411-1
The overall purpose of the Medi-Cal Program is to provide to the extent practicable, health care benefits to eligible persons. In the administration of the program, the Department shall allow, to the extent practicable, eligible persons to receive health care in the same manner as the general public.

The Department shall emphasize and encourage access to health care through enrollment in organized, managed care plans of the type available to the general public. The benefits available shall not duplicate those provided under other federal or state laws or under other contractual or legal entitlements of the person or persons receiving them.

(W&IC §14000)

411-2
Persons administrating aid under any public assistance program shall conduct themselves with courtesy, consideration and respect toward applicants for and recipients of aid under that program, and shall endeavor at all times to perform the duties in such a manner as to secure for every person the amount of aid to which he/she is entitled, without attempting to elicit any information not necessary to carry out the provisions of law applicable to the program, and without comment or criticism of any fact concerning applicants or recipients not directly related to the administration of the program. (W&IC §10500)

413-1 ADDED 4/10
DHCS has developed a general limited-English proficient (LEP) policy to clarify the responsibilities of counties in providing effective language services and to ensure that applicants/beneficiaries are informed of the availability of free interpreter services.

DHCS is mandated by a portion of Title VI of the Civil Rights Act of 1964 as amended (42 USC section 2000d et seq.) and the Dymally-Alatorre Bilingual Services Act (Government Code Section 7290 et seq.) to provide LEP individuals with meaningful access to services by providing language assistance. DHCS is responsible for the administration of the State's Medi-Cal program and for ensuring that county and local welfare/health agencies comply with these federal mandates and state laws.

(ACWDL 10-03, January 12, 2010)

413-1A ADDED 4/10
Counties are responsible for ensuring that limited-English proficient (LEP) individuals have access to meaningful language services, and must take necessary steps to ensure that interpretive services and written translations are provided to LEP applicants/beneficiaries, regardless of the size of the language group.

The following areas serve as guideposts for counties in providing effective language services to LEP individuals:

Informing Signs: Counties must place signs near any reception desk or window and other initial points of contact. All such signs should be clearly visible.

Identifying Language Preference: Counties must identify the preferred language(s) for written and verbal communications for applicants/beneficiaries.

Bilingual Staffing: Counties with a substantial number of LEP persons must employ a sufficient number of qualified bilingual persons to ensure that provision of services in the language of the LEP person are accessible.

Interpreter Services: When the LEP population is less than five percent in acounty at a location, the county is not required to necessarily have bilingual workers, but it must still offer and provide free interpreter services in the language the applicant/beneficiary has specified for oral communication. This means that if a LEP applicant/beneficiary who has identified a need or preference to communicate in a non-English language comes to the office or is contacted by phone, an interpreter must be provided by the county at no cost to the individual.

Use of Family Members and Friends as Interpreters: A family member or friend may only be used to interpret if the free interpreter services have been offered to the applicant/beneficiary and the applicant/beneficiary provides written consent indicating that he/she prefers to voluntarily use a family member or friend or their own professional interpreter.

Minors Used as Interpreters: Counties are prohibited from using minor children (under the age of 18) as interpreters, except temporarily under extenuating circumstances.

(ACWDL 10-03, January 12, 2010)

413-1B ADDED 4/10
Use of Translated Documents: The counties' delivery of services, benefits and programs to limited-English proficient (LEP) applicants/beneficiaries must be done by using translated forms, translated NOAs and/or other translated written material mailings that have been required and provided by DHCS. If DHCS has provided written translated materials, the counties must use the translated document, and not the English version for those preferring non-English materials.

In addition, if using a translated NOA, any added information that is unique to the applicant/beneficiary on the notice must be in his/her language. This means that an explanation of the action that is not printed on the NOA must be in the same language in which the notice is printed. If the NOA is translated into a threshold language, the information notice on the reverse side (NA Back 9) must also be in that same threshold language.

Counties are required to provide interpretation services to all LEP applicants/beneficiaries regardless of whether the DHCS has translated the forms, notices, and/or other translated written materials. This means that upon the request of the applicant/beneficiary, counties must, at a minimum, provide oral interpretation of all forms, notices, and/or other written material mailings. Written translations can range from translation of an entire document to translation of a short description of the document.

(ACWDL 10-03, January 12, 2010)

413-1C ADDED 4/10
Documentation: Counties are required to ask applicants/beneficiaries their preferred language for oral and written communication and document the preferred language(s) in the applicant's/beneficiary's files. Once known, the county is then required to document information or actions regarding language services in the case file including the acceptance or refusal of

written materials in the applicant's/beneficiary's native language and how bilingual services are provided.

(ACWDL 10-03, January 12, 2010)

413-4
The DHCS has made available copies of the Medi-Cal form 210, as revised August 2001, in the following languages: Spanish, Vietnamese, Khmer, Hmong, Armenian, Chinese, Korean, Russian, Farsi, and Lao. These copies are available as of January 2, 2002, although the Spanish version has been available since September 2001. (All-County Welfare Directors Letter No. 01-68, December 17, 2001)

413-5 ADDED
5/16 At application and annual renewal, counties are to provide the MC 4034 or GEN 1365 - Multilingual Notification. The counties are to send the notice of interpretive services with all NOA mailings if the state translation is not available.

(Medi-Cal Eligibility Division Information Letter l 14-54, November 5, 2014; ACWDL 08-32, July 30, 2008)

414-1
County departments which have established a procedure for screening potential applicants prior to application shall determine the Medi-Cal Program under which the person or family should be processed; and provide information regarding Medi-Cal eligibility to all persons being screened and inform each person being screened of that person's rights under the Medi-Cal Program, even if it appears that the person is ineligible. (§50142)

414-2
A person or family applying and approved for any public assistance program specified in §50227 or IHSS shall not be required to submit a separate application for Medi-Cal. Medi-Cal eligibility is established automatically. (§50145)

414-3
Persons or families denied Medi-Cal eligibility under any program other than SSI/SSP shall have their circumstances evaluated by the county department prior to denial. If it appears that eligibility would exist under any program other than SSI/SSP, the application shall be processed under that program. The date of application shall be the date of the original application. (§50180)

414-4
At the time the Statement of Facts is given or mailed to an applicant, the county department shall set a reasonable deadline for returning the Statement of Facts to the county department and inform the applicant of the deadline. If the form is not submitted by the deadline, the county shall attempt to contact the applicant to determine the reason for the delay. The county shall extend the deadline for returning the Statement of Facts if a valid reason for the delay is found or deny the application or discontinue eligibility if a valid reason for the delay cannot be established. (§50165)

414-4A

Before a Notice of Action (NOA) is issued by the county to deny a new applicant Medi-Cal benefits, the county must ensure the NOA contains specific reasons for the denial action and the appropriate corresponding regulations.

For example, at the face-to-face interview, the eligibility worker (EW) gives the applicant a written request of the items which are needed to establish eligibility, with a specific due date. This is the "first contact".

If the first due date passes with no response from the applicant, the EW makes another request, in writing or by phone, which again informs the applicant of the necessary items, and gives the applicant 10 calendar days to respond. This is the "second contact". The two contacts must be documented in the case file with the date, method of contact and the result of each contact.

If the second due date passes with no response from the applicant, the EW issues an NOA, as described in paragraph 1, above.

(All-County Welfare Directors Letters No. 90-07 and 97-48, November 18, 1997)

To discontinue a beneficiary, the county must comply with Senate Bill No. 87 procedures. (ACWDL No. 02-59, December 23, 2002)

414-5
The legislature finds and declares that nursing facility residents face particular barriers to eligibility because they may have great difficulty or be unable to assist in completing Medi-Cal eligibility paperwork requirements when their own resources are too diminished to pay for their care.

Nursing facilities have no role in assuring completion of the Medi-Cal application process. They may be left with neither a source of private payment nor government reimbursement.

It is the legislative intent to ensure nursing facility residents receive assistance in the application process, that applications be processed timely, and that nursing facility participation in the Medi-Cal program be encouraged.

(Senate Bill 635, Statutes of 1992, §§1 and 2)

414-5A REVISED 2/14
LTC applicants should not be denied Medi-Cal due to the non-cooperation of the individual acting on their behalf, when that individual is not the competent spouse, conservator, guardian or executor.[AB1] In these cases, unless a suitable individual is located, the county should proceed with the diligent search procedures per Title 22 CCR §50163 in order to make the appropriate eligibility determination. (ACWDL 94-62, August 2, 1994)

414-6
The DHCS shall ensure that nursing facility applicants have access to assistance in identifying and securing information necessary to complete the Medi-Cal application and to make the eligibility determination.

The DHCS shall ensure that Medi-Cal applications for nursing facility residents are processed in a timely manner.

(W&IC §§14110.05(a) and (b))

414-7
County welfare departments (CWDs) must outstation eligibility workers (EWs) at Disproportionate Share Hospitals and Federally Qualified Health Centers unless the CWD can demonstrate that it is not feasible to do so. The CWDs are required to submit new petitions only for the sites which have not participated in the outstationing program in the past, and which presently meet the requirements for outstationing under the Omnibus Budget Reconciliation Act of 1990 (OBRA '90).

The original intent of outstationing still remains to make quick determinations of Medi-Cal eligibility for pregnant women and children.

(All-County Welfare Directors Letter No. 98-13, March 3, 1998, referencing OBRA '90)

414-8
When the county is redetermining eligibility and information or verification is needed from the beneficiary, and the beneficiary either fails to respond, or responds incompletely, there must be two contacts performed by the EW, and documented in the case file, before discontinuance can take place.

The EW contacts the county, explains in an informational notice or in a telephone call the verification or information needed, and gives the beneficiary a specific due date to respond. This is the first contact.

If the beneficiary fails to respond by the due date, the EW renotifies the beneficiary of the information needed and the due date. When this second contact is sent to the beneficiary as part of a notice of action (NOA), the NOA shall clearly state that if the information is not received by the due date, aid shall be discontinued effective the last day of the current month, or the last day of the following month if ten-day advance notice is required and cannot be given.

When information is received any time prior to the discontinuance date, the discontinuance action must be rescinded.

(All-County Welfare Directors Letter No. 97-48, November 18, 1997)

414-8A ADDED 03/08
Implementation of the Mail-In application did not eliminate the two contact requirement prior to denying the Medi-Cal application or the requirement to determine eligibility within the 45 or 90 days timeframe.

TWO CONTACT REQUIREMENT:

The requirement for two contacts begins upon receipt of the Mail-In Application/Statement of Facts (MC 210) form at the county offices as described below:

First Contact

The county evaluates the Mail-In Application/Statement of Facts (MC 210) form and concludes eligibility cannot be determined without additional information and/or verification from the applicant. The county contacts the applicant to request the additional information and/or verification and provides the applicant a reasonable deadline (at least ten-calendar days) to submit the information and/or verification.

