



champ | Children's Health Access
and Medical Program

A Program of the National Health Foundation

Adult Healthcare Programs

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English

Introduction

Using the manual to help adults access health coverage and services

Uninsured adults and those who assist them with accessing and using health resources need information about healthcare coverage and services for adults as well as their children! The information in this manual focuses on adults age 19 years old and above. However, some Medi-Cal programs cover all family members when there is linkage to a child (section 3).

This manual is designed for assistors who help families enroll in health coverage programs and who provide referrals to health services. Parts of Section 6 and all of Section 7 describe services available only to Los Angeles County residents, while other sections of the manual can be used by those assisting residents of any county in California. The term “assistor” as used in the manual refers to anyone who helps families identify and access health programs or health services. They may be health advocates who refer families to appropriate health resources or Certified Application Assistants (CAAs) whose primary role is assisting families enroll into health coverage programs.

Some of the important features of this helpful resource manual are listed below:

- Who is your client? (Page 1-3) matches health resources with the needs of adults by directing them to appropriate sections of the manual
- Screening guides (Beginning of Sections 3 and 4) help assistors compare programs and direct clients to appropriate Medi-Cal programs and services.
- Los Angeles County Programs (Section 7) describes health services that are specifically available to Los Angeles County residents
- Resource guide (Section 9) for assistors and clients who want to contact programs or find additional information on specific health programs and services
- Glossary (Section 10) defines terms used in the manual

Staying up to date on health programs and services for adults

Assistors who want to learn more about CHAMP, CHAMP-Net and National Health Foundation (NHF) are encouraged to use the contact information below.

- Call 1-213-538-0778 for more information
- Visit www.CHAMP-Net.org to learn more about CHAMP training and CHAMP-Net
- Visit www.nhfca.org for more information about National Health Foundation (NHF)

USE THE FOLLOWING CHART TO FIND HEALTH RESOURCES FOR CLIENTS

Look at the definitions under **Who is your client?** When you have found a description of a client who matches your client, use the page numbers at the right to direct you to the page containing health resources that may be appropriate for the client.

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General Overview of Medi-Cal Programs

What is Medi-Cal?

Medi-Cal is a program that pays for medically necessary health, dental, vision and mental health services for many low-income people. It provides comprehensive medical benefits to all individuals who are receiving CalWORKs and Supplemental Security Income (SSI) and to some other individuals who have limited resources and income.

Who is this program for?

Most Medi-Cal programs are for children under 21 years of age and adults 65 and older. However, there are many programs included under the Medi-Cal umbrella for adults between ages 21 and 65 who meet certain eligibility requirements. Sections 3, 4, 5 and 6 in this manual contain information on specific Medi-Cal programs and services for low-income adults.

However, not all low-income individuals or individuals needing healthcare can receive Medi-Cal services. Adults who do not qualify for Medi-Cal programs may be eligible for public or private programs described in Sections 6, 7 and 8.

What are the eligibility requirements?

In addition to meeting the residency, income and resource guidelines, individuals must fall into certain categories or have specific health care needs as indicated below:

- Persons receiving foster care or adoption assistance
- Aged (65 or older), blind or disabled according to Social Security Administration rules
- Some families with dependent children (must meet deprivation criteria)
- Families in transition from CalWORKs to employment
- Persons needing dialysis, tuberculosis services, breast or cervical cancer treatment or nursing home care
- Certain refugees and asylees
- Pregnant women and children under 21 may qualify for Medi-Cal

Eligibility requirements vary by Medi-Cal program. In addition to the requirements listed above, income and resources (for some programs only) will also be considered when determining eligibility.

What are the residency and citizenship requirements?

Applicants must be California residents to be eligible. Individuals with satisfactory immigration status or verified U.S. citizenship may be eligible for full-scope Medi-Cal at no cost and receive comprehensive services. Individuals who do not have satisfactory immigration status or verified U.S. citizenship may receive restricted or emergency Medi-Cal, which means that coverage is limited to pregnancy-related, nursing care and/or emergency care. Individuals living in California who fall under PRUCOL status (page 2-2) may be eligible for full-scope Medi-Cal.

What is PRUCOL?

PRUCOL (**P**ermanently **R**esiding **U**nder the **C**olor **O**f **L**aw) is a status applied to aliens residing in the U.S. The United States Customs and Immigration Service (USCIS) is aware that these persons are currently living in the U.S. and must provide the person with a “notice of action” stating that the application has been received.

Families need to inform Medi-Cal that they meet the satisfactory immigration requirements under PRUCOL and provide proof of their status to be able to qualify for full-scope Medi-Cal. Medi-Cal will then provide them with the appropriate forms to complete the Medi-Cal application process. For additional information on PRUCOL, contact a local Department of Public Social Services (DPSS) office or contact the Coalition for Humane Immigrant Rights of Los Angeles (CHIRLA) at 1-888-624-4752.

What benefits are covered?

Medi-Cal recipients who are eligible for no cost full-scope benefits receive comprehensive inpatient and outpatient health services and prescription drugs from Medi-Cal providers. Medical equipment and other benefits need prior approval. Some programs, such as restricted/emergency Medi-Cal and Minor Consent, cover only specific types of services, rather than full-scope coverage.

NOTE: Only some individuals are eligible for dental benefits. Please refer to the specific Medi-Cal program for more information.

How are services delivered?

In Los Angeles County, Medi-Cal recipients receive services in one of two ways:

- Fee-for-Service (FFS) In Los Angeles County, Share of Cost Medi-Cal beneficiaries use fee-for-service Medi-Cal, which means they can go to any healthcare provider who participates in Medi-Cal and receive care. Individuals who are eligible for restricted or emergency only Medi-Cal, including certain pregnant women who are eligible for pregnancy services only, are not eligible to join a health plan and will also receive care under FFS.
- Managed Care Certain Medi-Cal recipients who receive full-scope services will receive benefits from managed care plans. Most children, pregnant women (who are eligible to receive full-scope benefits), or families linked to CalWORKs or who receive benefits under 1931(b), receive services through managed care. Families under managed care will need to choose a health plan. Health Care Options is the organization in Los Angeles County that assists families with managed care enrollment, disenrollment, and transfers.

NOTE: Starting in June 2011, most seniors and persons with disabilities with Medi-Cal only (not Medicare) will be required to enroll in a Medi-Cal Health Plan. Beneficiaries have begun to receive notifications based on the month of their birthday to explain the changes. The transition will take place over a 12-month period starting in June 2011. For more information about these changes, visit: <http://www.dhcs.ca.gov/individuals/Pages/MMCDSPDBenInfCounty.aspx>.

Families and individuals who are enrolled in managed care will receive packets from Health Care Options for health plan enrollment. They will need to choose health and dental plans (only certain individuals are eligible for dental benefits) within 30 days of receiving their packets and should receive information and health plan cards from their health plan providers within 45 days.

In Los Angeles County, Medi-Cal managed care operates under a Two Plan Model, meaning that there is a commercial plan and a local initiative plan available to managed care recipients. The Commercial Plan is Health Net and its partner, Molina Healthcare. The Local Initiative is L.A. Care Health Plan and its partners, Blue Cross of California Partnership Plan, Inc., Community Health Plan, Care 1st Partner Plan, LLC, and Kaiser Permanente of California, LLC.

