Medi-Cal

Medi-Cal is California's program to pay for medical care for low-income people, especially families, children, the elderly, and people with disabilities. For information on applying for Medi-Cal in Los Angeles, you can phone (877)597-4777.

The state and federal government fund Medi-Cal. There are many Medi-Cal programs with different rules. Depending on which program you qualify for and how much money you make, Medi-Cal may pay for all your medical expenses or you might have to pay a share of the cost when you access health care services in a particular month.

AM I ELIGIBLE?

1. Groups of Eligibility

You can get Medi-Cal if you:

- Meet certain income and resource tests
- Are a California resident (which means that you intend to stay in California. This rule is not about immigration status)
- Fit within one of the eligible groups of people

The major groups who can get Medi-Cal are:

- People getting SSI, CalWORKs, foster care, adoption assistance, In-Home Supportive Services (IHSS), or certain immigrants receiving Entrant or Refugee Cash Assistance benefits. These groups get free Medi-Cal with no "Share of Cost."
- Pregnant women
- Children under age 21
- Adults 65 or over
- People of any age who are disabled or blind by SSI guidelines (whether or not you are getting SSI) (see page 26 "SSI")
- Certain families who are needy by CalWORKs guidelines, whether or not you are receiving CalWORKs (see page 4 "CalWORKs.) Briefly, one parent must be absent, deceased, medically documented as disabled or unable to work, unemployed, or under-employed. "Unemployed" means that the parent who has earned the most in the past two years is working less than 100 hours a month. "Underemployed" means that the family's earned income is below the federal poverty level.
- Caretaker relative of a minor child under 21
- Refugees (as defined by the federal government)
- People living in a skilled nursing home
- People infected with tuberculosis(unless undocumented)
- Women diagnosed with breast or cervical cancer.

Besides fitting into one of the above categories, you must also meet certain income and resource limits, described on pages 44 and 45.

2. Immigration status

If you are a California resident and meet other Medi-Cal requirements, you can apply for a restricted Medi-Cal card, even if you're undocumented. Restricted Medi-Cal means that you can get Medi-Cal to pay for emergency services, pregnancy-related care and long term care services.

Most legal immigrants can get regular (also called full-scope) Medi-Cal to cover all their medically necessary health needs. Many immigrants can get full health coverage, even if they do not have a green card, for example those who are victims of domestic violence, or those in the process of adjusting their legal status (i.e., they are applying for Legal Permanent Residency).(See page 60 Guide for Non-Citizens)

If you are receiving CalWORKs, SSI, foster care, certain refugee benefits, or In-Home Supportive Service (IHSS) you get Medi-Cal automatically and do not need to apply separately.

HOW DO I APPLY?

1. Get an application form

You can get one mailed to you by calling the DPSS toll-free number at (877) 597-4777. You can fill the application out and mail it back in. Or you can get one at a DPSS Office. (See page 66 "Welfare Offices.") Or you can get one at many hospitals and clinics, whether they are private or county-run. A few schools in Los Angeles County can have children apply for Medi-Cal at the same time they apply for the Free and Reduced-Cost Lunch program, using the same application.

2. How Children Can Get Medi-Cal Faster

If you are applying for Medi-Cal for your children under age 19 you should use the "Joint Medi-Cal and Healthy Families mail-in application." You can get one mailed to you from (877) 597-4777 or (800) 880-5305 (this number may have more staff speaking languages other than Spanish or English). Once you send in your mail-in application and it is screened and it appears that your child qualifies for free Medi-Cal, your child will receive no-cost Medi-Cal temporarily while the county reviews your application for Medi-Cal. If your child qualifies, your child will have all the benefits of Medi-Cal for at least two months, beginning with the first day of the month in which your mail-in application was received.

If your child instead seems to qualify for the Healthy Families program, you will receive a letter within 10 days. (see page 48 "Health Care for Children.")

If the LA County Department of Public Social Services (DPSS) determines that your child is eligible for Medi-Cal, the no-cost Medi-Cal will continue (beyond the temporary period) until your child is found no longer eligible for Medi-Cal, as long as you turn in your paperwork every year.

If DPSS determines that your child is not eligible for no-cost Medi-Cal, your child's accelerated enrollment will end on the last day of the month in which DPSS makes that decision.

The **income limits** to get free Medi-Cal depend on whether you are a family, a child, 65 or older, or disabled. If your income is too high to get free Medi-Cal, you can still qualify, but you will have to pay a share of cost.

