STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY GRAY DAVIS, *Governor*

DEPARTMENT OF HEALTH SERVICES
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December 12, 2001

MEDI-CAL ELIGIBILITY PROCEDURES MANUAL LETTER NO.: 255

TO: All Holders of the Medi-Cal Eligibility Procedures Manual

19D – Home and Community-Based Waiver Programs

Enclosed are updated procedures and forms for waiver programs. The Department of Developmental Services and Model Nursing Facility waivers require special Medi-Cal eligibility income and resource determinations. The other four waivers expand services.

Please note the changes on pages five and seven that exempt a second vehicle in certain programs.

Filing Instructions:

Remove Pages:	**Insert Pages:**
Article 19D	Article 19D
Article 19D-1 through 19D-17	Article 19D 1 through 19D-44

If you have any questions, please contact Ms. Margie Buzdas of my staff at (916) 657-0726.

Sincerely,

Original signed by

Richard Brantingham, Acting Chief
Medi-Cal Eligibility Branch

Enclosures

COUNTY WAIVER CONTACTS
APRIL 2001

CONTACT	COUNTY
Nan Toy Human Resources Agency P.O. Box 1320 Santa Cruz, CA 95061 (408) 454-4142 (408) 454-4092 FAX	Santa Cruz
Janet Wright Department of Social Services P.O. Box 6005 Redding, CA 96099-6005 (916) 245-6464 (916) 225-5087 FAX	Shasta
Allyson Volkman Human Services P.O. Box 1019 Loyalton, CA 96118 (530) 993-6726 (530) 993-6767 FAX	Sierra
Nadine Della Bitta Human Services Department 818 South Main Street Yreka, CA 96097 (916) 841-2750 (916) 841-2790 FAX	Siskiyou
Diana Perez Health and Social Services 1745 Enterprise Drive, MS 2-100 Fairfield, CA 94533 (707) 421-7805 (707) 421-7237 FAX	Solano
Kim Seamans Human Services Department 2550 Paulin Drive P.O. Box 1539 Santa Rosa, CA 95402 (707) 565-5304 (707) 565-5353 FAX	Sonoma
Meribeth Ruiz Department of Social Services P.O. Box 42 Modesto, CA 95353-0042 (209) 558-2675 (209) 558-2189 FAX	Stanislaus

19D -- HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVERS

I. BACKGROUND

The Social Security Act [Section 1915(c)], Section 14132(s) of the Welfare and Institutions Code, and Section 51346 of Title 22, California Code of Regulations permits states to request waivers of otherwise applicable federal law in order to provide certain services to persons at home or in the community as a cost neutral alternative to institutionalized health care provided such non-institutional services meet the health and safety needs of the beneficiary. The goal is that the beneficiary will experience an enhanced and enriched quality of life if allowed to return home or to the community. The Department of Health Services (DHS) currently has six such waivers in effect.

Congress also authorized Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for eligible individuals under 21 years of age. EPSDT is a Medi-Cal benefit which requires that states provide medically necessary screening, vision, hearing, and dental services to Medi-Cal beneficiaries. One of the services which may be provided is licensed skilled nursing in the home. Therefore, Medi-Cal eligible children who are institutionalized will now be able to return home from institutionalization or those who are home can remain at home because they can receive additional medical services under the EPSDT program if certain criteria, including cost effectiveness, are met. It is no longer necessary that all children be in a waiver to receive expanded benefits if the child has a zero share of cost (SOC) under regular Medi-Cal income/property rules. The following procedures apply if a waiver is required.

Assembly Bill (AB) 2279, Chapter 329, Statues of 1998, provides for the expansion of the Personal Care Services Program (PCSP) to the aged, blind or disabled medically needy. Prior to this, PCSP services were offered to categorical and mandatory Medi-Cal coverage groups (e.g., Supplemental Security Income (SSI) recipients, Pickle beneficiaries, CalWORKs and Section 1931(b) recipients and pregnant women or children in the federal poverty level programs who meet the criteria for this program. PCSP is a component of the In-Home Supportive Services (IHSS) program. PCSP provides the following services:

- Assistance to ambulate
- Bathing, oral hygiene, dressing, and grooming
- Care and assistance with prosthetic devices
- Bowel, bladder and menstrual care
- Repositioning, range of motion exercises and transfers
- Feeding and assurance of adequate fluid intake
- Respiration
- Paramedical services
- Assistance with self-administration of medications
- Ancillary services e.g., meal preparation, laundry, shopping and domestic services (these are only offered if other basic PCS are provided).

Unlike IHSS, PCSP does not allow a parent of a minor child or spouse to be the care provider. Persons who are receiving benefits under either of the two waivers [Model Nursing and Department of Developmental Service(DDS)] that disregard parental and spousal income and property and who are not eligible for IHSS services solely because that program does not disregard parental and spousal income, are eligible for the PCSP (Section 14132.95(f) of the Welfare and Institutions Code).

II. OVERVIEW

The applicant must be Medi-Cal eligible in the non-institutional setting before being served by a waiver. The following procedures describe the process counties are to follow in determining Medi-Cal eligibility. Depending on the circumstances, this determination may be initiated while the applicant is still institutionalized or in a living arrangement different from the setting covered by the waiver. Agencies responsible for waiver service authorization will refer waiver applicants to the county welfare department (CWD) for these eligibility determinations. In some situations these agencies will not determine whether it is medically appropriate for the applicant to be in a waiver or to receive services until the county completes the Medi-Cal eligibility determination.

A. Medi-Cal Eligibility Waiver Determination -- Overview

There are several factors counties must consider such as the following:

1. Whether eligibility is to be based on regular Medi-Cal rules or special Medi-Cal rules depending on the type of waiver that the applicant will be in.

2. Whether the determination is based on anticipated circumstances or on actual circumstances (i.e., the current living arrangement is appropriate for the waiver and the referring agency already has determined it medically appropriate for the applicant to be in the waiver).

3. Whether the Individual is a New Applicant or a Beneficiary with a Change in Circumstances.

   - New Applicant:

     If the waiver applicant is not currently receiving Medi-Cal, he/she must complete an Application for Public Assistance and a Statement of Facts.

     The individual who is not currently receiving Medi-Cal will need an initial Medi-Cal eligibility determination based on his/her anticipated living situation. If the applicant has a parent or spouse in the home, the major concern is usually whether he/she will be eligible or have a high SOC due to parental or spousal income or excess property. Therefore, individuals who are interested in leaving an institution and are applying for Medi-Cal and additional in-home services under a waiver need to know about their eligibility should they return home, e.g., whether they will be Medi-Cal eligible or have a SOC.

   - Beneficiary with a Change in Circumstances:

     In some cases, the waiver applicant will be institutionalized and Medi-Cal eligible as an institutionalized individual prior to a referring agency contacting the CWD; however, depending on the waiver and circumstances, many persons may already be deinstitutionalized prior to requesting an eligibility determination. Some may have never been institutionalized but have a high SOC or are in jeopardy of becoming institutionalized because their insurance is being terminated.

If the waiver applicant is currently receiving Medi-Cal-Only, the individual's move from an institutional setting to a non-institutional setting or from one community setting to another community setting generally will be treated by the county as a change in circumstances rather than a new application. The applicant does not complete a new Application for Public Assistance, but the county may require a new Statement of Facts if appropriate.

If the person is currently institutionalized and is already receiving Medi-Cal, he/she is likely either a Medically Needy beneficiary in his/her own Medi-Cal family budget unit (MFBU) or is receiving Supplemental Security Income (SSI) and automatic SSI-based Medi-Cal. A new eligibility determination based on a non-institutional living arrangement is required prior to the person being discharged either to the home of his/her spouse or parents or to a community setting to ensure continuing Medi-Cal eligibility so he/she can receive waiver services. NOTE: Some people may not lose SSI upon returning home because the family income/property is below the SSI limit. Persons who are on SSI or qualify for a zero SOC Medi-Cal card because the family income/property is below the limit should not be in the Model or DDS waivers.

B. County Contact

Each county shall designate a waiver contact person. The county waiver contact person will receive the request for a Medi-Cal eligibility determination from the referring agency, coordinate the Medi-Cal eligibility determination, and answer questions about the program even though the actual determination may be made by other county staff. The contact for each county is attached to these procedures. It is important that applicants be directed to the county contacts because they understand how to process those waivers that disregard parental and spousal income and resources. Once the county receives a referral, the county will determine Medi-Cal eligibility based on the criteria for the appropriate waiver including the living arrangement covered by the waiver.

III. WAIVERS TYPES

There are six types of waivers. The first two have special Medi-Cal eligibility determination requirements. The last four follow regular eligibility rules.

A. Department of Developmental Services Home and Community-Based (DDS) Waiver

B. Model-Nursing Facility (Model-NF)

C. In-Home Medical Care Services (IHMC) Waiver

D. Nursing Facility (NF) Services Waiver

E. Acquired Immune Deficiency Syndrome (AIDS) Waiver

F. Multipurpose Senior Service Program (MSSP) Waiver

DESCRIPTION AND PROCESSING

A. Department of Developmental Services (DDS) Home and Community-Based Services Waiver

B.

1. Description

The DDS HCBS waiver is limited to developmentally disabled children and adults who live at home and meet the admission criteria for an intermediate care facility for the developmentally disabled as defined in the California Health and Safety Code. Waiver eligibility will be determined by the regional centers, but counties are responsible for the Medi-Cal determination. Services provided include homemaker, home health, residential habilitation, day habilitation, skilled nursing, transportation, specialized medical equipment and supplies, personal care, respite, environmental modifications, chore service, personal emergency response systems, physical therapy, occupational therapy, physiology services, vehicle adaptations, communication aides, and crisis intervention.

2. Referring Agency: Department of Developmental Services (DDS) - Regional Centers

The regional centers of DDS are responsible for the DDS Home and Community-Based Services (HCBS) Waiver. DDS contracts with local regional centers which are responsible for seeking Medi-Cal for their clients. These regional centers are nonprofit agencies. The regional center will determine the medical appropriateness of waiver coverage before referral to the CWD by reviewing the applicant's medical, social, and developmental care needs. If appropriate, the regional center will refer him/her to the county for an eligibility determination or redetermination via the Department of Developmental Services Waiver Referral form (DHS 7096). If no responsible relative is available to act on the applicant's behalf or he/she does not wish to apply for the applicant, the regional center may do so, although they may not necessarily be the child's conservator. Counties may share ongoing eligibility information with the regional centers regardless of who acts on the client's behalf. See the attached list for the name and address entitled "Contacts for Regional Centers".