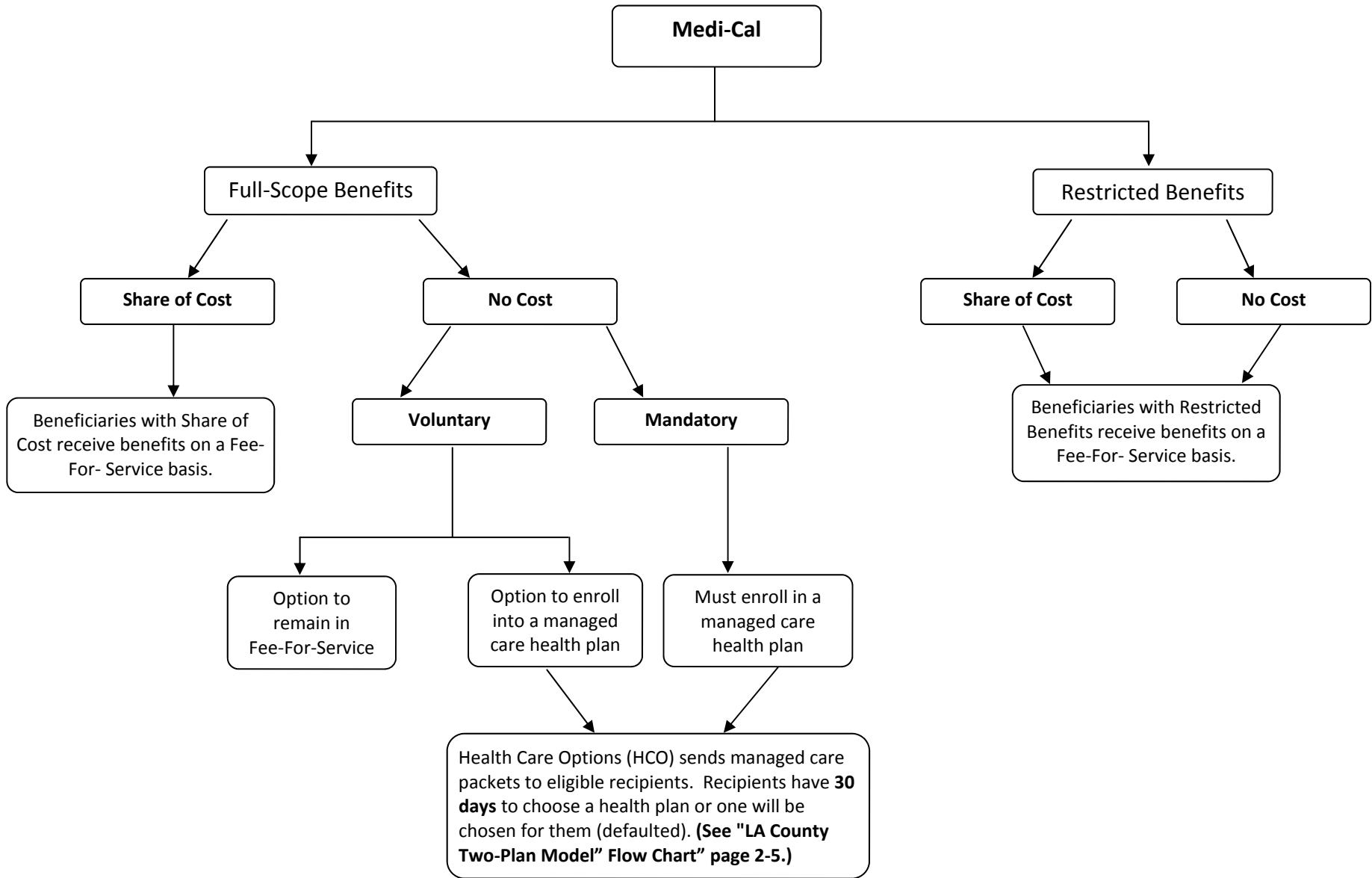
The service delivery method a Medi-Cal enrollee receives is determined by the Aid Code assigned by Medi-Cal. Dependent upon their aid code, certain enrollees are eligible to choose either fee-for-service or managed care.

What happens next?

After families or individuals have been enrolled in Medi-Cal, they should receive informational packets from the program that provides information on benefits, membership services phone numbers, directory listings of the participating providers and membership cards.

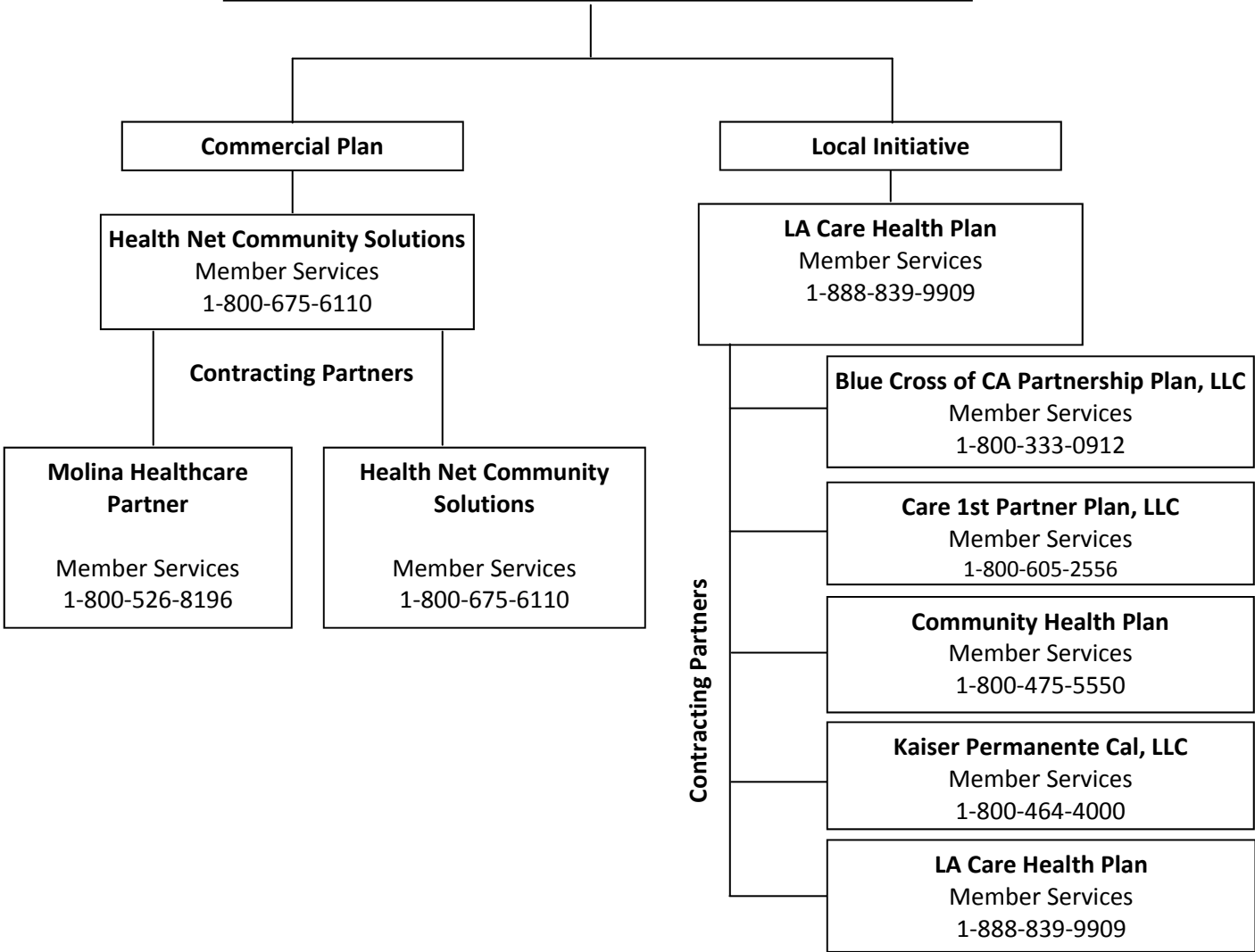
The following three pages provide additional information on how Medi-Cal is organized in Los Angeles County. Contact information is provided on the following pages.

