LOS ANGELES COUNTY – DEPARTMENT OF MENTAL HEALTH / *CENTRAL BUSINESS OFFICE*

CBO DISPATCH

The "B" means BUSINESS

CBO Dispatch No.: NGA 15-002 Issue Date: January 26, 2015

LOSS OF MEDI-CAL ELIGIBILITY

Recently, programs received an RMD Bulletin advising that thousands of Medi-Cal beneficiaries were at risk of losing their benefits as a result of failing to submit required renewal paperwork requested by the Department of Public Social Services (DPSS).

The attached Medi-Cal Reference Guide is to be used to assist programs with answering questions from beneficiaries when a renewal is required. The Medi-Cal Reference Guide provides information regarding how and where a beneficiary can complete their annual renewal. Beneficiaries who fail to provide the requested information will be terminated; however, there is a 90-day window *after* the termination date in which they are permitted to provide the required information to re-establish eligibility. After the 90-day window has expired, a new application must be submitted.

Also attached is an unfilled sample of the Medi-Cal Renewal Form. This form is sent to beneficiaries when they need to complete their annual renewal. This 10-page document is sent pre-populated with the information that DPSS has in their files with a request to update or validate the information. The Medi-Cal Renewal Form will also identify a due date for the information to be returned to DPSS. ***Please note that the Renewal Form must be completed and submitted with supporting documentation even if the client's information has not changed.***

The Central Business Office (CBO) is advising programs to verify Medi-Cal eligibility every month to identify any client who has lost their benefits so that eligibility may be re-established within the 90-day window. In addition, asking your clients if they have received a renewal packet in the mail and working with them to provide the requested information may help avoid the termination of benefits. Renewals are required on an annual basis so please keep the Medi-Cal Reference Guide available to help you help your clients when they receive a renewal packet.

WE'RE WORKING FOR YOU…

If you have any questions or require further information, please contact CBO at (213) 480-3444 or RevenueManagement@dmh.lacounty.gov.

DOES NOT APPLY TO FEE-FOR-SERVICE PROVIDERS

Medi-Cal Reference Guide

01/13/14

What Is An Annual Renewal?	• An eligibility review that is conducted once every 12 months to re-establish continued eligibility for Medi-Cal.
How Can I Complete My Annual Renewal?	• **By mail** – Complete and return the renewal documents in the self-addressed envelope provided.  • **By Phone** – Call the Customer Service Center at **1-866-613-3777** and request an appointment to see your worker  • **In Person** – Return your Renewal information at your DPSS district office.
How Long Do I Have To Complete My Renewal?	• Renewal packets are mailed two months prior to the renewal due month, allowing the beneficiary at least 60 days to provide the required information.
What Happens If I Don't Provide The Required Renewal information?	• Medi-Cal benefits will be terminated.
What Is The 90-Day Cure Period?	• The beneficiary has 90 days after the termination date to provide the required information needed to re-establish eligibility. This 90-day timeframe is referred to as the "cure period."
What If My Discontinuance Is Over 90 Days?	• After the 90-day cure period has expired, a new application must be submitted.
How Can I Submit A New Application?	• **Online** @ Your Benefits Now: **https://www.dpssbenefits.lacounty.gov/ybn/Index.html**  • **By Mail** - request an application by calling **1-866-613-3777**. • **In Person** at your nearest DPSS office.

For further information about Medi-Cal or other programs such as: General Relief, CalFresh and CalWORKs please visit our website **http://dpss.lacounty.gov/default.cfm.**

You can get this notification in another language or in large print or another way that's best for you. Call 1-800-XXX-XXXX (TTY: 1-888-XXX-XXXX).

Medi-Cal Renewal Form

Respond By:

Case Number:

Date

Name

Address Line 1

Address Line 2

It is time to renew your Medi-Cal coverage.

We need some information from you to help you keep your Medi-Cal for the next year.