Income Limits (accurate until April 2006)

Number of Persons	Pregnant Women and Children to Age 1 (count pregnant women as 2)	Children age 1 through 5	Children age 6 through 18: Parents and relatives caring for children	Need Level
1	$1,595	$1,061	$798	$600
2	$2,139	$1,422	$1,070	$750
2 Adults				$934
3	$2,682	$1,783	$1,341	$934
4	$3,225	$2,145	$1,613	$1,100
5	$3,769	$2,506	$1,885	$1,259
6	$4,312	$2,868	$2,156	$1,417
Each additional person:	+ $544	+ $362	+$272	+$134

This application has a place to check if adults in the household want Medi-Cal, too. The Medi-Cal worker should call and follow up to help the adult apply.

2. CHDP "Gateway"
Children who receive a CHDP visit are screened for temporary eligibility for Medi-Cal. If a child is eligible, he/she is pre-enrolled in temporary, full-scope Medi-Cal at no cost for up to 60 days (for the month of the visit and the month after). See pg. 49 for a full description.

3. Deemed Eligibility for Infants

Infants who receive a CHDP visit who were born to a woman on Medi-Cal at the time of birth and who were living with her at the time should receive Medi-Cal ongoing until the age of one, when an annual redetermination form must be filled out.
For questions or problems with this, call MCH Access (213)749-4261 or the Health Consumer Center (800)896-3203.

4. Fill out and turn in the form

If you want help, or are disabled, it may be a good idea to get help filling out the form in an interview with an eligibility worker at a Medi-Cal office, or other site but it is not required. The Medi-Cal office is required to provide translation services and to assist you if you have a disability that makes it hard for you to complete the application. You will go over the form you filled out and may be asked for additional information. If more information is needed you will be given a list of what is needed and a specific date by which the information must be mailed to the Medi-Cal office. A "return appointment" is not necessary.
If you do not have all the necessary documents, you or someone you know may sign a statement explaining why not. You may be able to receive benefits while you continue to gather the required information. The eligibility worker should help you get some of your missing papers. Give DPSS copies, not originals, of any documents.
Make a copy for yourself! Then hand in or mail in the form. Get a receipt if you hand in the form. If you mail the form it is a good idea to send it by certified mail to get back a receipt proving DPSS got it.

5. Provide needed papers

• Identification with your name and current address on it. For example, a birth certificate, driver's license, or California ID card. If you lack ID, you can also fill out a form called "PA 853" and swear that you are who you say you are), or documents requred to verify income or disability status may also serve as proof of identity.
•Social Security Number or Card (or proof of application for the card) for those requesting "full-scope" benefits.
•Proof of income (like check stubs, a W2, a copy of your tax return, or monthly bank statements if you have a bank account, or a self-affidavit (statement of income if you are paid in case or do not have any other way to prove income)
•Proof that you live in Los Angeles County (a document that has your name and an address on it, school attendance records, pay stubs, etc.) for each adult on the application. To be eligible, you must be a "resident", which means you must live in the state and intend to stay (even if undocumented)
•Proof of citizenship or acceptable immigration status for each person on the application that has declared acceptable immigration status. If you are a parent applying for children only, you do not need to submit proof or your immigration status.
•Proof of your housing situation (rent receipts, lease agreement, etc.)
•Vehicle registration if ownership of more than one vehicle is declared.
•Verification of child or dependent care, educational expenses and/or health insurance premiums or court ordered child support payments can be used as deductions, but are not needed to determine eligibility.

6. Cooperate with Child Support Services

If one parent is absent, you have to cooperate with DPSS and a county agency called the Department of Child Support Services (DCSS.) You must provide information you have about the other parent such as an address or social security number, to establish who your child's absent father or mother is and whether that parent can provide the child with medical insurance.
If you do not cooperate with DCSS you are denied Medi-Cal, but your children

do not lose coverage. Cooperation is not required if applying only for the children. Once the children are receiving Medi-Cal they can't be cut off because of a parent's non-cooperation with DCSS. Pregnant women do not have to give information to DCSS until after the birth of the baby.

Under some circumstances you have good cause for not cooperating. Talk to your worker about this. For example:
- You don't know where the absent parent is, or have no other information about the other parent,
- You are afraid of the absent parent, you or your children may be in danger, or you are a victim of domestic violence
- Rape or incest has occurred
- You are planning to place the child for adoption

7. Wait for Approval

Normally, the Medi-Cal office will approve or deny your application within 45 days of receiving it, except for the faster ways for children, described above. If the state must evaluate a disability, the approval or denial can be delayed up to 90 days. Call (877) 597-4777 or a legal aid office for help if you are not contacted within 45 days about your Medi-Cal. If Medi-Cal says that you are not eligible, you can appeal the denial of benefits. (see pg. 62 Hearings and Complaints)

8. The Medi-Cal Card

Once you have been "approved," you may ask your worker for a written verification of your eligibility status from the Medi-Cal Eligibility Data Systems (MEDS) or your medical provider may be able to verify your eligibility status through their Point of Service system.