Voluntary and Mandatory Medi-Cal Beneficiary Flow Chart



Los Angeles County Two Plan Model

MAXIMUS Health Care Options	
Armenian	1-800-840-5032
Cambodian	1-800-430-5005
Chinese	1-800-430-6006
English	1-800-430-4263
Farsi	1-800-840-5034
Hmong	1-800-430-2022
Lao	1-800-430-4091
Russian	1-800-430-7007
Spanish	1-800-430-3003
Vietnamese	1-800-430-8008



Medi-Cal Key Players in Los Angeles County

Department of Public Social Services (DPSS)

Determines Medi-Cal eligibility



Once Medi-Cal eligibility has been determined and family members are in managed care Medi-Cal, they will receive a welcome packet from the agency below.

Health Care Options (HCO)

Assists in enrolling eligible members into a health plan. HCO processes health plan enrollment, disenrollment, transfers between LA County's two main plans and Medical Exemption requests. For questions or problems call 1-800-430-4263.



Once families have selected their desired health plans, the family members who are enrolled in Medi-Cal should familiarize themselves with the member service departments of their selected health plans.

Member Services at the Health Plan

This is the department that family members can contact if they are having problems or delays when trying to access their healthcare services. See page 2-5 for phone numbers.

What is the cost?

Applicants who are not eligible for no cost Medi-Cal may be eligible for Share of Cost (SOC) Medi-Cal, which means that families or individuals must pay an amount each month for services before Medi-Cal pays. Under SOC Medi-Cal, there are no income limits for eligibility for those who meet program requirements, but the Share of Cost sometimes can be very high. The share of cost applies only to months when Medi-Cal services are received. If no Medi-Cal services are received during a certain month, families do not pay the share of cost.

How is share of cost determined?

Share of cost is determined by subtracting the Medi-Cal Maintenance Need Level (MNL) amount, according to family size, from the monthly family income after allowed deductions. The BIC (Benefits Identification Card) issued to Medi-Cal recipients will allow providers to get information about the SOC that must be paid by the recipient before Medi-Cal will pay.

The following table shows the monthly maintenance need level by family size.

Family Size	Monthly Maintenance Need Level
1	\$600
2 (one adult, one child)	\$750
2 (adults)	\$934
3	\$934
4	\$1100
5	\$1259
6	\$1417
Each additional person	Add \$14

For example, a family of four with a net monthly income of \$1,500 (after allowed deductions) would have a monthly share of cost of \$400 (net monthly income \$1,500, minus MNL for a family of four \$1,100, leaves a \$400 share of cost).

Are there resources limits?

Resources are items that a family may own and can include cars, houses, jewelry, savings or checking accounts, etc. Some Medi-Cal programs look at applicants’ resources. In order to be eligible for those programs, applicants’ resources must fall within approved limits. Most Medi-Cal programs use the **Resource Limit Chart** to determine resources (see chart on page 2-8).

Families do not have to count the house they reside in. Resource limits for a family of one is different for 1931(b) and other Medi-Cal Programs. Please see the chart on page 2-8 for more information.

Resource Limit Chart

Number in Family	Resource Limit (value of things owned)	Number in Family	Resource Limit (value of things owned)
1*	\$2,000	6	\$3,600
2	\$3,000	7	\$3,750
3	\$3,150	8	\$3,900
4	\$3,300	9	\$4,050
5	\$3,450	10 or more	\$4,200

**For Medi-Cal 1931(b), a family of 1 has a resource limit of \$3,000.*

There are special rules that apply to individuals who own their own businesses, and resource limits are different for the 1931(b) program and for families where one spouse is in long-term inpatient care. For example, under 1931(b), the value of a vehicle is taken into account, and households with one or two family members have the same resource limit of \$3,000 (see page 3-4 for more detailed information on Medi-Cal 1931(b)). Families should report all of their property and resources even though some things may not count.

What about other insurance?

Individuals and families are allowed to have private health insurance in addition to Medi-Cal coverage. Medi-Cal will pay last and will not cover co-payments or deductibles but will cover any eligible services not covered by private insurance. For example, a person who is covered by private insurance but whose coverage does not include pregnancy could use private insurance for other services but use Medi-Cal for pregnancy-related services. Some Medi-Cal programs cover dental services, while many private plans do not.

How to apply:

Interested applicants can find a district DPSS office in their area by looking in the local white pages under County Government to request mail-in applications, apply by phone or make appointments. They may also apply online: <https://www.dpssbenefits.lacounty.gov>. Applications may also be completed at community and county clinics, hospitals, some school sites and other locations where on-site Medi-Cal eligibility staff are located. Eligibility workers will help applicants make certain that all forms have been completed and verification documents submitted. Different programs may have different applications.

- Who can apply on behalf of the applicant?
When a person is unable to apply on his/her own behalf, spouses, legal guardians, friends, neighbors, hospital staff or public agency representatives may apply on their behalf. Applicants can name authorized representatives who have certain rights but cannot represent clients in all situations.
- How long does it take for a Medi-Cal application to be processed?
The date of application is the date on which the application is received by the DPSS office. Application processing time is no more than **90 days** for applicants who apply on the basis of disability, **45 days** for others. Los Angeles County has set a processing goal of no more than 30 business days.

- What is Retroactive Medi-Cal?
Beneficiaries may apply for Retroactive Medi-Cal for payment of medical bills incurred during the three-month period prior to application if they met Medi-Cal eligibility requirements during that time period.

Contact information:

For information or to receive an application for Medi-Cal, call 1-888-747-1222 or visit www.dhs.ca.gov/publications/forms/ to download a Medi-Cal application.



Assistor Tips!!!

- Screening adults for Medi-Cal program eligibility can be challenging because Medi-Cal follows a fixed priority in screening, first determining if there is a program for which the entire family qualifies in order to maximize benefits.

Screening Priority for Medi-Cal Applications

- ↳ 1931(b)
- ↳ 1931(b) Sneeede (if applicable)
- ↳ Transitional Medi-Cal (TMC) (if previously received 1931(b) or CalWORKs)*
- ↳ Continuous Eligibility for Children (CEC)*
- ↳ Aged & Disabled Federal Poverty Level (A&D FPL)
- ↳ Regular Medi-Cal (Medically Needy and Medically Indigent)
- ↳ Regular Sneeede
- ↳ Percentage Programs (for children and pregnant women)
- ↳ Healthy Families (for children up to age 19)

*For TMC and CEC, the application would have to be made during an existing eligibility period.