Second Contact

The applicant fails to provide or provides incomplete information and/or verification by the requested deadline. The county contacts the applicant to notify him/her that the needed information and/or verification to complete the eligibility determination has not been received, or was received incomplete. The county provides the applicant a reasonable deadline (at least ten-calendar days) to submit the requested information and/or verification.

(ACWDL 08-07, February 27, 2008)

414-8B ADDED 3/08
County-to-applicant contact is a communication that meets the following requirements:

It requests specific information or action that is needed to complete the applicant's Medi-Cal eligibility determination.

It provides a due date by which the applicant must supply the specified information or complete the requested action.

It may be either verbal or written. Verbal contact is defined as live communication between the county and applicant (voice mail or answering machine messages left by the county for the applicant are not defined as verbal contact). If the beneficiary calls back and either talks to a worker or leaves a voice mail message with sufficient information to determine eligibility, the county is not required to make another contact.

(ACWDL 08-07, February 27, 2008)

414-8C ADDED 3/08
Case files must document the contact date, method of contact and result of the contact.

Two contacts are required prior to denial. However, counties are not precluded from making additional contacts to obtain needed information from the applicant. For example, more than two contacts would be required if the county receives new information via IEVS reports, or when an applicant provides new information about income or property after submission of the Statement of Facts form.

The CWD shall provide the applicant a reasonable deadline of at least 10 calendar days to submit the requested information or verification. In situations when the individual is making a reasonable effort to cooperate and is unable to comply due to circumstances beyond his/her control, the CWD may permit additional time for the applicant to obtain the required information or verification.

Limited English proficient (LEP) applicants and/or applicants with disabilities may require interpretive or additional assistance throughout the application process. CWDs shall apprise all

applicants/beneficiaries of their rights to ask for an interpreter if they have difficulty speaking or understanding the English language. CWDs shall take appropriate steps to ensure that alternative communication services are available to all Medi-Cal applicants/ beneficiaries, including LEP individuals and applicants /beneficiaries with disabilities.

(ACWDL 08-07, February 27, 2008)

414-8D ADDED 03/08
The second contact requirements apply to Medi-Cal applicants. This is to be distinguished from the three step process (*ex parte*, telephone contact and the written contact) to determine continued eligibility for beneficiaries as mandated by Senate Bill 87. (ACWDL 08-07, February 27, 2008)

414-10
Income maintenance staff shall be continuously responsible for making and recording decisions on eligibility, and for maintaining and recording correct grant determinations in public assistance cases and share of cost determinations in medically needy share of cost cases. (Manual of Policy and Procedures (MPP) §§11-501.1, .2)

414-11
State law requires a simplified application package and mail-in process for pregnant women and children and eliminated the requirement that these applicants complete a face-to-face interview. (W&IC §14011.1)

The DHCS reminds counties that: "It is unacceptable for counties to call in every mail-in applicant as a routine practice." [Emphasis in original] The law permits face-to-face interviews if the applicant requests one, when there is good cause for the interview, suspicion of fraud, to complete the application process, when entire families wish to apply, or when income is too high to qualify for no-cost Medi-Cal. (All County Welfare Directors Letter No. 98-42, October 2, 1998)

414-11A
Eligibility staff are allowed to request the applicant to complete a face-to-face interview only for good cause or suspicion of fraud. Situations which may result in a request for an interview include questionable information on the application form or verifications provided; individual/family has no visible means of support or means of support is not reported; obvious discrepancies exist between information on the application and the Income and Eligibility System's records of assets or income; or self-employed person whose income and expenses do not match reported income, and questionable information could not be resolved by telephone contact and/or mail.

Applicants do have the right to request a face-to-face interview with eligibility staff if they so desire.

(All-County Welfare Directors Letter No. 00-31, May 8, 2000)

414-12
With each redetermination notification to the beneficiary, the county must ensure that the MC 219--Important Information for Persons Requesting Medi-Cal, Child Health and Disability Prevention program brochure--and any other required program information are mailed with the redetermination form to ensure the beneficiary understands his/her rights and responsibilities to

these programs. If a beneficiary requests information and explanation for any program or referral to any services, eligibility staff must take appropriate action and document such action in the case record. (All-County Welfare Directors Letter No. 99-36, p.6, July 16, 1999)

414-13
In general, a Medi-Cal application is defined as a written request for aid. (§50022)

However, if a request for a Medi-Cal application is made by phone, the county shall complete a SAWS 1 (i.e., an application form) on the applicant's behalf to protect the applicant's date of application and retroactive months of eligibility, and shall mail the MC 210/SAWS 2 (i.e., a complete application form) to the applicant for completion. (All-County Welfare Directors Letter No. 00-31, May 22, 2000)

414-13A
The DHCS has determined that the following procedures shall be used with a mail-in application to protect the applicant's beginning date of aid and eligibility to receive retroactive months of Medi-Cal.

The date of the SAWS 1 will be used, as follows:

> If the applicant picks up an application from the county office and has contact with a county employee, the county employee is responsible for obtaining a SAWS 1 at the time the request for an application is made. A "county employee" is a person who works for the department authorized by the county board of supervisors to administer aid programs, including Medi-Cal.

> If the applicant calls the county office and requests an application to be mailed to them, the county employee taking the request is responsible for completing the SAWS 1 on behalf of the applicant. A copy of the SAWS 1 must be forwarded with the application at the time of mailing. It is not required that applicants sign the SAWS 1.

> If the application is obtained with no direct contact with a county employee, the date of application will be the date the application is received by the county office. The date received with be the date used by the county employee when completing the SAWS 1 on behalf of the applicant. It is not required that applicants sign the SAWS 1.

Note: Should the applicant request CalWORKs or CalFresh assistance, he/ she must be told to apply in person. The SAWS 1 for the mail-in process only serves for the purpose of Medi-Cal only benefits.

(All-County Welfare Directors Letter No. 01-06, January 18, 2001)

414-13B
The following needs to be included when an application is mailed to, or handed to, an applicant:

All of the following:

> A cover letter is mandatory: DHCS has developed the enclosed camera-ready cover letter, translated in the 11 threshold languages (i.e., English, Spanish, Vietnamese, Cambodian,

Hmong, Armenian, Cantonese, Korean, Russian, Farsi, and Lao), for county use. This cover letter must be used with each application mailed and no substitute will be permitted.

> The appropriate Medi-Cal application, e.g., MC 321 HFT (Healthy Families), MC 322 (Property).

> A list of the verifications that the applicant will need to submit for the approval of Medi-Cal benefits. The date the application and verifications are to be returned to the county office must be included.

> MC 219 (Rights and Responsibilities).

> MC 13 (Statement of Citizenship) for each family member applying for Medi-Cal benefits.

> MC 007 (Medi-Cal Information Notice).

> Postage paid pre-addressed return envelope.

Once the Statement of Facts is completed and returned county staff may determine that additional forms are necessary, including but not limited to, the Disability Evaluation packet and releases of information, Authorized Representative, Board and Care forms, District Attorney Family Support agreement and questionnaire, and Other Health Coverage questionnaire.

County staff must also mail information determined to be relevant to the well being and benefit of the applicant/beneficiary, such as but not limited to, Child Health and Disability Prevention (CHDP) Program and the special supplemental food program for Women, Infants and Children (WIC).

(All-County Welfare Directors Letter No. 01-06, January 18, 2001)

414-13C ADDED
2/16The application date for Medi-Cal and other insurance affordability programs is the date the individual leaves the voicemail requesting an application, and not the date of the following business day that the county worker receives the voicemail message. This would be regardless of whether the individual called the county directly or was transferred to the county from a Covered California Customer Service Representative. (MEDIL I 16-01, January 25, 2016)

414-14 ADDED 9/07
Counties must provide:

To all applicants, the “U.S. Citizens and Nationals Applying for Medi-Cal Must Show Proof of Citizenship and Identity” (DHCS 0001); and

To all beneficiaries, the “Proof of Citizenship and Identity: New Requirements for Medi-Cal Beneficiaries Who Are U.S. Citizens or Nationals” (DHCS 0002).

(ACWDL 07-12, June 4, 2007)

415-1

The Medi-Cal application shall be denied or eligibility discontinued under any of the following circumstances:

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

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

(3) The beneficiary failed, without good cause, to return a status report. [Note that status reports were no longer required as of January 1, 2001, per All-County Welfare Directors Letter No. 00-64.]

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

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

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

(7) The applicant or beneficiary:

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

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

(1) Providing information to establish paternity for a child under 18, born out of wedlock, for whom Medi-Cal is requested.

(2) Obtaining medical support and payments.

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

(§50175(a))

415-1A ADDED
10/15Discontinuances at redetermination or change in circumstances are subject to the preliminary injunction issued on June 23, 2015, in Korean Community Center of the East Bay, et al. v. Department of Health Care Services, et al.

To provide adequate notice of Medi-Cal discontinuance for failure to respond, the notice of action must list the specific information or verification(s) missing and needed to redetermine eligibility. The notice of action must not use generic language to explain why the individual could

not be found eligible, such as, “there was not enough information to redetermine eligibility,” without explaining specifically which information or verification(s) is needed from the beneficiary, such as, “you did not provide proof of your income.”

In addition all discontinuance notices of action for Failure to Respond include this 90-day cure period language:

> You have 90 days from the date you are discontinued to provide the needed information. If we do not get the information by <discontinuance date + 90 days>, you must re-apply for Medi-Cal. If you return or otherwise provide the information requested above before <discontinuance date + 90 days> and the information establishes continued eligibility, your eligibility will go back to the date you were discontinued as though you returned the form or otherwise provided the needed information timely. (Welfare and Institutions Code, Section 14005.37(i).)

(All County Welfare Directors Letter No. 15-27, July 31, 2015)

415-1B
When an individual fails to cooperate with the county (e.g., fails to provide verification of income or property, provides insufficient information to make an eligibility determination, or loses contact with the county), the county may deny or discontinue Medi-Cal only for the noncooperative individual and the person(s) for whom he/she is responsible. A spouse is responsible to his/her spouse, and a parent to his/her child(ren). (All-County Welfare Directors Letter No. 92-09, January 24, 1992, p. 5)

415-1C ADDED 7/06
Title 42, Code of Federal Regulations, Section 435.916 (a) states that the agency must redetermine the eligibility of Medicaid recipients, with respect to circumstances that may change, at least once every 12 months. Welfare and Institutions Code (W&I), Section 14012 states that reaffirmation shall be filed annually and may be required at other times in accordance with general standards established by the California Department of Health Services (DHCS)

The Medi-Cal Annual Redetermination requires the beneficiary to cooperate with a full eligibility review by completing an Annual Redetermination form to provide information on household circumstances and verification of income and/or property. The beneficiary must cooperate with the Annual Redetermination requirements to ensure continuing Medi-Cal coverage.

