COUNTY REFERRALS TO DHS, INVESTIGATIONS

1) Sacramento
1250 Sutterville Rd., Rm. 130
Sacramento, CA 95822
(916) 324-8447

Alpine	Amador
Butte	Calaveras
Colusa	El Dorado
Glenn	Lassen
Modoc	Nevada
Placer	Plumas
Sacto.	Shasta
Sierra	Siskiyou
Sutter	Tehama
Trinity	Tuolumne
Yolo	Yuba

2) Fresno
3374 E. Shields Ave., Rm. E-1
Fresno, CA 93726
(209) 445-5516

Fresno	Kings
Madera	Mariposa
Merced	Tulare

3) San Francisco
939 Market Street, Ste. 204
San Francisco, CA 94103
(415) 557-2330

Alameda	Contra Costa
Del Norte	Humboldt
Lake	Marin
Napa	San Francisco
San Mateo	Solano
Sonoma	Mendocino

4) San Jose
111 N. Market Street, Rm. 420
San Jose, CA
(408) 277-1749

Monterey	San Benito
San Joaquin	Santa Cruz
Santa Clara	
Stanislaus	

5) Bakersfield
4800 Stockdale Hwy.
Bakersfield, CA 93309
(805) 395-2705

Inyo	Kern
Mono	San Luis Obispo

6) Santa Ana
28 Civic Center Plaza, Rm. 840
Santa Ana, CA 92701
(714) 558-4503

So. Los Angeles	Orange

7) Los Angeles
1449 W. Temple Street, Rm. 225
Los Angeles, CA 90026
(213) 620-2335

Los Angeles	Santa Barbara
Ventura	

8) San Bernardino
1840 Commercecenter Circle
San Bernardino, CA 92408
(714) 383-4667

Riverside	San Bernardino

9) San Diego
1350 Front Street, Rm. 4021
San Diego, CA 93101
(619) 237-7947

Imperial	San Diego

10) Toll Free Numbers

Northern Region Investigations:
(for #'s 1,2,3 and 4)
1-800-822-6223

Southern Region Investigations:
(for #'s 5 thru 9)
1-800-822-6222

11) COUNTY REFERRALS TO DHS, RECOVERY

Department of Health Services
General Collections Section
1250 Sutterville Road, Room 206
Sacramento, CA 95822
(916) 322-2280
1-800-238-3377

REQUIRED FORMS FOR REFERRAL PACKAGES

For both Resources/Assets and Wages/Earnings potential overpayments, the referral package to DHS shall include:
(DO NOT SEND ORIGINAL COUNTY RECORDS)

1. MC 609
   1 Copy

   Confidential Medi-Cal Complaint Report
   (Attachment III)

   - Note in upper right hand corner:
     - o "IEVS" in red ink (if applicable)
     - o Case status (note whether case is open or closed and the date case was opened or closed).

2. MC 224 A/B

   Medi-Cal Potential Overpayment Reporting Worksheet - Income/Property
   (Attachment IV & V)

   - Note in upper right hand corner:
     - o "IEVS" in red ink (if applicable)
     - o Case status (note whether case is open or closed and the date was opened or closed).

Note:

If the county is unable to establish an overpayment period or potential overpayment amount, complete the MC 224 A/B with all available information.

3. MC 210
   1 Copy (or State approved county form)

   Medi-Cal Statement of Facts

   - Include all MC 210's covering the potential overpayment period.

4. MC 217
   1 Copy

   Medi-Cal Responsibility Checklist

   - Include all MC 217's covering the potential overpayment period.

5. MC 176R
   1 Copy (or State approved county form)

   - Resource Verification Questionnaire

6. <u>IEVS Abstract</u> 1 Copy	- Assets/Earnings clearance
7. <u>Bank Records</u>	- Copies of all statements provided by client
8. <u>Earnings Statements</u>	- Copy from EDD, and copies of all client's pertinent pay stubs. - Copy of employer's report
9. <u>Case Narrative</u> 1 Copy	- Copy of case narrative relating to the potential overpayment period.