While Medi-Cal will screen first for the 1931(b) family programs, **approval for percentage programs for children and pregnant women should not be delayed** if resources/property is the only missing information. Medi-Cal should enroll those applicants in the appropriate percentage programs temporarily until they can be evaluated for the 1931(b) program.

- While income charts and guidelines can be helpful in guiding clients toward appropriate programs, there are various factors including immigration status, income deductions and exclusions, resources, and guidelines affecting step-families or families where children have their own incomes (Sneeede rules) that are taken into account when determining eligibility. In some cases, the assistor's most effective role may be in helping clients work with their eligibility workers to find the programs most appropriate for their specific circumstances, assisting clients during the application process and helping them understand communications from Medi-Cal.
- For access to All County Letters and All County Information Notices and answers to frequently asked questions about Social Services, visit www.dhs.ca.gov/mcs/mcpd/MEB/ACLs/default.htm.
- Remind adults to inform Medi-Cal of changes in address or other contact information and to pay attention to all communications from Medi-Cal and also their health plans if they are enrolled in managed care. Adults are required to fill out a Mid-Year Status Report (MSR) each six months for a determination of continued eligibility under Medi-Cal. Some individuals, including pregnant women, children and disabled recipients are exempt from the MSR requirement.

Medi-Cal Programs for Families, Parents and Caretakers

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Program Details

✧ **Medi-Cal 1931(b)**page 3-2

✧ **Transitional Medi-Cal** page 3-4

✧ **Four-Month Continuing Medi-Cal**page 3-6

✧ **Medically Needy Medi-Cal for Children, Parents and Caretaker Relatives**.....page 3-7

Who is eligible for programs in this section?

- The programs in this section provide healthcare coverage for the entire family. Parents, caretaker relatives and minors (0-21) may be eligible for healthcare coverage if they meet all of the eligibility requirements.



Assistor Tips!!!

- Assistors may be able to help applicants check their eligibility status in one or both of the following ways:
 - Medi-Cal uses various computer systems to verify eligibility status. Although most of these systems are not available for use by assistors or recipients, assistors may be able to work with the Children’s Health and Disability Prevention (CHDP) Program and/or Medi-Cal provider staff to check the status of Medi-Cal applications through the Medi-Cal Point of System (POS) data system.

Note: Other data systems used to verify Medi-Cal eligibility status:

- SAEVS (Supplemental Automated Eligibility Verification System)*
- LEADER (Los Angeles Eligibility Determination Evaluation Reporting System)
- MEDS (Medi-Cal Eligibility Data System)
- AEVS (Automated Eligibility Verification System)*

* This service can be used by non-providers. Call 1-800-427-1295 for more information.

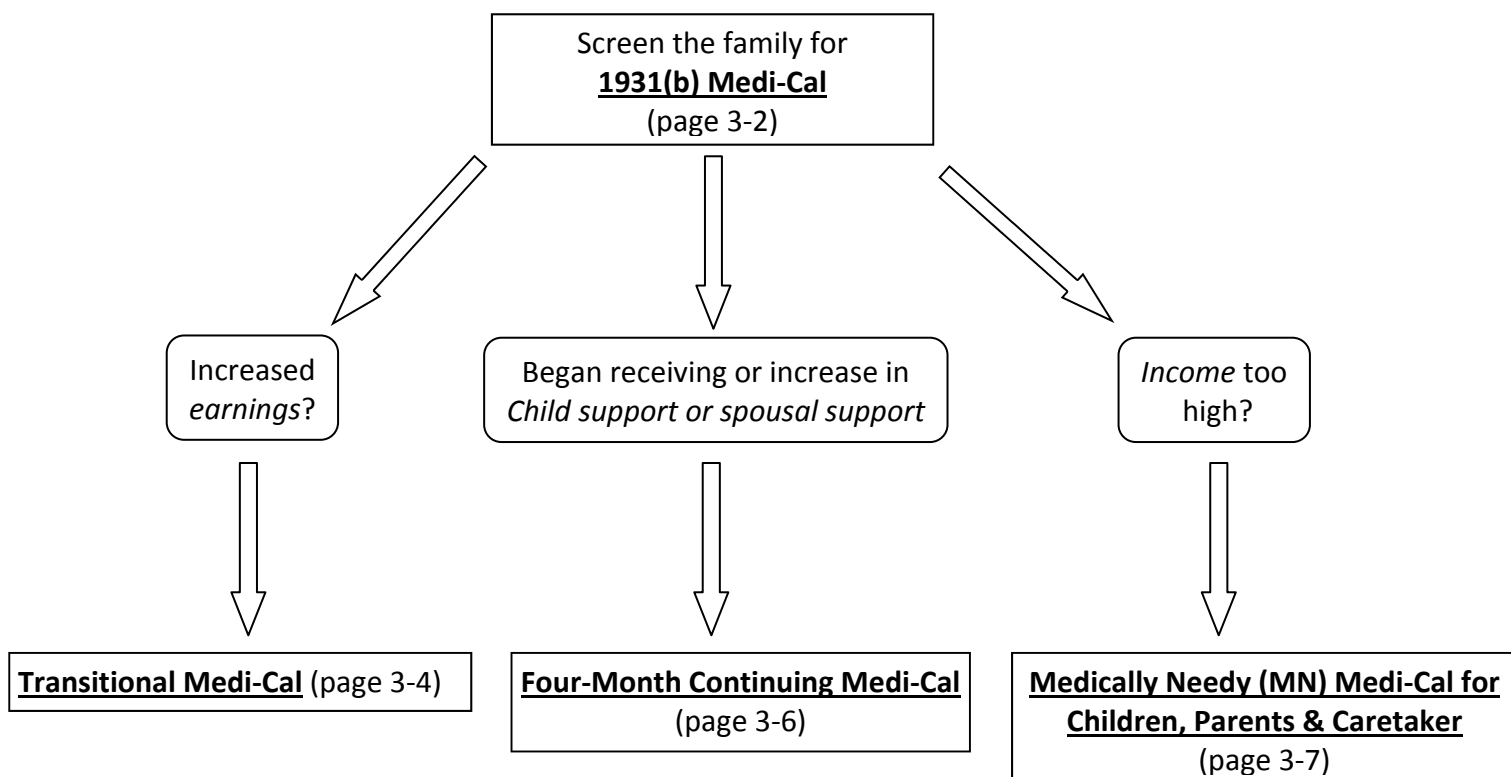
- Applicants can fill out a form to designate assistors as their authorized representatives. Assistors can then contact applicants' eligibility workers to inquire about eligibility and case status. This form must be provided to the eligibility worker before information can be provided to the assistor.
- Families enrolled in Medi-Cal have a right to a State Fair Hearing if the health services they want or need are unfairly denied, delayed or stopped. Hearings must be requested within 90 days of the denied, delayed or stopped services. A request may be submitted in one of three ways:
 - To the county welfare department at the address shown on the Notice of Action
 - To the California Department of Social Services, State Hearings Division, P.O. Box 944243, Mail Station 19-37, Sacramento, California 94244-2430
 - To the State Hearings Division at fax number (916) 229-4110

OR

You may make a toll-free call to request a State Hearing by calling:
California Department of Social Services
Public Inquiry and Response
Phone 1-800-952-5253 (Voice)
1-800-952-8349 (TDD)

Screening Guide: Medi-Cal Programs for Families

Follow the flow chart below when screening a family for Medi-Cal. First screen the family for eligibility for Medi-Cal 1931(b). Proceed with the following programs based on whether there was an increase in income, earnings or child and/or spousal support.