3. Eligibility Requirements

The individual must meet all standard Medi-Cal eligibility rules such as California residency and cooperation when determining eligibility for the waiver.

- If the individual is eligible for Medi-Cal with no SOC without using the special waiver rules, he/she is not eligible for the waiver. The county should contact the regional center and inform their contact that the waiver is not appropriate. However, if after a preliminary screening, it appears that the applicant will be property ineligible or has a SOC using parental or spousal income and property, the special rules below apply:

- The applicant is treated as if he/she were institutionalized for purposes of the treatment of income and resources.

- If the applicant is a child, parental income and resources are not considered even though the child lives in the home.

- If the applicant is an adult, spousal impoverishment rules apply.

- A second vehicle is exempt if the vehicle has been modified to accommodate the physical handicap(s) or medical needs of the individual. Verification shall be by the physician's written statement of necessity.

- The individual is in his/her own MFBU. If other family members wish to be aided, the individual is treated similar to those on public assistance (PA) e.g., the individual may be used to link other family members although the individual is not in the family's MFBU.

- The waiver is limited to those who are eligible with or without a share of cost for full benefits. A person residing in a nursing home under the state-only aid code of 53, a person in another limited scope aid code, or a person who does not have satisfactory immigration status is not eligible.

- The county should use the most beneficial full scope Medi-Cal program to determine eligibility that is applicable to the applicant, e.g., the Aged and Disabled program, the Medically Needy program (MN), the Medically Indigent (MI) program, or the Percent programs. Eligibility is based on the waiver individual's own income and resources, including amounts remaining after spousal impoverishment rules are applied.

  For example: A child under age19 who has a SOC in the MN or MI program or excess property may be eligible under the appropriate Percent program which disregards property using a family size of one. He/she would then be reported to MEDS using the appropriate waiver aid code.

- A disability determination is not required unless (1) eligibility is based on a Medi-Cal program requiring that the individual be disabled, (2) the individual has no other basis for linkage or, (3) there would be an advantage if the applicant were disabled, e.g., income deductions available only to the disabled. This determination of disability may be advantageous in the future when the child becomes an adult.

- Aid codes for the DDS Waiver are:

  6V No SOC 6W SOC

  In some counties, persons in 6V may choose to be in a managed care plan. It is not mandatory.

B. DHS Model Nursing Facility Waiver (Model-NF)

1. Description

The Model-NF waiver is limited to persons who in the absence of the waiver program would otherwise require the nursing facility level of care or sub-acute services for at

least 90 consecutive days but who wish to live at home or in the community. Individuals under the age of 21 must be able to access a waiver service which is not covered under the EPSDT program. Inpatient status prior to the enrollment of waiver services is no longer required. Services provided include but are not limited to: case management, skilled nursing, home health aides, language services, speech, hearing, family training and therapy, and physical therapy and adaptations to the home.

2. Referring Agency: DHS In-Home Operations (IHO)

The purpose of IHO is to ensure that necessary, appropriate, and quality medical and nursing services are authorized and provided in the home setting. IHO staff facilitate the proposal documentation and development between each waiver participant and provider. This process allows for review of all issues related to the recipient level of care, evaluation of Durable Medical Equipment, medication, nursing hours, cost-effectiveness and verification by IHO staff that the home environment is appropriate to meet the health and safety needs of the recipient. Final approvals of individual waiver requests are subject to review by a Medi-Cal physician and other staff.

3. Referral Process

The medical component may not have been completed by IHO staff prior to the agency referral to the county. If not, the county will receive a Model Waiver Screening Form Notice (DHS 7097) from IHO indicating the need for a determination and the applicable living condition. The county should call the IHO Eligibility Liaison or return the form indicating the results of the eligibility determination and await notification from the section before reporting any eligibility to the Medi-Cal Eligibility Data System (MEDS).

When the medical component has been completed, the county will receive a copy of the Model-Nursing Facility (NF) Waiver Medical Eligibility Notice, a copy of which is attached. The county should contact the IHO Eligibility Liaison for the date of eligibility if the medical determination has already been completed and the eligibility date is not stated. If the applicant is determined to be ineligible for any reason, the county should also inform the IHO Eligibility Liaison.

For more information, counties may contact the following:

In-Home Operations
Intake Unit
700 North Tenth Street
P.O. Box 942732
Sacramento, CA 95814
(916) 324-1020

4. Eligibility Requirements

The Model waiver has the same Medi-Cal eligibility rules as the DDS waiver. In-Home Operations will do some prescreening of income and property prior to referring the individual to the county. The requirements are:

The individual must meet all standard Medi-Cal eligibility rules such as California residency and cooperation when determining eligibility for the waiver.

- If the individual is eligible for Medi-Cal with no SOC without using the special waiver rules, he/she is not eligible for the waiver. The county should contact IHO and inform the contact that the waiver is not appropriate. However, if after a preliminary screening, it appears that the applicant will be property ineligible or has a SOC using parental or spousal income and property, the special rules below apply:

- The applicant is treated as if he/she were institutionalized for purposes of the treatment of income and resources.

- If the applicant is a child, parental income and resources are not considered even though the child lives in the home.

- If the applicant is an adult, spousal impoverishment rules apply.

- A second vehicle is exempt if the vehicle has been modified to accommodate the physical handicap(s) or medical needs of the individual. Verification shall be by the physician's written statement of necessity.

- The individual is in his/her own MFBU. If other family members wish to be aided, the individual is treated similar to those on public assistance (PA) e.g., the individual may be used to link other family members although the individual is not in the family's MFBU.

- The waiver is limited to those who are eligible with or without a share of cost for full benefits. A person residing in a nursing home under the state-only aid code of 53, a person in another limited scope aid code, or a person who does not have satisfactory immigration status is not eligible.

- The county should use the most beneficial full scope Medi-Cal program to determine eligibility that is applicable to the applicant, e.g., the Aged and Disabled program, the Medically Needy program (MN), the Medically Indigent (MI) program, or the Percent programs. Eligibility is based on the waiver individual's own income and resources, including amounts remaining after spousal impoverishment rules are applied.

  For example: A child under age19 who has a SOC in the MN or MI program or excess property may be eligible under the appropriate Percent program which disregards property using a family size of one. He/she would then be reported to MEDS using the appropriate waiver aid code.

- A disability determination is not required unless (1) eligibility is based on a Medi-Cal program requiring that the individual be disabled, (2) the individual has no other basis for linkage or, (3) there would be an advantage if the applicant were disabled, e.g., income deductions available only to the disabled. This determination of disability may be advantageous in the future when the child becomes an adult.

- Aid Codes for the In-Home Medical Care (Model) Waiver are:

  6X Model Waiver No SOC 6Y Model Waiver SOC

  In some counties, persons in 6X may choose to be in a managed care plan. It is not mandatory.

C. In-Home Medical Care (IHMC) Waiver

1. Description

   The IHMC waiver is limited to individuals who in the absence of the waiver program require care in an acute hospital for at least 90 days. Services provided include but are not limited to: case management, skilled nursing, home health aides, utility coverage, case management, and minor physical adaptations to the home.

2. Referring Agency: DHS In-Home Operations (IHO).

   Generally, if the applicant is not referred, the county probably will not be aware that the applicant is seeking a waiver and will process the determination as they normally do.

3. Eligibility Requirements

   No special Medi-Cal eligibility rules apply. If the applicant is living in the home, he/she is not in a separate MFBU from his/her parent/spouse.

D. Nursing Facility Level of Care (NF) Waiver

1. Description

   The NF waiver (formerly referred to as the Skilled Nursing Facility Waiver) is limited to individuals who in the absence of the waiver program would require care in a nursing facility or a sub-acute facility for at least 90 consecutive days care. Services provided include, but are not limited to: case management, skilled nursing, home health aides, language services, speech, hearing, family training and therapy, physical therapy and adaptations to the home. Individuals under the age of 21 may access services under the NF waiver that are not covered under the EPSDT program.

2. Referring Agency: DHS In-Home Operations (IHO).

   Generally, if the applicant is not referred, the county probably will not be aware that the applicant is seeking a waiver and will process the determination as they normally do.

3. Eligibility Requirements

No special Medi-Cal eligibility rules apply. If the applicant is living in the home, he/she is not in a separate MFBU from his/her parent/spouse.

E. DHS Acquired Immune Deficiency Syndrome (AIDS) Waiver

1. Description

The AIDS waiver is limited to persons with a diagnosis of Human Immunodeficiency or Acquired Immune Deficiency Syndrome (AIDS) with symptoms related to Human Immunodeficiency Virus (HIV) disease who would otherwise require care in skilled nursing facilities or acute hospitals. Services provided include case management, skilled nursing, attendant care, psycho-social counseling, non-emergency medical transportation, homemaker services, specialized medical equipment and supplies, minor physical adaptations to the home, a limited supplement for infants and children in foster care, nutritional counseling, and nutritional supplements/ home delivered meals.

2. Referring Agency: Office of AIDS

DHS Office of AIDS, Community Based Case Section
611 North 7th Street, P.O. Box 942732
Sacramento, CA 95814
(916) 327-6768 FAX: (916) 327-3177

Applicants for this waiver have had the medical component for waiver inclusion completed prior to referral to the county.

3. Eligibility

No special Medi-Cal eligibility rules apply.

F. Department of Aging Multipurpose Senior Service Program (MSSP) Waiver

1. Description

The MSSP waiver program is limited to the frail elderly who are over sixty-five years of age and receive Medi-Cal under an appropriate aid code. MSSP clients reside in their own homes within a particular service area. Potential clients are screened for eligibility as to Level of Care Determination (LOC) and must be certifiable for placement in a nursing facility. Clients have to be appropriate for case management services and be able to be served within MSSP's cost limitations.

MSSP provides interdisciplinary case management services including the coordination and use of existing community resources. Case managers initiate and oversee the process of assessments, care plan development, service arrangement, ongoing monitoring and reassessments. Clients may be linked to services including but not limited to: housing assistance, protective services, personal care, respite care, transportation, meal services, and special communications. Case managers can authorize the purchase of services with waiver funds when there is no existing community resource to meet client needs. Case managers are responsible for the provision and ongoing review of services in the client's plan of care.

2. Referring Agency: Department of Aging

The California Department of Aging (CDA) has an inter-agency agreement with the Department of Health Services (DHS), which is the single State Medicaid agency. Within CDA, the MSSP Section of the Medi-Cal Services Branch is the unit responsible for reviewing and monitoring MSSP sites for contract compliance. Government and private nonprofit agencies hold contracts to administer MSSP sites at the local level. Referrals for MSSP sites come from a variety of sources including but not limited to: local county agencies, social service and aging organizations, hospitals, home care organizations and a variety of community based organizations.