You can renew your Medi-Cal in any one of these ways:

- By mail: Complete this form and mail it to:
  [Medicaid Agency]
  [100 State Street]
  [Any city, State]
- In person: Visit our office at [Medicaid Agency] [100 State Street] [Any city, State]. Office hours are [8:30 a.m. to 5 p.m. Monday to Friday].
- By Phone: Renewing by phone is quick and easy. Please call 1-866-613-3777 Monday- Friday, 7:30a.m. to 5:30p.m.

How to complete this form:

To make sure you or your family continue to have Medi-Cal coverage, you must let us know if there are any changes or not to the information on this form.

1. Please review the information about you and members of your household and let us know about any changes.
2. Send us or upload copies of documents that show your most current information for information even if your information has not changed.
3. Return this form or provide this information online by_____.
4. If you return this form by mail, please make sure to sign the form on page 10.

Whose information we need:

We need the most current information about every member of your household who is living with you or is listed on your tax return, if you file taxes. We need information from:

- People in your household who currently have Medi-Cal,
- People in your household who would like to apply.
- We may need some information about people in your household who live with you or are listed on your tax return, who do not have Medi-Cal and who do not want to apply for Medi-Cal. Their information will be kept private and used only to help those in your household who want to keep or apply for Medi-Cal.

You do not need to file a tax return to apply for or renew your Medi-Cal.

What happens if my information is different:

If anyone in your household does not qualify for Medi-Cal because the information on this form has changed, we will use your new information to check to see if you or other people in your household qualify for other affordable health coverage, including Covered California. Your information will be kept private and will be used only to see if you or your family qualifies for affordable health coverage. We may need more information from you to find you the most affordable health coverage.

Questions? Call [state agency] at **1-800-XXX-XXXX**. The call is free. (TTY: 1-888-XXX-XXXX). You can call [days and hours of operation]. Or visit <web address>

1 Your current household

Please check the information below and tell us if there are any changes.

Is the address below correct? ❑ Yes
If Yes, go to Section 2.

❑ No. If not, please write the correct information below.

Ernie Roberts

Home address:
1234 America Ave. Apt. 1A
Anywhere, ST 12345

Mailing address:
5678 Broad St.
P.O. Box 6789
Anywhere, ST 12345

Phone:
Home: 111-222-3333
Other:

Name *(first, middle, last & suffix)*

Home address — Apartment #

City *(home)* — State — ZIP code

Mailing address, only if different from above. — Apartment #

City *(mailing)* — State — ZIP code

What number can we call to contact you: • Home • Cell • Work

Phone Number:

What is the best time to reach you at this number?

(Optional) Is there another number we can use to call you? • Home • Cell • Work

Phone Number:

(Optional) What email address can we contact you?

Questions? Call [state agency] at **1-800-XXX-XXXX**. The call is free. (TTY: 1-888-XXX-XXXX). You can call [days and hours of operation]. Or visit <web address>

2 Who is in your household

Please check the information below about people in your household who want to renew Medi-Cal. Please tell us if there are any changes to the information we have about people living with you or who are listed on your federal tax return.

Name	Tax Filing Status (e.g., primary tax filer, dependent)	How is this person related to the primary tax filer or head of household	Who claims this person as a dependent?	Correct Information?
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No

If the information above is not correct, please write the correct information into the space provided below. If there are other members of your household, please write their information in below.

Name	Tax Filing Status	Relationship to Tax Filer	Who claims this person as a dependent?

3 Income and Expenses

We were not able to renew your Medi-Cal using the income below that we have for you or your household members from electronic data sources. Please let us know if the information below is correct or not. We need paper documentation showing us what your most current income is. Please attach any of the following that show income before taxes or deductions: recent pay stubs, benefits or award letters, checks received or signed statement from employer, or last year's tax return. If income is from self-employment, send a copy of your most recent tax return or profit and loss statement.

The income information below is only for individuals within your household we could not otherwise verify. If you have members of your household not listed below it is because we were able to verify their income and no other income information is needed for the individual.

[Pre-Populated Name]:

Our records show that this individual's monthly income is:_____.

This estimate includes the income sources and amounts below. Please let us know if this information is correct or has changed. If this information has changed, please tell us the correct information.