Medi-Cal 1931(b)

Who is this program for?

Medi-Cal 1931(b) provides no-cost medical benefits to low-income families (children, parents and caretaker relatives):

- who receive CalWORKs payments
- OR
- who do not receive CalWORKs but who meet the eligibility requirements that were in place for the Aid to Families with Dependent Children (AFDC) program with the passage of welfare reform legislation on July 16, 1996.

What are the eligibility requirements?

- CalWORKs families automatically qualify for Medi-Cal 1931(b)
- OR
- Families that are California residents with children through age 18 (19 if attending school) where deprivation exists. Deprivation means that one or both parents are disabled or a child is considered deprived of parental support because one or both parents are absent, unemployed, incapacitated, underemployed or deceased. Underemployment means working less than 100 hours per month.

NOTE: The primary wage earner can work 100 hours or more a month if the family's earned countable income is at or below 100% FIG. If the family's earned countable income is above 100% FIG, the primary wage earner must work less than 100 hours per month.

Related caretakers may qualify for this program if they provide care and supervision to children when there are no natural or adoptive parents in the home. The caretaker must have a relation to the child by blood, marriage or adoption. Medi-Cal makes a determination based on whether caretakers have responsibility for the children living in their homes depending on various factors, such as whether they make health and school related decisions for the children.

If the child's parent does live in the home, a relative that can prove they make the child's health and school decisions may still be considered eligible for Medi-Cal 1931(b) as the child's caretaker relative. In those situations, there could be a Medi-Cal case that includes family members from three generations, for example, grandmother, mother and child.

Income requirements and options for applying deductions are more generous under Medi-Cal 1931(b) than they are for CalWORKs. Therefore families who lose CalWORKs or who did not receive CalWORKs may still be eligible for Medi-Cal 1931(b).

(Visit <http://healthconsumer.org/cs0151931b.pdf> for details on options for 1931(b) deductions.)

Medi-Cal 1931(b) has different rules for determining eligibility for "applicants" and "recipients".

- An applicant is a person/family who did not receive Medi-Cal under CalWORKs or the Medi-Cal 1931(b) Only Program in any of the four prior months.
- A recipient is a person/family who received Medi-Cal under CalWORKs or Medi-Cal 1931(b) Program in **one (or more)** of the **four** prior months.

How does immigration status affect eligibility?

In order to receive full-scope benefits, satisfactory immigration status or verified U. S. citizenship is required. Restricted or emergency services, including pregnancy-related care, are available when satisfactory immigration status is not present or U. S. citizenship is not verified.

What benefits are covered?

Benefits are either full-scope or restricted depending on immigration or verified U. S. citizenship status.

How are services delivered?

- Full-scope beneficiaries generally receive services through managed care plans. Family members go to providers, hospitals, clinics and pharmacies that participate in their particular health plans. Family members can choose different plans if they wish.
- Individuals who are eligible for restricted Medi-Cal, are not eligible to join a health plan and will receive care under FFS.

What is the cost?

There is no cost.

Do resources count?

Yes, resources do count. The family has 10 days to notify Medi-Cal of any changes. Resource requirements are different for Medi-Cal 1931(b) than for other Medi-Cal programs in the following ways:

- The value of the first car is counted based on the vehicle determination worksheet (unlike other programs where the first car is generally not counted). The first \$4,650 is exempted from the value of the first car. Cars with a value of less than \$1,500 are not counted. The first home, clothing, and certain other items are also not counted.
- Family sizes of 1 have a resource limit of \$3,000 and a family size of 2 also has a resource limit of \$3,000. For each additional family member, \$150 is added to the property limit (see page 2-8 for a chart of resource limits).

How to apply:

Interested applicants can find district DPSS offices in their areas by looking in their local white pages under County Government to request mail-in applications, apply by phone or make appointments. For a list of local DPSS offices or an application visit: <http://dpss.lacounty.gov>. They may also apply online: <https://www.dpss.lacounty.gov>.

Contact Information:

For more information or to receive an application for Medi-Cal, call 1-888-747-1222. Call the Medi-Cal Health and Nutrition hotline at 1-877-597-4777, visit <http://dpss.lacounty.gov> or visit a local Department of Public Social Services office or visit www.medi-cal.ca.gov for more information on Medi-Cal programs.

NOTE: If families are denied Medi-Cal, make certain that Medi-Cal 1931(b), not CalWORKs, rules were applied. If they have lost CalWORKs, find out if they have been screened for Medi-Cal 1931(b).

Transitional Medi-Cal (TMC)

Who is this program for?

The program provides up to 12 months of no-cost benefits to families that have lost eligibility for CalWORKs or Medi-Cal 1931(b) due to increased employment earnings.

What are the eligibility requirements?

- Families must live in California during the 12 months they receive services.
- Families must have received either CalWORKs or Medi-Cal 1931(b) during at least three of the last six months before losing benefits.
- Families must have at least one eligible child under 18 in the home to receive TMC.
- Families must submit quarterly reports. Families will lose TMC eligibility if the report is not submitted in a timely manner.
- During the first six months, there are no income requirements. After the first six months, monthly family income must be at or below 185% FIG, and families need to be employed and meet program reporting requirements.

At the end of TMC, the families will be evaluated again to determine if they are eligible for any Medi-Cal programs. Families keep their eligibility until a determination is made.

How does immigration status affect eligibility?

In order to receive full-scope benefits, individuals must have satisfactory immigration status or verified U. S. citizenship. Individuals without satisfactory immigration status or verified U. S. citizenship are eligible to receive restricted or emergency services, including pregnancy-related care.

What benefits are covered?

Benefits are either full-scope or restricted depending on immigration or verified U. S. citizenship status.

How are services delivered?

- Full-scope beneficiaries generally receive services through managed care plans. Family members go to providers, hospitals, clinics and pharmacies that participate in their selected health plan. Family members can choose different plans if they wish.
- Individuals who are eligible for restricted Medi-Cal, are not eligible to join a health plan and will receive care under FFS.

What is the cost?

There is no cost.

Do resources count?

Resources do not count for this program.

How to apply:

Since these families have recently been enrolled in Medi-Cal through the CalWORKs program, they may want to check directly with their eligibility workers about continuing coverage under this program. Interested applicants can find district DPSS offices in their areas by looking in their local

white pages under County Government to request mail-in applications, apply by phone or make appointments.

Contact Information:

For more information or to receive an application for Medi-Cal, call 1-888-747-1222 or visit <http://www.dhcs.ca.gov/formsandpubs/forms/Pages/Applications.aspx> or <http://dps.lacounty.gov> to download a Medi-Cal application.



Assistor Tips!!!

