Transmittal
Data Dictionary & Instructional Guide for County Medi-Cal Staff

Effective July 1 2002

HFAV Automated Transmittals

County Transmittals

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Process Description: HFAV (SPE or HFP) Forwards Application to the County (Application originates at HFAV)

The SPE has four days in which to process the initial application. Processing includes contacting the applicant for additional or missing information, following file clearance procedures, assigning CINs, and reporting AE (if applicable) and application information to MEDS. If enough information is available to screen to no-cost Medi-Cal, but not enough information can be gathered in the four-day time frame to assign a CIN, the application will be forwarded to the CWD, but without AE being issued. If not enough information is available to determine if the application should be screened to no-cost Medi-Cal within the four-day time frame, the application will be forwarded to HFP for additional research. If enough information to screen to no-cost Medi-Cal is received by the 20th day, the application will be forwarded to the CWD by HFP. Otherwise, the application will be denied.

Step	Action	
1	**County reviews HFAV Transmittal Form**	
2	**File Clearance at CWD – See Attachment VII**	
3	**SPE indicates Retroactive Medi-Cal only is requested** • Send MC 210A to applicant for processing	
4	**Process Medi-Cal application and take the following actions:**	
	IF	**THEN**
	• Individual is granted Medi-Cal →	• Complete MEDS eligibility transactions
	• AE child is denied Medi-Cal →	• Report denial to MEDS
5	**Refer back to Healthy Families if applicant has not marked "I do not want Healthy Families," and:**	
	IF	**THEN**
	Medi-Cal denied and potentially eligible to HF (family income under 250% for children).	**Prepare HFAV transmittal:** • Complete county section on HFAV Transmittal and forward with application, copy of NOA, budget worksheets, and birth certificates (if available). • Include a completed County Summary Transmittal (MC 363 S) for all second referrals made. **Mail to: Healthy Families** **Attn: Research 1** **PO Box 138005** **Sacramento, CA 95813-8005**
	OR	
	Medi-Cal granted and eligible to SOC Medi-Cal and potentially eligible to HF (family income under 250% of the FPL).	
Special Program Note	AE will continue until CWD sends MEDS approval or denial transaction.	

Process Description: County Forwards Application Originating at CWD to Healthy Families Program.

Step	Action	
1	**County Assesses Share of Cost Medi-Cal, Discontinues, or Denies**	
2	**County Reviews Application**	
	IF	**THEN**
	• Applicant requested Healthy Families → → → →	• Go to Step 3
	• Healthy Families not requested → → → → → →	• No further action is needed
3	**Refer to Healthy Families when:**	
	Medi-Cal Denied or discontinued and...	
	• potentially eligible to HF (family income under 250% for children).	
	Medi-Cal Granted and ...	
	• Eligible to SOC Medi-Cal and potential eligible to HF (family under 250% for children).	
4	**Prepare County Detail Transmittal (MC 363) for HFP:**	
	Complete County Transmittal (MC 363) and attach:	
	Mandatory	**If Available**
	• The most recent application (MC 210, MC 321) or redetermination form (MC 210 RV)	• Birth certificate (if available)
	• Copy of the Medi-Cal Notice of Action sent to the client, showing the SOC amount or reason for discontinuance or denial.	• Proof of tribal affiliation (American Indian or Alaska Native) if available
	• Copy of the Medi-Cal Budget Computation Worksheet (computer printouts are acceptable). This is MANDATORY unless complete budget computation is found on the NOA.	• Immigration verification
		• Proof of residency
5	**Complete the County Summary Transmittal (MC 363 S) for all referrals made to HFP**	
6	**Forward County Transmittal to HFP:**	
	Healthy Families **Attn: Research 1** **PO Box 138005** **Sacramento, CA 95813-8005**	

HFAV Summary Transmittal (HF LT 79) - Applications Forwarded to CWD	
Case Level Information	
County Name	This field identifies the county to which the application is referred. If forwarded to the wrong county, please return immediately to: **Healthy Families** **Attn: PC Inventory Control Unit** **P.O. Box 138005** **Sacramento, CA 95813-8005**
Case Control Number	The Case Control Number (CCN) is the number assigned to the case by the HFAV that appears on this transmittal. The number in this field will match up with the one on the summary transmittal. This field will always contain eleven digits. From left to right, the first four digits are the year (e.g. 2002), and the next three digits are the Julian date which is based on a 365 day year or a 366 day year for a leap year (e.g. January 1st is 001 and December 31 is 366. See Attachment V for a copy of the Julian calendar). The last four digits of the CCN are the consecutive SPE processing numbers for the day (e.g. 0001 would be the first application processed that day). For example, *20020010001* would be the first application that SPE processed on January 1, 2002. Applications processed through Health-e-App will be identified by a 4000 sequence number in the last four digits. For example, *20020014001* would be the first Health-e-App that SPE processed on January 1, 2002.
No HFP Indicator	A 'Y' in this field indicates the applicant does not want HFP. A 'N' in this field indicates the applicant did not opt-out of HFP, but it was determined that one or more family members do not qualify for HFP coverage. Do not refer an application back to HFP when there is a 'Y' in this field, unless the applicant has since given their authorization.
Retro Medi-Cal	This field (Y/N) indicates that Retroactive Medi-Cal has been requested. The CWD will need to have the applicant complete a MC 210A for the retro months.
Others Want Medi-Cal	This field (Y/N) identifies that a member not listed has requested Medi-Cal. This may indicate that an individual has requested aid and SPE was unable to assign a CIN. Or, if an outdated application (prior 7/01) was received, this may indicate that an individual listed in part 3 of the application is requesting coverage. The CWD will need to review for Medi-Cal eligibility.
Individual Level Information	
Member	This field gives a numeric value to each member on the application: 1 = Applicant 2-99 = Other family members
Last Name, First Name	These fields indicate the individual name. CWD should review these fields for accuracy.
Program Indicator	This field indicates what program the individual was screened for and contains the following data elements: • **M = Medi-Cal** • **H = Healthy Families** • **N = Not Applying**
Pregnant Indicator	This field (Y/N) indicates if it is indicated on the application that an individual is pregnant.
Total Cases Transmitted	This number should agree with the total number of applications listed on the summary, as well as the total number of applications actually received by the CWD in that batch.