ATTACHMENT III

State of California—Health and Welfare Agency

Department of Health Services

☐ IEVS ☐ non-IEVS

FOR DHS STAFF USE ONLY

Case No.

Date

CONFIDENTIAL MEDI-CAL COMPLAINT REPORT

CASE STATUS

☐ Active _____ Effective Date

☐ Closed _____ Effective Date

1. Who is complaint against:

☐ Provider (Give Medi-Cal Provider No. if Known) Provider No.: _____

☐ Recipient (Give SSN and Date of Birth Below) County Case No.: _____

ame (Recipient/Provider) SSN DOB (M/D/Y)

ddress City ZIP Telephone

2. Name of Person Reporting Complaint

Address City ZIP Telephone

ynopsis of Complaint (If client has an authorized representative, provide name, telephone number and address here. If additional space is required, attach a second sheet.)

Complaint taken by (if different than No. 2) Date

Address Telephone

FOR DHS STAFF USE ONLY

Initial/Date	Action Taken
☐ MEDS	☐ Unfounded Allegation
☐ CDR	☐ Case Opened
☐ Other	☐ Referred to _____

igned to: _____ Date _____

State of California—Health and Welfare Agency

Department of Health Services

ATTACHMENT IV

MEDI-CAL POTENTIAL OVERPAYMENT REPORTING WORK SHEET—INCOME

SECTION I

☐ IEVs ☐ non-IEVs

County ID: County Aid Serial FBU

Recipients Included In Potential Overpayment

Case Status
☐ Active—effective date: _____
☐ Closed—effective date: _____

Social Security Number

Recipient Phone Number
( )

SECTION II

The share of cost should have increased for the period(s) _____

because _____

_____ and the county was not informed:

☐ on the statement of facts ☐ within ten days of the change stated above.

The overpayment is computed as follows: (County completes boxes 1–6.)

1 Month(s)/ Year	2 Correct Net Income	3 Correct Maintenance Need	4 Correct Share of Cost (2–3)	5 Share of Cost Met	6 Potential Overpayment (4–5)	DHS Investigation/Recovery use only 7 Amount Paid by Medi-Cal	8 Overpayment (lower of 6 or 7)
	$	$	$	$	$	$	$
	$	$	$	$	$	$	$
	$	$	$	$	$	$	$
	$	$	$	$	$	$	$
	$	$	$	$	$	$	$
	$	$	$	$	$	$	$
	$	$	$	$	$	$	$
	$	$	$	$	$	$	$
	$	$	$	$	$	$	$
	$	$	$	$	$	$	$
	$	$	$	$	$	$	$
	$	$	$	$	$	$	$
	$	$	$	$	$	$	$
						Total *Actual* Overpayment	$

If additional space is required, attach a second sheet.

SECTION III—COUNTY WORKER COMPLETING FORM

Name (PLEASE PRINT)

County

Signature

EW No.

Phone Number
( )

MC 224A (2/89) (replaces MC 239E)

MEDI-CAL POTENTIAL OVERPAYMENT REPORTING WORK SHEET—PROPERTY

SECTION I

☐ IEVs ☐ non-IEVs

County ID: County Aid Serial FBU

Recipients Included In Potential Overpayment

Case Status
☐ Active—effective date: _____
☐ Closed—effective date: _____

Social Security Number

Recipient Phone Number
( )

SECTION II

Recipient should have been ineligible for Medi-Cal for _____ [month(s)/year(s)]

because property was above the allowable property limit.

The potential overpayment is computed as follows: (County completes boxes 1—4.)

1 Month/Year	2 Value of Property Held By Recipient	3 Medi-Cal Property Value Limits	4 Potential Overpayment (2—3)	DHS Investigations/Recovery use only 5 Amount Paid By Medi-Cal	6 Overpayment (lower of 4 or 5)
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$
			Total *Actual* Overpayment		$

If additional space is required, attach a second sheet.

SECTION III—COUNTY WORKER COMPLETING FORM

Name (PLEASE PRINT) County

Signature EW No. Phone Number
( )