- If wage earners get jobs or have higher earnings at any time, families need to inform their eligibility workers.

Four-Month Continuing Medi-Cal

Who is this program for?

The program affects families who have lost eligibility for Medi-Cal through CalWORKs or Medi-Cal 1931(b) either because they began to receive child support or spousal support or because of an increase in the amount of child support or spousal support received. It allows them to receive full-scope benefits at no cost, under certain conditions, for four additional months.

What are the eligibility requirements?

Families need to have received CalWORKs or Medi-Cal 1931(b) during at least three of the last six months before losing benefits. Eligibility begins the first month in which families would have been ineligible for CalWORKs or Medi-Cal 1931(b). Family members must be California residents during the four-month period.

NOTE: In most cases, children with no-cost Medi-Cal are not affected and therefore do not enroll in this program because they have continued eligibility for 12 months.

How does immigration status affect eligibility?

In order to receive full-scope benefits, individuals must have satisfactory immigration status or verified U. S. citizenship. Individuals without satisfactory immigration status or verified U. S. citizenship are eligible to receive restricted or emergency services, including pregnancy-related care.

What benefits are covered?

Benefits are either full-scope or restricted depending on immigration or verified U.S. citizenship status.

How are services delivered?

- Full-scope beneficiaries generally receive services through managed care plans. Family members go to providers, hospitals, clinics and pharmacies that participate in their selected health plans. Family members may choose different plans if they wish.
- Individuals who are eligible for restricted Medi-Cal are not eligible to join a health plan and will receive care under FFS.

What is the cost?

There is no cost to families who qualify.

Do resources count?

Resources do not count for this program.

How to apply:

Interested applicants can find district DPSS offices in their areas by looking in their local white pages under County Government to request mail-in applications, apply by phone or make appointments. For a list of local DPSS offices or an application visit: <http://dpss.lacounty.gov>. They may also apply online: <https://www.dpss.lacounty.gov>. Since these families have recently been on Medi-Cal, they may want to check directly with their eligibility workers about continuing coverage under this program.

Contact Information:

For more information or to receive an application for Medi-Cal, call 1-888-747-1222. Call the Medi-Cal Health and Nutrition hotline at 1-877-597-4777, visit <http://dps.lacounty.gov> or visit a local Department of Public Social Services office or visit www.medi-cal.ca.gov for more information on Medi-Cal programs.

Medically Needy (MN) Medi-Cal for Children, Parents and Caretakers

Who is this program for?

The program covers parents, some caretaker relatives, and children under the age of 21 in families where deprivation criteria are met. Families whose incomes are too high to qualify for Medi-Cal 1931(b) may be eligible for this program.

What are the eligibility requirements?

- In order for parents or caretaker relatives to qualify for Medically Needy Medi-Cal, the deprivation criteria must be met. That means that at least one parent is absent, deceased, incapacitated or unemployed. (The unemployment definition is that the principal wage earner works less than 100 hours per month).
- Families must be California residents to be eligible.

Caretaker relatives are eligible for this program, but individuals cannot qualify as caretaker relatives eligible for this program if the children's parents live in the home, unless parental rights have been terminated.

NOTE: Caretaker relatives living in the home with the parent of the child are eligible under Medi-Cal 1931(b) rules as long as the parent does not have care and control over the child.

NOTE: Eligibility for Medi-Cal 1931(b) should be checked first since there are no work hour limitations for that program. For MN Medi-Cal, the primary wage earner cannot work more than 100 hours per month. Also, deductions are more generous in the Medi-Cal 1931(b) program.

How does immigration status affect eligibility?

In order to receive full-scope benefits, individuals must have satisfactory immigration or verified U.S. citizenship status. Individuals without satisfactory immigration or verified U. S. citizenship status are eligible to receive restricted or emergency services, including pregnancy-related care.

What benefits are covered?

Benefits are either full-scope or restricted depending on immigration or verified U. S. citizenship status.

How are services delivered?

- Full-scope beneficiaries generally receive services through managed care plans. Beneficiaries go to providers, hospitals, clinics and pharmacies that participate in their selected health plan. Family members can choose different plans if they wish.
- Individuals who are eligible for restricted Medi-Cal are not eligible to join a health plan and will receive care under FFS.

What is the cost?

- Families whose incomes are at or below 100% FIG receive services at no cost. However, most families in MN Medi-Cal have a share of cost, where they pay for part of services received and Medi-Cal pays for the rest.
- If Share of Cost Medi-Cal enrollees who meet their share of cost obligation for the month, Medi-Cal will pay for their medical costs for the remainder of the month.

NOTE: In addition to deductions normally allowed for Medi-Cal, this program also allows

deductions for educational expenses and health insurance premiums.

Do resources count?

Yes, resources do count for this program. Resources are items that a family may own and can include cars, houses, jewelry, savings or checking accounts, etc. Please refer to page 2-8 for the Resource Limit Chart.

How to apply:

Interested applicants can find district DPSS offices in their areas by looking in their local white pages under County Government to request mail-in applications, apply by phone or make appointments. For a list of local DPSS offices or an application visit: <http://dpss.lacounty.gov>. They may also apply online: <https://www.dpss.lacounty.gov>.

Contact Information:

For more information or to receive an application for Medi-Cal, call 1-888-747-1222. Call the Medi-Cal Health and Nutrition hotline at 1-877-597-4777, visit <http://dpss.lacounty.gov> or visit a local Department of Public Social Services office or visit www.medi-cal.ca.gov for more information on Medi-Cal programs.

Medi-Cal 1931(b) and Medically Needy Program Comparison

	Medi-Cal 1931(b)	MN Medi-Cal
What are the eligibility requirements for parents?	Parents who work more than 100 hours per month may qualify.	Parents who work more than 100 hours per month do not qualify. If household consists of single parent, the parent would qualify possibly with a share of cost.
Are caretaker relatives eligible?	Caretaker relatives may be eligible if child’s parent lives in the home.	Caretaker relatives are not eligible if the child’s parent lives in the home, unless parent parental rights have been terminated.
What are the resource limits?	Resource limits are stricter than MN.	Resource limits are less strict than Medi-Cal 1931 (b).



Assistor Tips!!!

- Families may qualify for more than one Medi-Cal program. It is important to consider which program is most beneficial and appropriate for the family. Remember that Medi-Cal workers are instructed to follow the priorities listed on page 2-10 in determining eligibility.