Your permanent white plastic Medi-Cal card is mailed to your address. It is called a "Benefit Identification Card" or BIC. Each person listed on your application will get one, even if they aren't eligible for Medi-Cal, because if the family must pay a monthly Share of Cost, the medical expenses of every person listed on the application can be used to meet the Share of Cost. If you don't get your plastic card by the end of the month, or if you lose your card, contact your worker.

9. Authorization for service under Fee-for-Service or "Regular" Medi-Cal

When you are not in a health plan, before many medical services can be performed for you the state has to give an authorization for the service. This does NOT apply to emergency care, office visits, and most drugs). It is the job of the doctor, pharmacist, or other service provider, not the patient, to get this authorization from the state. However, if the state denies or changes the authorization, the state will notify you and your doctor. You can appeal any unreasonable delay, denial, reduction, or termination of care. (See pg. 62 "Hearings and Complaints") for information about grievances and complaints.

10. If you are pregnant

If a woman is not more than 30 weeks pregnant and has too much income to be eligible for Medi-Cal, she may be eligible for a program called AIM (Access for Infants and Mothers) may help. Call AIM at (800) 433-2611.
Any pregnant woman can be "presumed eligible" at certain clinics and given limited pregnancy-related Medi-Cal immediately, without proving pregnancy or providing information on property, car, or resources. This will help you get early prenatal care, lab tests and medication. You still have to turn in a regular Medi-Cal application and provide the resources information by the end of the next month if you want to continue your Medi-Cal. Even to get full Medi-Cal you have 60 days to provide proof of pregnancy.
When you apply for Medi-Cal during pregnancy, you should add your spouse or any other eligible children to your case.

Call your worker to report the name and date as soon as the baby is born to add the new baby to your family case record. Later get a document of the birth to the worker as soon as possible. The baby needs his or her own card by the end of the month after birth. But, you should not have to fill out a new Medi-Cal application for your baby. If you have trouble reaching your worker to tell the worker about the birth of your baby, some WIC offices and clinics have "Newborn Referral Forms" you can mail to DPSS. Or you can get one yourself on the computer at http://dhs.ca.gov/publications/forms/Medi-Cal/eligibilitybytitle.htm and download the form called, "Newborn Referral" . It is number MC 330.
If you take your baby to a CHDP provider, this can also activate a new case for the baby through the "CHDP Gateway"(see pg. 49)

11. If you are disabled

If you have specific severe physical or mental problems, (such as mental retardation or inability to walk) or if you have AIDS, you may also be able to get Medi-Cal based on disability even before the state determines you are disabled. Bring medical reports that show you are disabled when you apply. Both children and adults can get disability Medi-Cal.

12. If you are a woman with Breast or Cervical Cancer

If you are a woman under 65 without health insurance who has been both screened and diagnosed with breast or cervical cancer, you can get free Medi-Cal immediately, and during the entire time you are receiving cancer treatment, if your monthly income is less than $1595. There are no resource limits for this program. To get on Medi-Cal right away (called "accelerated eligibility"), you must go to a provider who participates in this program to file an internet application. You should state that you want the internet application to serve as a Medi-Cal application so you will be eligible for the program for a longer period of time.

To find a county facility who participates in this program or who will screen you for cancer, call the Los Angeles County Office of Women's Health at (800) 793-8090. If you cannot qualify for the above program because of age or immigration status, you may still get time limited Medi-Cal for cancer-related services only under a more limited "state only" program. Under that program, breast cancer treatment is limited to 18 months and cervical cancer to 24 months. Call the above number for more information.

13. Retroactive Benefits

If you had medical, dental or pharmacy services from a Medi-Cal provider in the 3 months before you applied for Medi-Cal, ask your worker for a form to apply for "retroactive benefits." The mail-in application also asks if you want this. If you were eligible for Medi-Cal during those 3 months, Medi-Cal may pay those bills. If you've already paid the bills and Medi-Cal covers the services, your clinic, doctor, dentist, or pharmacist must provide the refund to you. If you have trouble getting a refund, call The Health Consumer Center at (800) 896-3203.

INCOME LIMITS

Your **countable income** determines whether or not you can get Medi-Cal for free or whether you have to pay a "Share of Cost." (You only pay a "share of cost" in months when you actually use services.) Certain types of income don't count or can be subtracted. The several different Medi-Cal programs count the income limits differently.