3. Eligibility

MSSP clients must have one of the following qualifying Medi-Cal aid codes: 10, 14, 16, 18, 1H, 20, 24, 26, 28, 60, 64, 66, 68, and 6H. Three other aid codes may be eligible for MSSP: 17, 27, and 67; these are only eligible with the supplemental identifying aid codes of 1F, 2F or 6F. Applicants who appear eligible for Medi-Cal but are not receiving benefits should be referred to the county welfare department for Medi-Cal eligibility determination. No special Medi-Cal eligibility rules apply.

V. GENERAL PROCESSING INFORMATION

A. Notices of Action (NOA)

All waiver applicants should receive a NOA approving or denying Medi-Cal eligibility. The county will send a NOA to the applicant and a copy to the appropriate State referring agency or Regional Center. Model Nursing and DDS waiver applicants have special NOAs. The Office of AIDS sends out a special NOA. Copies of these NOAs are included in these procedures. NOTE: If the Model waiver applicant is still institutionalized but wishes to know whether he/she would be Medi-Cal eligible or the amount of his/her SOC upon discharge, the Screening Form may be sent to the referring agency indicating this information prior to the regular NOA.

B. Beginning Date of Waiver Eligibility

The effective date of Medi-Cal coverage for applicants of a waiver where the waiver has special eligibility rules should be the date the following two requirements are met:

1. The referring agency determines that it is medically appropriate for the waiver applicant to be in that waiver, and

2. The county determines that the waiver applicant meets the Medi-Cal eligibility requirements under that waiver.

Counties should contact IHO or the Regional Center to determine the effective date unless it is indicated on the referral form. NOTE: Retroactive eligibility rules as stated in Section 50710 of the California Code of Regulations remain in effect.

C. There may be waiver persons requesting In Home Supportive Services (IHSS). The IHSS residual component does not waive parental income and resources of parents or use spousal impoverishment rules; therefore, it is unlikely that the beneficiary will be eligible. Counties may refer these persons to the PCSP component of IHSS; however, a parent or spouse may not be the provider of services.

D. Annual Redetermination

The county shall redetermine eligibility as required by Section 50189. Only information about the waiver beneficiary is required. Counties should check with IHO or the referring Regional Center at the yearly determination to verify that the waiver beneficiary is still medically eligible for the waiver.

E. Medi-Cal Family Budget Unit (MFBU)

Persons in the Model Nursing and DDS waivers are in their own MFBU. Spousal Impoverishment rules apply. Since the waiver person is in his/her own MFBU, the maintenance need or income limit for the waiver person is based on a family size of one. If there are multiple persons in the same household applying for these waivers, each person is in his/her own MFBU. If other family members are applying for or are receiving regular Medi-Cal, the Model or DDS waiver person should be treated similar to public assistance (PA) persons, e.g., they are not in the MFBU with other family members; however, they may be used to link other family members. Persons applying for the other four waivers are considered part of the household if they are determined to be living in the home; therefore, regular Medi-Cal MFBU rules apply. NOTE: It if is more beneficial for the person to be in the MFBU with the other family members, the waiver applicant may choose not to be in the waiver and to be determined under regular Medi-Cal rules. The county should notify the referring agency of this decision.

F. SSI Personal Needs Allowance (PNA)

Effective June 1, 1990, federal law began allowing a former institutionalized SSI child the same PNA as an institutionalized SSI child as long as the non-institutionalized child is in a home and community-based waiver. Because the Social Security Administration (SSA) needs to confirm that such a child is in a waiver before the PNA can begin or that such child remains in a waiver for the PNA to continue, counties may be requested to verify such information at the time waiver coverage begins and then at the SSA redetermination. Since such information is confidential, counties must first have permission from the child's parent or from another appropriate adult before releasing this information to SSA. The DHS 7071 form was developed to secure this parental consent and may be used to release this information to SSA. Although DHS has developed a system to allow the waiver aid code to continue, counties should be aware that in some cases (depending on how SSA enters the information), when the waiver beneficiary begins receiving the PNA, MEDS will convert the waiver aid code to an aid code of 60. If this occurs and the waiver person is still living in the home and is not eligible for a regular SSI payment, counties should contact DHS so this may be corrected.

G. Quality Control

Counties should indicate that a special income and resource determination was used when determining eligibility for persons in the Model and DDS waivers to prevent confusion when persons such as Quality Control review the file. A copy of the DDS referral form or IHO notice should also be in the file.

VI. FORMS

1. Department of Developmental Services Waiver Referral Form (DHS 7096)
2. Spanish DDS Waiver Referral Form (DHS 7096 SP)
3. Model Waiver Screening Form (DHS 7097)
4. Medi-Cal Waiver Information and Authorization [formerly called the "SSI Payments for Disabled Children Living at Home (DHS 7071)]
5. Model Waiver Medi-Cal Eligibility Notice
6. Approval Notice of Action for the DDS Waiver (MC 341)
7. Spanish Approval Notice of Action for the DDS Waiver (MC 341 SP)
8. Denial or Discontinuance Notice of Action for the DDS Waiver (MC 342)
9. Spanish Denial or Discontinuance Notice of Action for the DDS Waiver (MC 342 SP)
10. Approval Notice of Action for the Model Waiver (MC 343)
11. Spanish Approval Notion of Action for the Model Waiver (MC 343 SP)
12. Denial or Discontinuance Notice of Action for the Model Waiver (MC 344)
13. Spanish Denial or Discontinuance Notice of Action for the Model Waiver (MC 344 SP)
14. AIDS Medi-Cal Waiver Program Notice of Action (MCWP2)
15. Spanish AIDS Medi-Cal Waiver Program Notice of Action (MCWP2 SP)
16. Regional Center Contacts
17. In-Home Operations Brochure
18. County Waiver Contacts

DEPARTMENT OF DEVELOPMENTAL SERVICES WAIVER REFERRAL

COUNTY USE ONLY	
Casename	Case number
Worker name	Worker number

CALIFORNIA REGIONAL CENTER—Please complete this portion and forward to the appropriate County Waiver Contact Perso

Name of applicant

Address (number, street)	City	State	ZIP code
Social Security number	Date of birth	Telephone ( )	

Parent/Guardian (if applicable)

Address of parent/guardian (if different)	City	State	ZIP code

STATUS

- ☐ New Medi-Cal applicant.
- ☐ Currently receives Medi-Cal with a share of cost. Reevaluate under special institutional deeming rules.

LIVING ARRANGEMENT

- ☐ The applicant is currently in an institution. *Please determine Medi-Cal eligibility based on his/her anticipated return to the*
  Anticipated date of discharge _____.
- ☐ The applicant is currently living in the home.
- ☐ Other: _____

This is to certify that the individual named above has met the admission criteria for an intermediate care facility for the developm disabled as defined in the California Health and Safety Code, Chapter 2, Section 1250.

Signature of Regional Center contact person

➤

Printed name of Regional Center contact person	Title	Telephone ( )	
Regional Center address (number, street)	City	State	ZIP code

NOTE TO COUNTY: The eligibility determination waives parental and spousal income and resources even applicant lives in the home. See Section 19D of the Medi-Cal Eligibility Procedures Manual. I applicant/beneficiary is entitled to zero share of cost Medi-Cal under regular eligibility rules, no waiver is requirec

Please send a copy of the Notice of Action to the Regional Center when the determination is completed.

White: County copy *Yellow: Regional Center Copy*

DHS 7096 (7/99)

ENVÍO A PROGRAMAS ESPECIALES DEL DEPARTAMENTO QUE PROPORCIONA SERVICIOS A PERSONAS CON INCAPACIDADES ADQUIRIDAS AL NACER O DURANTE EL DESARROLLO

COUNTY USE ONLY	
Case name	Case number
Worker name	Worker number

CENTRO REGIONAL DE CALIFORNIA—Por favor, llene esta parte y envíela a la persona encargada de programas especiales del condac

Nombre del/de la solicitante

Dirección (número, calle)	Ciudad	Estado	Código postal
Numero de Seguro Social	Fecha de nacimiento	Teléfono ( )	

Padre/Madre/Tutor(a) legal (si es pertinente)

Dirección del padre/madre/tutor(a) legal (si es diferente)	Ciudad	Estado	Código postal

SITUACIÓN

- ☐ *Nuevo(a) solicitante* de Medi-Cal.
- ☐ Actualmente recibe Medi-Cal con una parte del costo. Volver a evaluar conforme a reglas institucionales especiales consideradas.

ARREGLOS DE VIVIENDA

- ☐ El/la solicitante vive actualmente en una instalación. Por favor determine la elegibilidad de Medi-Cal basándose en su regreso pr al hogar. Fecha prevista para que se le dé de alta _____.
- ☐ El/la solicitante vive actualmente en el hogar.
- ☐ Otro: _____

Esto es para certificar que el individuo mencionado anteriormente ha cumplido con los requisitos de ingreso a un centro de convale para personas con incapacidades adquiridas al nacer o durante el desarrollo, según se define en la sección 1250, capítulo 2, del Cód Seguridad y Salud de California.

Firma de la persona encargada del Centro Regional

➤

Nombre en letra de molde de la persona encargada del Centro Regional	Título	Teléfono ( )	
Dirección del Centro Regional (número, calle)	Ciudad	Estado	Código postal

NOTA AL CONDADO: La determinación de elegibilidad posterga el ingreso y los recursos paternos/matern conyugales, aun si el/la solicitante vive en el hogar. Vea la sección 19D del Manual de Procedimientos de Elegibil de Medi-Cal. Si el/la solicitante/beneficiario(a) tiene derecho a Medi-Cal sin parte del costo conforme a las re regulares de elegibilidad, no se requiere ninguna postergación.

Por favor, envíe una copia de la Notificación de Acción al Centro Regional cuando se complete la determinación.

White: County copy *Yellow: Regional Center Copy*

DHS 7096 (SP) (7/99)

State of California—Health and Welfare Agency | Department of Hea

MODEL WAIVER SCREENING

COUNTY USE ONLY	
Case name	Case number
Worker name	Worker number

SECTION I: STATE REFERRAL AGENCY IN-HOME OPERATIONS (IHO)—Please complete this portion and forward appropriate county contact person. If the applicant has already been confirmed for the medical portion of the Model Waiver send a copy of the Department of Health Services Medi-Cal MWP Letter 1 instead of this form.