Income 1 _____ How often received _____

Is this correct? ❑ Yes ❑ No If no, enter correct information_____

Questions? Call [state agency] at **1-800-XXX-XXXX**. The call is free. (TTY: 1-888-XXX-XXXX). You can call [days and hours of operation]. Or visit <web address>

Income 2 _____ How often received: _____

Is this correct? ❑ Yes ❑ No If no, enter correct information _____

Income 3 _____ How often received: _____

Is this correct? ❑ Yes ❑ No If no, enter correct information _____

Please enter below any additional income you expect that is not shown above?

Source of Income	Amount	How often received

Fluctuating Income

You told us that your income changes from month to month and gave us an estimate of what you thought your income would be for the past 12 months.

Last year, you told us your income would be _____

What do you think your income will be for the next 12 months? _____

Expenses/Tax Deductions

Our records show that this individual had the following tax expenses (deductions) last year. Please let us know if this will be the same for next year or not:

Tax Deduction 1 _____ How often paid? _____

Is this correct? ❑ Yes ❑ No If no, enter correct information _____

Tax Deduction 2 _____ How often paid? _____

Is this correct? ❑ Yes ❑ No If no, enter correct information _____

Tax Deduction 3 _____ How often paid?_____

Is this correct? ❑ Yes ❑ No If no, enter correct information _____

[Pre-Populated Name]:

Our records show that this individual's monthly income is:_____.

This estimate includes the income sources and amounts below. Please let us know if this information is correct or has changed. If this information has changed, please tell us the correct information.

Income 1 _____ How often received _____

Is this correct? ❑ Yes ❑ No If no, enter correct information _____

Source of Income	Amount	How often received

Fluctuating Income

You told us that your income changes from month to month and gave us an estimate of what you thought your income would be for the past 12 months.

Last year, you told us your income would be _____

What do you think your income will be for the next 12 months? _____

Expenses/Tax Deductions

Our records show that this individual had the following tax expenses (deductions) last year. Please let us know if this will be the same for next year or not:

Tax Deduction 1 _____ How often paid? _____

Is this correct? ❑ Yes ❑ No If no, enter correct information _____

Tax Deduction 2 _____ How often paid? _____

Is this correct? ❑ Yes ❑ No If no, enter correct information _____

Tax Deduction 3 _____ How often paid?_____

Is this correct? ❑ Yes ❑ No If no, enter correct information _____

4 Other Health Insurance

Please let us know if the information below is still correct. If someone in your family now has other health insurance not listed below, please write it in below.

Name	Type of Insurance	Do you still have this coverage?
		❑ Yes ❑ No
		❑ Yes ❑ No

Questions? Call [state agency] at **1-800-XXX-XXXX**. The call is free. (TTY: 1-888-XXX-XXXX). You can call [days and hours of operation]. Or visit <web address>

5 Incarceration

Our information shows that one or more people in your household is incarcerated. Is this information correct?

Name	Is this individual incarcerated?
	❑ Yes ❑ No
	❑ Yes ❑ No

6 Deceased

Our information shows that one or more in your household has died. Is this information correct?

Name	Is this individual deceased?
	❑ Yes ❑ No
	❑ Yes ❑ No

7 Other Household Changes

Is anyone in your household between the ages of 18 and 26 years old and was either in foster care, in any state, on his or her 18th birthday or who lost foster care assistance, in any state, due to having reached the maximum age limit?

• Yes • No ***If yes,*** who? _____

Is anyone in your household 19 to 20 years old and a full-time student? • Yes • No

If yes, who? _____

Questions? Call [state agency] at **1-800-XXX-XXXX**. The call is free. (TTY: 1-888-XXX-XXXX). You can call [days and hours of operation]. Or visit <web address>

Does anyone in your household have a physical, mental, emotional, or developmental disability?
• Yes • No

If yes, who? _____

Does anyone in your household need help with long-term care or home and community-based services?
• Yes • No

If yes, who? _____

Is anyone in your household pregnant? • Yes • No

If yes, who? _____

If yes, what is her expected due date? _____

How many babies are expected? _____

Has anyone in your household moved into or out of the home in the past 12 months? • Yes • No