As described below, in some Medi-Cal programs, hundreds of dollars of your gross total income will not be counted. Medi-Cal can only count the income of the family unit being given the Medi-Cal benefit. Don't count the income of your grandparents, brothers, sisters, uncles, aunts, cousins, friends or others who live in the house, but are not part of the application.

As a general rule, families applying for Medi-Cal can deduct from total income:

- $90 each month for each working adult
- Up to $175 for child care for each child age two and over
- $200 for childcare for each child under age two
- Court-ordered child and spousal support paid
- Educational expenses
- Business expenses of self-employed parents.

Once a family qualifies for Medi-Cal, hundreds of dollars of their earnings might not count against their eligibility. For example, they can deduct the first $240 of income plus half the remaining earned income.

Elderly (65 and older), blind or disabled persons can deduct:

- $20
- $65 from earned income
- Half of any remaining earned income
- Any health insurance premiums paid by you.

Some elderly or disabled people, even though not receiving SSI, may get free Medi-Cal if your countable monthly income is less than $1048(an individual) or $1457 (a married couple, both disabled or elderly). This is called the "Aged and Disabled Federal Poverty Level Medi-Cal program. You cannot get free Medi-Cal if income is even a dollar over these limits. Special income deductions and exemptions apply, so even if you think your income may be too high, you can apply and check with your Health Consumer Center at 800-896-3203 or Legal Aid.

Special low-cost Medi-Cal for working disabled persons:

If you are a disabled working person, you can get lower cost Medi-Cal if your income is less than $1,940 for an individual or $2,603 for a married couple, both disabled and working). ("Working" means having any monthly earned income) This is called the "250% Working Disabled Medi-Cal" program. If you qualify, you will have to pay a monthly premium that goes up the more income that you have. These monthly premiums range from $20 to $250 for an individual and $30 to $375 for a couple (both receiving 250% benefits). Again, special income deductions and exemptions apply, so apply even if you think your income may be too high and check with the Health Consumer Center (800) 896-3203 or Legal Aid.

SHARE OF COST

Some people must pay, or agree to pay, a "Share of Cost" for each month that you have a medical expense. Medi-Cal will then pay the rest of the bill for covered services that month. You do NOT have to pay a Share of Cost if:

- You are in one of the groups listed above that receive free Medi-Cal (such as those getting CalWORKs, SSI, foster care, adoption assistance, IHSS, 1931(b) Medi-Cal, or the aged and disabled programs)
- Your countable income is below the limit in the chart on page 42.

If you have Medi-Cal with a Share of Cost, your Share of Cost starts over every month. You don't have to pay anything in months that you have no medical expense. You can use your past medical bills and the medical bills of family members listed on your application to meet your Share of Cost, whether you have already paid those bills or not. You just have to be obligated to pay the bill. You cannot count the same billed item or service twice, but you can carry the balance of an unpaid bill over to later months if a bill is for more than your Share of Cost. If your income goes down, tell your worker so that your "Share of Cost" will go down.

1. Share of Cost for pregnant women

Any pregnant woman applying for Medi-Cal who is told she will have a share of cost should consider the Access for Infants and Mothers (AIM) program(call 800-433-2611.) An increase in income is not counted toward a Share of Cost during pregnancy and up to 60 days after the birth.

2. Share of Cost for children

Children whose income is too high for free Medi-Cal can get Medi-Cal with a Share of Cost, even if they also have the Healthy Families program [see the chapter Health Care for Children]. This can be helpful because Medi-Cal covers a broader scope of services than Healthy Families.

An increase in income is not counted toward a share of cost for children up to age 19 who are on no-cost Medi-Cal until their next scheduled annual redetermination. So, even if the child's parents start making more money and the parents have to start immediately paying a Share of Cost as a result, the child still receives Medi-Cal for free for a while.

3. Share of Cost if you are under 65, not blind, not disabled

To find out your monthly Share of Cost, start with your gross monthly income. Include spouse or parent income, but not other people living in your house. Subtract from this total your monthly child care expenses (up to $200 for a child under age 2 or up to $175 for a child age 2 or older) and $90 for work-

related costs and any health insurance premiums paid by you. Then subtract the need level for your family size on the far right side of the chart on the top of page 42. The balance is your monthly Share of Cost.

4. Share of Cost if you are over 65, blind or disabled

To find out your monthly Share of Cost, start with your unearned income, and subtract $20. Subtract any health insurance premiums paid by you. Subtract $65 from your earned income and divide the balance in half. Then subtract the need level amount for your family size in the chart on top of page 42 from that amount.