HFAV Detail Transmittal (HF FM 80) – Applications Forwarded to CWD

Case Level Information	
County	This field identifies the county to which the original application is mailed. The HFAV will send the original application to the county in which the applicant lives (which is the county of responsibility). A copy of the application will NOT be forwarded to the county of residence for any children when different from the county of residence for the applicant. For instances in which a non-custodial parent is applying for children not in their care, the CWD shall follow the instructions outlined in ACWDL 00-36, dated June 26, 2000. If the original application is forwarded to the wrong county, please return immediately to: **Healthy Families** **Attn: PC Inventory Control Unit** **P.O. Box 138005** **Sacramento, CA 95813-8005**
Date Original Application Forwarded to CWD	If this date is filled in, Healthy Families or Single Point of Entry previously sent an original application to the CWD on this date. Healthy Families/Single Point of Entry is resending this transmittal to indicate that information on one or more members on this application has changed due to receipt of further documentation. **Effective with the 08/15/2002 revision.**
Case Control Number	The Case Control Number (CCN) is the number assigned to the case by the HFAV that appears on this transmittal. The number in this field will match up with the one on the summary transmittal. This field will always contain eleven digits. From left to right, the first four digits are the year (e.g. 2002), and the next three digits are the Julian date which is based on a 365 day year or a 366 day year for a leap year (e.g. January 1st is 001 and December 31 is 366. See Attachment V for a copy of the Julian calendar). The last four digits of the CCN are the consecutive SPE processing numbers for the day (e.g. 0001 would be the first application processed that day). For example, *20020010001* would be the first application that SPE processed on January 1, 2002. Applications processed through Health-e-App will be identified by a 4000 sequence number in the last four digits. For example, *20020014001* would be the first Health-e-App that SPE processed on January 1, 2002.
Date Received	This is the date on which the application was received at the HFAV. For new applications and Add-A-Persons (non-AER) this is the application date to be used by the counties. (Please note that the application date for HFP Annual Eligibility Reviews (AER) applications, and any Add-A-Person requests associated with them, is the date referred.)
Date Referred	This is the date Healthy Families determined the application should be referred to Medi-Cal. For HFP Annual Eligibility Reviews (AER), and any Add-A-Person requests associated with them, this is the application date to be used by the counties. (Please note that the application date for new applications or non-AER Add-A-Persons is the date received at SPE.)
Opt out of HF	Y = Applicant opted out of Healthy Families coverage. Process application, even if income is too high for no-cost Medi-Cal. Do not forward back to HFP unless the applicant has requested you to. In this case, either get a signed statement, or, if the request was verbal, indicate this in the comments section. N = Applicant did not opt out of Healthy Families coverage, but it was determined that one or more family members do not qualify for Healthy Families coverage. Process these individuals for Medi-Cal.
Unlisted Member Wants Medi-Cal	Y = Another family member (not listed on the transmittal) wants Medi-Cal N = No other family members want Medi-Cal Unlisted Member Wants Medi-Cal: This field will be populated with 'Y' only if an older version of the joint application is received, and indicates that an individual listed in part 3 of that application is requesting coverage. CWD will need to review for Medi-Cal eligibility
Retro MC Requested	Y = A family member(s) on this case accrued medical expenses over the past three months, and the applicant is requesting that these expenses be covered through retroactive Medi-Cal N = Applicant is not requesting retroactive Medi-Cal The CWD will need to have the applicant complete an MC 210A for the retro months.

Type	SPE = The case was determined Medi-Cal through Single Point of Entry. HF = The case was determined Medi-Cal by an Eligibility Enrollment Specialist (EES) through Healthy Families. AER = The case was determined Medi-Cal during the Annual Eligibility Review. The Medi-Cal application date is the 'date referred.' ADD = The case was determined Medi-Cal while adding a new person to the case. For non-AER adds, the Medi-Cal application date is the date the Add-A-Person form is received at the HFAV.
Individual Level Information	
Member	This field gives a numeric value to each member on the application: 1 = Applicant 2-99 = Other family members
Multiple CINs	This field is currently for HF use only. Disregard at this time. **Has been removed on the 08/15/2002 revision.** See Attachment VII for special instructions on multiple CINs.
CINs	This field indicates the CIN that SPE assigned to the individual. See Attachment VII for additional information. There may be additional county action required.
Last Name, First Name	These fields indicate the individual name. CWD should review these fields for accuracy.
Relation to Applicant	This indicates the individual's relationship to the applicant as identified by the HFAV. For responsible relative and unit determination for the Medi-Cal Program, please refer to Article 8 of the Medi-Cal Procedures Manual. For transmittal use, the codes are:

1	Applicant's child	G	Grandparent	Q	Cousin
2	Second adult's child	H	Dependent of a minor dependent	R	Collateral dependent
3	Significant other	I	Mother or father-in-law	S	Spouse
4	Ex-step parent	J	Brother or sister	T	Stepfather
A	Aunt or uncle	K	Grandchild	U	Unborn
B	Stepchild	L	Legal guardianship	V	Stepmother
C	Common child	M	Adopted child	W	Ward
D	Son or daughter-in-law	N	Niece or nephew	X	Ex-spouse
E	Brother or sister-in-law	O	Other	Y	Self
F	Foster Child	P	Parent	Z	Unknown

Date of Birth	This field indicates the date of birth of the individuals. The CWD should review these fields for accuracy.
SSN	This field indicates the social security numbers of the individuals, if available. The CWD should review these fields for accuracy.
Screened For	This field indicates what program the individual was screened for and contains the following data elements: **M = Medi-Cal** **H = Healthy Families** **N = Not applying for either program**
Pregnant Indicator	This field (Y/N) indicates if individual indicated on the application that she was pregnant. **Counties shall expedite eligibility determinations for all pregnant applicants.**
AE Start Date	Effective date of Accelerated Enrollment for this individual. Eligibility for benefits will begin the first day of the month of enrollment. **This eligibility will only be terminated when county reports a Medi-Cal eligibility determination or denial action to MEDS.** Refer to ACWDL No. 02-36 for detailed information on this program.
Budget Unit	This field shows the budget unit to which the individual belongs for income computation purposes during program screening, and corresponds with the HFP budget computation fields.

Income Section

These fields show the information and methodology used by the HFAV during the screening process in order to make the referral. This should be used by the CWD as a tool only, and the CWD must follow Medi-Cal regulations.

NOTE: THE ORIGINAL TRANSMITTAL HAD SIX FIELDS ASSOCIATED WITH THIS SECTION. BECAUSE OF THE CONFUSION ASSOCIATED WITH THEM, THE TRANSMITTAL WAS REVISED AND REFLECTS THE FOLLOW FIELDS (08/15/02 REVISION).

Member	This is the member associated with the corresponding income information.
Frequency of Income	A = Weekly B = Bi-weekly C = Bi-monthly D = Monthly E = Yearly

Type of Income

1	Employee pay stubs	G	RSDI - Retirement Survivor Disability Income
2	Federal Tax Form	H	Veterans
3	Award Letter	I	Railroad Retirement
4	W2 (not accepted by HFP)	J	SDI – State Disability Income
5	Bank statements w/direct income deposits	K	Worker's Compensation
6	Employer Statement	L	Unemployment
7	Quarterly P/L	M	Pension/Retirement
8	NOA	N	Grants
9	Child Support	O	Settlements
A	Alimony	P	Gift
B	SSA	Q	Lottery/Bingo
C	Self Employment Statement (not accepted by HFP)	R	Other
F	Affidavit		

Income Type Amount	This is the amount of income for this member income type and frequency, as determined by the HFAV.

HFAV Budget Unit Section

Budget Unit	This is the Budget Unit number the HFAV associated with the corresponding income and individual information.
Family Size	This is the total number of family members on this case used by the HFAV to determine income levels for the corresponding Budget Unit.
Total Gross Income	This is the total income, before deductions, associated with the corresponding Budget Unit, as determined by the HFAV.
Deductions	This is the amount deducted from the **Total Gross Income** for this Budget Unit by the HFAV, and includes the $90 deduction for work related expenses, when appropriate.
Total Net Income	This is the total income, after deductions, associated with the corresponding Budget Unit as determined by the HFAV.
%FPL	This is the percentage of the Federal Poverty Level for the Corresponding Budget Unit. This percentage is determined by **Family Size** and **Total Net Income,** as determined by the HFAV.
Members	The numbers listed correspond with the individuals included in this Budget Unit.

County Response Section (replaces the MC 354 Transmittal)	
Case Name	Enter the case name
Case Number	Enter the county case number
County Representative	Enter the name of the person completing the form
Telephone Number	Enter the telephone number of the person completing the form
Reasons for return to SPE	Check all appropriate boxes for why transmittal is being forwarded to SPE: • **Applicant checked "I do not want Healthy Families." Applicant now wants Healthy Families:** Verify the applicant has given permission for the mail-in application to be forwarded to the HFP. CWD shall process the Medi-Cal application and if any individuals appear eligible to HFP, forward it to the HFAV along with applicable documentation (Medi-Cal budget worksheets, a copy of the Medi-Cal NOA, proof of residency, and alien documentation). • **CIN was missing, now located or a new one assigned:** This box is checked when the CIN was missing in the top portion of the transmittal, and the CWD assigned a new one, the wrong CIN was listed, or if the instructions in Attachment VII indicate a need to notify SPE. CWD must enter the Member number for the person with the change and enter the County Assigned CIN number. See attachment VII for more information on CIN selection. • **Amount of child support or child care expense shown on application not verified:** CWD shall only return for this reason if SOC Medi-Cal has been assessed. CWD shall indicate the member number and SOC amount and attach NOA and budget calculations. • **Changes in household membership:** CWD shall complete this box when, during the initial application process, an individual is being added/deleted to the Medi-Cal case which changes the eligibility determination from no-cost Medi-Cal to HFP. • **Not eligible to Medi-Cal:** FUTURE USE ONLY. • **Case returned as household contains individuals eligible to Medi-Cal as PA recipient:** 1931b eligible, CalWORKs, SSI/SSP, 1931(b), or Foster Care eligible. These individuals are not counted in the family size, and their income is not included in the budgeting process. • **Case returned as Share of Cost Determined:** CWD shall complete the member number, indicate the SOC by the individual, complete the comments section and attach the Medi-Cal Budget Worksheets and Medi-Cal NOA.
Member Changes	Enter member number from the top portion of the transmittal for person with change.
County Assigned CIN	If the CIN used by the CWD is different than the CIN listed in the top portion of the transmittal, list the correct one in this field.
Active Case Individual On	If any members being included in the budget unit by the HFAV are PA recipients, enter the program here.
Not Eligible to Medi-Cal	If an adult's countable income is less than 100% of the FPL but denied due to excess property or no deprivation, mark the appropriate box. *This field will only be used when Parental Expansion is implemented.*
Comments	Include information such as the county has additional family income from a source not listed on the application; job change; weekly pay stubs rather than bi-weekly, different family composition, etc. The HFAV must have a record of why the county has determined that an individual is ineligible to no-cost Medi-Cal.
Enclosures	Check the boxes that apply, and include a copy of the completed county manual budget worksheet, such as the MC 175-5 or facsimile, or system print out indicating the income calculation used to determine the child is not eligible for a no-cost Medi-Cal percent program. Healthy Families will be able to use the Medi-Cal SOC NOA income for a child listed on the NOA.