If yes, who _____

What is your relationship to this person? _____

If yes, who _____

What is your relationship to this person? _____

Do any of these individuals want to apply for Medi-Cal? • Yes • No

If yes, who? _____

If anyone in your household who currently has Medi-Cal recently gained lawful immigration or citizenship status in the past 12 months, list the name(s) below:

Name of Person (include first and last name)	New Status

Questions? Call [state agency] at **1-800-XXX-XXXX**. The call is free. (TTY: 1-888-XXX-XXXX). You can call [days and hours of operation]. Or visit <web address>

8 Signature

PRIVACY STATEMENT

This renewal form is for renewing benefits through the Department of Health Care Services (DHCS) and determining eligibility for health insurance through Covered California. The personal and medical information you provide on it is private and confidential. Covered California or DHCS needs it to identify you and the other people on this renewal form and to administer our programs. We will share your information with other state, federal, and local agencies, contractors, health plans, and programs only to enroll you in a plan or program or to administer programs, and with other state and federal agencies as required by law.

You must answer all of the questions on this renewal form unless they are marked "optional." If your renewal form is missing anything that we require, we will contact you to get it. If you do not provide it, we will not be able to make a decision on your renewal. You may have to submit a new application, or you may not be able to get health insurance through Covered California, or your application for benefits renewal may be denied.

In most cases, you have the right to see personal information about you that is in federal and state records. You can see it in an alternative format (such as large print) if you need that. For more information or to see Covered California records, contact the Privacy Officer at:

Covered California
Attn: Privacy Officer
P.O. Box 989725
West Sacramento, CA 95798-9725
Phone: 1-800-300-1506
TTY: 1-888-889-4500

For the Department of Health Care Services, contact the
Information Protection Unit at:
P.O. Box 997413, MS 4721
Sacramento, CA
95899-7413
Phone: 1-866-866-0602
TTY: 1-877-735-2929

These state and federal laws give us the right to collect and keep the information on the renewal form: Covered CA: 42 U.S.C. § 18031; CA Government Code §§ 100502(k) and 100503(a) DHCS: CA Welfare and Institutions Code § 14011 and Article 3, Chapters 5 and 7, Parts 2 and 3, Division 9. We must give you this Privacy Statement under CA Civil Code § 1798.17.

You can find the Notices of Privacy Practices for the Medi-Cal program at www.dhcs.ca.gov and for Covered California at www.CoveredCA.com.

Questions? Call [state agency] at **1-800-XXX-XXXX**. The call is free. (TTY: 1-888-XXX-XXXX). You can call [days and hours of operation]. Or visit <web address>

RIGHTS AND RESPONSIBILITIES

The information I gave on this renewal form is true as far as I know. I know that I may be subject to a penalty if I do not tell the truth.

I understand that the information I give will be used only to see if those in my family who are applying to renew health insurance will qualify.

I understand that Covered California and the Medi-Cal program will keep my information private, as the law requires. For more information, or access to personal information in records maintained by the Medi-Cal program and Covered California, I can contact my county social services office or I can contact the Covered California Privacy Officer at 1-800-300-1506 (TTY: 1-888-889-4500).

I understand that to be eligible for Medi-Cal, I am required to apply for other income or benefits to which I or any member of my household is entitled, unless he or she has good cause for not doing so. Examples of such income or benefits are pensions, government benefits, retirement income, veteran's benefits, annuities, disability benefits, Social Security benefits (also called OASDI or Old Age, Survivors, and Disability Insurance), and unemployment benefits. But such income or benefits do not include public assistance benefits, such as CalWORKs or CalFresh. If I have a question about a possible source of income, I can call my county social services office or Covered California at 1-800-300-1506 (TTY: 1-888-889-4500) for help.

I know that I must tell Covered California or my Medi-Cal county social services office about changes to anything I stated in this renewal form. To report changes, I can call my county social services office. Or I can call Covered California at 1-800-300-1506 (TTY: 1-888-889-4500) or visit CoveredCA.com.