RESOURCE LIMITS

Unless the resource test does not apply to you, your family's resources must be below the following limits to get Medi-Cal:

# in Family	Resource Limit
1	$2,000
2	$3,000
3	$3,150
4	$3,300
5	$3,450
6	$3,600
7	$3,750
8	$3,900
9	$4,050
10 or more	$4,200

Some assets do not count. The home you live in, furnishings, personal items, and some non-term life insurance policies don't count. Other real estate with a value under a certain limit is not counted if it is sold or rented. For some Medi-Cal programs one car does not count, and for some programs a car is not counted if its value is under $4,650.
The Resource Limit does not apply to pregnant women for care related to their pregnancy. The Resource Limit does not apply to children under age 19.

Section 1931(b) Medi-Cal

You are probably getting "Section 1931(b)" Medi-Cal if you are caring for a child or children under 19 and you are getting free Medi-Cal which is not based on a disability. For this program, the resource limit for either one or for two persons is $3000. Otherwise the limits are the same as on the above chart. Like CalWORKs, the first car is not automatically exempt from the resource limit. A vehicle, regardless of it's value, does not count that is worth less than $1500 after deducting what you still owe on it and the cost of repairs and damages. Also, a vehicle worth less than $4650 does not count. If worth more, the extra amount counts against the $3000 resource limit. There are exemptions for vehicles used as part of employment and for transporting a family member with a disability.

STAYING ON MEDI-CAL

1. Once a Year Eligibility Form for everyone

People receiving Medi-Cal must have their eligibility rechecked (or "redetermined") every 12 months. You get a form in the mail, must fill it out and send it back. You do not have to send in copies of documents with your redetermination form. Until their 19th birthday, children only have to report changes in income or who is in the household at this annual eligibility review.

2. Mid-Year Status Report for Adults

Medi-Cal law has changed and adults now must fill out a new form – the Mid-Year Status Report (MSR) – in order to keep Medi-Cal. Some groups of people do not have to fill our the MSR: a child under 21; the parent or guardian of a CalWORKS child; pregnant women, or a woman in the Breast or Cervical Cancer Program. The report should come about 5 months after you start getting Medi-Cal and must be returned to the Medi-Cal office by the date on the form.

3. Reporting Changes for Adults

Adults must report to DPSS any significant changes that may affect your eligibility within 10 days after the change. You must quickly report to your worker if you move, begin making more money (or less money), someone moves in or out of your house or you are pregnant. Even if you report a change that hurts your eligibility, you have important rights before the DPSS cuts your Medi-Cal.

4. Losing welfare does not mean that you lose Medi-Cal

CalWORKs and Medi-Cal have different eligibility rules. While it is true that you automatically get Medi-Cal when you participate in CalWORKs, leaving CalWORKs (for example because of a sanction, time-limit, or failure to comply with GAIN, RITE or REP rules) does not mean that you lose free Medi-Cal. If you lose your Medi-Cal after you leave welfare, contact the Health Consumer Center at (800) 896-3203 or Legal Aid for help and advice.

5. Transitional Medi-Cal

You might be eligible for up to 1 year of free (no Share of Cost) Medi-Cal (called transitional Medi-Cal or TMC) if you lost CalWORKs or Section 1931(b) Medi-Cal because you started to work and are earning too much money. To be eligible, you must have received CalWORKs or Section 1931(b) Medi-Cal during at least 3 of the last 6 months, and you lost CalWORKs or Section 1931(b) Medi-Cal because you started making too much money. During the first six months of TMC if you are eligible, you and your family qualify for free Medi-Cal no matter how much income you have. After that, you remain eligible for TMC if your income is not more than the limits in the chart on the next page.

Adults can get TMC for up to one year and children can receive it for up to 6 months. There is no lifetime limit on TMC. If your income goes down you can qualify again for regular Medi-Cal. If it then goes up again you can return to TMC with new time limits. When children reach the 6 month limit, they are eligible for Healthy Families and should be "bridged" into the Healthy Families Program. (See pg. 48 "Health Care for Children")

There are no "resource" or property limits for TMC. TMC requires regular reports like a QR-7 for cash aid, but on a different form.

