC over $500 until or unless the SOC is met (ACWDL 08-48 and 08-48E)

470-5 Exemption of payments made from California Victims of Crimes (50534, 50448)

470-6 AAP exempt income; AAP recipient not in MFBU with other household members (ACWDL 92-83)

470-7 Quarterly interest payments are excluded up to $60 as irregular unearned income (ACWDL 92-37; 50542)

470-8 Exemption of interest and dividend income for purposes of determining income eligibility for some SSI/SSP based Medi-Cal programs (ACWDL 05-17)

470-9 MN person in board and care has unavailable income if income is paid to facility for care and support, and exceeds maintenance need level; after 4/1/00 there is a $315 deduction allowable (50515(a)(3); *Pettit* v. *Bontá*; ACWDL 00-56)

470-10 Monthly equivalent to the $25 weekly increase in UIB shall be exempt income and, as such, shall not be considered for purposes of determining Medi-Cal eligibility or share-of-cost; one-time $250 economic recovery payments for specified retirees, disabled persons are exempt (ACWDL 09-22; ACWDL 09-23)

Section 480-489

480-1 Conversion of property in itself has no effect on eligibility (50407)

481-1 Eligibility exists if property limit is met at any time during month (50420(c))

481-2 Property limit for one is $2,000 (50420)

481-3 Property limit for different MFBUs (50420)

481-5 California cannot use lower resource standard than used under cash assistance program (42 CFR 435.840)

481-6 Spenddown of excess property to establish eligibility after month in which excess property precluded eligibility (ACWDL 97-41 *Principe v. Belshé*)

481-6A Example of establishing eligibility for Medi-Cal after being over the property limit for the entire month by spending down on qualified medical expenses (ACWDL 97-41)

481-6A QMB, TB, Pickle and 250% working disabled programs use SSI resource rules, which limit resources to $2000 for one person and $3000 for individual and spouse (ACWDL 99-67; 20 CFR 415.1205(c))

482-1 Owner of property is generally person with legal title (50404)

482-1A Property held in name of person may not be available in certain circumstances (ACWDL 90-01)

482-2 Resources of married individual in SNF are separate property and community property share at time of admission (W&IC 14006.2(c))

483-1 Separate property and share of community property of any person in MFBU shall be considered in determining eligibility (50403)

483-2 Applicants shall be informed that they may establish eligibility by bringing property within limit during month and must be given MC 007; same rule applies to those who inquire about Medi-Cal (ACWDL 91-78, ACWDL 98-07, ACWDL 00-11)

483-2A Requirement to give applicant information about spenddown following *Principe*, whether or not there appears to be excess property (ACWDL 97-41)

483-2B Requirement to give all LTC applicants 10-point type forms explaining property transfers (ACWDL 00-11; W&IC 14006.3, .4)

483-2C County department responsibilities for informing all Medi-Cal applicants or potential applicants at screening (ACWDL 90-01; 50154)

483-3A Treatment of certain MQTs and SLDs as available property prior to 1/28/98 (ACWDL 93-07; 50489-50489.9)

483-3B Rules regarding MQTs and SLDs established 8/11/93 or after (42 USC 1396p (c), (d); ACWDL 94-01; 50489)

483-4 Unavailable property not considered in determining eligibility (50402, ACWDL 90-01)

483-4A Evidentiary requirements when property is in applicant's or beneficiary's name and it is claimed that the property belongs to another (ACWDL 90-01)

483-5 Property unavailable when individual is unconscious, comatose, or incompetent at any time during the month (ACWDL 97-41)

483-3A Property of incompetent individual considered available if another individual can get access to the property (ACWDL 94-62)

483-6 Loans which require repayment included in property reserve; other loans, income, then property (50483)

483-7 Definition for purposes of trusts, annuities, SLDs (50489(b)(1)-(b)(12))

483-8 Trusts are MQTs, OBRA 93 or others (50489(c))

483-9 Verification of written and oral trusts; no oral trust for real property (50489(e))

483-10 Before denying eligibility based on OBRA 93 trust or annuity, county must notify claimant it will consider, and must actually consider, whether undue hardship exists (50489.5(h))

483-11 Determinations of August 11, 1993 and following for value of annuities, payments from annuities, and county duty to advise applicant/beneficiary when annuity is improperly annuitized, after having considered whether restructuring annuity will cause undue hardship (MEPM 9J-13, 14)

483-12 Treatment of pension funds, including IRAs (ACWDL 90-01; 50458)

483-12A Reasons funds in IRA may be unavailable (ACWDL 02-51)

483-13 Medi-Cal Procedures Manual on trusts for minors (MEPM 9J)

484-1 Mortgages, deeds of trust, and notes are to be included in the property reserve; which mortgages are classified as real property (50441)

484-2 Net market value of property is owner's equity minus encumbrances (50415)

484-3 Stocks, bonds, mutual funds to be included; method of valuation (50456)

484-4 Life estate interest in real or personal property, valuation (50442)

484-5 Valuation of personal property under Code (W&IC 14006(g))

484-6 Value of property holdings determined as of date of application (W&IC 14006(h), (i))

485-1 Motor vehicles–exemption; determination of value, nonexempt vehicles (50461; ACWDL 96-55)

486-1 Income received and deposited in an account during a month is not property in that month (50453(a)(1); ACWDL 91-28)

486-2 Exclusion of certain business property (50485, ACWDL 91-28)

486-2A Clarification of treatment of business property (ACWDL 91-28, ACWDL 95-22)

486-2B "Necessary for employment" defined; examples of exempt business property (ACWDL 91-28)

486-3 Life insurance policies–when exempt; face value of term life insurance now considered if value exceeds $1500 alone or with other life insurance (50475; ACWDL 08-02)

486-3A Endowment Life Insurance Contracts not considered life insurance for Medi-Cal eligibility purposes (ACWDL 08-02)

486-3B Endowment Life Insurance Contracts treated like a trust for Medi-Cal eligibility purposes (ACWDL 08-02)

486-3C Assets held in Endowment Life Insurance Contracts are considered available property and included in the property reserve (ACWDL 08-02)

486-4 Mobile homes--real property v. personal property (50463(a))

486-5 Entire amount in savings or checking to which applicant has unrestricted access is included property unless clear evidence establishes otherwise (50453)

486-5A Modification to availability of checking and savings accounts (ACWDL 90-01; ACWDL 91-28; 50453)

486-6 Six-month exemption of retroactive SSI and Title II benefits (50455(b))

486-7 Exemption of recreational items (50469)