Medi-Cal Programs for the Aged, Blind and Disabled

✧ Quick Screening Guide.....page 4-1

Program Details

✧ Aged and Disabled Federal Poverty Level Programpage 4-2

✧ Aged, Blind and Disabled Medically Needy Medi-Calpage 4-4

✧ 250% Working Disabled Program.....page 4-6

✧ Medicare Savings Programs.....page 4-8

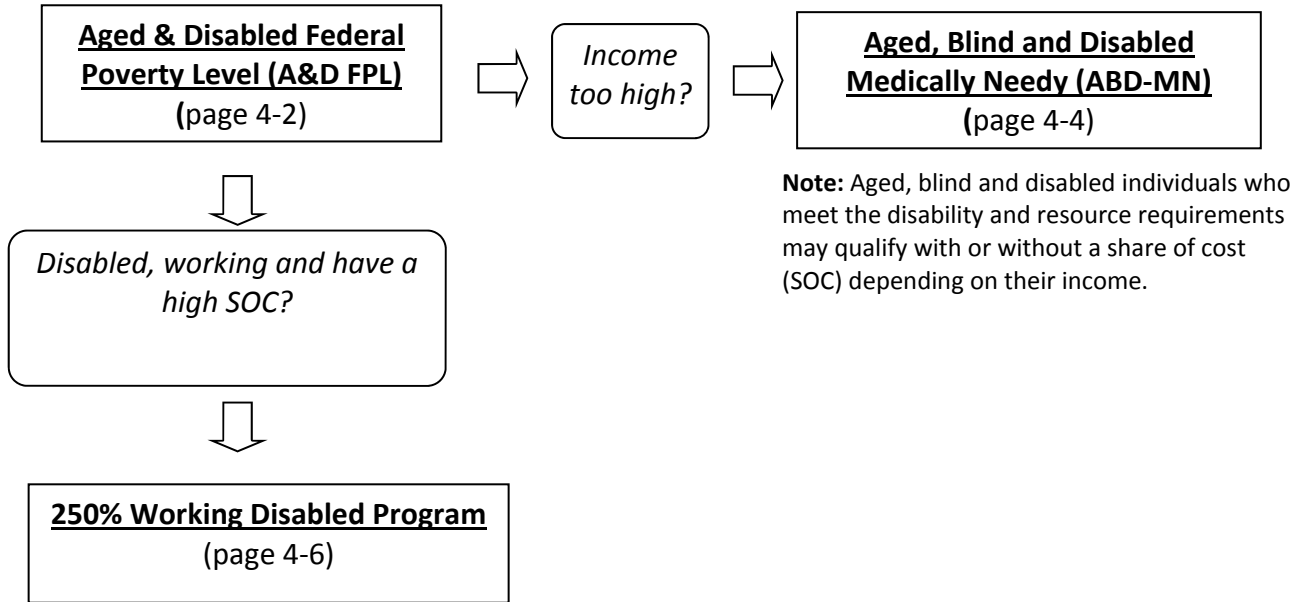
✧ The Pickle Amendment.....page 4-9

Who may be eligible for programs in this section?

- Low income aged, blind or disabled individuals with limited resources
- Low-income aged, blind or disabled individuals not eligible for Medi-Cal who need help paying for Medicare costs
- Individuals who have lost SSI due to cost of living increases in social security payments

Flow Chart: Medi-Cal for the Aged, Blind and Disabled

If individuals or families meet the disability and resource requirements, screen for the following programs:



If disabled individuals need help paying for Medicare premiums, refer them to the following programs:

Medicare Savings Programs (MSP) (page 4-8)



Assistor Tips!!!

- Disabled individuals who are receiving SSI (Supplemental Security Income) are automatically eligible for Medi-Cal. For details on SSI eligibility, visit <http://www.ssa.gov/pubs/11125.html>. SSI recipients who also receive Medicare are eligible for QMB/MSP benefits. The QMB/MSP application needs to be processed at the local Department of Public Social Services (DPSS) office.

Aged & Disabled Federal Poverty Level (A&D FPL)

Who is this program for?

This program provides Medi-Cal coverage at no cost to aged and disabled individuals who meet income and resource requirements for the program. Blind individuals are also eligible, but must be determined disabled per SSA Standards.

What are the eligibility requirements?

- Individuals must be 65 years of age or over
- OR**
- Disabled according to Social Security Administration (SSA) criteria*
- AND meet the following requirements**
- Individuals must have resources at or below the limits (see resource chart on page 2-8) and net countable incomes at or below 100% FIG.
 - For this program, there is an income disregard of \$230 for an individual and \$310 for a couple (if both are applying). This means that in order to be eligible, the monthly countable income must be at or below \$1138 for an individual applying or \$1,536 for a married couple.
- Individuals must be California residents

*To qualify as disabled, individuals must be receiving Social Security Disability Income (SSDI) or meet Social Security's rules for disability. Income must be higher than the limit to qualify to receive SSI (Supplemental Security Income).

How does immigration affect eligibility?

In order to receive full-scope benefits, applicants must be U.S. citizens or permanent legal residents. Individuals without satisfactory documentation are eligible to receive restricted scope benefits that cover emergency and pregnancy-related services only.

How are services delivered?

In Los Angeles County, most disabled and elderly participants receiving full-scope benefits are enrolled in fee-for-service Medi-Cal, which means they can go to any provider who participates in Medi-Cal.

NOTE: Beginning in June 2011, most seniors and persons with disabilities (including disabled children) who are on Medi-Cal only and not receiving Medicare, must enroll in a Medi-Cal Health Plan. These individuals will be required to select a Medi-Cal Health Plan of their choice that is available in their county; otherwise one will be assigned to them. Once a Health Plan is assigned, beneficiaries can obtain care from the doctors, hospitals and providers in their plan. Individuals requesting information about the mandatory Medi-Cal managed care enrollment must contact Health Care Options at 1-800-430-4263.

What is the cost?

Services are free; eligible individuals have no share of cost under this program. If income is above the allowable limit for this program, the applications can be reviewed under the ABD Medically Needy Program on the next page.

Are there resource limits?

Yes, this program takes resources into consideration. Resources are items a family may own, such as cars, houses, jewelry, savings or checking accounts, etc (see page 2-8). Applicants may have resources up to \$2,000 in value (\$3,000 for a couple). For this program, some resources, such as home and car, are not counted.

How to apply:

Interested applicants can find district DPSS offices in their areas by looking in their local white pages under County Government to request mail-in applications, apply by phone or make appointments. For a list of local DPSS offices or an application visit: <http://dpss.lacounty.gov>. They may also apply online: <https://www.dpss.lacounty.gov>. If the applicant claims disability but has not been certified as disabled, a disability evaluation referral is submitted to the state. The application will remain pending until the state completes the disability evaluation. It can take up to 18 months to process the application.

Contact Information:

For more information or to receive an application for Medi-Cal, call 1-888-747-1222. Call the Medi-Cal Health and Nutrition hotline at 1-877-597-4777, visit <http://dpss.lacounty.gov> or visit a local Department of Public Social Services office or visit www.medi-cal.ca.gov for more information on Medi-Cal programs.

Aged, Blind and Disabled Medically Needy (ABD-MN) Medi-Cal

Who is this program for?

This program is for persons who are aged, blind or disabled who meet SSI disability and resource requirements. They may qualify with or without a share of cost (SOC) depending on their income.

What are the eligibility requirements?

- Individuals must be California residents
- If a parent or child in the family qualifies for Medi-Cal under the Aged & Disabled Federal Poverty Level Program (A&D-FPL), other family members may qualify for Medi-Cal under Medically Needy Medi-Cal. For determining the maintenance need level, the family member covered under the A&D FPL program would be included.

How does immigration status affect eligibility?

In order to receive full-scope benefits, applicants must be U.S. citizens or permanent legal residents. Individuals without satisfactory documentation are eligible to receive restricted or emergency services.

How are services delivered?

In Los Angeles County, most disabled and elderly participants receiving full-scope benefits are enrolled in fee-for-service Medi-Cal, which means they can go to any provider who participates in Medi-Cal. However, they have the option of choosing to enroll in a managed care plan.