The Annual Redetermination is different from the change-of-circumstances redetermination process described in W&I Code, Section 14005.37. The change-of-circumstance redetermination is conducted whenever the beneficiary reports a change of circumstances or when the county learns of a change in circumstances that may affect ongoing eligibility. The Annual Redetermination is conducted once every 12 months with a full eligibility review. Any change-of-circumstances redetermination during the 12-month period does not change the Annual Redetermination due month.

(ACWDL 06-16, May 10, 2006)

415-1D ADDED 7/06

The county must ensure that the beneficiary understands the Annual Redetermination process and requirements, as well as his or her rights and responsibilities under the Medi-Cal program. The county must inform the beneficiary that completing the Annual Redetermination in a timely manner will ensure continuing benefits coverage if he/she remains eligible and that non-cooperation may cause interruption or termination of Medi-Cal benefits at the end of the twelfth month.

The first step in processing the Annual Redetermination is to mail the Annual Redetermination Notice and form to the beneficiary by the last date of the eleventh month. The county shall inform the beneficiary of the date that the Annual Redetermination form must be returned in order to continue benefits. A new Medi-Cal Annual Redetermination Notice (MC 210 RV) has been developed and contains the following information:

Purpose of the Annual Redetermination,
Requirements of the Annual Redetermination,
Date the required forms must be completed and returned to the county for benefits to continue

(ACWDL 06-16, May 10, 2006)

415-1E ADDED 7/06
To simplify the processing of the Annual Redetermination, the county shall mail only the MC 210 RV form that the beneficiary must complete along with mandated program information that must be provided at the Annual Redetermination. Counties are not required to complete an *ex parte* review prior to mailing the Annual Redetermination packet to the beneficiary.

There are two Annual Redetermination forms for the Medi-Cal Annual Redetermination. The MC 210 RV is for the general Medi-Cal population and the MC 262 is for those beneficiaries residing in an LTC. The beneficiary or his/her representative must complete a MC 210 RV or MC 262 and return it by the due date for benefits to continue.

The MC 219 is a required form that explains the beneficiary's rights and responsibilities under the Medi-Cal program. The counties must provide the MC 219 to the beneficiary at Annual Redetermination, but the beneficiary is not required to sign and return the MC 219 to the county.

(ACWDL 06-16, May 10, 2006)

415-1F ADDED 7/06
The county shall limit the scope of the eligibility review to information that is necessary to determine ongoing eligibility and information that relates to circumstances that are subject to change, such as income and non-exempt resources and/or property. The county must allow the beneficiary at least 20 days to complete and return the required forms to the county. If a beneficiary requests information and explanation for any program or referral to any services, the county must ensure the beneficiary's request is met and the action taken is annotated in the case record.

The county must not require the beneficiary to attend a face-to-face interview unless the information and/or discrepancy cannot be resolved with one or more steps of the *ex parte* process, a follow-up telephone contact and/or by mail (MC 355) or one more of the following circumstances apply:

The beneficiary requests a face-to-face interview and assistance with the forms;

The county, after reviewing the information/verifications provided by the beneficiary and there is a suspicion of fraud;

The individual/family has no visible means of support, such as in-kind income, or the individual's specified means of support is not reported for the individual and/or family; or

There are obvious discrepancies between information reported to the county and Income Eligibility Verification System on assets or income.

(ACWDL 06-16, May 10, 2006)

415-1G
If the beneficiary contacts the county or returns the (Annual Redetermination) form to the county after Medi-Cal has been terminated for more than 30 days, the county shall determine if good cause existed under Title 22, CCR, Section 50175 (c).

Counties shall evaluate good cause for each case separately. There will be situations that are unique to the individual beneficiary. If good cause exists, the county shall allow the beneficiary to complete the Annual Redetermination and restore Medi-Cal without any break in benefits.

If the beneficiary contacts the county after Medi-Cal has been terminated for more than 30 days and he/she does not have good cause, the county shall advise the beneficiary that he/she must reapply for Medi-Cal and complete the application and eligibility determination process.

(ACWDL 06-16, May 10, 2006)

415-1H
If the beneficiary returns a signed and complete Annual Redetermination form with requested verification within 30 days of Medi-Cal termination, the county must determine eligibility as though form was returned in a timely manner. (ACWDL 06-16, May 10, 2006)

415-1I ADDED
1/16Except where, as provided in Section 14005.39(a), a county has facts clearly demonstrating that a Medi-Cal beneficiary cannot be eligible for Medi-Cal due to an event, such as death or change of state residency, a county shall perform redeterminations of eligibility for Medi-Cal beneficiaries every 12 months and shall promptly redetermine eligibility whenever the county receives information about changes in a beneficiary's circumstances that may affect eligibility for Medi-Cal benefits. (W&IC §14005.37(a), in pertinent part; W&IC §14005.39(a))

415-2
Applicants and beneficiaries whose eligibility is determined by the county department shall:

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

(2) Make available to the county department all documents needed to determine eligibility and share of cost (SOC).

(3) Report all facts pertinent to eligibility and SOC.

(4) Report any changes within 10 calendar days.

(5) Cooperate in quality control investigations.

(6) Report, apply for, and utilize all other available health care coverage.

(7) Complete Medi-Cal status reports as required.

(8) Notify the county of residence changes outside the county which has approved aid.

(9) Cooperate with the State, County, and DA, as required.

(10) Assign medical support and medical care payment rights, as required.

(§50185(a))

415-2A
In order to be eligible for medical services, an applicant or beneficiary shall cooperate in identifying the absent parent, securing medical support, and determining paternity. The DA will make the determination of whether or not the person has cooperated, but the County Welfare Department will make the good cause determination. (All-County Welfare Directors Letter No. 97-64, December 19, 1997; Medi-Cal Eligibility Procedures Manual §23E-1)

415-2B
If good cause for noncooperation in establishing paternity, obtaining medical support payments or identifying third party liability, is claimed, Medi-Cal is granted pending the good cause determination if the applicants are otherwise eligible. Once good cause is established, it continues unless the mother/caretaker parent rescinds the claim for good cause and is able to cooperate with medical support enforcement. The county shall review at redetermination to determine if circumstances have changed. It is not necessary to process another claim for good cause. (Medi-Cal Eligibility Procedures Manual §23E-1)

415-2C
Good Cause claims in regard to establishing paternity, obtaining medical support payments and identifying third party liability, shall be determined by the county welfare department. Suspension of child support services will occur as long as good cause exists, and Medi-Cal will not be discontinued or denied until the Good Cause determination has been made. If the applicant/beneficiary did not cooperate without good cause, Medi-Cal will be discontinued or denied to the custodial parent, but not the children unless the application is withdrawn.

GOOD CAUSE DETERMINATION REQUIREMENTS - Good Cause may be determined if the following conditions exist:

- Efforts to establish paternity or establish, modify or enforce a support obligation would increase risk or physical, sexual, or emotional harm to the child for whom support is being sought.

- Efforts to establish paternity or establish, modify, or enforce a support obligation would increase the risk of abuse to the parent or caretaker with whom the child is living.

- The child for whom support is sought was conceived as a result of incest or rape. A conviction for incest or rape is not necessary for this paragraph to apply.

- Legal proceedings for the adoption of the child are pending.

- The applicant/beneficiary is being assisted to resolve the issue of whether to keep or relinquish a child for adoption.

- The applicant/beneficiary is cooperating in good faith but is not able to identify or assist in locating the alleged father or absent parent.

- The individual presents any other reason that would make efforts to establish paternity or establish, modify, or enforce a support obligation contrary to the best interests of the child.

EVIDENCE TO SUPPORT GOOD CAUSE CLAIM

- Police, governmental agency, or court records, documentation from a domestic violence program, or a legal, clerical, medical, mental health, or other professional from whom the applicant or recipient has sought assistance in dealing with abuse, physical evidence of abuse, or any other evidence that supports the claim of good cause.

- Statements under penalty of perjury from individuals, including the applicant/beneficiary with knowledge of the circumstances surrounding the good cause claim.

- Birth certificates or medical, mental health, rape crisis, domestic violence program, or law enforcement records that indicate that the child was conceived as the result of incest or rape.

- Court documents or other records that indicate legal proceedings for adoption are pending.

- A written statement from a public or licensed private adoption agency that the applicant/beneficiary is being assisted by the agency to resolve the issue of whether to keep the child or relinquish the child for adoption.

(Medi-Cal Eligibility Procedures Manual (MEPM) §23E-2, 3)

415-2D
The Family Support Division/District Attorney's (FSD/DA) office shall have staff available in person or by telephone at every county welfare office and shall interview each applicant to obtain information necessary to establish paternity, and establish, modify, or enforce a support order. While the county makes the good cause determination for noncooperation, the FSD/DA shall make the determination of noncooperation, and, in making this finding, it shall take into consideration:

- The age of the child for whom support is sought.

- The circumstances surrounding conception of the child.

- The age or mental capacity of the parent or caretaker of the child for whom aid is being sought.

- The time that has elapsed since the parent or caretaker last had contact with the alleged absent parent.

Cooperation is defined as including:

- Providing the name of the alleged parent or absent parent, and other information about that person if known, including the names and addresses of relatives or associates.

- Submitting to genetic tests, including tests of the child.

- Providing the address of the absent parent.

- Providing Social Security number of the absent parent.

- Providing the telephone number or numbers of the absent parent.

- Providing the absent parent's place of employment or school.

- Appearing at interviews and court hearings.

(Medi-Cal Eligibility Procedures Manual §23E-1)

415-3
A person or family whose eligibility is denied or discontinued for any of the reasons specified in subsection (a) may have the denial or discontinuance rescinded by providing evidence that the person or family had good cause for not meeting the condition specified by the county department. (§50175(b)(2))

415-3A ADDED
2/16When beneficiaries submit information prior to the discontinuance date, counties are to rescind the discontinuance action before the beneficiary loses coverage in the following month. After rescinding the discontinuance action, counties are to review the information for completeness. If the information is complete, the counties shall determine eligibility and send a notice of action. If the information is not complete, counties must obtain any missing information through the ex parte review, calling the beneficiary and/or sending the MC 355 form to obtain missing information, allowing 30 days for response.
(MEDIL I 15-22E, January 27, 2016)

415-4
Good cause for failure to cooperate in meeting the requirements of §50175(a) includes, but is not limited to:

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

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

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

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

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

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

(7) Failure to cooperate in obtaining medical support and payments for the individual or for any other individual for whom application is made; in identifying and providing information to assist the appropriate authorities in pursuing any third party who is or may be liable to pay for medical care, services and support; and in establishing paternity: but this failure met the good cause criteria in §50771.5.