Name of applicant			
Address (number, street)	City	State	ZIP code
Social Security number	Date of birth	Telephone ( )	
Parent/Guardian (if applicable)			
Address of parent/guardian (if different)	City	State	ZIP code

LIVING ARRANGEMENT

- ☐ The applicant is currently in an institution. Please determine Medi-Cal eligibility based on his/her anticipated return to the Anticipated date of discharge _____.
- ☐ The applicant is currently living in the home
- ☐ Other. _____

STATE AGENCY CONTACT (IHO)

Name	Title	Telephone ( )		Date
Address (number, street)		City	State	ZIP code

SECTION II: COUNTY DEPARTMENT OF SOCIAL SERVICES—Please complete and return to IHO as soon as po Completion of this form is based only on information received from the applicant or his/her representative at th of the interview. When the final determination has been made, please also send a copy of the Notice of Action.

TYPE OF DETERMINATION: ☐ Preliminary ☐ Formal

- ☐ The applicant/beneficiary appears/continues to be eligible for Medi-Cal using waiver of parental/spousal income/property rules bu have a share of cost (SOC) of $_____.
- ☐ The applicant/beneficiary appears/continues to be eligible for Medi-Cal using waiver of parental/spousal income/property rules wil SOC.
- ☐ The applicant does *not* appear to be eligible for Medi-Cal using waiver of parental/spousal income/property rules due to his/h excess property/assets.
- ☐ The applicant/beneficiary is eligible for zero SOC Medi-Cal using regular income/property rules; therefore, no waiver is required.

COUNTY CONTACT

Name	Title	Telephone ( )		Date
Address (number, street)		City	State	ZIP code

White. State copy *Yellow: County copy* *Pink: IHO*

DHS 7097 (7/97)

Department of Health Servic

MEDI-CAL WAIVER INFORMATION AND AUTHORIZATION

COUNTY USE ONLY	
Case name	Case number
Worker name	Worker number

Parent/Guardian: If your child was receiving Supplemental Security Income (SSI) payments while in an institution, is under 18 years of age, is not receiving Medi-Cal benefits, is now living at home, and is currently in a home- and community-based waiver program, he/she may be eligible t receive a monthly SSI personal needs payment. Please complete this portion of the form and forward to the County Waiver Person if your child is i a Model or Developmental Services Waiver. For other waivers, forward this form to the State of California, Department of Health Services, Medi-Ca Eligibility Branch, Room 1650, 714 P Street, P.O. Box 942732, Sacramento, CA 94234-7320. After the County or State has verified that your child i in a Medi-Cal waiver, submit this form to the Social Security Administration for a determination. SSA will continue to contact the County or Stat each year prior to continuing the personal needs payment.

Name of child

Address (number, street)	City	State	ZIP code
Social Security number	Date of birth	Telephone ( )	
Parent/Guardian			
Address of parent/guardian (if different)	City	State	ZIP code
Type of waiver			

I, the parent or guardian of the above child, authorize the County of _____ or the State of California to disclose to the Social Security Administration information about the above child's status in the MediCal home- and community-based waiver program.

Signature ➤	Date

COUNTY DEPARTMENT OF SOCIAL SERVICES: Please verify that the above child is currently receiving Medi-Cal benefits at home and is receiving services under the Model or DDS waiver.

I certify that the above named child is receiving Medi-Cal benefits under one of the following home- and community-based waivers:

- ☐ Model Nursing Facilities Waiver (Parental income and resources do not apply.)
- ☐ Developmental Services Waiver (Parental Income and resources do not apply.)

Signature of county authorizing person

➤

Printed name	Title	Telephone ( )	
County address (number, street)	City	State	ZIP code

STATE OF CALIFORNIA, DEPARTMENT OF HEALTH SERVICES: Please verify that the above child is currently receiving Medi-Cal benefits and receiving waiver services.

Signature of state authorizing person

➤

Printed name	Title	Telephone ( )	
State address (number, street)	City	State	ZIP code

White: Parent copy *Yellow: County copy*

DHS 7071 (6/97)

STATE OF CALIFORNIA-HEALTH AND HUMAN SERVICES AGENCY GRAY DAVIS, Governor
DEPARTMENT OF HEALTH SERVICES
700 NORTH TENTH STREET, SUITE 102
P.O. BOX 942732
SACRAMENTO, CA 94234-7320
(916) 324-1020

«DATE»

«PCGNAME»
«PCGADDRESS»
«PCGCITYSTATEZIP»

«SALUTATION»:

MODEL-NURSING FACILITY (NF) WAIVER MEDI-CAL ELIGIBILITY NOTICE

Applicant:	**«BENENAME»**
Social Security Number:	**«SSN»**
Date of Birth:	**«DOB»**
Address:	**«BENEADDRESS»**
Telephone:	**«BENEPHONE»**

This notice is to confirm that the above-named individual has been determined medically eligible for Model-NF waiver services by the Department of Health Services, In-Home Operations (IHO).

It is now necessary for the individual to make an application for Medi-Cal program eligibility, or be redetermined eligible for Medi-Cal as a member of his/her own Medi-Cal Family Budget Unit through the County Welfare Department.

Please contact «COUNTYCONTACT» in «COUNTY» County at «COUNTYPHONE», to make an appointment to complete the Medi-Cal eligibility application. Should you have any questions regarding this notice, please contact me at (916) 324-5941.

Sincerely,

Christine Tsukamoto
Eligibility Analyst
In-Home Operations

cc: «COUNTYCONTACT»
«COUNTYDEPT»
«COUNTYADDRESS»
«COUNTYCITYSTATEZIP»

Note to County: Counties should contact an IHO Eligibility Analyst for the Medi-Cal effective date.

State of California—Health and Human Services Agency

Department of Health Services
Medi-Cal Program

MEDI-CAL
NOTICE OF ACTION
DEPARTMENT OF DEVELOPMENTAL SERVICES
WAIVER
APPROVAL FOR BENEFITS

(COUNTY STAMP)

Notice date: _____

Case number: _____

Worker name: _____

Worker number: _____

Worker telephone: _____

This affects: _____

_____
(Name)

The Department of Developmental Services Waiver program is limited to developmentally disabled persons who live at home and meet the admission criteria for an intermediate care facility for the developmentally disabled.

☐ You are eligible for this program at no cost.

☐ You are eligible for this program with a monthly share-of-cost of $ _____.

Please notify your worker if there are any changes in your medical condition, living situation, income, or property.

Always present your Benefits Identification Card (BIC) to your medical provider whenever you need care. This card is good as long as you are eligible for Medi-Cal. DO NOT THROW AWAY YOUR BIC.

The regulation which requires this action is California Code of Regulations, Title 22, Section 51346.

cc: Regional Center

MC 341 (11/00)

State of California—Health and Human Services Agency

Department of Health Services
Medi-Cal Program

NOTIFICACIÓN DE ACCIÓN DE MEDI-CAL
APROBACIÓN DE LA EXTENSIÓN DE BENEFICIOS DEL DEPARTAMENTO DE SERVICIOS PARA PERSONAS CON INCAPACIDADES ADQUIRIDAS AL NACER O DURANTE EL DESARROLLO

(COUNTY STAMP)

Fecha de la notificación: _____

Número del caso: _____

Nombre del/de la trabajador(a): _____

Número del/de la trabajador(a): _____

Teléfono del/de la trabajador(a) _____

Esto afecta a: _____

_____
(Nombre)

El programa de Extensión de Beneficios del Departamento de Servicios a Personas con Incapacidades Adquiridas al Nacer o Durante el Desarrollo se limita a personas incapacitadas, desde el punto de vista del desarrollo, que viven en el hogar, y que cumplen con los criterios de ingreso de un centro de convalecencia de cuidados intermedios para las personas incapacitadas desde el punto de vista del desarrollo.

☐ Usted reúne los requisitos para este programa sin costo alguno.

☐ Usted reúne los requisitos para este programa con una parte del costo mensual de $_____.

Por favor, notifique a su trabajador(a), si hay algún cambio en su condición médica, situación de vivienda, ingresos o bienes.

Siempre presente su Tarjeta de Identificación de Beneficios *(BIC)* a su proveedor médico, cada vez que necesite atención. Esta tarjeta es válida mientras usted reúna los requisitos para recibir beneficios de Medi-Cal. NO TIRE SU *BIC*.

La regulación que exige esta acción es la Sección 51346, del Título 22, del Código de Regulaciones de California.

cc: Centro Regional

MC 341 (SP) (11/00)

State of California—Health and Human Services Agency

Department of Health Services
Medi-Cal Program

MEDI-CAL
NOTICE OF ACTION
DEPARTMENT OF DEVELOPMENTAL SERVICES WAIVER
DENIAL OR DISCONTINUANCE OF BENEFITS

(COUNTY STAMP)

Notice date: _____

Case number: _____

Worker name: _____

Worker number: _____

Worker telephone: _____

This affects: _____

_____
(Name)

The Department of Developmental Services Waiver program is limited to developmentally disabled persons who live at home and meet the admission criteria for an intermediate care facility for the developmentally disabled.

Your benefits under this program will be discontinued effective the last day of _____.

☐ Your application date of _____ is denied.

Here is/are the reason(s) why:

☐ Your property is over the limit of _____.

☐ The regional center has informed us that you are no longer eligible for waiver services.

☐ You are now living in a community care facility.

You will receive another notice if you are eligible for another Medi-Cal program.

DO NOT THROW AWAY YOUR PLASTIC BENEFITS IDENTIFICATION CARD (BIC). You can use it again if you become eligible or are eligible for another Medi-Cal program.

The regulation which requires this action is California Code of Regulations, Title 22, Section 51346.

cc: Regional Center

MC 342 (11/00)

State of California—Health and Human Services Agency

Department of Health Services
Medi-Cal Program

NOTIFICACIÓN DE ACCIÓN DE MEDI-CAL

NEGACIÓN O DESCONTINUACIÓN DE LA EXTENSIÓN DE BENEFICIOS DEL DEPARTAMENTO DE SERVICIOS A PERSONAS CON INCAPACIDADES ADQUIRIDAS AL NACER O DURANTE EL DESARROLLO

(COUNTY STAMP)

Fecha de la notificación: _____

Número del caso: _____

Nombre del/de la trabajador(a): _____

Número del/de la trabajador(a): _____

Teléfono del/de la trabajador(a): _____

Esto afecta a: _____

_____
(Nombre)

El programa de Extensión de Beneficios del Departamento de Servicios a Personas con Incapacidades Adquiridas al Nacer o Durante el Desarrollo se limita a personas incapacitadas desde el punto de vista del desarrollo, que viven en el hogar y que cumplen con los criterios de ingreso de un centro de convalecencia de cuidados intermedios para las personas incapacitadas desde el punto de vista del desarrollo.