486-8 Property purchased or sold under contract of sale; determination of ownership and income (50405)

486-9A Burial fund cannot be commingled and cannot be undesignated without losing its exemption (50479(b); ACWDL 92-58)

486-9B Exempt burial funds (50479(a))

486-10 Exemption of burial trusts, federal requirements (20 CFR 416.1231(b), 42 CFR 435.845(d))

486-11 Title IV and BIA assistance is exempt for income and property purposes (ACWDL 94-06; PL 102-325; 20 USC 1087uu)

486-12 Home equity conversion plans and reverse mortgages (ACWDL 08-17)

487-1 Transfers of property more than two years prior to initial application presumed non-disqualifying; applies only to certain institutionalized persons (50408, 50409; 42 USC 1396p(c), W&IC 14002, W&IC 14006; ACWDL 90-01)

487-1A Policy in treatment of nonexempt property on or after 1/1/90 (ACWDL 90-01; 42 USC 1396p, 42 USC 1396r)

487-2 Transfer of exempt property does not result in ineligibility; applies only to certain institutionalized persons (42 USC 1396p(c), W&IC 14002, W&IC 14006; 50408(a); ACWDL 90-01)

487-2A Policy as to which transfers of property on or after 1/1/90 do not affect eligibility (ACWDL 90-01; 42 USC 1396a, 42 USC 1396p, 42 USC 1396r)

487-3 No disqualifying transfer if adequate consideration received; definition of adequate consideration; applies only to certain institutionalized persons (42 USC 1396p(c), W&IC 14002, W&IC 14006, 50408(a)(3), (a)(6); ACWDL 90-01)

487-4 Transfer of property not disqualifying when adequate consideration is received, or when no intent to establish eligibility or reduce share of cost; applies only to certain institutionalized persons (42 USC 1396p(c), W&IC 14002, W&IC 14006, 50409(b); *Beltran v. Myers*; ACWDL 90-01)

487-5 Period of ineligibility after transfer of property to qualify for aid; how computed; applies only to certain individuals (50411; ACWDL 90-01; 42 USC 1396p

487-6 Restricted benefits for disqualifying transfers of property for LTC patients (ACWDL 92-57)

487-6A Current and prior year Statewide APPR for Medi-Cal transfer of property period of ineligibility (ACWDL 09-05; ACWDL 10-08)

487-6B Statewide APPR for Medi-Cal transfer of property period of ineligibility (ACWDL____)

487-7 Counties must send cases to DCHCS property analyst if they conclude a potentially disqualifying property transfer took place. The property analyst will notify the county whether or not to send a NOA to restrict services due to a disqualifying transfer. (ACWDL 97-05)

488-1 Under *Sneede*, property is to be allocated to other family members only if there is a duty to support. (*Sneede* v. *Kizer*; ACWDL 90-76)

Section 490-499

490-1 Definition of real property (50074)

490-2 Lien procedure for property formerly a home when person is in long-term care (50428)

490-3 Conversion of property in itself has no effect on eligibility (50407)

491-1 Eligibility exists if property limit is met at any time during month (50420(c))

491-2 Property limit for one is $2,000 (50420)

491-3 Property limit for different MFBUs (50420)

491-5 California cannot use lower resource standard than used under cash assistance program (42 CFR 435.840)

491-6 Spenddown of excess property to establish eligibility after month in which excess property precluded eligibility (ACWDL 97-41; *Principe v. Belshé*)

491-6A Example of establishing eligibility for Medi-Cal after being over the property limit for the entire month by spending down on qualified medical expenses (ACWDL 97-41)

491-7 QMB, TB, Pickle and 250% working disabled programs use SSI resource rules, which limit resources to $2000 for one person and $3000 for individual and spouse (ACWDL 99-67; 20 CFR 415.1205(c))

492-1 Separate property and share of community property of any person in MFBU shall be considered in determining eligibility (50403)

492-2 Applicants shall be informed that they may establish eligibility by bringing property within limit during month and must be given MC 007; same rule applies to those who inquire about Medi-Cal (ACWDL 91-78, ACWDL 98-07, ACWDL 00-11)

492-2A Requirement to give applicant information about spenddown following *Principe*, whether or not there appears to be excess property (ACWDL 97-41)

492-2B Requirement to give all LTC applicants 10-point type forms explaining property transfers (ACWDL 00-11; W&IC 14006.3, W&IC 14006.4)

492-2C Requirement to give applicants notice that a home can be transferred for less than FMV (ACWDL 02-60; W&IC 14006.7)

492-3 Utilization requirement generally (50416)

492-3A Modifications to utilization requirements (ACWDL 90-01, ACWDL 91-28; 50416)

492-5A Treatment of certain MQTs and SLDs as available property prior to 1/28/98 (ACWDL 93-07; 50489-50489.9)

492-5B Rules regarding MQTs and SLDs established 8/11/93 or after (42 USC 1396p; ACWDL 94-01; 50489)

492-6 $6,000 other real property exemption (50427)

492-7 Unavailable property not considered in determining eligibility (50402, ACWDL 90-01)

493-1 Owner of property is generally person with legal title (50404)

493-1A Property held in name of person may not be available in certain circumstances (ACWDL 90-01)

493-2 Resources of married individual in SNF are separate property and community property share at time of admission (W&IC 14006.2(c))

494-1 Net market value of property is owner's equity minus encumbrances (50415)

494-2 Life estate interest in real or personal property, valuation (50442)

494-3 Determination of market value of real property (50412)

495-2 Exclusion of certain business property (50485, ACWDL 91-28)

495-2A Clarification of treatment of business property (ACWDL 91-28, ACWDL 95-22)

495-3 Situations where property no longer used as a home remains exempt as a principal residence (50425(c))

495-3A Subjective intent to return home is sufficient to establish that home is exempt property (ACWDL 95-48; 50425(c))

495-3B Home can be real or personal property, fixed or mobile, on land or water (50044)

495-4 Value of property holdings determined as of date of application (W&IC 14006(h), (i))

496-1 Transfers of property more than two years prior to initial application presumed non-disqualifying; applies only to certain institutionalized persons (50408, 50409; 42 USC 1396p(c), W&IC 14002, W&IC 14006; ACWDL 90-01)

496-1A Policy in treatment of nonexempt property on or after 1/1/90 (ACWDL 90-01; 42 USC 1396p, 42 USC 1396r-5)

496-2 Transfer of exempt property does not result in ineligibility; applies only to certain institutionalized persons (42 USC 1396p (c), W&IC 14002, W&IC 14006; 50408(a); ACWDL 90-01)