(§50175(c))

415-5
Applicants and beneficiaries are required to report any changes in the facts pertinent to the determination of eligibility and share of cost within 10 calendar days following the date the change occurred. (§50185(a)(4))

415-5A ADDED 10/13
The beneficiary must be notified of the responsibility to report to the county, within 10 days, significant changes that may affect eligibility. (W&IC 14005.31(b)(4))

415-6
An applicant or beneficiary shall as a condition of Medi-Cal eligibility take all actions necessary to obtain unconditionally available income. This includes applying for such income and cooperating in supplying the information requested by the agency making the award determination. The person who refuses to apply for and accept unconditionally available income shall be rendered ineligible by such refusal. (§50186)

415-7
Each applicant or beneficiary shall, as a condition of Medi-Cal eligibility, obtain and provide to the county a Social Security Number (SSN). The SSN shall be provided at the time of application unless the applicant must apply for the number. Medi-Cal shall not be denied, delayed or discontinued for an applicant or beneficiary because of the SSN requirement unless the applicant or beneficiary refuses to cooperate. The county is required to assist the applicant or beneficiary by explaining how to apply for an SSN. If the applicant or beneficiary fails to cooperate in applying for or providing an SSN, then the applicant or beneficiary (or his or her child if the SSN is requested for the child) shall be ineligible. Furthermore, the county shall notify the beneficiary if the information provided by that beneficiary does not result in verification of the

SSN by SSA, then Medi-Cal eligibility shall be discontinued if the beneficiary fails, without good cause, to respond to the notice within 60 days. (§50187)

415-8
The caretaker parent has the right to refuse to cooperate in medical support for himself/herself and for the children. In this situation, the parent is denied Medi-Cal but the children are not. (All-County Welfare Directors Letter (ACWDL) No. 93-56, August 11, 1993, referencing §50175(a)(7); Medi-Cal Eligibility Procedures Manual (MEPM) §23E-1) The same rule applies if the parent fails to cooperate, without good cause, in identifying a parent or determining paternity. (ACWDL No. 97-64, December 19, 1997; MEPM §23E-2; W&IC §14008.7)

415-8A
Good cause exists for failure to cooperate in securing medical support and payments, establishing paternity, or identifying and providing information concerning liable or potentially liable third parties when such failure is reasonably anticipated to result in serious physical or emotional harm to the child for whom support is to be sought, or to the parent or caretaker relative with whom the child is living. Good cause also exists if the county believes that proceeding to secure medical support or establish paternity would be detrimental to the child for whom support would be sought because conception of that child resulted from incest or forcible rape; adoption proceedings are pending in court; or the applicant or beneficiary has been assisted by an agency for three months or less in deciding whether to keep or relinquish the child. (§§50771.5 (a)-(c))

415-9
"Serious physical or emotional harm" for purposes of establishing good cause under §50771.5(b) means substantial reduction of the capacity of the parent to care for the child adequately.

Factors which shall be considered for determining emotional harm include the present emotional state of the individual subject to emotional harm; the emotional history of that individual; the intensity and probable duration of the emotional impairment; the degree of cooperation required; and the extent of the individual's involvement in the proceeding to be undertaken.

The burden of proof for establishing good cause is on the applicant/beneficiary or parent/caretaker relative.

(§§50771.5(d)-(f))

415-10
Once good cause is established for failure to cooperate in securing medical support, it continues unless the caretaker parent rescinds the claim for good cause and is able to cooperate. (All-County Welfare Directors Letter No. 93-56, August 11, 1993)

415-11 ADDED 9/07
Pursuant to federal law, satisfactory documentation of citizenship/national status and identity must be obtained for:

Most U.S. citizen/U.S. national applicants at the time of application; and

Most U.S. citizen/U.S. national beneficiaries at the time of their next annual redetermination on or after the date of this ACWDL.

(ACWDL 07-12, June 4, 2007)

415-11A ADDED 9/07
Assembly Bill 1807 (Chapter 74, Statutes of 2006) amended Welfare and Institutions Code Section 14011.2 to provide authority to implement the new documentation of citizenship/identity requirements of the Deficit Reduction Act (DRA). The new law requires the California Department of Health Services (DHCS) to implement the federal documentation of citizenship/identity requirement with as much flexibility as is allowed under federal law and policy.

(ACWDL 07-04, June 4, 2007)

416-1A
The elimination of quarterly status reports (QSRs) does not affect the beneficiary's responsibility to report, within ten days, changes affecting Medi-Cal eligibility, such as changes in income, property, family composition, other health coverage.

Counties must act on any changes of which they are aware, whether those changes are discovered, reported directly by the Medi-Cal beneficiary, or reported by the beneficiary or his or her public assistance unit.

(All-County Welfare Directors Letter No. 00-64, December 8, 2000)

416-3 REVISED 3/09
Effective August 1, 2003, Medi-Cal recipients were required to complete a semi-annual status report. (Welfare and Institutions Code §14011.16; ACWDL 03-41, July 8, 2003)

There were changes to the Medi-Cal status reporting requirements contained in Assembly Bill (AB) 1183, Chapter 758, Statutes of 2008. As a result of this statute, Section 14011.16 of the Welfare and Institutions (W&I) Code was amended to require children under age 19 to file a mid-year status report (MSR) and Section 14011.17 of the W&I Code was added to exempt certain groups from the reporting requirements.

MSR directions provided in ACWDL Nos. 03-41, 04-06, 04-26 and 04-34 are superseded and are obsolete. (ACWDL 08-56, Welfare and Institutions Code §14011.16)

416-4 ADDED 3/09
The following are exempt from mid-year status report requirements:

Pregnant women whose eligibility is based on pregnancy;
Beneficiaries receiving Medi-Cal through the Adoptions Assistance Program;
Beneficiaries who have a public guardian;
Medically Indigent children not living with a parent or relative and who have a public agency assuming their financial responsibility (including foster children);
Individuals receiving minor consent services;
Beneficiaries in the State administered Breast and Cervical Cancer Treatment Program (BCCTP);

Beneficiaries who are California Work Opportunity for Kids (CalWORKs) recipients and custodial parents whose children are CalWORKs recipients

(ACWDL 08-56, December 3, 2008; Welfare and Institutions Code (W&IC) 14011.17)

416-4A ADDED 3/09
Section 14011.16 of the W&I Code permits DHCS to exempt other groups as necessary from the MSR requirements for simplicity of administration. In addition to the mandated group of exempt beneficiaries, DHCS shall exempt:
All pregnant and postpartum women who have reported their pregnancy to the county;
All infants less than one year of age (including deemed infants (DE) and non-DE children);
Former Foster Care Children;
Children who have a disability that is verified in the case record;
Beneficiaries receiving Transitional Medi-Cal (TMC).

(ACWDL 08-56, December 3, 2008; Welfare and Institutions Code (W&IC) 14011.16)

416-4B REVISED 7/09
Children under the age 19 must comply with MSR requirements. Therefore, DHCS now requires that counties send the MSR to all non-exempt children up to age 21. (ACWDL 08-56, December 3, 2008

Senate Bill (SB) X3 24 amended Section 14005.25 of the Welfare & Institutions (W&I) Code concerning CEC and repealed Section 14011.18 of the W&I Code reporting requirements for MSR. The amendment to Section 14005.25 suspends the reduction of CEC from 12 months to 6 months during October 2008 through December 2010. The existing statute for MSR provides that the child reporting requirement is only in effect for those periods when the CEC is reduced to six months, so the suspension of the CEC change to six months also means the suspension of the MSR requirement for children. (ACWDL 09-15, March 27, 2009)

416-4C ADDED 3/09
The fact that a beneficiary is exempt from MSR does not affect any other reporting obligations. Medi-Cal beneficiaries are required to report changes in circumstances within ten (10) days as explained in the Rights and Responsibilities form MC 219 and to complete a timely annual redetermination. (ACWDL 08-56, December 3, 2008)

416-4D ADDED 3/09
To qualify for exemption from the MSR requirements based on pregnancy, a non-exempt beneficiary must notify a county eligibility worker that she is pregnant prior to the county sending the MSR or during the MSR process. Contact includes, but is not be limited to, telephone contact, submission of the annual redetermination (RV) form MC 210 RV or the MSR form MC 176 S on which pregnancy is reported.

Once the county is notified, the pregnant woman will be determined exempt from the MSR reporting requirement for the duration of her pregnancy and the 60-day postpartum period. The mandatory MSR requirements will resume at the next regular interval after the 60-day postpartum period ends, unless the beneficiary qualifies for another MSR exemption. The MSR should be due six months after the last RV or initial eligibility month, according to the same schedule prior to her pregnancy exemption. When a beneficiary reports her pregnancy after 30 days of discontinuance, counties must review good cause regulation, Title 22, California Code

of Regulations (CCR) Section 50175(c) and, if good cause exists, rescind any prior termination based on failure to return the MSR that was due during the time the beneficiary was pregnant or in the 60-day postpartum period.

(ACWDL 08-56, December 3, 2008)

416-4E ADDED 3/09
Counties will now be required to Bridge children to the Healthy Families Program (HFP) when the MSR documents an income increase that would result in a child no longer being eligible for no-cost Medi-Cal. Therefore, DHCS has added the standardized consent statement to Page 2 of the MSR form.

The statement reads as follows: "I do not want Medi-Cal to share my child's information with the low-cost Healthy Families Program". If the box is checked, counties shall Bridge the child for one month, but will not forward the case information to the HFP.

Counties are reminded that they are to follow the instructions given in ACWDL 07-03 to confirm that the beneficiary does not want their information to be sent to the HFP if the box is checked. If the box is left unchecked, counties shall Bridge the child and follow current procedures for sending case information to HFP. The direction regarding sending information to HFP provided by the parent or guardian on the MSR supersedes any prior direction provided on the application or RV forms previously submitted to the county office.