County Summary Transmittal Form (MC 363 S)	
County Name	This field identifies the county from which the application is referred.
Number of Referrals	This number should agree with the total number of applications listed on the summary, as well as the total number of applications sent.
Contact Person and Telephone	This field is to contain the person at the CWD to be contacted, if necessary, by the HFAV regarding the transmittal and/or the applications, and their phone number.
Case Name	The name of the case the application is identified by at the CWD.
Case Number	The county case number for the application.

County Detail Transmittal (MC 363)– Medi-Cal to Healthy Families Transmittal Form *For use with county-initiated applications. Do not use for HFP referrals being returned back to HFP, which should transmitted via the County Response Section of the HFAV Detail Transmittal (HF FM 80)*	
County Name	This field identifies the county from which the application is referred.
County Representative and Telephone Number	This field is to contain the name of the person at the CWD to be contacted, if necessary, by the HFAV regarding the application, and their phone number.
Date Referred	This is the date the CWD mails the application to the HFAV.
Case Name	The name of the case the application is identified by at the CWD.
Case Number	The county case number for the application.
Applicant Name	The name of the person identified as "applicant" on the application. This may or may not be the case name.
Language: Spoken	This is the language the applicant (or the applicant's representative) speaks.
Written	This is the language the applicant (or the applicant's representative) writes.
Applicant phone number	This is the phone number of the person identified as the "applicant" on the application.
Check All Appropriate Boxes	**One or More Individuals:** • **Changed mind about not wanting Healthy Families:** Applicant has requested that the application be forwarded to HFP, even though they had previously checked the "I do not want HFP" box. If the applicant has requested this in writing, please include with the application. If the request was verbal, please make a notation of this in the "comments" section. • **Were determined ineligible for Medi-Cal (see comments):** If any individual on the application is determined ineligible for no-cost Medi-Cal for reasons other than having a SOC and appear to HFP eligible, check this box and complete the comments section. • **Were determined to have a share of cost (see below):** If any individual on the application is determined to have a SOC, mark this box and enter the amount in the section below. **Type of application:** • **Food stamps only application:** *For future use only. The HFAV cannot process Food Stamps applications for HFP at this time.* • **School lunch application:** *For future use only. The HFAV cannot process school lunch applications for HFP at this time.* • **Redetermination (RV):** *For future use only. The HFAV cannot process redetermination forms for HFP at this time.*
HF Requested	Yes = the individual on this line is requesting HF benefits. No = the individual on this line is not requesting HF benefits, but is included in the MFBU for budgeting purposes.
M/C FBU	Yes = the individual on this line is included in the MFBU for budgeting purposes. No = the individual on this line is not included in the MFBU for budgeting purposes.
List All Household Members	List all household members by name.
CIN Number	This is the CIN attached to the individual. The HFAV will use this CIN, so it is important that this field is completed accurately, and that any CIN discrepancies be resolved.
Social Security Number	List each individuals social security number in this field, if available.
Sex	Identify the gender of each individual.

Date of Birth	Enter the date of birth of each individual in this field.
Relationship to Applicant	Enter the relationship of each individual to the person identified as the applicant.
Individual Gross Income	Enter the gross income used in the budget for each individual. If the individual has multiple sources of income, use separate lines for each.
Type of Income	Identify the type of income for each individual. If the individual has multiple sources of income, use separate lines for each.
Share of Cost Amount	Enter the SOC for each individual in this field.
Enclosures	Check all applicable boxes:

Mandatory Enclosures	**Enclose if Available**
• Medi-Cal NOA(s) and Budgets. • Copy of the application	• Birth Certificate • Immigration Documents • Proof of residency

Comments	Explain why the application is being forwarded to the HFP. Be sure to identify any household members who are receiving CalWORKs, SSI, 1931(b) or Foster Care Benefits.