Sus beneficios bajo este programa se descontinuarán a partir del último dia de _____.

☐ Su fecha de solicitud del _____ se niega.

A continuación se le da(n) la(s) razón(es):

☐ Sus bienes están por encima del límite de _____.

☐ El centro regional nos ha informado que usted ya no reúne los requisitos para los servicos de extensión.

☐ Usted ahora vive en un establecimiento de cuidado en la comunidad.

Usted recibirá otra notificación, si usted reúne los requisitos para otro programa de Medi-Cal.

NO TIRE SU TARJETA DE IDENTIFICACIÓN DE BENEFICIOS DE PLÁSTICO *(BIC)*. Usted puede usarla de nuevo si reúne los requisitos para otro programa de Medi-Cal.

La regulación que exige esta acción es la Sección 51346, del Título 22, del Código de Regulaciones de California.

cc: Centro Regional

MC 342 (SP) (11/00)

State of California—Health and Human Services Agency

Department of Health Services
Medi-Cal Program

MEDI-CAL
NOTICE OF ACTION
MODEL NURSING FACILITY WAIVER
APPROVAL FOR BENEFITS

(COUNTY STAMP)

Notice date: _____

Case number: _____

Worker name: _____

Worker number: _____

Worker telephone number: _____

Worker hours: _____

This affects: _____

_____
(Name)

The Model Nursing Facility Waiver program is limited to persons who require the nursing facility level of care or subacute services but who wish to live at home or in the community. The income and property of a parent or spouse is not used in the determination for the applicant or beneficiary.

☐ You are eligible for this program at no cost.

☐ You are eligible for this program with a monthly share-of-cost of $ _____.

- You do not have to fill out monthly or quarterly status reports to get Medi-Cal.
- You must report within ten days any changes in your income, property, medical condition, or household situation.
- You will have to complete a form for your Medi-Cal annual review.
- Getting Medi-Cal does not reduce any time limits for the CalWORKS program.

Please notify your worker if there are any changes in your medical condition, living situation, income, or property.

Always present your Benefits Identification Card (BIC) to your medical provider whenever you need care. This card is good as long as you are eligible for Medi-Cal. DO NOT THROW AWAY YOUR BIC.

The regulation which requires this action is California Code of Regulations, Title 22, Section 51346.

cc: In-Home Operations

MC 343 (1/01)

State of California—Health and Human Services Agency

Department of Health Services
Medi-Cal Program

NOTIFICACIÓN DE ACCIÓN DE MEDI-CAL
APROBACIÓN DE BENEFICIOS DEL PROGRAMA DE SERVICIOS DE EXTENSIÓN EN UN CENTRO DE CONVALECENCIA MODELO

(COUNTY STAMP)

Fecha de la notificación: _____

Número del caso: _____

Nombre del/de la trabajador(a): _____

Número del/de la trabajador(a): _____

Teléfono del/de la trabajador(a): _____

Horario del/de la trabajador(a): _____

Esto afecta a: _____

_____
(Nombre)

El Programa de Servicios de Extensión en un Centro de Convalecencia Modelo *(Model Nursing Facility Waiver)* se limita a personas que necesitan el nivel de atención de un centro de convalecencia o de servicios subagudos, pero que desean vivir en sus hogares o en la comunidad. Los ingresos y bienes de uno de los padres o cónyuges no se utilizan en la consideración del/de la solicitante o beneficiario(a).

☐ Usted reúne los requisitos para recibir beneficios bajo este programa, sin costo alguno.

☐ Usted reúne los requisitos para recibir beneficios bajo este programa, con una parte del costo mensual de $ _____.

- Usted no tiene que llenar reportes sobre la situación mensuales ni trimestrales para obtener beneficios de Medi-Cal.
- Usted tiene que reportar, en un plazo de diez días, cualquier cambio en sus ingresos, bienes, condición médica o situación en el hogar.
- Usted tendrá que completar un formulario para su evaluación anual de Medi-Cal.
- El obtener Medi-Cal no reduce ningún límite de tiempo para el programa *CalWORKS*.

Por favor, notifíquele a su trabajador(a), si hay algún cambio en su condición médica, situación de vivienda, ingresos o bienes.

Siempre presente su Tarjeta de Identificación de Beneficios *(BIC)* a su proveedor médico, cada vez que necesite atención. Esta tarjeta es válida mientras usted reúna los requisitos para recibir beneficios de Medi-Cal. NO TIRE SU TARJETA *BIC*.

La regulación que exige esta acción es la Sección 51346, del Título 22, del Código de Regulaciones de California.

cc: In-Home Operations

MC 343 (SP) (1/01)

State of California—Health and Human Services Agency

Department of Health Services
Medi-Cal Program

MEDI-CAL
NOTICE OF ACTION
MODEL NURSING FACILITY WAIVER
DENIAL OR DISCONTINUANCE OF BENEFITS

(COUNTY STAMP)

Notice date: _____

Case number: _____

Worker name: _____

Worker number: _____

Worker telephone number: _____

This affects: _____

_____
(Name)

The Model Nursing Facility Waiver program is limited to persons who require the nursing facility level of care or subacute services but who wish to live at home or in the community. The income and property of a parent or spouse is not used in the determination for the applicant or beneficiary.

☐ Your benefits under this program will be discontinued effective the last day of _____.

☐ Your application date of _____ is denied.

Here is/are the reason(s) why:

☐ Your property is over the limit of $_____.

☐ You no longer have nursing services.

☐ You are no longer/not living in the home.

You will receive another notice if you are eligible for another Medi-Cal program.

DO NOT THROW AWAY YOUR PLASTIC BENEFITS IDENTIFICATION CARD (BIC). You can use it again if you become eligible or are eligible for another Medi-Cal program.

The regulation which requires this action is California Code of Regulations, Title 22, Section 51346.

cc: In-Home Operations

MC 344 (1/01)

State of California—Health and Human Services Agency

Department of Health Services
Medi-Cal Program

NOTIFICACIÓN DE ACCIÓN DE MEDI-CAL
NEGACIÓN O DESCONTINUACIÓN DE BENEFICIOS DEL PROGRAMA DE SERVICIOS DE EXTENSIÓN EN UN CENTRO DE CONVALECENCIA MODELO

(COUNTY STAMP)

Fecha de la notificación: _____
Número del caso: _____
Nombre del/de la trabajador(a): _____
Número del/de la trabajador(a): _____
Teléfono del/de la trabajador(a): _____
Horario del/de la trabajador(a): _____
Esto afecta a: _____

_____
(Nombre)

El Programa de Servicios de Extensión en un Centro de Convalecencia Modelo *(Model Nursing Facility Waiver)* se limita a personas que necesitan el nivel de atención de un centro de convalecencia o de servicios subagudos, pero que desean vivir en sus hogares o en la comunidad. Los ingresos y bienes de uno de los padres o cónyuges no se utilizan en la consideración del/de la solicitante o beneficiario(a).

☐ Sus beneficios bajo este programa se descontinuarán a partir del último día de_____.

☐ La fecha de su solicitud del _____ se ha negado.

Enseguida se da(n) la(s) razón(es):

☐ Sus bienes están por encima del límite de $_____.

☐ Usted ya no recibe servicios de convalecencia.

☐ Usted ya no vive en el hogar.

Usted recibirá otra notificación si usted reúne los requisitos para otro programa de Medi-Cal.

NO TIRE SU TARJETA DE IDENTIFICACIÓN DE BENEFICIOS *(BIC).* Usted puede utilizarla de nuevo, si vuelve a reunir o reúne los requisitos para recibir beneficios de otro programa de Medi-Cal.

La regulación que exige esta acción es la Sección 51346, del Título 22, del Código de Regulaciones de California.

cc: In-Home Operations

MC 344 (SP) (1/01)

AIDS Medi-Cal Waiver Program
NOTICE OF ACTION (NOA)
DENIAL/REDUCTION/TERMINATION OF AIDS MEDI-CAL WAIVER BENEFITS

Name _____ **Date of Notice** _____

Address _____ **Medi-Cal I.D. #** _____

_____ **Waiver I.D. #** _____

Date Services Expire _____

Medi-Cal regulations allow for the provision of certain AIDS Medi-Cal Waiver Program (MCWP) Home and Community-Based Services (HCBS) to persons who meet specific criteria. We have taken the following action with respect to services requested: for the reasons noted:

___ 1. Denied your application or ended services for causes such as program noncompliance or personal safety of caregivers or agency staff, specifically
_____.

___ 2. Denied your application or ended services because you do not meet eligibility requirements as follows:

☐ You have not submitted adequate proof of Medi-Cal eligibility, your Medi-Cal eligibility cannot be verified or you are not eligible or no longer eligible for Medi-Cal.

☐ Your medical condition and/or medical needs do not currently meet the Nursing Facility or higher level of care and/or or your diagnosis of asymptomatic HIV or AIDS does not meet eligibility requirements, or your score on the evaluation that is used (the Cognitive and Functional Ability Scale) was too low.

___ 3. Denied and/or reduced some portion of the services requested. Your medical condition and/or medical needs have improved necessitating a change in services ordered.

___ 4. Continuing to provide HCBS to you is not cost effective (i.e., the estimated cost of providing you with those services exceeds cost guidelines set by the State).

___ 5. Cost of services provided to you has reached the $13,209 calendar year annual cost cap. No more AIDS Medi-Cal Waiver services can be provided to you this calendar year.

___ 6. The services you need are fully available to you through private insurance, Medicare, Medi-Cal, or another program.

___ 7. You no longer desire HCBS.

___ 8. Other_____

This NOA is required by Code of Federal Regulations, Title 42, Chapter IV, Subpart E, and the California Code of Regulations, Title 22, Section 51346. You have the right to ask for a State Hearing (SH) if you disagreed with any MCWP action. You only have ninety (90) days to ask for a hearing. The 90 days started the day after the MCWP gave or mailed you this notice. See page 2 for your appeal rights.

Denial or termination of AIDS MCWP benefits will not affect other medical or social services you are eligible to receive through California's Medi-Cal Program or other public benefit programs.

You may reapply for AIDS MCWP benefits at a future time if you believe you have become eligible.

Please call me for further information or if you have any questions. I may be reached at (_____) _____.