(ACWDL 08-56, December 3, 2008)

416-4F REVISED 7/09
Using the non-exempt beneficiary's current reporting schedule, counties must implement the new mid-year status reports (MSR) requirements of the W&I Code, Sections 14011.16, 14011.17 and 14011.18 effective January 1, 2009, in accordance with the changes to the children's eligibility resulting from the reduced Continuous Eligibility for Children (CEC) time period. All non-exempt Medi-Cal beneficiaries shall be required to complete and file an MSR form six months after the initial eligibility month or the month in which the most recent RV was due, whichever is later. Counties shall mail the MSR in sufficient time to be received by a non-exempt beneficiary by the 10th of the month. The MSR form must be returned to counties by the 5th of the following month. (ACWDL 08-56, December 3, 2008)

Senate Bill (SB) X3 24 amended Section 14005.25 of the Welfare & Institutions (W&I) Code concerning CEC and repealed Section 14011.18 of the W&I Code reporting requirements for MSR. The amendment to Section 14005.25 suspends the reduction of CEC from 12 months to 6 months during October 2008 through December 2010. The existing statute for MSR provides that the child reporting requirement is only in effect for those periods when the CEC is reduced to six months, so the suspension of the CEC change to six months also means the suspension of the MSR requirement for children.

Counties must immediately:
Restore CEC for any child who was discontinued for failure to submit the MSR or had their CEC reduced to six months;
Discontinue sending the MSR to child-only cases immediately;
Exempt certain beneficiaries from MSR requirements; and

Use a revised MC 176S (rev 3/09) for the MSR which has deleted the child reporting requirement.

(ACWDL 09-15, March 27, 2009)

416-4G ADDED 3/09
A CalWORKs beneficiary who is discontinued from CalWORKs for failure to submit a QR7 is transitioned to Medi-Cal only. . As such the former CalWORKs beneficiary is no longer exempt from the MSR requirements unless the beneficiary is transitioned to another non-exempt category. The county shall require these non-exempt beneficiaries to complete a MSR six months after their initial CalWORKs eligibility month or the most recent annual redetermination. (ACWDL 08-56, December 3, 2008)

416-4H ADDED 3/09
Counties shall continue the current policy to mail the MSR to the non-exempt beneficiary in the sixth month (MSR mail month) beginning the first month of eligibility which is usually the month of application or the month in which the most recent RV was due. The non-exempt beneficiary is to complete and return the MSR in the seventh month (MSR due month). The non-exempt beneficiary is to receive the MSR no later than the tenth day of the MSR mail month to be completed and returned by the fifth day of the MSR due month. When the fifth or tenth days of the month fall on a holiday or weekend, the county shall extend the deadline to the next business day.

(ACWDL 08-56, December 3, 2008)

416-4I ADDED 3/09
The MSR is considered incomplete when:

The box in Section 1 is checked but the MSR is not signed and dated in Section 3; OR
The box in Section 1 is not checked but a box in Section 2 is checked “yes” and no explanation is given if an explanation is required; OR
The box in Section 1 is not checked and Section 2 is completed; however, the MSR is not signed and dated in Section 3.

When the beneficiary submits an incomplete MSR, the county must follow the SB 87 process before initiating any discontinuance action:
Conduct the ex parte review – an evaluation of all sources of information available to the county (all case files used should be open and current or not closed for more than 45 days);
Attempt telephone contact with the beneficiary;
Mail out the MC 355 (request for information form).

(ACWDL 08-56, December 3, 2008)

416-4J ADDED 3/09
When the beneficiary submits the completed MSR after the 5th of the MSR Due Month and before the effective discontinuance date, the county must evaluate the MSR for continued eligibility. If the MSR is completed and continued eligibility exists, the county must rescind the impending discontinuance action and notify the beneficiary.

When the beneficiary submits the completed MSR within 30 days after the discontinuance date, the county must evaluate the MSR for continued eligibility and rescind the discontinuance action if continued eligibility exists. Since Medi-Cal is based on whole month of eligibility, (if eligible in any day of the month, eligible for the entire month), the county may evaluate the MSR for continued eligibility and rescind the discontinuance action for beneficiaries who submit a complete MSR on the 31st day of the month after the discontinuance date.

When the beneficiary submits the MSR within 30 days after the discontinuance date and the form is incomplete, the county must follow the steps for incomplete MSRs. If the beneficiary provides the necessary information within the timelines described and continued eligibility is established, the county shall rescind the discontinuance action. A notice of action shall be sent to the beneficiary.

When the non-exempt beneficiary submits the completed MSR after the last day of the month following the discontinuance date, counties should review the case to determine whether good cause regulations Title 22, CCR Section 50175 (c) apply to the situation. If good cause is determined, counties shall accept the completed MSR and process it as if it were submitted timely. If no good cause is determined, the county shall notify the beneficiary that there is no change to the discontinuance action taken and if the beneficiary wishes to receive Medi-Cal benefits again, he/she shall complete a new Medi-Cal application to determine eligibility.

(ACWDL 08-56, December 3, 2008)

416-4K ADDED 3/09
Any time the MSR, or other mail, is returned to the county as undeliverable, the county is required to follow the three-step SB 87 process to redetermine eligibility. The county must not terminate eligibility for loss of contact before following these three steps. After following this process and the beneficiary's whereabouts remain unknown, the county can terminate the case. (ACWDL 08-56, December 3, 2008)

416-4L ADDED 3/09
If the non-exempt beneficiary is required to submit a MSR when a change of county residence is reported, and the Sending County has already sent the beneficiary a MSR in the mail, the beneficiary has the responsibility to submit the MSR. During the transition between counties, the Sending County continues to be the county of responsibility to ensure the beneficiary completes the MSR. (ACWDL 08-56, December 3, 2008)

417-1
Procedural instructions for implementing the *Edwards* v. Myers court order include the requirement that the county is to provide uninterrupted Medi-Cal coverage with no share of cost for families or persons discontinued from AFDC until a reevaluation of the family's or person's eligibility for Medi-Cal Only is completed and adequate and timely notice is issued. If the reason for the AFDC discontinuance is also a condition of Medi-Cal eligibility, or the Medi-Cal Only eligibility can be completed at the same time the AFDC determination of ineligibility is made, extended Medi-Cal benefits under this category are not required.

In making the redetermination, the county does not need to seek additional information beyond that already in the file. If the available information would permit continued Medi-Cal eligibility on some other basis, then a notice reflecting the changed Medi- Cal eligibility should be sent. Where the county has insufficient information to determine whether a recipient is still eligible for

Medi-Cal, the AFDC termination notice should specify the information needed to reinstate Medi-Cal. (Medi-Cal Eligibility Procedures Manual §4-O)

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. (Welfare & Institutions Code §§14005.31, .32, and .37, effective July 1, 2001)

417-1A REVISED 7/10
Refugee Medical Assistance/Entrant Medical Assistance (RMA/EMA) program is a special program that provides full-scope medical assistance through the Medi-Cal program but is not a Medi-Cal program

RMA/EMA program grants medical assistance for a period of eight months and that eligibility must be terminated at the end of the eight-month eligibility period.

To ensure uninterrupted medical coverage for refugees who are Medi-Cal eligible at the end of the RMA/EMA eligibility period, counties must complete a determination of Medi-Cal eligibility before RMA/EMA eligibility ends whenever possible.

Counties will need to send a notice of action (DHCS 7110) and a Medi-Cal application to RMA/EMA beneficiaries no later than 60 days before the end of the eight-month RMA/EMA eligibility period.

(ACWDL 08-43 which supersedes Medi-Cal Eligibility Procedures Manual § 24-B11)

417-2
Pursuant to the settlement in *Edwards* v. *Kizer* when a recipient of AFDC is discontinued the county must continue Medi-Cal benefits until a determination of eligibility or ineligibility for Medi-Cal only is made. Medi-Cal may be discontinued concurrently with AFDC only if the recipient has died; moved out of state; made a written request for the discontinuance of Medi-Cal and AFDC; there is a loss of contact with the recipient as evidenced by returned mail; or the recipient has entered an institution or is incarcerated. (All-County Welfare Directors Letter (ACWDL) 90-06, January 8, 1990)

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. (Welfare & Institutions Code §§14005.31, .32, and .37, effective July 1, 2001)

417-2A
State law provides that:

(1) Subject to paragraph (2) below, for any person whose eligibility for benefits under W&IC §14005.30 [which basically deals with §1931(b) benefits] has been determined with a concurrent determination of eligibility for cash aid under Chapter 2 (commencing with W&IC §11200 [which basically deals with CalWORKs benefits]), loss of eligibility or termination of cash aid under Chapter 2 shall not result in a loss of eligibility or termination of benefits under W&IC §14005.30 absent the existence of a factor that would result in loss of eligibility for benefits under that section for a person whose eligibility under W&IC §14005.30 was determined without a concurrent determination of eligibility for benefits under Chapter 2.

(2) Notwithstanding paragraph (1), a person whose eligibility would otherwise be terminated pursuant to that paragraph shall not have his or her eligibility terminated until the transfer procedures set forth in W&IC §14005.32 or the redetermination procedures set forth in W&IC §14005.37 and all due process requirements have been met.

(W&IC §14005.31(a))

417-2B
The DHCS shall prepare a simple, clear, consumer-friendly notice, which shall be used by the counties in order to inform Medi-Cal beneficiaries whose eligibility for cash aid under Chapter 2 (commencing with W&IC §11200) has ended, but whose eligibility for benefits under W&IC §14005.30 continues pursuant to W&IC §14005.31(a), that their benefits will continue. To the extent feasible, the notice shall be sent out at the same time as the notice of discontinuation of cash aid, and shall include all the following:

(1) A statement that Medi-Cal benefits will continue even though cash aid under the CalWORKs program has been terminated.

(2) A statement that continued receipt of Medi-Cal benefits will not be counted against any time limits in existence for receipt of cash aid under the CalWORKs program.

(3) A statement that the Medi-Cal beneficiary does not need to fill out monthly or quarterly status reports in order to remain eligible for Medi-Cal, but shall be required to submit an annual reaffirmation form. The notice shall remind individuals whose cash aid ended under the CalWORKs program as a result of not submitting a status report that they should review their circumstances to determine if changes have occurred that should be reported to the Medi-Cal eligibility worker.

(4) A statement describing the responsibility of the Medi-Cal beneficiary to report to the county, within 10 days, significant changes that may affect eligibility.

(5) A telephone number to call for more information.

(6) A statement that the Medi-Cal beneficiary's eligibility worker will not change, or, if the case has been reassigned, the new worker’s name, address, and telephone number, and the hours during which the county's eligibility workers can be contacted.

(W&IC §14005.31(b), effective July 1, 2001, per W&IC §14005.31(c))

417-2C
State law provides that:

(a)(1) If the county has evidence clearly demonstrating that a beneficiary is not eligible for benefits pursuant to W&IC §14005.30, but is eligible for benefits under other provisions of law, the county shall transfer the individual to the corresponding Medi-Cal program. Eligibility under W&IC §14005.30 shall continue until the transfer is complete.