Income Limit for Transitional Medi-Cal

# in Family	Gross Income Limit
1	$1,476
2	$1,978
3	$2,481
4	$2,984
5	$3,486
6	$3,989
7	$4,491
8	$4,994
9	$5,497

6. Four Month Continuing Medi-Cal

If you lose CalWORKs or Section 1931(b) because you start getting more child or spousal support, an adult can get free Continuing Medi-Cal, regardless of your income, but just for 4 months. It is important that you turn in a CW-7 or any other change reporting form explaining why you are leaving CalWORKs or Section 1931(b), to help make sure you get Transitional or Continuing Medi-Cal. The children's free Medi-Cal continues until their next scheduled annual redetermination, perhaps as long as a year, because of "CEC" (Continuous Eligibility for Children.)

7. Former Foster Children

If you were in Foster Care on your 18th birthday, you are automatically eligible for free Medi-Cal until you turn 21, even if you income goes up. If you lose Medi-Cal , call the Health Consumer Center at (800) 896-3203 for assistance.

8. "Bridge" for children from Medi-Cal to Healthy Families

If Medi-Cal determines that your child is no longer eligible for no-cost Medi-Cal because of a change in family circumstances (e.g. because your family income has increased) DPSS is suppose to continue your child's Medi-Cal for at least one month while the county sends the information (with your permission) to Healthy Families to see if you child qualifies for that program. This is called the "*Bridging Program*." You should not be required to apply separately for Healthy Families or to provide any information again, unless they need it to find you eligible.

9. Keep Medi-Cal until DPSS proves you are no longer eligible

DPSS must send you a written notice of action at least 10 days before it cuts off, denies, delays or reduces your Medi-Cal benefits. The notice explains its action and your right to ask for a fair hearing. (See pg. 64 Hearings and Complaints).

Once you start getting Medi-Cal benefits, you have a special right called redetermination. That means that when a change occurs affecting your Medi-Cal eligibility, DPSS must determine whether you are eligible for any other type of Medi-Cal, before sending you a notice of action cutting off your benefits. They have to look in your available records, including CalWORKs, Food Stamps and other records for any missing necessary information. DPSS can send you a form that only asks for the information it needs; it cannot ask for information it already has or does not need to determine whether you are still eligible for Medi-Cal.

DPSS must give you at least 20 days to complete the form. If you do not send in a completed form, DPSS will send you a written notice of action that you will lose your Medi-Cal benefits. If your form is incomplete, DPSS must first try to contact you by telephone and writing to get missing information before it cuts your benefits. If you send in your form within 30 days of being cut from Medi-Cal, and that information show you were still eligible, DPSS must restore Medi-Cal benefits without making you reapply.

10. If You Move

You should have no interruption of service if you move within California. Keep using your Medi-Cal card. If you move to a new county, report if you can to DPSS and also to the welfare office in the new county, and the counties will manage the transferring of your case.

11. If You Were Billed Twice

The doctor or health service provider cannot bill both you and Medi-Cal for the same care. If you think your doctor has billed you unfairly, you should contact the Health Consumer Center at (800) 896-3203 or Legal Aid.

12. Lost or Stolen Cards

Notify your worker and a replacement card will be sent to you. If there is a medical emergency, you may receive a written notice of eligibility at your welfare office.

HOW DO I CHOOSE MY CARE?

There are two ways to receive your medical care under Medi-Cal:
"Fee for service" (regular Medi-Cal), or HMO ("Health Maintenance Organization.") These are also called "health plans" or "managed care." Most participants must enroll in a HMO.

Medi-Cal recipients who may, but do not have to, enroll in an HMO include:
- People who get Medi-Cal through SSI
- Children in foster care or the Adoption Assistance Program
- Recipients over 65 years old
- Certain pregnant woman
- People who get health care from an Indian Health Service Program.

Medi-Cal recipients who cannot enroll in a Medi-Cal HMO
- People who get Medi-Cal only for emergency and pregnancy related services (restricted Medi-Cal)
- Recipients with a Share of Cost or who also have private insurance, CHAMPUS PRIME HMO, or Medicare HMO.

1. Fee for Service (Regular Medi-Cal)

In regular Medi-Cal you can use any doctor, clinic, hospital, pharmacy or other provider willing to accept Medi-Cal. You must tell the doctor or clinic that you have Medi-Cal before you get care. If you don't, the provider can legally bill you for all services that you get. A provider cannot accept your Medi-Cal for some part of your care and then charge you money and refuse to bill Medi-Cal for other parts of your care, unless that provider does not provide that service under Medi-Cal. For example, a doctor cannot accept your Medi-Cal for your prenatal care but then refuse to bill Medi-Cal for your blood tests and try to charge you.