Glossary of Acronyms and Forms

ADD	Add-A-Person Form. If the HFAV determines an individual requesting benefits on an Add-A-Person form (non-AER) to be potentially eligible to no-cost Medi-Cal, this form serves as an appliction for Medi-Cal. The application date is the date the form was received by the HFAV.
AE	Accelerated Enrollment. AE gives children (under the age of 19) who are screened to no-cost Medi-Cal at the HFAV quicker access to temporary, fee-for-service, full-scope, no-cost Medi-Cal. Children are enrolled by the HFAV, but only the CWD can end AE eligibility.
AER	Annual Eligibility Renewal. Form used by HFP for their annual reviews. If HFP determines that a beneficiary is no longer HFP eligible, and appears to be no-cost Medi-Cal eligible, the AER serves as an application for Medi-Cal. The application date is the date referred to the CWD by the HFAV.
CIN	Client Index Number. The statewide number used by the Medi-Cal and HFP to identify applicants and beneficiaries.
CMSP	County Medical Services Program. A program available in some counties to provide health care benefits for medically indigent adults not eligible to Medi-Cal due to linkage.
CWD	Acronym for County Welfare Department. These departments determine Medi-Cal eligibility.
FPL	Federal Poverty Level. Income level used to determine eligibility to the Percent Programs.
HF	Healthy Families
HFAV	Healthy Families Administrative Vendor. This is the vendor contracted by the Managed Risk Medical Insurance Board (MRMIB) to provide services at the SPE and HFP.
HFP	Healthy Families Program.
MC 175-5	Medi-Cal Budget Worksheet.
MC 210	Statement of Facts for Medi-Cal
MC 210A	Statement of Facts for Retroactive Medi-Cal.
MC 210RV	Medi-Cal Statement of Facts for annual renewal.
MC 321	Healthy Families and Medi-Cal Joint Mail-In application.
MC 363	Medi-Cal to Healthy Families Transmittal
MEDS	Medi-Cal Eligibility Data System.
MFBU	Medi-Cal Family Budget Unit. Persons who will be included in the Medi-Cal eligibility and SOC determination.
MRMIB	Acronym for the Managed Risk Medical Insurance Board, who administers the Healthy Families Program (HFP) and the Single Point of Entry (SPE).
NOA	Notice of Action. The official notification of Medi-Cal program eligibility, ineligibility, and change.
PA	Public Assistance. Programs such as CalWORKs, SSI/SSP, 1931(b) Only, and Foster Care are considered PA programs. PA individuals are excluded from the budgeting process when determining Medi-Cal or HF eligibility for other household members.
SOC	Share of Cost. This is the amount of money an individual must pay during a month before Medi-Cal will begin to cover health care costs. The amount is determined by the CWD.
SPE	Single Point of Entry

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Attachment I

HFAV Summary Transmittal (HF LT 79)

Applications Forwarded to CWD

County : ENTER COUNTY NAME

Case Control Number	Opt out of HF	Retro Medi-Cal	Others Want Medi-Cal	Type
00000000000	N	N	N	SPE

Member	Last Name	First Name	Screened For	Pregnant Indicator
1	ENTER LAST NAME	ENTER FIRST NAME	M	N
2	ENTER LAST NAME	ENTER FIRST NAME	M	N
3	ENTER LAST NAME	ENTER FIRST NAME	M	N
4	ENTER LAST NAME	ENTER FIRST NAME	M	N
5	ENTER LAST NAME	ENTER FIRST NAME	M	N

Case Control Number	Opt out of HF	Retro Medi-Cal	Others Want Medi-Cal	Type
00000000000	N	N	N	SPE

Member	Last Name	First Name	Screened For	Pregnant Indicator
1	ENTER LAST NAME	ENTER FIRST NAME	M	N
2	ENTER LAST NAME	ENTER FIRST NAME	M	N
3	ENTER LAST NAME	ENTER FIRST NAME	M	N
4	ENTER LAST NAME	ENTER FIRST NAME	M	N
5	ENTER LAST NAME	ENTER FIRST NAME	M	N

Total Cases Transmitted : 2

End of Transmittal

Attachment II

Application Forwarded to CWD

County: ENTER THE COUNTY NAME **Date Original Application Forwarded to CWD mm/dd/yyyy**

Case Control Number	Date Received	Date Referred	Opt out of HF	Unlisted Member Wants Medi-Cal	Retro MC Requested	Type
00000000000	mm/dd/yyyy	mm/dd/yyyy	N	N	N	SPE

Member	CIN #	Last Name	First Name	Middle Initial	Relation to Applicant	Date of Birth	SSN	Screened For	Pregnant Indicator	AE Start Date	Budget Unit
#	00000000A	ENTER LAST NAME	ENTER FIRST NAME		Y	mm/dd/yyyy	000-00-0000	N	N	01/01/2001	#
#	00000000A	ENTER LAST NAME	ENTER FIRST NAME		C	mm/dd/yyyy	000-00-0000	H	N	01/01/2001	#
#	00000000A	ENTER LAST NAME	ENTER FIRST NAME		C	mm/dd/yyyy	000-00-0000	H	N	01/01/2001	#
#	00000000A	ENTER LAST NAME	ENTER FIRST NAME		C	mm/dd/yyyy	000-00-0000	H	N	01/01/2001	#
#	00000000A	ENTER LAST NAME	ENTER FIRST NAME		C	mm/dd/yyyy	000-00-0000	H	N	01/01/2001	#
#	00000000A	ENTER LAST NAME	ENTER FIRST NAME		C	mm/dd/yyyy	000-00-0000	H	N	01/01/2001	#
#	00000000A	ENTER LAST NAME	ENTER FIRST NAME		C	mm/dd/yyyy	000-00-0000	H	N	01/01/2001	#
#	00000000A	ENTER LAST NAME	ENTER FIRST NAME		C	mm/dd/yyyy	000-00-0000	H	N	01/01/2001	#
#	00000000A	ENTER LAST NAME	ENTER FIRST NAME		C	mm/dd/yyyy	000-00-0000	H	N	01/01/2001	#
#	00000000A	ENTER LAST NAME	ENTER FIRST NAME		C	mm/dd/yyyy	000-00-0000	H	N	01/01/2001	#