(2) The DHCS shall prepare a simple, clear, consumer-friendly notice to be used by the counties, to inform beneficiaries that their Medi-Cal benefits have been transferred pursuant to paragraph (1) and to inform them about the program to which they have been transferred. To

the extent feasible, the notice shall be issued with the notice of discontinuance from cash aid, and shall include all of the following:

(A) A statement that Medi-Cal benefits will continue under another program, even though aid under Chapter 2 (commencing with §11200) has been terminated.

(B) The name of the program under which benefits will continue, and an explanation of that program.

(C) A statement that continued receipt of Medi-Cal benefits will not be counted against any time limits in existence for receipt of cash aid under the CalWORKs program.

(D) A statement that the Medi-Cal beneficiary does not need to fill out monthly or quarterly status reports in order to remain eligible for Medi-Cal, but shall be required to submit an annual reaffirmation form. In addition, if the person or persons to whom the notice is directed has been found eligible for transitional Medi-Cal as described in W&IC §§14005.8, 14005.81, or 14005.85, the statement shall explain the reporting requirements and duration of benefits under those programs, and shall further explain that, at the end of the duration of these benefits, a redetermination, as provided for in W&IC §14005.37 shall be conducted to determine whether benefits are available under any other provision of law.

(E) A statement describing the beneficiary's responsibility to report to the county, within 10 days, significant changes that may affect eligibility or share of cost.

(F) A telephone number to call for more information.

(G) A statement that the beneficiary's eligibility worker will not change, or, if the case has been reassigned, the new worker's name, address, and telephone number, and the hours during which the county's Medi-Cal eligibility workers can be contacted.

(W&IC §14005.32(a), effective July 1, 2001, per W&IC §14005.32(c))

417-2D
State law provides as follows:

"(a) Except as provided in Section 14005.39, whenever a county receives information about changes in a beneficiary's circumstances that may affect eligibility for Medi-Cal benefits, the county shall promptly redetermine eligibility. The procedures for redetermining Medi-Cal eligibility described in this section shall apply to all Medi-Cal beneficiaries. [Emphasis added]

"(b) Loss of eligibility for cash aid under that program shall not result in a redetermination under this section unless the reason for the loss of eligibility is one that would result in the need for a redetermination for a person whose eligibility for Medi-Cal under Section 14005.30 was determined without a concurrent determination of eligibility for cash aid under the CalWORKs program.

"(c) A loss of contact, as evidenced by the return of mail marked in such a way as to indicate that it could not be delivered to the intended recipient or that there was no forwarding address, shall require a prompt redetermination according to the procedures set forth in this section.

"(d) Except as otherwise provided in this section, Medi-Cal eligibility shall continue during the redetermination process described in this section. A Medi-Cal beneficiary's eligibility shall not be terminated under this section until the county makes a specific determination based on facts clearly demonstrating that the beneficiary is no longer eligible for Medi-Cal under any basis and due process rights guaranteed under this division have been met.

"(e) For purposes of acquiring information necessary to conduct the eligibility determinations described in subdivisions (a) to (d), inclusive, a county shall make every reasonable effort to gather information available to the county that is relevant to the beneficiary's Medi-Cal eligibility prior to contacting the beneficiary. Sources for these efforts shall include, but are not limited to, Medi-Cal, CalWORKs, and CalFresh Program case files of the beneficiary or of any of his or her immediate family members, which are open or were closed within the last 45 days, and wherever feasible, other sources of relevant information reasonably available to the counties.

"(f) If a county cannot obtain information necessary to redetermine eligibility pursuant to subdivision (e), the county shall attempt to reach the beneficiary by telephone in order to obtain this information, either directly or in collaboration with community-based organizations so long as confidentiality is protected.

"(g) If a county's efforts pursuant to subdivisions (e) and (f) to obtain the information necessary to redetermine eligibility have failed, the county shall send to the beneficiary a form, which shall highlight the information needed to complete the eligibility determination. The county shall not request information or documentation that has been previously provided by the beneficiary, that is not absolutely necessary to complete the eligibility determination, or that is not subject to change. The form shall be accompanied by a simple, clear, consumer-friendly cover letter, which shall explain why the form is necessary, the fact that it is not necessary to be receiving CalWORKs benefits to be receiving Medi-Cal benefits, the fact that receipt of Medi-Cal benefits does not count toward any time limits imposed by the CalWORKs program, the various bases for Medi-Cal eligibility, including disability, and the fact that even persons who are employed can receive Medi-Cal benefits. The cover letter shall include a telephone number to call in order to obtain more information. The form and the cover letter shall be developed by the department in consultation with the counties and representatives of consumers, managed care plans, and Medi-Cal providers. A Medi-Cal beneficiary shall have no less than 20 days from the date the form is mailed pursuant to this subdivision to respond. Except as provided in subdivision (h), failure to respond prior to the end of this 20-day period shall not impact his or her Medi-Cal eligibility.

"(h) If the purpose for a redetermination under this section is a loss of contact with the Medi-Cal beneficiary, as evidenced by the return of mail marked in such a way as to indicate that it could not be delivered to the intended recipient or that there was no forwarding address, a return of the form described in subdivision (g) marked as undeliverable shall result in an immediate notice of action terminating Medi-Cal eligibility.

"(i) If, within 20 days of the date of mailing of a form to the Medi-Cal beneficiary pursuant to subdivision (g), a beneficiary does not submit the completed form to the county, the county shall send the beneficiary a written notice of action stating that his or her eligibility shall be terminated 10 days from the date of the notice and the reasons for that determination, unless the beneficiary submits a completed form prior to the end of the 10-day period.

"(j) If, within 20 days of the date of mailing of a form to the Medi-Cal beneficiary pursuant to subdivision (g), the beneficiary submits an incomplete form, the county shall attempt to contact the beneficiary by telephone and in writing to request the necessary information. If the beneficiary does not supply the necessary information to the county within 10 days from the date the county contacts the beneficiary in regard to the complete form, a 10-day notice of termination of Medi-Cal eligibility shall be sent.

"(k) If, within 30 days of termination of a Medi-Cal beneficiary's eligibility pursuant to subdivision (h), (i), or (j), the beneficiary submits to the county a completed form, eligibility shall be determined as though the form was submitted in a timely manner and if a beneficiary is found eligible, the termination under subdivision (h), (1), or (j) shall be rescinded.

"(l) If the information reasonably available to the county pursuant to the redetermination procedures of subdivisions (d), (e), (g), and (m) does not indicate a basis of eligibility, Medi-Cal benefits may be terminated so long as due process requirements have otherwise been met."

(m) The department shall also develop a timeframe for redetermination of Medi-Cal eligibility based upon disability, including ex parte review, the redetermination form described in subdivision (g), timeframes for responding to county or state requests for additional information, and the forms and procedures to be used. The forms and procedures shall be as consumer-friendly as possible for people with disabilities. The timeframe shall provide a reasonable and adequate opportunity for the Medi-Cal beneficiary to obtain and submit medical records and other information needed to establish eligibility for Medi-Cal based upon disability.

(W&IC §14005.37(a) through (m), effective July 1, 2001, per W&IC §14005.37(n))

417-2E
State law provides that if Medi-Cal benefits may be terminated without a redetermination of eligibility when a county has facts clearly demonstrating that a Medi-Cal beneficiary cannot be eligible for Medi-Cal due to an event, such as death or change of state residency, Medi-Cal benefits shall be terminated without a redetermination under W&IC §14005.37. (W&IC §14005.39(a), to be implemented on or before July 1, 2001)

Whenever Medi-Cal eligibility is terminated without a redetermination, as provided in subdivision (a), the Medi-Cal eligibility worker shall document that fact or event causing the eligibility termination in the beneficiary's file, along with a written certification that a full redetermination could not result in a finding of Medi-Cal eligibility. Following this written certification, a notice of action specifying the basis for termination of Medi-Cal eligibility shall be sent to the beneficiary.

(W&IC §14005.39(b), effective July 1, 2001)

417-2F
The Senate Bill (SB) 87 process consists of three steps. The county must follow each step until the beneficiary's continued Medi-Cal eligibility or ineligibility is accurately redetermined. The county is not permitted to substitute any step of this process with another county process or procedure.

STEP ONE

Ex Parte Review: The county evaluates all available information to establish continued Medi-Cal eligibility. If the county cannot establish continued Medi-Cal eligibility after the ex parte review, the county is required to complete Step Two. The county may use information contained in any state or county public assistance or public benefit case file in making the ex parte determinations.

STEP TWO

Direct Contact: The county contacts the beneficiary via telephone to request information not available during the ex parte review. The county should inform the beneficiary that his/her Medi-Cal eligibility is being redetermined and more information is needed to confirm continued eligibility. The county should further inform the beneficiary that his/her continued eligibility can be established in various ways including an allegation of disability.

If the telephone contact with the beneficiary cannot establish continued Medi-Cal eligibility and all eligibility possibilities have been exhausted, then Step Three is not required. If telephone contact with the beneficiary is not possible, then Step Three must be completed.

STEP THREE

Forwarding The Request For Information Form (MC 355). The county shall complete and send the MC 355 form to the beneficiary seeking information to establish continued Medi-Cal eligibility only if it cannot determine eligibility under Steps One and Two.

(All-County Welfare Directors Letter No. 02-59, December 23, 2002)

417-3 REVISED 9/07
Families who are terminated from AFDC (now CalWORKs) due to collection or increased collection of child/spousal support payments are eligible for four months continuing Medi-Cal benefits. This is the only four-month program which exists, although §50243 has not been repealed or amended. The sunset date for this program has been eliminated and the program continues indefinitely (ACWDLs No.90-32, 90-33, and 90-66)

417-6
Effective January 1, 1998 when a recipient received CalWORKs (or AFDC) in three of the six months before becoming ineligible for those benefits, and the discontinuance resulted from increased earnings, the family was potentially eligible for six months of Transitional Medi-Cal (TMC) benefits. However, the family first must be evaluated for eligibility under the §1931(b) program. Once the §1931(b) program was implemented, persons who received §1931(b) for three of the six months prior to termination from that program due to increased earnings are also potentially eligible for TMC, even if the family never received CalWORKs.

This six-month TMC program requires no additional eligibility requirements other than that the family must continue to have a child living in the family, and the family must reside in California.

(Medi-Cal Eligibility Procedures Manual (MEPM) §5B-3, 4)

417-6A ADDED 3/07
If a family returns to CalWORKs or §1931(b) during any of the TMC periods, or if they receive *Edwards* benefits during the TMC period, those months are counted as if the family received

TMC in those months. The family may receive, if eligible, any remaining months in the TMC period. (MEPM §5B-11(J.))