496-2A Policy as to which transfers of property on or after 1/1/90 do not affect eligibility (ACWDL 90-01; 42 USC 1396a, 42 USC 1396p, 42 USC 1396r

496-3 No disqualifying transfer if adequate consideration received; definition of adequate consideration; applies only to certain institutionalized persons (42 USC 1396p(c), W&IC 14002, W&IC 14006, 50408(a)(3), (a)(6); ACWDL 90-01)

496-4 Transfer of property not disqualifying when adequate consideration is received, or when no intent to establish eligibility or reduce share of cost; applies only to certain institutionalized persons (42 USC 1396p (c), W&IC 14002, W&IC 14006, 50409(b); *Beltran v. Myers*; ACWDL 90-01)

496-5 Period of ineligibility after transfer of property to qualify for aid; how computed; applies only to certain individuals (50411; ACWDL 90-01; 42 USC 1396p(c))

496-6 Restricted benefits for disqualifying transfers of property for LTC patients (ACWDL 92-57)

Section 500-519

502-1 Amount of maintenance need effective (50603, ACWDL 95-19) [NOTE: Please submit worksheet]

502-2 Maintenance Need (Long-Term Care) (50605(a))

502-3 Persons entitled to upkeep allowance; calculation of upkeep allowance (50605(b))

502-4 Computation of share of cost; general (50653(a))

502-4A Share of cost for LTC patients (50653(a)(2))

502-5 Prescribed drug or service, not covered by Medi-Cal, may be applied to share of cost (ACWDL 89-54; *Johnson v. Rank*)

502-6 Maintenance need allowance is reduced to $35 only when a single individual is in a LTC facility for an entire month (ACWDL 97-32)

504-1 County duty to retroactively revise share of cost when change resulting in a decrease in share of cost is reported in timely manner; option of adjustment or corrected MC 177S (50653.3(a))

504-1A BIC cards have replaced MC 177 forms and Medi-Cal cards in all counties as of 6/1/97 (Denti-Cal Bulletin Vol. 13, No. 13 (6/97); (50653.3, 50657; ACWDL 96-06)

505-1 Three-month retroactive eligibility (50197(a), replacing 50710(a), eff. 9/19/00)

505-1A Basic Medi-Cal beginning date of aid rule (50193(c), replacing 50701(c), eff. 9/19/00)

505-2 Three-month retroactive coverage, limitations (50197(a)(3), replacing 50710(a)(3), eff. 9/19/00)

505-3 Retroactive coverage, when application must be made (50148)

505-4 Determining income in retroactive months (ACWDL 02-43)

506-4 General rules on *Hunt* v. *Kizer* (MEPM 10R-1)

506-5 Definitions for Hunt purposes (MEPM 10R-1 through 4)

506-6 Applying old medical bills for Hunt purposes (MEPM 10R-4, 5)

506-7 Criteria for applying current and old medical bills under Hunt (MEPM 10R-5, 6)

506-8 Verification requirement under Hunt (MEPM 10R-6, 7)

506-12 Principe spenddown of excess property cannot be used to meet share of cost, or for Hunt purposes (ACWDL 97-41)

506-13 Eligible and Ineligible MFBU members are eligible to have the cost of their health services used to meet the share of cost for the MFBU (50657(a)(1)(A) and (B))

511-1A When potential overpayment occurs; no potential overpayment if beneficiary/representative reports within competence, or fails to perform an act which is a condition of eligibility due to CDHS or county error (50781)

511-1B Potential overpayment occurs when the beneficiary fails to report other health coverage, and the beneficiary receives double reimbursement or CDHS has to pay for the services (50781.5)

511-2 Determination of potential overpayment and referral to CDHS (50783)

512-2 Computation of Medi-Cal overpayment; overpayment due to incorrect share of cost computation (50786(a)(2)(B))

512-3 Computation of excess property overpayment (50786(a)(2)(A))

512-3A *Principe* v. *Belshé* does not modify overpayment rules for beneficiaries who have failed to report property holdings (ACWDL 97-41)

512-4 State law provides that, in situations when beneficiary reported within competence, there is no liability for any overpayment (W&IC 14009(d))

512-5 Managed care capitation rates are treated as a covered service when computing the Medi-Cal overpayment (ACWDL 01-38)

513-1 Repayment demand may be made against beneficiary or financially responsible person (50787(c))

514-1 Right to demand repayment of Medi-Cal overpayments; notice required; suspension if hearing requested (50787(a), (b))

Section 520-529

520-1 Medi-Cal card shall be proof of authorization for covered services (50733(a))

521-1 Conditions under which county can issue current or past Medi-Cal cards (50743)

522-1 Replacement of Medi-Cal card, limitations (50746(a))

522-2 Examples of county administrative error when Medi-Cal card is requested more than one year after service (MEPM 14E-1; ACWDL 94-77; 50746)

522-3 After NOA denying Medi-Cal eligibility due to excess property, applicant may still establish eligibility up to three years later, and county must rescind and issue benefits including NOA if necessary (ACWDL 97-41)

522-4 Issuance of replacement Medi-Cal card more than one year after month of service due to extenuating circumstances (MEPM 14E-2, 3)

523-1 Authority for CDHS to impose restrictions for improper utilization of Medi-Cal services; time of restriction (50793(a), (d))

523-2 Restrictions are temporarily suspended if hearing is requested (50793(f), (g))

523-3 General rule is limit on prescribed drugs to six per month unless there is prior authorization (W&IC 14133.22)

526-2 Share of cost met when provider certifies payment for services to be made by patient (50657(a)(6))

526-3 Retroactive adjustment of share of cost when eligibility for deduction is determined at later date (MEPM 12C)

526-3A Adjustments to be made when share of cost is less than originally computed (MEPM 12C)

526-4 *Principe* spenddown of excess property cannot be used to meet share of cost, or for *Hunt* purposes (ACWDL 97-41)

527-1 When Medi-Cal applicant incurs medical costs while application is pending, and *benefits* are later approved, DHS must reimburse beneficiary for out-of-pocket costs (*Conlan* v. *Bontá*)

527-2 Reimbursement process for out-of-pocket medical expenses of Medi-Cal beneficiaries (ACWDL 07-01)

527-3 Required reimbursement process (*Conlan* v *Shewry*)

527-4 Criteria for processing *Conlan* claims (*Conlan* v *Shewry*)

527-5 Revised Plan for Beneficiary Reimbursement (*Conlan* v *Shewry*)