I know that Covered California or the Medi-Cal program must not discriminate against me or anyone on this renewal form because of race, color, national origin, religion, age, sex, sexual orientation, marital status, veteran's status, or disability. If I think Covered California or the Medi-Cal program has discriminated against me, including the failure to provide reasonable accommodations as required under state and federal law, I can make a complaint by contacting the U.S. Department of Health & Human Services at www.hhs.gov/ocr/office/file or the California Office of the Attorney General at http://oag.ca.gov/contact/general-comment-question-or-complaint-form.

If I believe that Covered California or the Medi-Cal program has discriminated against me or anyone else on this renewal form in connection with a Medi-Cal eligibility determination, I can also file a complaint with the Department of Health Care Services, Office of Civil Rights by calling 1-916-440-7370 (TTY: 1-916-440-7399).

I understand that any changes in my information or information of any member(s) in the applicant's household may affect the eligibility of other members of the household.

By applying for Medi-Cal, I confirm that no one applying for health insurance on this renewal form is confined, after the disposition of charges (judgment), in a jail, prison, or similar penal institution or correctional facility.

I understand that I must report income changes to my Medi-Cal county social services office or Covered California because it may affect the eligibility for Medi-Cal benefits or the amount of premium assistance (or tax credits) that I may be eligible to receive. I also understand if I receive too much premium assistance (or tax credits) during the benefit year, I will have to repay the extra premium assistance back to the IRS when I file my federal income taxes for the benefit year.

I give my permission to the Medi-Cal program or Covered California to check other agencies' computer records to

Questions? Call [state agency] at **1-800-XXX-XXXX**. The call is free. (TTY: 1-888-XXX-XXXX). You can call [days and hours of operation]. Or visit <web address>

verify citizenship, satisfactory immigration status, tax information, and other information related only to eligibility to see if I and other people on this renewal form qualify for health insurance. If someone on the renewal form qualifies for Medi-Cal:

I know that if Medi-Cal pays for a medical expense, any money I or anyone on this renewal form get from other health insurance or legal settlements related to that expense will go to Medi-Cal as payment for the expense until the expense is paid in full. For parents whose child or children qualify for Medi-Cal:

I know I will be asked to help the agency that collects medical support from any parent on this renewal form who does not live with the child and does not send support for the child. If I think that helping will harm me or my children, I can tell the Medi-Cal program and I will not have to help.

Your right to appeal:
If I think Covered California or the Medi-Cal program has made a mistake, I can appeal its decision. To appeal means to tell someone at Covered California or the Medi-Cal program that I think its decision is wrong and ask for a fair review of the action.

I know that I can find out how to appeal by calling 1-855-795-0634 (TTY: 1-800-952-8349) for the Medi-Cal program or calling1-800-300-1506 (TTY: 1-888-889-4500) for Covered California enrollees.

I know that I must file an appeal within 90 days of the decision. I know that I can represent myself or have someone else represent me in my appeal, such as an authorized representative, a friend, a relative, or a lawyer.

I know that if I need help, someone at Covered California, the Medi-Cal program, or the county social services office can explain my case to me.

DECLARATION
I declare under penalty of perjury under the laws of the State of California that what I say below is true and correct.

I understood all questions on this renewal form and gave true and correct answers as far as I know. Where I did not know the answer myself, I made every reasonable attempt to confirm the answer with someone who did know.

I know that if I do not tell the truth on this renewal form, there may be a civil or criminal penalty for perjury that may include up to four years in jail. (See California Penal Code Section 126.)

I know that the information in this renewal form will be used to decide if the people who are applying qualify for health insurance. The Medi-Cal program and Covered California will keep the information private, as required by federal and California law.

I agree to notify the Medi-Cal program or my Medi-Cal county social services offices or Covered California by calling 1-800-300-1506 (TTY: 1-888-889-4500) or visiting CoveredCA.com if anything changes on this renewal form for any person applying for health insurance.

Signature of Applicant or Authorized Representative

Date and Place: _____

Signature: _____

Questions? Call [state agency] at **1-800-XXX-XXXX**. The call is free. (TTY: 1-888-XXX-XXXX). You can call [days and hours of operation]. Or visit <web address>