Member	Frequency of Income	Type of Income	Income Type Amount
#	C	Enter code. For help, press F1.	0.00
#	C	Enter code. For help, press F1.	0.00

Budget Unit	Family Size	Total Gross Income	Deductions	Total Net Income	% FPL	Members
#	#	0.00	0.00	0.00	100	#
#	#	0.00	0.00	0.00	100	#
#	#	0.00	0.00	0.00	100	#
#	#	0.00	0.00	0.00	100	#

County Response Area *(only complete if returning application for Healthy Families to reassess or to report a CIN is changing)*

Case Name:

Case Number: 00000000000

County Representative:

Telephone Number: (000) 000-0000

Reasons for return to SPE: *(check all appropriate boxes)*

Date Referred:

- ☐ Applicant checked "I do not want Healthy Families." Applicant now wants Healthy Families
- ☐ CIN was missing, now located or a new one assigned
- ☐ Amount of child support or child care expense shown on application not verified
- ☐ Changes in household membership
- ☐ Not eligible to Medi-Cal (see below)
- ☐ Case returned as household contains individual eligible to Medi-Cal as a PA recipient (see below)
- ☐ Case returned as Share of Cost Determined (see below)

Member Changes *(enter member number from above for person with change)*	County Assigned CIN # *(if missing above)*	Active Case Individual on *(CalWORKs, SSI/SSP, 1931b, Foster Care)*	Not Eligible to Medi-Cal *(check appropriate box)*: <100% of FPL and denied Medi-Cal for	
			excess property	no deprivation
#	00000000A	Enter case	☐	☐
#	00000000A	Enter case	☐	☐
#	00000000A	Enter case	☐	☐

Comments: Explain why county is returning the application. Example: change in family composition, income, income documentation/sources provided to the county are different from what was used at SPE screening.

Enclosures: The following documents are enclosed which were not included with the original application or reflect updated information

- ☐ Medi-Cal Notices of Action (Mandatory for cases ineligible to Medi-Cal
- ☐ Medi-Cal Budget Worksheets (Mandatory if not displayed on NOA)
- ☐ Immigration
- ☐ Residency
- ☐ Birth Certificate
- ☐ Other _____

COUNTY SUMMARY TRANSMITTAL

County Name: _____ Number of Referrals: _____

Contact Person: _____ Telephone: _____

Case Name	Case Number

ATTACHMENT IV

State of California—Health and Human Services Agency

Department of Health Services

MEDI-CAL TO HEALTHY FAMILIES TRANSMITTAL

Healthy Families
P.O. Box 138005
Sacramento, CA 95813-9984

County name

County representative

Telephone number

Date referred

Case name (last) (first)

Case number

Applicant name (last) (first)

Language
Spoken: _____ Written:

Applicant phone number

One or more individuals ***(check all applicable boxes)***:

Changed mind about not wanting Healthy Families
☐ Were determined ineligible for Medi-Cal (see comments)
Were determined to have a share-of-cost (see below)

Type of application ***(check all applicable boxes)***:

Food stamps only application
☐ School lunch application
Redetermination (RV)

HF Requested		M/C FBU		LIST ALL HOUSEHOLD MEMBERS		CIN Number	Social Security Number	Sex		Date of Birth	Relationship to Applicant	Individual Gross Income	Type of Income (UIB, SDI)	Share-of-Cost Amount
Yes	No	Yes	No	Last Name	First Name			Male	Female					

ENCLOSURES: ***the following documents are enclosed with the application (check all applicable boxes).***

Mandatory: Medi-Cal NOA(s) and Medi-Cal Budgets (if not on NOA)
Copy of appropriate application

If available: Birth certificate Immigration Residency
Other_____

Comments: Explain why county is forwarding the application. If a member of the household is on CalWORKS, SSI, or Foster Care, please indicate person(s) and type(s) of assistance.

MC 363 (7/02)

JULIAN DATE CALENDAR

(PERPETUAL)

Day	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Day
1	001	032	060	091	121	152	182	213	244	274	305	335	1
2	002	033	061	092	122	153	183	214	245	275	306	336	2
3	003	034	062	093	123	154	184	215	246	276	307	337	3
4	004	035	063	094	124	155	185	216	247	277	308	338	4
5	005	036	064	095	125	156	186	217	248	278	309	339	5
6	006	037	065	096	126	157	187	218	249	279	310	340	6
7	007	038	066	097	127	158	188	219	250	280	311	341	7
8	008	039	067	098	128	159	189	220	251	281	312	342	8
9	009	040	068	099	129	160	190	221	252	282	313	343	9
10	010	041	069	100	130	161	191	222	253	283	314	344	10
11	011	042	070	101	131	162	192	223	254	284	315	345	11
12	012	043	071	102	132	163	193	224	255	285	316	346	12
13	013	044	072	103	133	164	194	225	256	286	317	347	13
14	014	045	073	104	134	165	195	226	257	287	318	348	14
15	015	046	074	105	135	166	196	227	258	288	319	349	15
16	016	047	075	106	136	167	197	228	259	289	320	350	16
17	017	048	076	107	137	168	198	229	260	290	321	351	17
18	018	049	077	108	138	169	199	230	261	291	322	352	18
19	019	050	078	109	139	170	200	231	262	292	323	353	19
20	020	051	079	110	140	171	201	232	263	293	324	354	20
21	021	052	080	111	141	172	202	233	264	294	325	355	21
22	022	053	081	112	142	173	203	234	265	295	326	356	22
23	023	054	082	113	143	174	204	235	266	296	327	357	23
24	024	055	083	114	144	175	205	236	267	297	328	358	24
25	025	056	084	115	145	176	206	237	268	298	329	359	25
26	026	057	085	116	146	177	207	238	269	299	330	360	26
27	027	058	086	117	147	178	208	239	270	300	331	361	27
28	028	059	087	118	148	179	209	240	271	301	332	362	28
29	029		088	119	149	180	210	241	272	302	333	363	29
30	030		089	120	150	181	211	242	273	303	334	364	30
31	031		090		151		212	243		304		365	31