417-6B
If a family received CalWORKs for two months before being terminated and §1931(b) for two months before becoming ineligible due to increased earnings from employment, the family can receive TMC because they have received CalWORKs plus §1931(b) for at least three of the last six months. (MEPM §5B-12 (L.(5))

417-6C
The Transitional Medi-Cal (TMC) program provides for six-month, continuing, free, Medi-Cal eligibility for certain families which have been eligible for the §1931(b) program in at least three of the six months immediately preceding the month in which they became ineligible for §1931(b) benefits for employment related reasons, i.e., increased earnings from employment.

Eligibility shall begin with the month the family became ineligible for §1931(b), and continue for six months, unless the family no longer includes at least one child, as defined in §50030. In certain instances, it may continue for an additional six months for children under 19 years of age, and for all others for a total of 18 months. (All-County Welfare Directors Letters (ACWDLs) No. 90-77, June 28, 1990 and No. 95-85, December 29, 1995; Draft Regulation §50244 as set forth in ACWDL No. 90-66; ACWDL No. 98-43, Errata, November 12, 1998)

417-6D
The following persons are among those not eligible for TMC:

> Persons who were not eligible for CalWORKs or §1931(b) and whose income and resources were not counted when determining family members who were receiving CalWORKs or §1931(b) such as the non-needy caretaker relative.

> Persons who were convicted of fraud during the last six months in which the family was receiving §1931(b)-Only are also not eligible for TMC.

> Persons who remain eligible for §1931(b) because they are a *Sneede* class member and they are in a separate MBU.

> Persons who do not meet the CalWORKs definition of a child (over 18 and not enrolled in school and expected to graduate by age 19) are not eligible for TMC unless they met the definition of a child when initial TMC was approved. A child who becomes an adult during the TMC period may remain in TMC unless he/she is the youngest child in the home. In that case, the entire family must be terminated from TMC.

(Medi-Cal Eligibility Procedures Manual §5B-6, as revised effective February 11, 2002)

417-6E
TMC requires that the loss of CalWORKs or §1931(b) eligibility be "because of" an increase in hours or earned income if the increase in hours or earned income from employment is, by itself or in combination, sufficient to make the family ineligible. "Because of" is determined as follows:

Step 1.

Determine if the increase in hours or earnings from employment would have resulted in the loss of CalWORKs or §1931(b) eligibility if all other factors in the case remained the same (i.e., as if there were no other change in income, no change in family composition, no change in income standards, etc.) If yes, the family is eligible for TMC. If no, go to Step 2.

Step 2.

Determine if events other than the increase in hours or earnings from employment would have resulted in loss of CalWORKs or §1931(b) eligibility if the income (hours or disregards) had stayed the same. If yes, the family is not eligible for TMC. If no, go to Step 3.

Step 3.

Determine if the family is ineligible for CalWORKs or §1931(b) when all changes are considered. If yes, the family is eligible for extended Medicaid benefits. The increase in earnings from employment was essential to the loss of CalWORKs or §1931(b) eligibility. Without that increase, the family would not have lost CalWORKs or §1931(b) eligibility.

(Medi-Cal Eligibility Procedures Manual §5B-6, 7, as revised effective February 11, 2002)

417-6F
Persons receiving TMC shall be ineligible members of the MFBU of those persons who are not eligible for TMC when determining Medi-Cal eligibility for other family members. Those TMC persons may use their noncovered Medi-Cal health care costs to reduce other family members' or responsible relatives' share of cost in accordance with §50379 and the *Sneede* lawsuit settlement.

It is possible that some persons will be eligible for §1931(b) and some will be eligible for TMC because deprivation still exists for certain family members. Examples include certain unmarried parents with mutual and separate children as well as families with only a 20-year-old child, some of whom may be eligible for §1931(b), some for TMC, and the 20-year-old may be eligible for MI benefits.

Due to *Sneede* rules, some persons may continue to be eligible for §1931(b) even if some of the other family members are over the income or resource limits and eligible for TMC. Section 1931(b) persons may continue to receive Medi-Cal until they are no longer eligible. If they have received Medi-Cal under the §1931(b) program for three of the last six months, and have been terminated for increased hours or earnings from employment, they are then entitled to TMC for the entire TMC period if they remain eligible even though other members of the family have already been receiving TMC in prior months.

(MEPM §5B-10, as revised effective April 17, 2002)

417-7
Transitional Medi-Cal (TMC) may be extended for an additional six months after the initial six-month period, unless one of the following occurs:

1. The caretaker relative becomes unemployed without good cause.

2. The family's gross monthly earnings less child care costs necessary for employment of the caretaker relative or primary wage earner, averaged over a three-month period as determined by the TMC status report, exceeds 185% of the federal poverty level for the family.

3. There are no children living in the household.

4. The family fails to meet mandatory reporting requirements.

(All-County Welfare Directors Letter No. 90-66, June 28, 1990, pp. 2 and 3; MEPM §5B-4, 5)

417-7A
Senate Bill 391 amended state law and requires the Department of Health Care Services (DHCS) to implement certain informing provisions in the Transitional Medi-Cal (TMC) program. These requirements include:

> A written TMC) notice must be given to CalWORKs and §1931(b) recipients at the time that Medi-Cal eligibility is established and every six months thereafter.

> The above notice and form is to be provided to recipients when they are terminated from CalWORKs or §1931(b) for failure to meet reporting requirements.

Since Assembly Bill 2730 amended the W&I Code and requires the California Department of Social Services (CDSS) to provide information on TMC and Four-Month Continuing in all Notices of Action (NOAs) messages as well as providing a flyer when CalWORKs recipients are terminated for any reason except for fraud, the DHCS TMC notice is required for those recipients.

Since Medi-Cal has dropped the status reporting requirements, the DHS TMC flyer is only required for CalWORKs and §1931(b) applicants and for §1931(b) recipients if they fail to return the annual redetermination.

(All-County Welfare Director Letter (ACWDL) No. 01-45, August 7, 2001)

417-8A
Assembly Bill 1762 eliminated the state-only second year of Transitional Medi-Cal as of October 1, 2003. Counties still need to follow Senate Bill 87 procedures for such beneficiaries. (ACWDL 03-45, September 10, 2003)

417-9
Counties should make every attempt to process cases to determine if TMC eligibility exists when the family has been discontinued from CalWORKs or §1931(b) only Medi-Cal due to increased earnings from employment (not from State Disability or Temporary Workers Compensation), even in those cases in which the TMC flyer is returned months after the discontinuance of benefits. (All County Welfare Directors Letter No. 99-20, pp. 4, 5, May 7, 1999)

417-10 ADDED 7/06
Beneficiaries receiving Medi-Cal under TMC are not required to complete an Annual Redetermination while they are receiving TMC benefits.

Non-TMC MFBU members are required to complete the Annual Redetermination when it is due. If non-TMC members fail to cooperate with the Annual Redetermination, only non-TMC MFBU members shall be terminated from Medi-Cal. The TMC eligible MFBU members shall remain on TMC for the entire TMC period if they meet all requirements of TMC. At the end of their TMC period, the county shall review the TMC beneficiary's eligibility under other Medi-Cal programs.

(ACWDL 06-16, May 10, 2006)

417-11 REVISED 7/09
State law established the Continuous Eligibility for Children (CEC) program effective January 1, 2001.

Under the CEC, changes during the period from the last annual redetermination to the next annual redetermination (per §50189) which would otherwise move a child under age 19 from a zero SOC category (including a cash aid program) to an SOC category or to ineligibility are disregarded.

The CEC applies to all zero SOC Medi-Cal (except for State-Only Minor Consent Services) from the date of initial eligibility (and excludes retroactive months) and continues until the annual redetermination or the end of the month in which the child turns 19.

During this CEC period, any adverse changes in financial eligibility which would cause the child to have an SOC, or to be ineligible, are not to take effect until the yearly redetermination. Except for death or loss of California residency, CEC also protects the child from being discontinued for nonfinancial reasons, even if these changes adversely affect other family members. (All-County Welfare Directors Letter No. 01-01,

The CEC provision in Welfare and Institutions (W&I) Code Section 14005.25 is as follows: …"commencing on the first day of the month following 90 days after the operative date of amendments to this section that added this subdivision, the continuous eligibility time period provided in paragraph (1) of subdivision (a) shall be reduced to six months." Additionally, W&I Code Section 14011.16 amends the semi-annual reporting exemption for children under age 19 now requiring children to file the semiannual status report, referred to as the Midyear Status Report (MSR).

(ACWDL 01-01, January 8, 2001, implementing Assembly Bill No. 2900, Chapter 995, Stats. 2000, ACWDL 08-55, December 3, 2008)

Senate Bill (SB) X3 24 amended Section 14005.25 of the Welfare & Institutions (W&I) Code concerning CEC and repealed Section 14011.18 of the W&I Code reporting requirements for MSR. The amendment to Section 14005.25 suspends the reduction of CEC from 12 months to 6 months during October 2008 through December 2010. The existing statute for MSR provides that the child reporting requirement is only in effect for those periods when the CEC is reduced to six months, so the suspension of the CEC change to six months also means the suspension of the MSR requirement for children. (ACWDL 09-15, March 27, 2009)

417-12
State law provides that to the extent federal financial participation is available, the DHCS shall exercise the option under 42 United States Code §1396a(e)(12) to extend continuous eligibility to children 19 years of age and younger. A child shall remain eligible pursuant to this

subdivision from the date of a determination of eligibility for Medi-Cal benefits until the earlier of either:

(1) The end of a 12-month period following the eligibility determination.

(2) The date the individual exceeds the age of 19 years.

(W&IC §14005.25(a))

417-13
The DHCS provided answers as to its interpretation of the Continuing Eligibility for Children (CEC) program in its All-County Welfare Directors Letters (ACWDLs) Nos. 99-106, 01-01 and 01-40. The following policies are set forth in ACWDL No. 01-40. The CEC program was established under Assembly Bill 2900. It is a zero SOC program for children under 19 who are receiving free Medi-Cal.

The CEC period begins with first month Medi-Cal eligibility is established or the first month impacted by an annual redetermination and ends 12 months later (unless the child turns 19 in less than 12 months). The CEC is triggered only when there is a change from $0 SOC Medi-Cal either to an SOC Medi-Cal or when the child is determined to be ineligible for Medi-Cal for reasons other than attaining age 19, death, incarceration or loss of California residency.

The period of time that a child remains eligible for $0 SOC under the CEC program is referred to as the CEC guaranteed period. During the CEC guaranteed period, any change in family income, assets or other circumstances that results in a change from $0 SOC to an SOC or from eligibility to ineligibility is disregarded for the child but not for adult family members. The CEC period guarantees that the child under age 19 continues to receive $0 share of cost Medi-Cal for the guarantee period.