Sincerely,

_____ _____
Agency Representative Agency Name

STATE HEARING NOTICE - YOUR RIGHT TO APPEAL THE "NOTICE OF ACTION"

State Hearing Instructions--If you do not agree with the action described, you may request a State Hearing before an Administrative Law Judge employed by the California Department of Social Services (CDSS). This hearing will be conducted in an informal manner to assure that everyone present is able to speak freely. Your case manager can help you request a hearing. If you decide to request a hearing, you must do so within 90 days of the date of this notice. Your benefits will only continue until the *Services Expiration Date* listed at the top of page 1 which is at least 10 days from the date of this notice. If you are currently receiving AIDS MCWP services and you request a SH before the **Date Services Expire** indicated at the top of this notice (at least10 days after the date of this notice), you will continue to receive services until a SH decision is made. If you are currently receiving AIDS MCWP services and you request a SH after the **Date Services Expire**, your AIDS MCWP services will stop on the **Date Services Expire.** You must verbally notify your case manager if you file an appeal within this 10-day period.

If you wish to request a State Hearing, please complete the attached *Request for a State Hearing* form and mail it to the address listed below or call the phone number provided. You must provide all the information on the form; any information missing from the request form may delay the processing of your State Hearing request. If you ask for a hearing the State Hearings Division will set up a file. You have the right to see this file before your hearing and to get a copy of the AIDS waiver provider's written position on your case at least two days before the hearing. The SHD may give your hearing file to the California Department of Health Services and the United States Department of Health and Human Services per Welfare and Institutions Code Sections 10850 and 10950.

How to Request a State Hearing—You must either complete the attached *Request for a State Hearing* form and mail it to:

California Department of Social Services
State Hearings Division
P.O. Box 944243
Sacramento, CA 94244-2430

Or call

Toll-Free Number: (800) 952-5253
Teletypewriter (TTY only: (800) 952-8349

"Your Rights" Pamphlet Available--"Your Rights under California Welfare Programs pamphlet" issued by CDSS, provides useful information about State hearings. This pamphlet will be sent to you when your hearing request is processed.

Authorized Representative--You can represent yourself at the State Hearing or be represented by a friend, attorney, or any other person; but, you are expected to arrange for the representative yourself. You can get help in locating free legal assistance by calling the toll-free number of the Public Inquiry and Response Unit (PIAR) at (800) 952-5253.

The PIAR office can also provide further information about your hearing rights. Assistance is available in languages other than English, including Spanish.

Code of Federal Regulations, Title 42,Section 431.220, Subpart E, Chapter IV, and the California Code of Regulations, Title 22, Section 51014.1, require that this **Notice of Action/State Hearing Notice** be mailed at time of denial of an application when it is determined that you are not eligible for waiver services or at time of reduction or termination of existing services. The Notice must be mailed **at least 10 calendar days** (excluding the mailing date) before the effective date of reduction or termination of services.

Attachment

REQUEST FOR A STATE HEARING

Name	**Medi-Cal I.D. Number**
Address	**City**

I am requesting a State Hearing because of Medi-Cal related action by _____, an AIDS Medi-Cal Waiver agency related to the following reason(s):

- ☐ Denial of my application or ending of services for causes such as noncompliance or personal safety of caregivers or agency staff **OR**
- ☐ Denial of my application or ending of services because I do not meet eligibility requirements **OR**
- ☐ Denial and/or reduction of some portion of the service(s) requested **OR**
- ☐ Ending of services because it is no longer cost effective to do so or the costs of services provided have reached the $13,209 calendar year annual cost cap.
- ☐ Denial of my application or ending of services because services I need are fully available through private insurance, Medicare, Medi-Cal, or another program or I no longer desire Home and Community Based services.
- ☐ Other _____

Describe the basis for your appeal below:

_____

_____

_____

☐ I speak a language other than English and need an interpreter for my hearing. (The State will provide the interpreter at no cost to you.)

Language:	Dialect:

☐ I want the person named below to represent me at this hearing. I give my permission for this person to see my records or go to the hearing for me. (This person can be a friend or relative but cannot interpret for you.)

Name: _____ Phone Number: _____

Street Address: _____

City: _____ State _____ Zip Code _____

Signature: _____

Mail to: California Department of Social Services
State Hearings Division
P.O. Box 944243
Sacramento, CA 94244-2430
Toll-Free Number: (800) 952-5253
Teletypewriter (TTY) only: (800) 952-8349

The AIDS Medi-Cal Waiver Program is administered by the Community Based Care Section, Office of AIDS, Department of Health Services, 611 N. Seventh Street, P.O. Box 942732, Sacramento, CA 94234-7320, (916) 445-0553.

MCWP2 (rev 02-2001)

Programa de Exención para Personas con el Sindrome de Inmunodeficiencia Adquirida (SIDA) bajo el Programa de Asistencia Médica de California (Medi-Cal)
NOTIFICACION DE ACCION (NOA)
NEGACION/REDUCCION/DESCONTINUACION DE LOS BENEFICIOS DE ESTE PROGRAMA

Nombre _____ **Fecha de la notificación** _____

Dirección _____ **Medi-Cal - # de identificación** _____

_____ **Exención - # de identificación** _____

Fecha en que los servicios se descontinuarán _____

Los reglamentos de Medi-Cal permiten que se proporcionen ciertos servicios de casa y servicios basados en la comunidad (HCBS) a través del Programa de Exención bajo el Programa de Medi-Cal (MCWP) para Personas con SIDA si estas personas cumplen con los requisitos específicos. En relación a los servicios que se solicitaron, hemos tomado la siguiente acción debido a las razones indicadas:

___ 1. Negamos su solicitud o descontinuamos sus servicios debido a motivos tales como la falta de cumplimiento con los requisitos del programa o problemas en relación a la seguridad personal de los proveedores de cuidado o del personal de la agencia/oficina, especificamente
_____.

___ 2. Negamos su solicitud o descontinuamos sus servicios debido a que usted no cumple con los requisitos de elegibilidad como se indica a continuación:

☐ Usted no ha presentado las pruebas adecuadas de elegibilidad para Medi-Cal, su elegibilidad para Medi-Cal no se *puede verificar, o no es o ha dejado de ser elegible para* Medi-Cal.

☐ *Actualmente,* su condición médica y/o sus necesidades médicas no cumplen con los requisitos para el cuidado en un establecimiento de cuidado médico continuo no intenso o a un nivel más alto y/o el diagnóstico de que usted tiene el virus de inmunodeficiencia humana (VIH) o SIDA sin presentar síntomas no cumple con los requisitos de elegibilidad, o su clasificación en la evaluación que se *utiliza (la tabla de habilidad cognoscitiva y habilidad para* funcionar) fue demasiado baja.

___ 3. Negamos y/o redujimos una porción de los servicios que se solicitaron. Su condición médica y/o sus necesidades médicas han mejorado lo cual ocasionó un cambio en los servicios que se ordenaron.

___ 4. El continuar proporcionándole los servicios HCBS ya no es lo más económico (es decir, el costo calculado para proporcionarle a usted esos servicios es más que las normas de costo establecidas por el Estado).

___ 5. El costo de los servicios que se le han proporcionado ha alcanzado los $13,209 que es lo máximo permitido anualmente para un año civil. Para este año civil, ya no puede recibir más servicios bajo el MCWP para Personas con SIDA.

___ 6. Los servicios que usted necesita están completamente disponibles a través de su seguro privado, Medicare (seguro médico federal), *Medi-Cal, u otro programa.*

___ 7. Usted ya no quiere los servicios HCBS.

___ 8. Otra razón: _____

Esta notificación de acción es un requisito del Código de Ordenamientos Federales, Título 42, Capítulo IV, Subparte E, y el Código de Ordenamientos de California, Título 22, Sección 51346. Usted tiene derecho a solicitar una audiencia con el estado (SH) si usted no está de acuerdo con alguna acción en relación al MCWP. Tiene solamente noventa (90) días para solicitar una audiencia. Los 90 días empezaron a contar al siguiente día de cuando el MCWP le dio o le envió por correo esta notificación. Para los derechos que tiene para apelar, vea la página 2.

La negación o descontinuación de los beneficios del MCWP para Personas con SIDA no afectará otros servicios médicos o sociales para los cuales usted es elegible bajo el Programa de Medi-Cal u otros programas de beneficios públicos.

En el futuro, puede volver a solicitar los beneficios del MCWP para Personas con SIDA si usted cree que ya es elegible.

Para más información o si tiene alguna pregunta, por favor llámeme. Mi número de teléfono es (___) _____.

Atentamente.

_____ _____
Representante de la agencia/oficina Nombre de la agencia/oficina

NOTIFICACION DE UNA AUDIENCIA CON EL ESTADO - SU DERECHO A APELAR LA "NOTIFICACION DE ACCION"

Instrucciones en relación a una audiencia con el estado--Si usted no está de acuerdo con la acción descrita, usted puede solicitar una audiencia con el estado ante un juez de leyes administrativas empleado por el Departamento de Servicios Sociales de California (CDSS). Esta audiencia se llevará a cabo en una manera informal para asegurar que todas las personas presentes puedan hablar libremente. La persona encargada de su caso puede ayudarle a solicitar una audiencia. Si usted decide solicitar una audiencia, tiene que hacerlo antes de que pasen 90 días a partir de la fecha de esta notificación. Sus beneficios solamente continuarán hasta la **"Fecha en que los beneficios se descontinuarán"** que aparece en la parte de arriba de la página 1, la cual es al menos 10 días después de la fecha de esta notificación. Si actualmente está recibiendo servicios bajo el MCWP para Personas con SIDA y usted solicita una audiencia con el estado antes de la **"Fecha en que los beneficios se descontinuarán"** anotada en la parte de arriba de esta notificación (al menos 10 días después de la fecha de esta notificación), usted continuará recibiendo los servicios hasta que se emita la decisión de la audiencia con el estado. Si actualmente está recibiendo servicios bajo el MCWP para Personas con SIDA y usted solicita una audiencia con el estado después de la **"Fecha en que los beneficios se descontinuarán"**, los servicios se descontinuarán en dicha fecha. Si usted presenta una apelación antes que se termine el período de 10 días, tiene que notificarle verbalmente al trabajador encargado de su caso.