527-6 IHSS recipients who paid their provider an excess share of cost can file a Conlan II claim to request reimbursement. (ACIN I-03-10)

Section 530-539

530-1 Medical justification must exist to show that requested services are necessary to protect life or prevent significant disability in reviewing TARs (W&IC 14133.3, 51303)

530-2 Retroactive approval of authorization requests when recipient has not identified self as a Medi-Cal recipient (51003(b)(4))

530-3 Definition of "prior authorization" (51003(a))

530-3A Definition of "reauthorization" (51003(c))

530-3B Information required on TAR; TAR received from fee-for-service provider reviewed for medical necessity only (51003(b),(d))

530-4 Use of Manual of Criteria for Medi-Cal Authorization for medically necessary procedures (51003(e))

530-5 Prior authorization--lowest cost item or source (51003(f))

530-6 Experimental services--no coverage (51303(g))

530-7 Beneficiary must use other health care coverage before using Medi-Cal (51005(a))

530-8 TAR must be approved or denied within average of five working days (W&IC 14133.9)

531-0 Restoration of limited adult dental services effective May 2014.(W&IC 14131.10(b)(2)(C))

531-1 Circumstances under which full dentures are a covered benefit (51307(e)(7))

531-1A	Removable prosthodontics-prior authorization required (Denti-Cal Manual of Criteria-Prosthodontics-General Policies Section 5)
531-1B	Dentures not prior authorized if patient unlikely to care for, utilize or adapt to new prosthesis (Denti-Cal Manual of Criteria- Prosthodontics General Policies Section 5)
531-1C	When prosthetic appliance can be authorized more than once in five-year period (Denti-Cal Manual of Criteria- Prosthodontics General Policies Section 5)
531-1D	Prosthodontics (removable) that are not covered benefits (Denti-Cal Manual of Criteria-Prosthodontics General Policies Section 5)
531-1E	Procedures for resin based partial dentures-no requirement for opposing full denture (Denti-Cal Manual of Criteria-Prosthodontics Procedures Section 5)
531-1F	Procedures for metal framework with resin based partial dentures-requirement for opposing full denture (Denti-Cal Manual of Criteria-Prosthodontics Procedures Section 5)
531-3	Circumstances under which laboratory crowns are covered as program benefit (51307(e)(6))
531-3A	Provider Manual criteria for restorative dentistry and crowns (Denti-Cal Manual of Criteria Restorative General Policies-Crowns Section 5)
531-3B	Laboratory processed crowns on root canal treated teeth (Denti-Cal Manual of Criteria-Restorative General Policies-Crowns Section 5)
531-3C	Covered benefits-dental caries; crowns not a benefit when tooth can be restored with amalgam (51307(b)(7), (8)); Denti-Cal Restorative General Policies Section 5)
531-5	Partial dental prostheses only a covered benefit when necessary for balance of complete artificial denture (51307(d)(4))
531-6	Denti-Cal criteria for periodontal services (Denti-Cal Manual of Criteria-Periodontal General Policies Section 5)
531-8	Certain endodontic benefits are covered (51307(e)(5))
531-8A	Endodontic General Procedures (Denti-Cal Manual of Criteria-Endodontic General Policies Section 5)
531-9	Statutory limitations on Denti-Cal benefits as of 8/15/93 (W&IC 14132(h))
531-11	Orthodontic requirements for handicapping malocclusion (Denti-Cal Provider Manual of Criteria Orthodontic General Policies Section 5)
531-11A	Information to be included with EPSDT supplemental service request (51340(d))

531-11B EPSDT exceptions to general orthodontic coverage (51340.1(a)(2))

531-11C Diagnostic casts are required to be submitted for orthodontic evaluation (Denti-Cal Provider Manual of Criteria Diagnostic Procedures Section 5)

531-11G Information to be included in EPSDT dental TAR; guidelines as to which claims will be approved (Medi-Cal Dental Program Provider Handbook-Special Programs, Section 9)

531-11H Maxillofacial services covered subject to prior authorization (Denti-Cal Manual of Criteria Oral and Maxillofacial Surgery General Policies Section 5)

531-11I If patient's orthodontic treatment extends beyond age 21, or if patient becomes ineligible for Medi-Cal during treatment, patient is responsible to pay for continuing treatment (Denti-Cal Provider Manual General Policies, Section 5)

531-11J Guidelines to standardize the use of the HLD Index in the orthodontic program (Denti-Cal Bulletin volume 13 #8)

531-12 Dental coverage under the CHDP program (Medi-Cal Dental Provider Handbook-Special Programs Section 9)

531-13 Address for provider appeals process Medi-Cal Dental Provider Handbook-Program overview, Section 2)

531-14 No adult dental after July 1, 2009 unless TAR submitted before June 30, 2009 (Denti-Cal Bulletin volume 25 #22)

531-14A Services exempted from the elimination of adult dental services effective July 1, 2009 (Denti-Cal Bulletin volume 25 #22)

531-14B Services that remain in place and are not changed by partial restoration of dental benefits. (Denti-Cal Bulletin May 2014, Volume 30 Number)

532-1 Definition of durable medical equipment (51160)

532-2 Durable medical equipment, general (51321)

532-2A Repair of durable equipment (51321)

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535-1 General rule is limit on prescribed drugs to six per month unless there is prior authorization (W&IC 14133.22)

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535-4 Step therapy standard for drug authorization (Medi-Cal Provider Manual)

535-5 State must strike balance between physician's decision and utilization controls in determining medical necessity of particular drugs. (*Paleski* v. *State Dept. of Health Services* (2006) 144 Cal.App.4th 713, 735)

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536-9 Criteria for authorizing out-of-plan services when a beneficiary is participating in an MHP (9 CCR 1830.220)

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536-11B Contents of the MHP NOA issued under 9 CCR 1850.210(a), (b), or (c) (9 CCR 1850.210(d))

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538-9A Eligibility requirements for Adult Day Health Care (W&IC 14525)

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538-9C Initial and subsequent treatment authorization requests may be granted for up to six calendar months. (W&IC 14526.1(a))

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538-9F Circumstances for reauthorization of an ADHC TAR (W&IC 14526.2(f))

538-10 Definition of EPSDT screening sources (51184(a))

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538-16 A PACE program must have an agreement with the Centers for Medicare and Medicare Services (42 CFR 460.30)

538-17 PACE appeals procedures (42 CFR 460.124)

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538-19 PACE, termination of enrollment (42 CFR 160)

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538-21 PACE, involuntary disenrollment (41 CFR 164, 166, 168, 172)