2. HMO ("health plans")

When you join a HMO, you must see the doctors, pharmacists and hospitals that are part of your plan. You must select a HMO and a primary care provider that is in the HMO. Unless you have an emergency, you must get approval for all care from your primary care provider. The HMO will receive money each month for your health care even if you don't get services. The HMO is responsible for providing or making arrangements for you to get all Medi-Cal covered services. Every one is supposed to be seen by a doctor within 4 months of joining the HMO.

After you are in a HMO, you may still use your Benefits Identification Card (BIC) to get family planning, dental, and mental health services outside of the HMO.

3.Dental care

Dental care is fee-for-service in Los Angeles unless you choose to join a dental plan. In fee-for-service, you must get all your dental services from a dental provider willing to accept Medi-Cal. If you decide to join a dental plan, you must select a primary care dentist and you must start all dental care with this dentist.

4. How to Choose a HMO

When you first enroll in Medi-Cal you will get a packet in the mail from the state. The packet will contain a "Medi-Cal Choice Form" that must be filled out with the doctor and HMO for each person in the family who is required to choose a HMO. You should get a big book with all the doctors, doctor groups and HMO choices. Fill it out the "choice form" and send it back to Health Care Options within 30 days. Keep the pink copy of the form for your records. It's a good idea to send the form by certified mail. If you don't complete the form and return it within 30 days, the state will choose a HMO for you that may not be convenient for you. To get a packet or more information, call Health Care Options at (800) 430-4263 or (800) 430-9009. The TDD line for hearing impaired is (800) 430-7077.
Consult with any health care provider you already have and want to keep seeing before choosing a plan. Also ask if you can keep going to the clinic, pharmacy and hospital you want.
You and your other family members may choose to join the same HMO and chose the same doctor, called a "Primary Care Provider" (PCP), or you can choose different HMOs and PCPs. Once you select a HMO, you will be mailed a plastic HMO membership card to use when you need medical services. Enrollment usually takes 30-45 days. If you or your family need medical care before you receive the HMO card, you may use the regular Medi-Cal card, or if you are already in a HMO and are just switching plans, use your current HMO until you are told you are in the new HMO.

People in the groups that may, but do not have to, enroll in a HMO will now automatically get a packet in the mail even though they do not have to join a plan. You should not be asked to make a choice of a HMO when you apply or at your redetermination. People who are already in an HMO when you apply for Medi-Cal should not get a packet in the mail.
You may be asked to attend a "Health Care Options" talk. You do not have to go. If you go, you do not have to choose a plan that day unless you want to.
You will get a second envelope in the mail about dental managed care. It is optional; you don't have to enroll. You can still use your Medi-Cal card with any dentist who accepts Denti-Cal.

5. Medical Exemptions

Most participants must enroll in a HMO; unless you apply for and receive a "medical exemption" in order to keep regular fee-for-service Medi-Cal. You may get an exemption if you have a "complex medical condition" such as pregnancy, kidney disease, diabetes, HIV/AIDS, cancer, asthma, or multiple sclerosis, or if you are in an Adult Day Health Care Program or if you receive skilled nursing services at your home. If one of your doctors or clinics that treat you is not part of any available offered HMO and you would lose them if you joined a HMO, you may qualify. You and your doctor must fill out a form (which is in the packet that you get in the mail) and send it to the state.
You may also call Health Care Options with any questions.
The exemption is good for up to one year, then you will get another packet in the mail to complete, or you must ask for another medical exemption.

6. Fees

In both HMOs and regular Medi-Cal, you may have to pay $1.00 for prescriptions and many services unless you are pregnant, over age 64, or under age 19. Also, there may be a charge of $5.00 for non-emergency care given in the emergency room. The state may increase these charges next year.

7. Hearings, Grievances, and Leaving a HMO

If your HMO denies services or you are not satisfied with the services, you have many options. You can file a grievance with your HMO. Your HMO must tell you how to file a grievance. The HMO must resolve your grievance within 30 days, or less if you have an emergency. If you are still not satisfied complain in writing to the Department of Managed Health Care HMO Help Center, IMR Unit, 980 Ninth Street, Suite 500, Sacramento, CA 95814-2725. Their phone number is (888) HMO-2219, TDD (877) 688-9891. Or you can go to their website at www.hmohelp.ca.gov.

Mandatory participants in HMOs can change to a different HMO for any reason. Voluntary participants can change HMOs or can go back to regular Medi-Cal for any reason. To change or leave a HMO, call Health Care Options at (800) 430-4263 and request a "choice form."

If you want help with complaints and grievances call an advocacy group for assistance or call the Health Care Consumer Center at (800) 896-3203 or the Managed Care Ombudsman (888) 452-8609. the Department of Managed Care at (888) HMO-2219 or the Medi-Cal Managed Care Ombudsman at (888) 452-8609. You can also find information online at www.dmhc.ca.gov/gethelp/complaint.asp.