The CEC period may not follow another continuous eligibility program such as the Transitional Medi-Cal (TMC) program. Example: a family included a 17-year-old completed the first year on TMC, and the prior annual redetermination was made before TMC began. If the family is found to be eligible for a second year of TMC, the 17-year-old would not be eligible for another year of $0 share of cost under CEC because TMC is viewed as another continuous eligibility program.

CEC can be applied to retroactive months when an application is approved, and zero SOC eligibility for retroactive benefits is established. Thus, a family with a zero SOC in the first retroactive month may establish CEC eligibility for the child in the second retroactive month, when the family is determined eligible with an SOC.

(ACWDL No. 01-40, July 20, 2001)

417-13A REVISED 4/10
New State law (Welfare and Institutions Code (W&IC) §14005.25) reduced the CEC program period from 12 months to 6 months effective January 1, 2009.

The CEC eligibility rules have not changed. The new State law only reduced the CEC period from a 12 to 6-month period effective January 1, 2009. The new CEC period is applicable as follows:

All children approved for CEC prior to January 1, 2009, for a 12-month CEC period who have passed their scheduled Mid-year status report (MSR) sending month will continue to receive CEC until their RV or until reporting a change in circumstances resulting in ineligibility under CEC rules. This rule is a one-time exemption and applies only to children who had an eligibility determination or RV due before July 1, 2008.
All children approved for CEC prior to January 1, 2009, for a 12-month CEC period who have not reached their 6-month CEC period are required to submit an MSR, at the end of their 6-month CEC period.

(ACWDL 08-55, December 3, 2008)

Senate Bill (SB) X3 24 amended Section 14005.25 of the Welfare & Institutions (W&I) Code concerning CEC and repealed Section 14011.18 of the W&I Code reporting requirements for MSR. The amendment to Section 14005.25 suspends the reduction of CEC from 12 months to 6 months during October 2008 through December 2010.

(ACWDL 09-15)

417-13B REVISED 4/10
New State law (Welfare and Institutions Code (W&IC) §14005.25) reduced the CEC program period from 12 months to 6 months effective January 1, 2009.

Effective January 1, 2009, CEC continues an otherwise Medi-Cal eligible child under age 19 years on no SOC Medi-Cal for up to a six-month period from the initial eligibility determination to the mid-year status report (MSR) or from the MSR to the annual redetermination (RV) by disregarding changes which would otherwise result in a SOC Medi-Cal category or take them from no SOC to ineligibility. CEC provides protection for children whose family income fluctuates during the CEC period.

(ACWDL 08-55, December 3, 2008)

Senate Bill (SB) X3 24 amended Section 14005.25 of the Welfare & Institutions (W&I) Code concerning CEC and repealed Section 14011.18 of the W&I Code reporting requirements for MSR. The amendment to Section 14005.25 suspends the reduction of CEC from 12 months to 6 months during October 2008 through December 2010.

(ACWDL 09-15)

417-14
The DHCS provided additional answers to its interpretation of the Continuing Eligibility for Children (CEC) program in All-County Welfare Directors Letter (ACWDL) No. 02-14. Some of these answers are set forth below.

(30) and (31)
Even if a child moves out of the home, CEC continues. The child is not considered an ineligible person; the child is an eligible member of the MFBU.

(36), (37) and (39)
The CEC program provides zero SOC Medi-Cal for the under-19-year-old child until the time of the next annual redetermination, regardless of whether that redetermination is completed before

or after the due date. The CEC period runs until the next annual redetermination, and is not affected by reevaluation of eligibility triggered by, e.g., reported changes in income or property.

(49)
Children discontinued from SSI/SSP are entitled to CEC benefits.

(ACWDL No. 02-14, March 8, 2002)

417-14A ADDED 7/06
There will be situations where one application covers one or more Medi-Cal Family Budget Unit (MFBU) members who are eligible in the month of application, and others who do not meet eligibility criteria until a later month or are added to the case during the 12-month annual redetermination period. In these situations, the MFBU members who were determined eligible first shall set the Annual Redetermination due month for all MFBU members even when new MFBU members are added to the case during the 12-month period.

When the Annual Redetermination is due for this type of case situation, all members of the family are part of the MFBU and will have their eligibility redetermined at the same time. However, if there are children added to the case during the 12-month period, and the children being added to the existing case already have Continuous Eligibility for Children (CEC) program eligibility from another case, these CEC children shall retain their original 12-month eligibility period under CEC even when the MFBU is determined to have a share-of-cost (SOC) after the Annual Redetermination. The CEC children added to the case later shall continue to get no SOC Medi-Cal under their original 12-month CEC period.

If applicable, when the MFBU is determined eligible for no-cost Medi-Cal at the Annual Redetermination, the county shall establish a new concurrent CEC period for all the children in the MFBU, including those children who were added to the existing MFBU with their own CEC period from another Medi-Cal case. (ACWDL 06-16, May 10, 2006)

417-14B REVISED 4/12
An infant born to a woman who was eligible for and receiving medical assistance (including coverage of an alien for labor and delivery as emergency medical services) on the date of the infant's birth, including retroactively, is deemed to have applied for medical assistance and to have been found eligible for such assistance for a period of one year.
A child born to a mother eligible for and receiving Medi-Cal on the date of the birth remains eligible until age one without considering the infant’s living arrangements (continuing to live with the mother) or the mother’s eligibility status. (42 U.S.C. 1396a (e)(4), ACWDL 11-33.)

417-15 ADDED 12/07
Continuing Eligibility for Children (CEC) applies to children discontinued from SSI/SSP who are within a continuous 12-month period beginning with the date of the last SSI/SSP determination that established SSI/SSP eligibility.

The *Craig v. Bonta* lawsuit provides that the SB 87 process applies to those discontinued from SSI/SSP. These former SSI beneficiaries are to continue on no-cost Medi-Cal until the county conducts an SB 87 annual redetermination (RV), such as finding the child eligible for CEC.

(ACWDL 07-11, October 16, 2007)

417-15A ADDED 12/07
For purposes of CEC, a determination of eligibility for SSI is a determination of eligibility for no-cost Medi-Cal. Assuming that there is no issue about whereabouts unknown or an out-of-state move, such a child is placed in CEC when the child is not yet due for an annual redetermination (RV) but would otherwise be determined ineligible or have a SOC due to a change in circumstances prior to his/her annual RV. There are no financial requirements for coverage under CEC.

Because of CEC, the regular SB 87 process for discontinued SSI individuals must be modified when the discontinued individual is under age 19. The regular SB 87 process provides that when any individual is discontinued from SSI, no-cost Medi-Cal continues until the county redetermines eligibility. If the county does not have sufficient information available to make such a determination for an adult or child over age 19, the county contacts the individual to request such information.

When the discontinued SSI individual is a child under age 19 and the county does not have sufficient information to make a RV for any Medi-Cal program, the county must first determine whether such child is or is not eligible for CEC based on the date the child was last determined eligible for SSI. Note: this determination must be made before the county can contact the child/family for more information.

(ACWDL 07-11, October 16, 2007)

417-16
The Bridging program provides one month of no-cost Medi-Cal to children who lose their full-scope, no-cost Medi-Cal and who are apparently eligible for the Healthy Families (HF) program.

As part of a waiver request, California proposed to expand the Bridging program for two months and include those adults who are also apparently eligible for the HF program. This waiver has not yet been approved. Two changes were made to persons instructions issued under All-County Welfare Directors Letter No. 99-06.

Modification 1: ACWDL No. 99-06 informed counties that one of the requirements for eligibility for Bridging was that the child's family income could not exceed 200 percent of the federal poverty level (FPL). The HF program now enrolls children with family income not exceeding 250 percent of the FPL.

Modification 2: ACWDL No. 99-06 told counties that the DHCS would be sending children in the Bridging program an HF application packet so they could apply for the HF program while they were still covered under the Bridging program. DHCS is not sending out such packets, but counties may either send out these packets with the notice of action, or counties may inform these eligibles to please call the Single Point of Entry (toll-free) at 1-800-888-5305 to request an HF packet.

(ACWDL No. 01-57, October 15, 2001)

417-16A ADDED 2/07
The Medi-Cal to Healthy Families (HF) Bridging program (Bridging) is for children under age 19 who no longer qualify for no share of cost (SOC), full-scope Medi-Cal, but who appear to be eligible for the Healthy Families Program (HFP). The program provides these children with one

additional month of no SOC, full-scope Medi-Cal to give time for the county to transfer the family's case information, with their consent, to the HFP or to give the family time to apply for the HFP if they have not given consent for the county to transfer this information.

Children who have been receiving no SOC, full-scope Medi-Cal, but are determined to be eligible in the following month for Medi-Cal with an SOC or would have an SOC if property were not considered, qualify for one additional calendar month of no SOC, full-scope Medi-Cal, as long as they appear to meet the eligibility requirements of the HFP. Summary of HFP eligibility requirements:
• United States citizen or qualified alien
• Under age 19
• Net family income must be at or below 250 percent of the federal poverty level (FPL)
• Not in any no SOC Medi-Cal program, such as 1931(b), FPL percent programs, the Aged and Disabled FPL program, Continuous Eligibility for Children (CEC) or other $0 share of cost programs.

(All County Welfare Director's Letter 07-03, February 2, 2007)

418-1
The county in which a person applies for Medi-Cal shall accept the application and statement of fact from such person on behalf of the county of responsibility. The information shall be forwarded to the county of responsibility no later than 15 days from the date of application. The county in which the person applies may, with the consent of the applicant or beneficiary, becomes the county of responsibility for determining initial eligibility and initiating an intercounty transfer. (§50135)

418-2
The following rules apply to Medi-Cal Intercounty Transfers (ICTs):

> Counties must ensure all Medi-Cal cases remain active throughout the ICT period with no interruption in benefits. Medi-Cal is a statewide program; counties may not terminate Medi-Cal benefits when a beneficiary moves from one county to another until an effective date of benefits for the beneficiary in the new county is confirmed.

> Counties may neither ask nor require a beneficiary to reapply for Medi-Cal benefits or apply for a redetermination of eligibility in the new county of residence solely due to the change in county residence.

> Counties shall not require the beneficiary to undergo any redetermination procedures during the ICT. ICT is a transfer of county responsibility for the beneficiary's case record. A redetermination of eligibility is not part of the ICT process.

> Counties shall not require the beneficiary to complete a new application or cooperate with a full eligibility review in the new county until the next annual redetermination date as determined by the beneficiary's old county of residence.

(All-County Welfare Directors Letter No. 03-12, February 21, 2003)