FOR LEAP YEAR USE REVERSE SIDE

ATTACHMENT V

JULIAN DATE CALENDAR

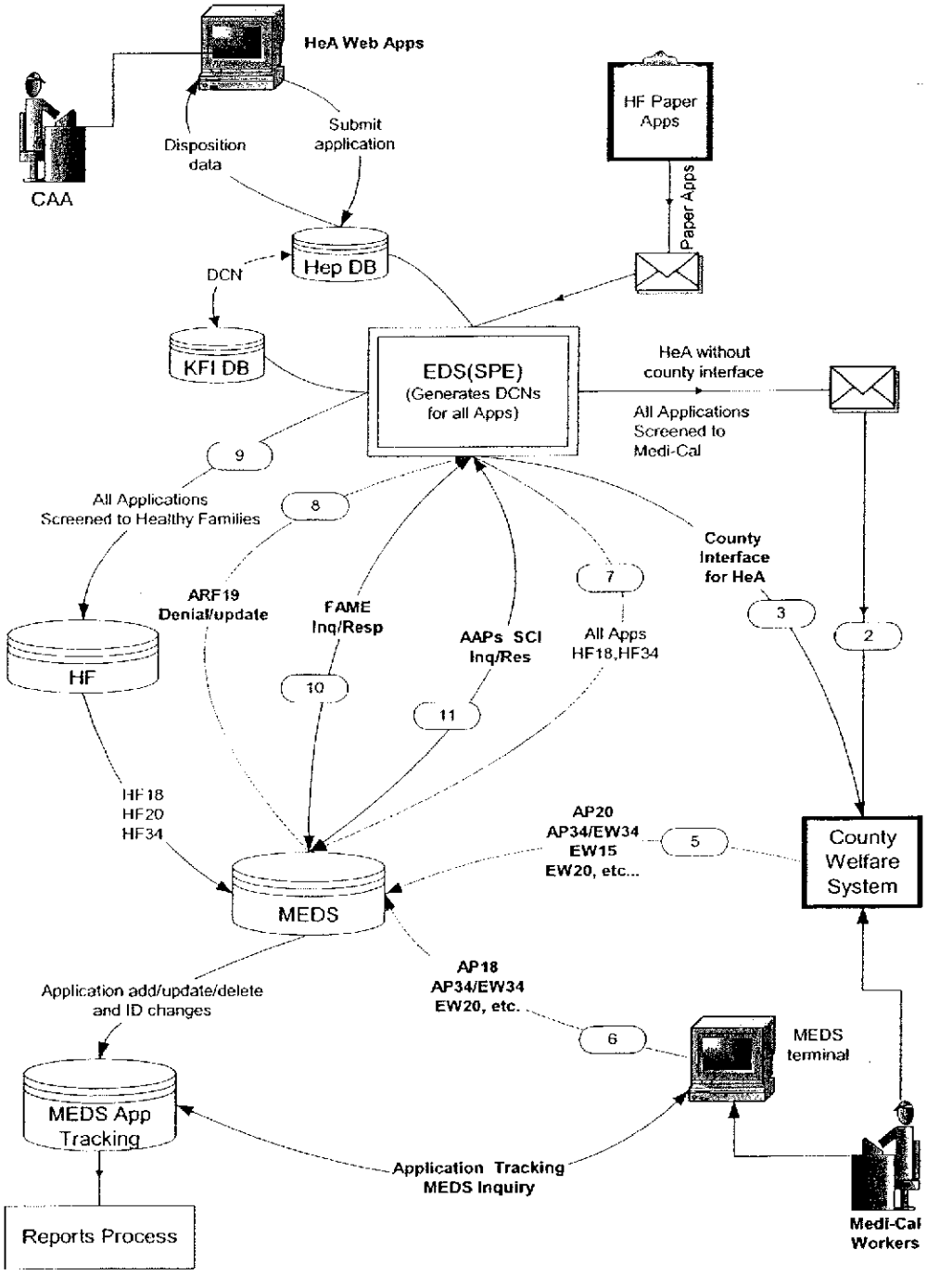
FOR LEAP YEARS ONLY

Day	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Day
1	001	032	061	092	122	153	183	214	245	275	306	336	1
2	002	033	062	093	123	154	184	215	246	276	307	337	2
3	003	034	063	094	124	155	185	216	247	277	308	338	3
4	004	035	064	095	125	156	186	217	248	278	309	339	4
5	005	036	065	096	126	157	187	218	249	279	310	340	5
6	006	037	066	097	127	158	188	219	250	280	311	341	6
7	007	038	067	098	128	159	189	220	251	281	312	342	7
8	008	039	068	099	129	160	190	221	252	282	313	343	8
9	009	040	069	100	130	161	191	222	253	283	314	344	9
10	010	041	070	101	131	162	192	223	254	284	315	345	10
11	011	042	071	102	132	163	193	224	255	285	316	346	11
12	012	043	072	103	133	164	194	225	256	286	317	347	12
13	013	044	073	104	134	165	195	226	257	287	318	348	13
14	014	045	074	105	135	166	196	227	258	288	319	349	14
15	015	046	075	106	136	167	197	228	259	289	320	350	15
16	016	047	076	107	137	168	198	229	260	290	321	351	16
17	017	048	077	108	138	169	199	230	261	291	322	352	17
18	018	049	078	109	139	170	200	231	262	292	323	353	18
19	019	050	079	110	140	171	201	232	263	293	324	354	19
20	020	051	080	111	141	172	202	233	264	294	325	355	20
21	021	052	081	112	142	173	203	234	265	295	326	356	21
22	022	053	082	113	143	174	204	235	266	296	327	357	22
23	023	054	083	114	144	175	205	236	267	297	328	358	23
24	024	055	084	115	145	176	206	237	268	298	329	359	24
25	025	056	085	116	146	177	207	238	269	299	330	360	25
26	026	057	086	117	147	178	208	239	270	300	331	361	26
27	027	058	087	118	148	179	209	240	271	301	332	362	27
28	028	059	088	119	149	180	210	241	272	302	333	363	28
29	029	060	089	120	150	181	211	242	273	303	334	364	29
30	030		090	121	151	182	212	243	274	304	335	365	30
31	031		091		152		213	244		305		366	31

(USE IN 1984, 1988, 1992, etc.)

ATTACHMENT VI

Draft Interface Initial Application received at SPE



3/21/2002,9:14:12 AM
C:\Documents and Settings\hernandl\
Local Settings\Temporary Internet Files\
OLKE\App tracking Process v03.vsd

Special County File Clearance Instructions

Step	Action	
1	**Check the MEDS record for the transmittal CIN**	
	IF	**THEN**
	• SPE linked to a MEDS record that belongs to a different individual and the individual on the transmittal is known to SCI	• ***Call the ITSDHELP hotline immediately to restore the erroneously chosen individual's record to what it was prior to the SPE update.*** Once the record is restored to its condition prior to the erroneous update, the prior BIC, if any, will be valid for the original individual.
	• SPE linked to a MEDS record that belongs to a different individual, the individual on the transmittal is not known to SCI and the county is using a consortia system that is linked to SCI	• ***Call the ITSDHELP hotline immediately to restore the erroneously chosen individual's record to what it was prior to the SPE update.*** Once the record is restored to its condition prior to the erroneous update, the prior BIC, if any, will be valid for the original individual. • Complete file clearance through CIN assignment.
	• SPE linked to a MEDS record that belongs to a different individual, the individual on the transmittal is not known to SCI and the county is not using a consortia system that is linked to SCI	• ***Call the ITSDHELP hotline immediately to restore the erroneously chosen individual's record to what it was prior to the SPE update.*** Once the record is restored to its condition prior to the erroneous update, the prior BIC, if any, will be valid for the original individual. • Submit an AP18/AP20 for the individual and check MEDS the following day to determine the CIN assigned during the MEDS batch update process.