538-22 PACE, deemed continued temporary eligibility (42 CFR 160)

539-1 TARs – when aid pending appropriate (*Frank* v. *Kizer*)

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Section 540-549

540-1 Out-of-state medical care; exemption for emergency services (51006(a), (b))

540-2 Statutory criteria for out-of-state care (W&IC 14022)

541-1 Provider cannot bill beneficiary after acceptance as Medi-Cal patient (W&IC 14019.4; 51002(a))

541-1A Provider appeals (51003.1(a)(1))

541-2 Provider billing requirements, authority for late payment of bills (51008, .5)

541-3 Provider or debt collector violates Civil Code § 1785.25 (private right of action for unfair debt practices) by reporting beneficiary's bill for covered Medi-Cal services to credit agency. (W&IC 14019.4(f))

541-4 If debt collector provided proof of Medi-Cal eligibility, provider can still bill patient until notified by the debt collector.(W&IC 14019.4(e))

541-5 Medi-Cal payment constitutes payment in full for the services provided. (W&IC 14019.3(d), 42 CFR 447.15)

541-6 Department fiscal intermediary will deny claims from providers if there is other health coverage unless there has been a denial of such coverage for the service involved. (50769(b))

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543-1 Right to state hearings for Medi-Cal beneficiaries denied, involuntarily discharged, or provided reduced substance abuse services (50951, 51341(p))

543-2 Right to pre-termination hearings for narcotic treatment applicants and beneficiaries under Title 9 (9 CCR 10010, 9 CCR 10170(a) and (b)(5), and 9 CCR 10420)

543-3 State must specify a single State agency to administer Medicaid program, and that agency must not delegate to others outside agency authority to exercise administrative discretion, or issue policies, rules, and regulations on program matters (42 CFR 431.10(b), (c))

Section 550-555

Level of Care

550-1 Level of care; criteria for skilled nursing care (51335(j))

550-3 Level of care; definition of skilled nursing care (51124(b))

550-4 Level of care; criteria for intermediate care (51334(l))

550-5 Level of care; definition of intermediate care (51120(a))

550-6 Level of care; definition of "out-of-home" care facility (MPP 46-140.1)

555-1 CMSP coverage excludes mental health, alcohol, and drug abuse services (W&IC 16801)

555-2 CMSP limited to certain named or contracting counties (W&IC 16809)

555-4 CMSP excludes sealants and orthodontics, but includes other services provided primarily to children (Denti-Cal Provider Manual 5-95)

Section 560-569

560-1 State must specify a single State agency to administer Medicaid program, and that agency must not delegate to others outside agency authority to exercise administrative discretion, or issue policies, rules, and regulations on program matters (42 CFR 431.10(b), (c))

560-2 Three in-home service programs; IHSS Plus Waiver, PCSP and IHSS-Residual (ACWDL 05-21)

560-2A Things needed to qualify for IHSS Plus Waiver (ACWDL 05-21)

560-2B Things needed to qualify for PCSP (ACWDL 05-21)

560-2C Services available for IHSS-Residual (ACWDL 05-21)

560-3 3.6% Service reduction effective 2/1/11 and 8/1/12 (ACL 10-61; ACL 12-33)

560-5 3.6% extended through June 2013. (ACL 12-33)

560-6 3.6% changed to 8% for 12 months commencing in July 2013. (ACL 13-47)

560-7 The 8% reduction is first applied to any unmet need with the exception of protective supervision. (ACL 13-47)

560-8 20% reduction in IHSS payment, currently suspended. (ACL 11-81, ACL 11-84)

561-1A Chronic disabling condition is disability standard for PCSP; PCSP only for categorically needy persons (51350(b))

561-1B Pickle eligible persons may have $0 share of cost if they meet other PCSP requirements and if they agree to not receive advance pay (W&IC 14132.95(k))

561-2 PCSP only for those who would be unable to remain safely at home; "home" defined (51350(b), 51145.1)

561-2A Home can be real or personal property, fixed or mobile, on land or water (50044)

561-2B State law authorizes PCSP for persons living in their homes and other authorized locations (W&IC 14132.95(a)(1))

561-5 All Medi-Cal eligibility determinations including those for PCSP recipients must follow Medi-Cal rules (ACWDL 04-27)

561-5A Medi-Cal eligibility determinations on PCSP and IHSS Plus Waiver cases done by Medi-Cal workers following Medi-Cal rules (ACWDL 05-21)

561-6 CDSS position is that IHSS recipient, who receives personal care services, and is an eligible recipient must sign a form SOC 426. Failure to sign the form results in loss of

personal care and ancillary services (ACWDL 99-13, ACL 99-25; 30-757.1; W&IC 12300(f), W&IC 14132.95)

561-6A State law and regulations do not permit person eligible for personal care services under PCSP to receive IHSS for those services (30-757.1; W&IC 12300(f), W&IC 14132.95; ACL 99-25)

561-7 CDSS policy, regarding noncompliance to respond to notice to submit SOC 426, is to send additional notice before discontinuing (ACL 99-25)

561-8 PCSP recipient may receive three month retroactive benefits if services actually received and out of pocket expenses incurred (ACL 02-18)

561-9 Non-citizens who are not qualified aliens are not eligible for federal full scope Medi- Cal (ACIN I-18-08)

561-9A To be eligible for PCSP/IPW, an individual must be eligible for federal full scope Medi-Cal (ACIN I-18-08)

562-1 Provider shall not be beneficiary's spouse; provider shall not be parent of a beneficiary who is a minor child (51181; 50014; 50030; Handbook 30-767.3)

562-2 Providers must be approved by CDHS and sign required forms (51483.1, 51204)

562-3 Beneficiaries or their representatives can choose provider (51483.1; 51204(a); MPP Handbook 30-767.4)

562-4 Contract agency providers selected per Welfare and Institutions Code (W&IC 12302.1) (51204(b); MPP Handbook 30-767.4(b))

562-5 Personal care provider can appeal to county, then to court (51015.2; W&IC 14104.5; MPP Handbook 30-767.5)

563-1 PCSP includes personal care and ancillary services; services covered by PCSP (51183; MPP Handbook 30-780.1)

563-1A Protective supervision and Domestic and Related-Only services are PCSP funded (ACL 05-05)

563-2 Needs assessment governed by MPP, Uniform Assessment Tool (51350(a); MPP Handbook 30-780.2(a))

563-3 Services limited to 283 hours monthly; no dollar limit (51350(b); MPP Handbook 30-780.2(b); ACL 95-42)