You can call (800) 400-0815 if your HMO gives you problems.
If your HMO is denying you care because it does not think it is medically necessary, but you disagree, you can ask for an independent medical review. An independent medical review is done by a group of doctors and professionals who do not work or accept money from your HMO.

You have the right to ask for a fair hearing. (see page 62, "Hearings and Complaints.") While waiting for a state hearing, the HMO must continue to provide medical services to you.

8. Medi-Cal Mental Health Managed Care

Mental Health services for Medi-Cal recipients are also provided through a managed care system operated through "Local Mental Health Plans" in each county. For further discussion of these services (see page 51 "Mental Health..Services.")

MEDI-CAL FOR TEENS

If you are between 12 and 21 years old, you can apply for "Minor Consent Services" to get free and confidential medical treatment without parental consent related to:

- Drug or alcohol abuse (except methadone treatment)
- Sexually transmitted diseases
- Pregnancy and abortion
- Family planning
- Outpatient mental health (not overnight in a hospital)
- Sexual abuse.

If you are under 21 and living with your parents, or temporarily away such as in school, you may apply for Medi-Cal to cover those specific services without your parents' consent or knowledge.

Your parents won't be required to give information about their income or resources or pay toward the medical services, unless you want Medi-Cal for services other than those listed above.

The DPSS won't tell your parents or send Medi-Cal mailings to your home without your permission. ''Minor Consent Services" are available regardless of your immigration status. They provide more services than Medi-Cal that is restricted due to immigration status.

To apply, fill out the regular Medi-Cal application and another short form for Minor Consent Services at DPSS or with an Eligibility Worker at the site where you are receiving care. You will have to fill out a new short form each month you need treatment, except for mental health services. For that, you need a letter from a mental health professional explaining that you meet certain conditions for getting mental health services and how long you will need treatment. You will still have to complete the short form each month to update your eligibility.

If you already get Medi-Cal through your parents' case, you may already have a plastic Medi-Cal card. But don't use the plastic card for Minor Consent services.

Health Care for Children

HEALTHY FAMILIES PROGRAM

Healthy Families is a program that provides low-cost health insurance for many low-income children. With Healthy Families, a family pays a small amount each month to receive health care for their children.

1. Am I Eligible?

To be eligible the applicants must be low-income, uninsured California resident children ages 1 to 19, who are not eligible for free Medi-Cal (Medi-Cal without a "Share of Cost") and who have had no other health insurance. The child must be without employer or private health insurance for at least three months before the application, with some exceptions. The child can obtain three months of retroactive Medi-Cal prior to becoming eligible for Healthy Families, or can be on "Share of Cost" Medi-Cal. Eighteen-year-olds can apply on their own. The child stays eligible for 12 months continuously once it is decided that he or she is eligible, even if the income changes.

2. Income Limits

To be eligible for Healthy Families, the monthly income must be between the amounts in the chart below.

Family Size	Age 1-5	Age 6-18
1	$1,062 - $1,994	$799 - $1,994
2	$1,423 - $2,673	$1,021-$2,673
3	$1,785 - $3,353	$1,342-$3,353
4	$2,146 - $4,032	$1,614-$4,032
5	$2,507 - $4,711	$1,886-$4,711
6	$2,869 - $5,390	$2,157-$5,390

Each additional member: +$680 to the number on the right hand side.

The cost of the items you own ("resources") does not count against you.

3. Residency Requirements

You must sign a statement that each person who is applying for Healthy Families intends to stay in California with no plans to leave. Immigrant children can be eligible if they are "qualified" immigrants (see page 58 "Guide for Non Citizens.")

4. What Does It Cost?

Depending on your income and which plan you choose, you will pay a premium of $4 to $9 per month for each child or starting July 1 of 2005, $12 to $15, if your income is slightly higher. However, you will never pay for more than 3 children, either $27 a month, or $45, depending on the income group you are in no matter how many children are covered. If a family falls in the higher income group, they will receive a report in the middle of the year to see if their income has dropped and they can pay less. Also, if a family pays three months of premiums in advance, they will get a fourth month of coverage for free. If a family pays 9 months in advance, they get 12 months of coverage. Except for the first month, you can pay your premiums at Rite Aid stores.

There is also a $5 co-payment for most outpatient services such as doctor's office visits, but not for preventive services like immunizations and dental check-ups. However, there is a "cap" or upper limit for these co-payments of $250 per family per year, so keep the receipts.