2	**Check for multiple MEDS records**	
	IF	**THEN**
	• County file clearance identified more than one MEDS record for the individual on the transmittal	• Do one or more EW11(s) as needed to merge the MEDS records
3	**Determine whether any file clearance response is needed to SPE**	
	IF	**THEN**
	• SPE linked to a MEDS record that belongs to a different individual and no MEDS record or only one MEDS record was found for the individual on the transmittal	• Report the correct CIN identified in step 1 to SPE. SPE will need to report AE to MEDS for that individual, if appropriate. Based on SPE reporting of AE, MEDS would issue a BIC to that individual.
	• SPE linked to a MEDS record that belongs to a different individual and multiple MEDS records were found for the individual on the transmittal	• Report the CIN and MEDS-ID from the ongoing MEDS record after completion of step 2 to SPE. SPE will need to report AE to MEDS for that individual, if appropriate. Based on SPE reporting of AE, MEDS would issue a BIC to that individual.
	• SPE linked to a correct MEDS record but multiple MEDS records were found for the individual and the CIN or MEDS-ID on the ongoing MEDS record after completing step 2 is different from the CIN or MEDS-ID reported on the transmittal	• Report the CIN and MEDS-ID from the ongoing MEDS record after completion of step 2 to SPE.

AE will only be terminated when the county reports a Medi-Cal eligibility determination or denial action to MEDS; therefore, it is imperative that this information be reported.

NOTE: If the applicant moves to another county during the application process, the original county shall complete the eligibility determination and report the action to MEDS prior to transferring to the new county of responsibility.

Electronic Transactions

When a child has Accelerated Enrollment (AE) eligibility on MEDS, is determined by the county to be eligible for Medi-Cal, and that eligibility is reported to MEDS, MEDS will automatically terminate the AE eligibility. When a child has Accelerated Enrollment (AE) eligibility on MEDS and is determined by the county to be ineligible for Medi-Cal, a denial must be reported to MEDS. When MEDS receives the denial transaction, MEDS will automatically terminate the AE.

To report denials to MEDS, counties may use either batch or online AP18 and AP34 transaction. A separate denial transaction must be sent for each individual who has AE established on MEDS. NOTE: Counties that have changed their batch systems to send EW34 transactions for denials and the MEDS version of the AP20 transaction for pending applications may continue to use those transaction codes, but may need to add additional data elements.

The AP18 transaction is used to report a pending application to MEDS. For purposes of AE termination, the AP18 transaction may be used to report the denial when a pending application has not been previously reported to MEDS by the county. If the pending application has been previously reported to MEDS by the county, the denial may be reported on an AP34.

County staff should refer to MEDS User Manual Letter No. 2002-01 for detailed information on application tracking and reporting denials to MEDS.