563-3B Non-severely impaired recipients of PCSP and CFCO who require protective supervision are entitled to the maximum of 195 hours plus any authorized need in addition to protective supervision up to a maximum of 283 hours. (ACIN I-28-06, ACL 14-60)

563-4 Grooming excludes cutting with scissors or clipping toenails (51350(f); MPP Handbook 30-780.2(f))

563-5 Menstrual care for application of sanitary napkins and cleaning (51350(g); MPP Handbook 30-780.2(g))

563-6 Paramedical services, specific inclusions (51350(g), (h); MPP Handbook 30-780.2(g), (h))

563-7 Range of motion exercises--limitations (51350(h)(2); MPP Handbook 30-780.2(h)(2))

563-8 Regional centers cannot be considered an alternative resource (ACL 98-53; *Arp v. Anderson*)

563-9 Non-parent may provide PCSP in home of an institutionally deemed child even if parent is in the home. (ACL 00-83)

564-1 PCSP for eligible Medi-Cal beneficiaries is governed by W&IC, CCR, and operated pursuant to MPP (W&IC 14132.95; MPP 30-700.2)

564-3 Statutory requirement that IHSS/PCSP recipient must live in his/her home or abode of choice (W&IC 12300(a))

564-4 CDHS definition of home (50044)

564-5A IHSS and PCSP eligibility determinations made following Medi-Cal rules (ACWDL 04-27)

566-2 PCSP list of care services (51183(a))

566-3 PCSP list of ancillary services (51183(b))

567-1 Intent of legislature that IHSS Plus Waiver be added as a Medi-Cal program; IHSS Plus Waiver population transitioned to IHSS Plus Option (IPO) program effective October 1, 2009 (W&IC 14132.951(a); ACIN I-33-10)

567-2 IHSS Plus Waiver incorporates eligibility requirements and benefits of existing IHSS program; IHSS Plus Waiver population transitioned to IHSS Plus Option (IPO) program effective October 1, 2009 (W&IC 14132.951(b); ACIN I-33-10)

567-3 To the extent FFP is available, IHSS Plus Waiver is furnished as a Medi-Cal program; IHSS Plus Waiver population transitioned to IHSS Plus Option (IPO) program effective October 1, 2009 (W&IC 14132.951(c)(d) ACIN I-33-10)

567-3A Services authorized under IHSS Plus Waiver administered under IHSS rules (W&IC 14132.951(e))

567-3B IHSS Plus Waiver program services to eligible Medi-Cal beneficiaries; IHSS Plus Waiver population transitioned to IHSS Plus Option (IPO) program effective October 1, 2009 (30-700.3 and .4; (ACIN I-33-10)

567-3C Eligibility requirements for IHSS Plus Waiver program (30-785(a) and (b))

567-4 DHS may implement IHSS Plus Waiver through ACWDL or similar publication for up to 18 months (W&IC 14132.951(h))

567-5 If conflict exists between terms of IHSS Plus Waiver and ACWDL, regulations or similar publication, terms of waiver controls (W&IC 14132.951(i))

567-6 IHSS and PCSP eligibility determinations made following Medi-Cal rules (ACWDL 04-27)

567-6A Medi-Cal eligibility determinations on PCSP and IHSS Plus Waiver cases done by Medi-Cal workers following Medi-Cal rules (ACWDL 05-21)

567-7 IHSS Plus Waiver recipients (ACL 05-05; ACWDL 05-21)

567-7A In IHSS Plus Waiver, presumptive disability determined under Medi-Cal regulations; Medi-Cal eligibility must be established before IHSS Plus Waiver eligibility is established (30-785(g)(2) and (3))

567-8B Supplemental payment program permitting share of cost comparison (W&IC 12305.1(a) and (b))

567-8C Non-citizens who are not qualified aliens are not eligible for federal full scope Medi- Cal (ACIN I-18-08)

567-8D To be eligible for PCSP/IPW, an individual must be eligible for federal full scope Medi-Cal (ACIN I-18-08)

567-9 Exemptions under the IHSS Plus Waiver program (ACWDL 05-29)

567-9A In-home caregiver wages exempt as income and property if spouse or minor child receive services from spouse or parent provider and services are through federal, state or local program (ACWDL 07-02)

567-10 A parent working less than full time may be paid as a provider under IPW; two parents working full time may not be paid providers under IPW (ACIN I-28-06)

567-11 ID waiver recipients who meet IPW criteria are eligible for the IPW; parents of minors who receive Medi-Cal under ID waiver may provide services under IPW (ACIN I-28- 06)

567-11A Children meeting DDS institutional deeming criteria qualify for Medi-Cal regardless of parent's income or resources (ACL 00-83)

567-12 Respite care is offered under IPW (ACIN I-28-06)

567-13 Under IHSS Plus Waiver, NSI recipients have 195 hour maximum, SI recipients have 283 hour maximum (ACIN I-28-06)

567-14 IHSS Plus Waiver overpayments determined under Medi-Cal regulations (30-785(o))

567-15 IHSS Plus Waiver population transitioned to IHSS Plus Option (IPO) program effective October 1, 2009 (ACIN I-33-10)

568-1 Assessing needs under hourly task guidelines based on individual need (30-757.1(a))

568-1A Hourly task guidelines and exceptions to those guidelines (30-757.1(a))

568-1B General functional index rankings; variable functioning discussed (ACL 06-34E1)

568-2A Meal preparation definition (ACL 06-34 errata, attachment C)

568-2B Meal preparation functional index (ACL 06-34 errata attachment B)

568-2C Meal preparation grid (ACL 06-34 errata, attachment C)

568-2D Meal preparation factors/exceptions (ACL 06-34 errata, attachment C)

568-2E IHSS recipient may choose to eat meals separately from other family members; no health and safety need required (ACL 08-18)

568-2F Meal preparation and clean-up must be done in recipient's home; unusual circumstances may necessitate occasional meal preparation and clean-up outside the home (ACL 08-18; ACL 09-30)

568-3A Meal cleanup definition (ACL 06-34 errata, attachment C)

568-3B Meal cleanup functional index (ACL 06-34 errata attachment B)

568-3C Meal cleanup grid (ACL 06-34 errata, attachment C)

568-3D Meal cleanup factors/exceptions (ACL 06-34 errata, attachment C)

568-4A Bowel and bladder care definition (ACL 06-34 errata, attachment C)

568-4B Bowel and bladder care functional index (ACL 06-34 errata attachment B)

568-4C Bowel and bladder care grid (ACL 06-34 errata, attachment C)