Si desea solicitar una audiencia con el estado, por favor complete el formulario de "Petición para una audiencia con el estado" adjunto y envíelo por correo a la dirección que aparece abajo o llame al número de teléfono que se proporciona. Usted tiene que proporcionar toda la información en el formulario; cualquier información que falte en el formulario pudiera atrasar la tramitación de su petición para una audiencia con el estado. Si usted solicita una audiencia, la División de Audiencias Administrativas preparará un expediente. Al menos dos días antes de su audiencia, usted tiene derecho a ver su expediente y a recibir una copia escrita de la declaración de posición sobre su caso del proveedor de la exención para las personas con SIDA. De acuerdo a lo estipulado en las Secciones 10850 y 10950 del Código de Bienestar Público e Instituciones, la División de Audiencias Administrativas puede darle su expediente de la audiencia al Departamento de Servicios de Salud de California y al Departamento de Servicios de Salud y Servicios Humanos de los Estados Unidos.

Cómo solicitar una audiencia con el estado—**Usted puede completar el formulario de "Petición para una audiencia con el estado" adjunto y enviarlo por correo al Departamento de Servicios Sociales de California (CDSS) a la siguiente dirección:**

California Department of Social Services
State Hearings Division
P.O. Box 944243
Sacramento, CA 94244-2430

o puede llamar al
Número de teléfono gratuito: (800) 952-5253
Teletipo (TTY) solamente: (800) 952-8349

Folleto disponible acerca de sus derechos--El folleto "Sus derechos bajo los programas de asistencia pública de California" publicado por el CDSS le proporciona información útil acerca de las audiencias con el estado. Le enviarán este folleto una vez que se tramite su petición para una audiencia.

Representante autorizado--En la audiencia con el estado, se puede representar a sí mismo o puede ser representado por un amigo, abogado, o cualquier otra persona; pero, usted tiene que hacer los arreglos para tener a un representante. Puede obtener ayuda para localizar asesoramiento legal sin costo llamando al número de teléfono gratuito de la Oficina de Preguntas y Respuestas al Público (PIAR) al (800) 952-5253.

La Oficina de PIAR también le puede proporcionar más información acerca de sus derechos en relación a una audiencia. Esta información se proporciona en varios idiomas aparte del inglés, incluyendo el español.

La Sección 431.220 del Código de Ordenamientos Federales, Título 42, Capítulo IV, Subparte E, y la Sección 51014.1 del *Código de Ordenamientos de California, Título 22, estipulan* que esta **Notificación de acción/Notificación de una audiencia con el estado** se tiene que enviar por correo cuando se niegue una solicitud debido a que se determinó que usted ya no es elegible para los servicios bajo una exención o cuando se reduzcan o descontinúen los servicios actuales. La notificación se tiene que enviar por correo **al menos 10 días consecutivos** (excluyendo la fecha en que se envió) antes de la fecha en que entre en vigor la reducción o descontinuación de los servicios.

PETICION PARA UNA AUDIENCIA CON EL ESTADO

Nombre	**Número de identificación de Medi-Cal**
Dirección	**Ciudad**

Estoy solicitando una audiencia con el estado debido a una acción relacionada a Medi-Cal que tomó _____, una agencia/oficina que *proporciona* exenciones para personas con SIDA para el Programa de Medi-Cal. El motivo (o motivos) aparece a continuación:

☐ Negación de mi solicitud o descontinuación de los servicios debido a motivos tales como la falta de cumplimiento con los requisitos del programa o problemas en relación a la seguridad personal de los proveedores de cuidado o del personal de la agencia/oficina, O

☐ Negación de mi solicitud o descontinuación de los servicios debido a que no cumplo con los requisitos de elegibilidad, O

☐ Negación y/o reducción de una porción de los servicios solicitados, O

☐ Descontinuación de los servicios debido a que el proporcionar los servicios ya no es lo más económico o porque el costo de los servicios proporcionados ha alcanzado los $13,209 que es lo máximo permitido anualmente para un año civil.

☐ Negación de mi solicitud o descontinuación de los servicios debido a que los servicios que necesito están completamente disponibles a través de un seguro privado, Medicare (seguro médico federal), Medi-Cal, u otro programa o debido a que yo ya no quiero los servicios de casa y basados en la comunidad.

☐ Otro motivo: _____

Describa a continuación en que se basa su apelación:

_____

_____

_____

☐ Hablo otro idioma que no es el inglés y necesito un intérprete para mi audiencia. (El Estado le proporcionará un intérprete sin costo para usted.)

Idioma:	Dialecto:

☐ Quiero que la persona cuyo nombre aparece a continuación me represente en esta audiencia. Otorgo el permiso para que esta persona vea mis expedientes o asista a la audiencia en mi nombre. (Esta persona puede ser un amigo o pariente pero no puede ser su intérprete.)

Nombre: _____ Número de teléfono: _____

Domicilio: _____

Ciudad: _____ Estado _____ Código postal _____

Firma:

Envíe por correo a: California Department of Social Services
State Hearings Division
P.O. Box 944243
Sacramento, CA 94244-2430
Número de teléfono gratuito: (800) 952-5253
Teletipo (TTY) solamente: (800) 952-8349

El Programa de Exención para Personas con SIDA bajo el Programa de Medi-Cal es administrado por la Sección del Cuidado Basado en la Comunidad en la Oficina del SIDA en el Departamento de Servicios de Salud; la dirección y número de teléfono son: *AIDS Medi-Cal Waiver Program, Community Based Care Section, Office of AIDS, Department of Health Services, 611 N. Seventh Street, P.O. Box 942732, Sacramento, CA 94234-7320, (916) 445-0553.*

MCWP (SP) (Rev. 02-2001)

MCWP2 (SP) (Rev. 12-2000) Attachment

March 22, 2001

CONTACTS FOR REGIONAL CENTERS 360 - 370

	REGIONAL CENTER	MEDICAID WAIVER COORDINATOR	ALTERNATE MEDICAID WAIVER COORDINATOR
360	FRANK D. LANTERMAN REGIONAL CENTER 3303 Wilshire Boulevard, Suite 700 Los Angeles CA 90010	Ardis Adrian, R.N. (213) 383-1300 X 746 (213) 383-6526 (FAX) ardis.adrian@lanterman.org	Grace Kotchouian, R.N. (213) 383-1300 Sylvia Flores (213) 383-1300 X 006
361	GOLDEN GATE REGIONAL CTR. 120 Howard Street, Fourth Floor San Francisco, CA 94105-1848	Candace Sultan, R.N. (415) 546-9222 X 400 candacepge@aol.com	Carla Kania, R.N. (415) 546-9222 X 200 (415) 546-9203 (FAX)
362	SAN DIEGO REGIONAL CENTER 14355 Ruffin Road, suite 205 San Diego, CA 92123-1648	Carol Jean Thomas, QMRP (858) 576-2985 cjthomas@sdrc.org	Roy Carroll, QMRP (858) 576-2992 (858) 496-4327 (FAX)
363	FAR NORTHERN REGIONAL CTR. 1377 East Lassen Avenue Chico, CA 95973	Mary McCart, QMRP (530) 895-8633 X 248 mmccart@farnorthernrc.org	(530) 895-1501 (FAX)
364	ALTA CALIFORNIA REGIONAL CENTER 2135 Butano Drive Sacramento, CA 95825	Peggy Ann Feldt, RNMS, QMRP (916) 978-6378 pfeldt@altaregional.org	(916) 489-1380 (FAX)
365	SAN ANDREAS REGIONAL CTR. 300 Orchard City Drive, Suite 170 Campbell, CA 95008	Michael Kottke, QMRP (408) 341-3529 sakottke@sarc.org	Ken Heritier, QMRP (408) 341-3514 (408) 376-0586 (FAX)
366	TRI-COUNTIES REGIONAL CTR. 520 East Montecito Santa Barbara, CA 93103	Rosie Ray, Manager *Federal Programs* (805) 884-7210 tc4lu@tri-counties.org	(805) 884-9374 (FAX)
367	CENTRAL VALLEY REGIONAL CENTER 5168 North Blythe Avenue Fresno, CA 93722-6429	Holly Lovett, QMRP (559) 738-2210 1945 East Noble Visalia, CA 93292-1516 hlovett@cvrc.org	Karen Champagne, QMRP (559) 738-2254 (559) 738-2265 (FAX)
368	RC OF ORANGE COUNTY 801 Civic Center Drive, Suite 300 Santa Ana, CA 92701	Katherine Long, MA (714) 796-5220 klong@rcocdd.com	(714) 796-3021 (FAX)
369	INLAND REGIONAL CENTER 674 Brier Drive San Bernardino, CA 92408	Margie Henderson (909) 890-3425 (909) 890-3007 (FAX) mhenderson@inlandrc.org	Clarice Schnepf, R.N. (909) 890-3428 (909) 890-3001 (FAX) cschnepf@inlandrc.org
370	REDWOOD COAST REGIONAL CENTER 525 Second Street, Suite 300 Eureka, CA 95501	Tina Moulton (707) 445-0893 X 363 tmoulton@redwoodcoastrc.org	(707) 444-3409 (FAX)

March 22, 2001

CONTACTS FOR REGIONAL CENTERS 371 - 380

REGIONAL CENTER	MEDICAID WAIVER COORDINATOR	ALTERNATE MEDICAID WAIVER COORDINATOR
371 NORTH BAY REGIONAL CENTER 10 Executive Court, Suite A Napa, CA 94558	**Julia Riccobono, QMRP** (707) 256-1276 juliar@nbrc.net	(707) 256-1112 (FAX)
372 KERN REGIONAL CENTER 3200 North Sillect Avenue Bakersfield, CA 93308	**Nancy Randall, R.N.** (661) 327-8531 x 246 nrandall@kemrc.org	**Melvina Mull** (661) 327-8531 x 368 mmull@kemrc.org (661) 324-5060 (FAX)
373 EAST LOS ANGELES RC 1000 South Fremont Avenue Alhambra, CA 91802-7916	**Jessie Valdez, Manager of Specialized Svs., QMRP** (626) 299-4719 jvaldez@elarc.org	**Judy Matthews, RN** (626) 299-4788 (626) 281-1163 (FAX)
374 SOUTH CENTRAL LARC 650 West Adams Blvd, Suite 400 Los Angeles, CA 90007	**Fezem Shabaf, RN** (213) 744-8850 fezems@sclarc.org	**Irene Olsakowski, RN** (213) 744-8872 (213) 744-8888 (FAX)
375 HARBOR REGIONAL CENTER Del Amo Business Plaza 21231 Hawthorne Boulevard Torrance, CA 90503	**Paula Fiebert, QMRP** (310) 543-0615 paulaf@hddf.com	**Laura Garabedian, R.N.** (310) 543-1711 (310) 540-9538 (FAX)
376 WESTSIDE REGIONAL CENTER 5901 Green Valley Circle, #320 Culver City, CA 90230-6938	**Bill Feeman, RN** (310) 258-4132 billf@westsiderc.org	**Dorothy Garrison, RN** (310) 258-4161 (310) 338-9744 (FAX)
377 VALLEY MOUNTAIN REGIONAL CENTER 7109 Danny Way Stockton, CA 95269	**Katina Richison, QMRP** (209) 955-3616 krichison@vmrc.net (209) 473-3539 (FAX)	**Joyce Young-Lofton, RN QMRP** (209) 529-2626 X 2133 (Modesto) (209) 955-3276 (Stockton)
378 NORTH LOS ANGELES RC 15400 Sherman Way, Suite 170 Van Nuys, CA 91406-4211	**Laura Rankin, QMRP** (818) 756-6270 laurar@nlacrc.com	**Maria Bratley** (818) 756-6381 (818) 756-6390 (FAX)
379 SAN GABRIEL/POMONA RC 761 Corporate Center Drive Pomona, CA 91768	**Elizabeth Wilson, QMRP** (909) 868-7793 ewilson@sgprc.org	**Liz Peery** (909) 868-7655 (909) 622-5123 (FAX) **Letha Sellars** (909) 868-7518
380 EAST BAY REGIONAL CENTER 7677 Oakport Street, Suite 1200 Oakland, CA 94621	**Bev Davis, QMRP** (510) 383-1281 (Direct) bdavis@rceb.org	(510) 633-5020 (FAX)

Medi-Cal Operations Division

IN-HOME OPERATIONS

HOME AND COMMUNITY-BASED OPTIONS

IN-HOME OPERATIONS CONTACT INFORMATION

MEDICAL CARE COORDINATION AND CASE MANAGEMENT SECTION-
In-Home Operations (IHO)

700 North 10th Street, Suite 102
PO Box 942732
Sacramento, CA 94234-7320
(916) 324-1020
(916) 324-0981 FAX

IHO Intake Unit

New Intakes/Information
(916) 324-5903/5915
(888) 899-2492 FAX Toll Free
(916) 324-5544 FAX (916 area code)

IHO Case Management Units

Sacramento Regional Office
(916) 324-1020

Los Angeles Regional Office
311 South Spring Street, 3rd Floor
P.O. Box 30650
Los Angeles, CA 90030

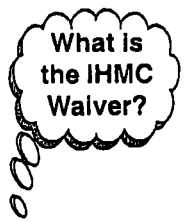
(213) 897-6774
(213) 897-7355/9314 FAX

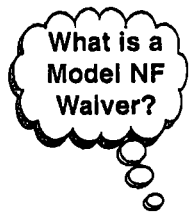
Gray Davis
Governor
State of California

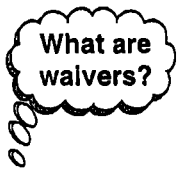
Grantland Johnson
Secretary
Health and Human Services Agency

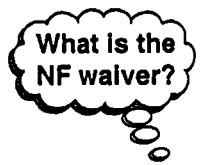
Diana M. Bontá, R.N., Dr.P.H.
Director

OSP 00 42777









ANSWERING YOUR QUESTIONS ABOUT MEDI-CAL IN-HOME OPERATIONS

WHAT IS MEDI-CAL's IN-HOME OPERATIONS PROGRAM?

In-Home Operations (IHO) oversees the development and implementation of home nursing programs. We authorize medically necessary long-term shift nursing services in the home for Medi-Cal beneficiaries who are eligible for the Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) program and/or one of three federal waiver programs. These home nursing services are authorized as an alternative for individuals who would otherwise qualify for care in nursing facilities recognized by Medi-Cal.

WHAT IS EPSDT?

EPSDT is a Medi-Cal program for individuals under the age of 21 who have full scope Medi-Cal eligibility. This benefit allows for periodic screenings to determine health care needs. Based upon the identified health care need, diagnostic and treatment services are provided. This program also allows for the provision of shift nursing services in the home for these individuals.

WHAT SERVICES ARE OFFERED UNDER THE EPSDT PROGRAM?

Under the EPSDT program, one may receive all services covered by Medi-Cal. Additionally, a beneficiary may receive skilled nursing services from a registered nurse (RN) or a licensed vocational nurse (LVN), Case Management, Pediatric Day Health Care, Nutritional and Mental Health Evaluations/Services. These additional services are also known as the EPSDT Supplemental Services.

WHAT ARE HOME AND COMMUNITY-BASED SERVICE (HCBS) WAIVERS?

HCBS waivers allow states who participate in Medicaid to develop creative alternatives for individuals who would otherwise require care in a nursing facility or hospital. The services offered under the waiver can cost no more than the alternative institutional level of care. Recipients of HCBS waivers must have full scope Medi-Cal eligibility. IHO has the responsibility for the In-Home Medical Care (IHMC), Nursing Facility (NF) and Model NF waivers.

WHAT SERVICES ARE OFFERED UNDER THESE THREE HCBS WAIVERS?

The available services under these HCBS waivers are RN or LVN Skilled Nursing Services, Certified Home Health Aide services, Case Management, Minor Home Modifications, Personal Emergency Response System, Family Training, Utility Coverage for life sustaining equipment, Extended State Plan Services for Personal Care and Therapies-physical, occupational, speech and family.

WHO PROVIDES THE IN-HOME SERVICES?

For EPSDT - licensed certified Home Health Agencies and/or individually enrolled supplemental service providers.
For HCBS - licensed and certified Home Health Agencies.

HOW DOES ONE GO ABOUT REQUESTING THE NURSING SERVICES?

Once the beneficiary has identified a provider of service, the provider submits information to the IHO Intake Unit. The provider must submit the following documents: Treatment Authorization Request (TAR), current history and physical, nursing assessment, home safety evaluation and a plan of treatment signed by a physician. These documents should support the need for the requested services.

IF OTHER SERVICES ARE NEEDED, HOW DOES ONE OBTAIN THEM?

A request for any service needed for the home nursing program must be submitted to IHO. These services must be medically necessary. Examples include therapy services, equipment and transportation.

HOW LONG CAN ONE HAVE THESE SERVICES?

A Medi-Cal beneficiary may receive in-home shift nursing and all related services as long as deemed medically necessary.

WHOM DO I CONTACT FOR FURTHER QUESTIONS?

For more information about IHO, please call (916) 324-1020 in Sacramento or (213) 897-6774 in Los Angeles.

COUNTY WAIVER CONTACTS
APRIL 2001

CONTACT	COUNTY
Joyce Cooper Social Services Agency 1106 Madison Street, Suite 307 Oakland, CA 94612 (510) 267-9442 (510) 267-9428 FAX	Alameda
Jackie Casey Department of Social Services P.O. Box 277 Markleeville, CA 96120 (530) 694-2235 (530) 694-2252 FAX	Alpine
Kim Crippen Department of Social Services 1003 Broadway Jackson, CA 95642 (209) 223-6569 (209) 223-6208 FAX	Amador
Gigi Gilbert Department of Social Welfare 42 County Center Drive P.O. Box 1649 Oroville, CA 94965 (530) 538-5149 (530) 538-6918 FAX	Butte
Connie McLain Department of Social Welfare 891 Mountain Ranch Road San Andreas, CA 95249 (209) 754-6444 (209) 754-6566 FAX	Calaveras
Nancy Montgomery Department of Health and Human Services Colusa, CA 95932 (916) 458-4985 (916) 458-5771 FAX	Colusa

COUNTY WAIVER CONTACTS
APRIL 2001

CONTACT	COUNTY
Roxane Haynes Medi-Cal Program Analyst Employment and Human Services Department 40 Douglas Drive Martinez, CA 94553 (925) 313-1633 (925) 313-1758 FAX email: rhaynes@ehsd.co.contra_costa.ca.us	Contra Costa
Terile Keevil Department of Health and Social Services 880 Northwest Drive Crescent City, CA 95531 (707) 464-3191 (707) 465-1783 FAX	Del Norte
Midge Mortensen Department of Social Services 3057 Briw Road Placerville, CA 95684 (530) 642-7159 (530) 626-9060 FAX	El Dorado
Karen Sebilian Department of Employment and Temporary Assistance 4449 East Kings Canyon Fresno, CA 93750-0001 (559) 253-9177 (559) 253-9250 FAX	Fresno
Becky Hansen Human Resources P.O. Box 611 Willows, CA 95988 (530) 934-6514 (530) 934-6521 FAX	Glenn
Kathy Cauble Department of Social Services 929 Koster Street Eureka, CA 95501 (707) 445-7706	Humboldt
Dora Juslin Department of Social Services 2995 South 4th Street, Suite 105 El Centro, CA 92243 (760) 337-6800 (760) 337-5716 FAX	Imperial

COUNTY WAIVER CONTACTS
APRIL 2001

CONTACT	COUNTY
Darlene Landis Health and Human Services 162-A Grove Street Bishop, CA 93514 (619) 872-1394	Inyo
Barbara Gause or Donna Dunkin Department of Human Services P.O. Box 511 Bakersfield, CA 93302 (661) 631-6094 (661) 633-7047 FAX	Kern
Aida Guzman Human Services Agency 1200 South Drive Hanford, CA 93230 (559) 582-3241 EXT. 4793 FAX 584-2749	Kings
Dorothy McDonald Department of Social Services 15975 Anderson Ranch Parkway P.O. Box 9000 Lower Lake, CA 95457 (707) 995-4205 (707) 995-4204 FAX	Lake
Mary Polley Welfare Department P.O. Box 1359 Susanville, CA 96130 (530) 251-8148	Lassen
Rene Lima Department of Public Social Services 12900 Crossroads Parkway South City of Industry, CA 91745 (562) 908-3529 (562) 908-0593 FAX	Los Angeles
Candy Lopez Department of Public Welfare Madera County P.O. Box 569 Madera, CA 93639 (559) 675-2364 (559) 675-7693 FAX	Madera

COUNTY WAIVER CONTACTS
APRIL 2001

CONTACT	COUNTY
John Paul Department of Health and Human Services P.O. Box 4160 San Rafael, CA 94913 (415) 499-7056 (415) 499-3790 FAX	Marin
Debbie Smith Department of Social Services P.O. Box 7 Mariposa, CA 95338 (209) 966-3609 (209) 966-5943 FAX	Mariposa
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Mary Ellen Arana Human Services Agency 2115 West Wardrobe Avenue Merced, CA 95341-001 (209) 385-3000 EXT. 5488 (209) 725-3583 FAX	Merced
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