568-4D Bowel and bladder care factors/exceptions (ACL 06-34 errata, attachment C)

568-5A Feeding definition (ACL 06-34 errata, attachment C)

568-5B Feeding functional index (ACL 06-34 errata attachment B)

568-5C Feeding grid (ACL 06-34 errata, attachment C)

568-5D Feeding factors/exceptions (ACL 06-34 errata, attachment C)

568-6A Routine bed baths definition (ACL 06-34 errata, attachment C)

568-6B Routine bed baths functional index (ACL 06-34 errata attachment B)

568-6C Routine bed baths grid (ACL 06-34 errata, attachment C)

568-6D Routine bed baths factors/exceptions (ACL 06-34 errata, attachment C)

568-7A Dressing definition (ACL 06-34 errata, attachment C)

568-7B Dressing functional index (ACL 06-34 errata attachment B)

568-7C Dressing grid (ACL 06-34 errata, attachment C)

568-7D Dressing factors/exceptions (ACL 06-34 errata, attachment C)

568-8 Hourly task guidelines for menstrual care (30-757.14(j), ACL 06-34 errata, attachment C)

568-9A Ambulation definition (ACL 06-34 errata, attachment C)

568-9B Ambulation functional index (ACL 06-34 errata attachment B)

568-9C Ambulation grid (ACL 06-34 errata, attachment C)

568-9D Ambulation factors/exceptions (ACL 06-34 errata, attachment C)

568-9E Time may be authorized to shadow/follow recipient with unsteady gait (ACL 08-18)

568-9F Maintenance exercise of assistance walking may be provided outside recipient's home; no time can be authorized for travel or assistance into or out of a vehicle for this service (ACL 08-18; ACL 09-30)

568-10A Transfers definition (ACL 06-34 errata, attachment C)

568-10B Transfers functional index (ACL 06-34 errata attachment B)

568-10C Transfers grid (ACL 06-34 errata, attachment C)

568-10D Transfers factors/exceptions (ACL 06-34 errata, attachment C)

568-11A Bathing, oral hygiene and grooming, definition (ACL 06-34 errata, attachment C)

568-11B Bathing, oral hygiene and grooming, functional index (ACL 06-34 errata attachment B)

568-11C Bathing, oral hygiene and grooming, grid (ACL 06-34 errata, attachment C)

568-11D Bathing, oral hygiene and grooming factors/exceptions (ACL 06-34 errata, attachment C)

568-12A Repositioning, rubbing skin, definition (ACL 06-34 errata, attachment C)

568-12B Repositioning, rubbing skin, grid (ACL 06-34 errata, attachment C)

568-12C Repositioning, rubbing skin factors/exceptions (ACL 06-34 errata, attachment C)

568-13A Care/assistance with prosthesis, definition (ACL 06-34 errata, attachment C)

568-13B Care/assistance with prosthesis grid (ACL 06-34 errata, attachment C)

568-13C Care/assistance with prosthesis factors/exceptions (ACL 06-34 errata, attachment C)

568-14 6-hour standard for domestic services (30-758.11 renumbered to 30-757.11(k)(1))

568-14A Time standard; general (30-758.2; former W&IC 12301.2 repealed)

568-14B Time standard; laundry (30-758.2 repealed, 30-757.135 renumbered to 30-757.134(c) and (d))

568-14C Time standard, food shopping (30-757.136 renumbered to 30-757.135 and .135(b)(1), 30-758.13 repealed)

568-14D Time standard; other shopping (30-758.14 repealed and renumbered to 30-757.135(c)(1))

568-14E Exception to time standards if threat to health or safety (30-758.4 repealed and renumbered in 30-757)

568-18 Respiration defined (30-757.14(b))

Section 570-579

570-1 Overview of the Medi-Cal waiver process (MEPM 19D-2, 3)

570-2 Six types of Medi-Cal waivers (MEPM 19D-3)

570-3 NOA required for applicants (MEPM 19D-10)

570-4 Effective date of Medi-Cal coverage when waiver has special eligibility rules (MEPM 19D-10)

570-5 Waiver persons may request IHSS, or PCSP (MEPM 19D-11)

570-6 MFBU rules for waiver persons (MEPM 19D-11)

571-1 Description of the DSS Home and Community-Based Services Waiver (MEPM 19D-4)

571-2 Eligibility requirements for DDS Home and Community-Based Services Waiver (MEPM 19D-4)

572-1 Description of the IHO waivers (MEPM 19D-6)

572-2 IHO is referring agency in Model NF waiver (MEPM 19D-6)

572-3 Eligibility requirements for Model NF waiver (MEPM 19D-6, 7, 8)

572-4 PACE participants entitled to spousal impoverishment treatment effective 7/1/97 (ACWDL 97-18)

572-4A Notice requirements to PACE participants; PACE participant may be living with community spouse (ACWDL 97-18)

573-1 Description, eligibility for Nursing Facility Level of Care waiver (MEPM 19D-8, 9)

574-1 Description, eligibility for AIDS waiver (MEPM 19D-9)

575-1 Description, referring agency, eligibility for IHMC waiver (MEPM 19D-8)

576-1 Purpose of MSSP is to serve elderly, frail individuals who are certifiable for placement in nursing facility (W&IC 9560(a); 42 USC 1396n(c))

576-1A MSSP program eligibility requirements and goals (ACWDL 03-22)

576-2 Services provided under MSSP (W&IC 9561)

576-3 MSSP waiver allows MSSP to grant hours above statutory IHSS maxima if maxima has been reached, and to exclude MSSP as an alternative resource when maxima IHSS not authorized (W&IC 9562(b); ACL 00-34)

576-4 Description of MSSP waiver (MEPM 19D-9)

576-5 Eligibility, aid codes for MSSP (MEPM 19D-10)

576-6 California Dept. of Aging has inter-agency agreement with CDHS to review and monitor MSSP (MEPM 19D-10)

576-7 MSSP eligibility determination (ACWDL 03-22)

Section 580-589

580-1 State must specify a single State agency to administer Medicaid program, and that agency must not delegate to others outside agency authority to exercise administrative discretion, or issue policies, rules, and regulations on program matters (42 CFR 431.10(b), (c))

580-2 Managed care plans must incorporate Knox-Keene protections. (Health and Safety Code 1340, et seq.)

580-2A Certain county plans exempt from Knox-Keene (W&IC 14087.95, W&IC 14087.54(b)(5) and (b)(3)(A) and (B))

580-3 Physician services must be provided in a timely manner under managed care plans. (28 CCR 1300.67.2.2(c)(1))

580-4 Plans must ensure that non-urgent appointments with specialists are available within 15 business days (28 CCR 1300.67.2.2(c)(5)(D), (G) and (H))

580-5 When there is a shortage of providers in a service area, plan must assist in finding providers outside the plan including specialty services (28 CCR 1300.67.2.2(c)(7)(B))

581-1 Definition of PHP "contract" (53108)

581-2 Definition of "disenrollment" from PHP (53114)

581-3 Generally, membership in PHP continues indefinitely after enrollment 53426)

581-3A College students living apart from parents stay in parents MFBU, choose plan where they are residing (MEDIL I-15-32)

581-4 Disenrollment for loss of eligibility, for good cause, or at beneficiary request (53260(a), W&IC 14412(a))

582-1 Coordinated Care Initiative (CCI) Initiative Managed care in select counties (W&IC 14182)

582-2 Medicare-Medicaid Plans under the Coordinated Care Initiative must assess the risk level of beneficiaries (Dual Plans Letter 15-001)

582-3 Medicare-Medicaid Plans must conduct health risk assessment (Dual Plans Letter 15-001)

583-1 Medi-Cal beneficiaries may have to participate in managed care plan to receive Medi-Cal services (W&IC 14131.15)

583-2 Mandatory Managed Care for Aged and Disabled effective 2011, one year allowance for continutity of care (ACDWL 11-24, ACWDL 11-24e)

584-1 Mandatory GMC enrollees (53906(a))

584-1A GMC plan definition (53902)

584-2 Duty to mail an enrollment form to eligible GMC beneficiaries; if beneficiary does not enroll within 30 days, the beneficiary may be assigned to a GMC plan (53921(c), (d))

584-3 Duty to provide information to GMC beneficiary of, e.g., processing time, alternative to GMC, restrictions on disenrollment from 2nd to 6th month of enrollment (53926.5(a))

584-4 Duty to provide information to GMC beneficiary of, e.g., available services, address and phone number of primary care provider, appropriate disenrollment form (53926.5(b))

584-5 GMC beneficiary must enroll in dental and PHP or PCCM plan (53921(e))

584-6 Assignment of GMC beneficiary to plan when person does not choose a plan within 30 days, or disenrolls and does not select a new plan (53921.5(a))

584-7 Primary health care services are to be within 10 miles of GMC beneficiary's residence (53922.5(a))

584-8 Disenrollment of beneficiary from GMC when person is an Indian, or has a complex medical condition (53923.5)

584-8A Denied request for exemption to be treated as request for continuity of treatment for existing medical condition. (All Plan Letter 15-001)

584-9 Duty to assign a primary care provider, criteria to be used to assign, and opportunity for beneficiary to change (53925)

584-10 Scope of benefits under GMC determined by contract. (53904(a)(1))

584-11 GMC plans must include preventive care plans (53904(a)(3))

584-12 GMC plans must provide full scope of benefits under Title 22 unless specifically excluded by contract. (53910.5(a))

584-13 GMC plans must have provisions for participating as Knox-Keene licensee (53200(a)(1))

514-14 A GMC plan shall provide accessibility to medically required, satisfactorily- credentialed specialists through contracting or referral.(GMC Model Contract Boilerplate)

585-1 Counties which are in Two-Plan Model Managed Care, and basic services provisions (53800(a), 53840(a))

585-2 Mandatory enrollment in Two-Plan Model (53845)

585-2A Duty of mail information to beneficiary; beneficiary is assigned a plan if no exemption form is submitted within 30 days (53882(c), (d))

585-2B Assignment of beneficiary to plan when no choice is made (53883(a), (b))

585-2C Health Care Options must consider the beneficiary's language needs, if known, in assigning the beneficiary to a plan (53884(b)(3))

585-2D Beneficiary entitled to continued fee for service Medi-Cal benefits whil-2Ee exemption claim or appeal is pending (W&IC 14182)

585-2E Member entitled to file grievance, grievance procedure does not modify right to appeal

through a state hearing (53858(i))

585-3 Voluntary enrollment in Two-Plan Model (53845(b))

585-4A Criteria for receiving fee-for-service when a beneficiary would otherwise be in a Two-Plan Model (53887(a), eff. 12/19/00)

585-4B No exemption granted for complex medical condition in certain instances, e.g., having been a plan member for 90 days (53887(a)(2)(B), eff. 12/19/00)

585-4C Denied request for exemption to be treated as request for continuity of treatment for existing medical condition. (All Plan Letter 15-001)

585-6 Obligations to make enrollment/disenrollment form available (53888)

585-7 Preference for placing family members in same plan (53884(b)(4))

585-8 Travel time to primary health provider should not exceed 30 minutes or ten miles, unless waived by beneficiary (53885)

585-9 Beneficiaries may continue in fee-for-service, after receiving exemptions, for limited period (53887(a)(3), (4))

585-10 Request for exemption from plan enrollment must be on HCO Form 7101 or 7102 (53887(b), eff. 12/19/00)

585-10A If request for exemption denied, the managed care provider must still consider alllowing existing continuity of care plan.

585-11 Time limits for processing enrollment and disenrollment requests (53889(e), (f), (g), eff. 12/19/00)

585-12 CCS services for children in managed care are billed on a fee-for-service basis (W&IC 14094.3)

585-13 Definition of CCS services (Health and Safety Code 123840)

586-1 Managed care plan must provide Medi-Cal covered services unless excluded under contract (53851)

586-2 Detailed description of basic health services to be included in health plans (Title 28 CCR 1300.67)

586-3 Prescriptions continued for persons transitioning into managed care (W&IC 14185, All Plan Letter 13-023)

586-4 Step Therapy may be required for prescription drugs in managed care plans. (Title 28 CCR 1300.67)

586-5 Medical necessity and EPSDT under managed care. (APL 14-017)

586-6 Expanded discussion of medical necessity in managed care (APL 13-021)

586-7 Types of services that must be furnished under managed care (APL 13-021)

586-8 Mental health services to be provided through managed care (APL 13-021)

586-9 Plans cannot alter services based on diagnosis or condition of recipient; utilization controls must be based on medical necessity (42 CFR 438.210)

586-10 Managed care plans must allow beneficiaries to continue use of any (single-source) drugs that are part of a prescribed therapy prior to the date of enrollment (All Plan Letter 15-001)

586-11 Managed care prior authorization guidelines for sedation in dental procedures (All-Plan Letter (APL) 15-012)