NOTE: Beginning in June 2011, most seniors and persons with disabilities (including disabled children) who are on Medi-Cal only and not receiving Medicare, must enroll in a Medi-Cal Health Plan. These individuals will be required to select a Medi-Cal Health Plan of their choice that is available in their County; otherwise one will be assigned to them. Once a Health Plan is assigned, beneficiaries can obtain care from the doctors, hospitals and providers in their plan. Individuals requesting information about the mandatory Medi-Cal managed care enrollment must contact Health Care Options at 1-800-430-4263.

What is the cost?

If countable family income is at or below the Maintenance Need Level (MNL), there is no cost for Medi-Cal services. If individuals or families have countable incomes above these limits, there will be a SOC. Non-covered medical expenses incurred during the month are applied towards meeting the SOC. Once the SOC is met, Medi-Cal will cover costs for the rest of the month.

Are there resource limits?

This program takes resources into consideration (see page 2-8). Resources are items a family may own, such as cars, houses, jewelry, savings or checking accounts, etc.

How to apply:

Interested applicants can find district DPSS offices in their local white pages under County Government to request mail-in applications. If the applicant claims disability but has not been certified as disabled, a disability evaluation referral is submitted to the state. The application will remain pending until the state completes the disability evaluation. It can take up to 18 months to process the application.

Contact Information:

For more information or to receive an application for Medi-Cal, call 1-888-747-1222. Call the Medi-Cal Health and Nutrition hotline at 1-877-597-4777, visit <http://dpss.lacounty.gov> or visit a local Department of Public Social Services office or visit www.medi-cal.ca.gov for more information on Medi-Cal programs.

250% Working Disabled Program (WDP)

Who is this program for?

This program expands full-scope Medi-Cal eligibility to include disabled working persons with incomes at or below 250% FIG. The WDP is considered a no share of cost program that requires the payment of a monthly premium.

What are the eligibility requirements?

- Applicants must meet Social Security disability criteria and have net incomes of up to 250% FIG (\$2,269 per month for individuals, \$3,065 for couples).
- Applicants must be California residents
- Supplemental Security Income (SSI) rules are used in determining countable income, except that any disability-based income received by the applicant is disregarded. Other benefits received by the applicants may count as income. Only the working disabled individuals' income and part of the income of their spouses may count.

NOTE: The number of hours applicants work, or the amount they make does not matter.

How does immigration status affect eligibility?

Applicants must be US citizens or have satisfactory immigration status. PRUCOL immigrants are eligible only if they are lawfully residing in the U.S. and were receiving SSI on Aug. 22, 1996 (see page 2-2).

What benefits are covered?

The program provides full-scope benefits to those who qualify.

How are services delivered?

In Los Angeles County, most disabled and elderly participants receiving full-scope benefits are enrolled in fee-for-service Medi-Cal, which means they can go to any provider who participates in Medi-Cal. As of July 1, 2009, beneficiaries receiving Medi-Cal benefits under the WDP can enroll in a managed care plan if they wish.

NOTE: Beginning in June 2011, most seniors and persons with disabilities (including disabled children) who are on Medi-Cal only and not receiving Medicare, must enroll in a Medi-Cal Health Plan. These individuals will be required to select a Medi-Cal Health Plan of their choice that is available in their County; otherwise one will be assigned to them. Once a Health Plan is assigned, beneficiaries can obtain care from the doctors, hospitals and providers in their plan. Individuals requesting information about the mandatory Medi-Cal managed care enrollment must contact Health Care Options at 1-800-430-4263.

What is the cost?

All eligible members must pay monthly premiums based on a sliding scale depending on their countable income. Monthly premiums are \$20 to \$250 per person (\$30 to \$375 for a couple). Beneficiaries who do not pay premiums for two consecutive months may be terminated under the WDP but can have their eligibility for other Medi-Cal programs re-determined by the County.

Are there resource limits?

This program takes resources into consideration (see page 2-8). Resources are items a family may own, such as cars, houses, jewelry, savings or checking accounts, etc. The WDP exempts all resources in the form of employer or individual retirement arrangements authorized under the

Internal Revenue Code (Individual Retirement Accounts, 401K, KEOGH Plans, Deferred Compensation, Thrift Plans and other employer pension plans).

How to apply:

Interested applicants can find district DPSS offices in their areas by looking in their local white pages under County Government to request mail-in applications, apply by phone or make appointments. For a list of local DPSS offices or an application visit: <http://dpss.lacounty.gov>. They may also apply online: <https://www.dpss.lacounty.gov>.

The application will remain pending until the state approves disability status. It can take up to 18 months to process the application. If a working disabled individual is already receiving Medi-Cal with a SOC and wishes to enroll in the WDP, he/she needs to contact his/her Medi-Cal Eligibility Worker to request evaluation under the WDP. There is no need to submit a new Medi-Cal application.

NOTE: The WDP does not count any disability income (SSA disability, State disability, private disability, etc.)

Contact Information:

For more information or to receive an application for Medi-Cal, call 1-888-747-1222. Call the Medi-Cal Health and Nutrition hotline at 1-877-597-4777, visit <http://dpss.lacounty.gov> or visit a local Department of Public Social Services office or visit www.medi-cal.ca.gov for more information on Medi-Cal programs.

Medicare Savings Programs (MSP)

Who are these programs for?

These programs help certain people over 65 or disabled individuals receiving Medicare to pay for Medicare costs.

Qualified Medicare Beneficiary Program (QMB): This program pays for Medicare Part A (hospitalization) and Part B (outpatient care) premiums, deductibles and co-payments for individuals with incomes at or below 100% FIG. Resources count for this program.

Specified Low-Income Medicare Beneficiary Program (SLMB): This program pays Medicare Part B premiums for individuals with incomes between 100% and 120% FIG. Resources count for this program.

Qualified Individual-1 (QI-1): This program pays for Medicare Part B premiums for individuals with incomes between 120% and 135% FIG. Resources are not counted for this program.

Qualified Disabled Working Individual (QDWI): This program pays for Medicare Part A premiums. The applicant must be disabled and currently working and have lost social security benefits as a result of returning to work. Resources are counted for this program.

For individuals who are covered by both Medi-Cal and QMB programs, Medicare pays first with Medi-Cal as the secondary payer.

How to apply:

Individuals can apply at their local Department of Public Social Services (DPSS) office.

Contact information:

If applicants encounter difficulties in applying, they can call the State of California “Medicare Buy-In” office toll free at 1-800-952-5294. Additional information on Qualified Medicare Beneficiary Programs can be found at <http://www.medicare.gov/Publications/Pubs/pdf/11445.pdf>.



Assistor Tips!!!

- Individuals will need to actively seek out this resource, as it is unlikely that the information will be routinely provided to them.
- Even if individuals covered by Medicare do not qualify for these programs, they can still use Medicare premium payments as expenses that are allowed under share of cost calculations for Medi-Cal.

NOTE: For resource limits please see page 2-8 of this manual.

The Pickle Amendment

Who does this amendment affect?

The Pickle Amendment, enacted in 1977, established a special medical category that allows certain individuals who have lost eligibility for Supplemental Security Income/State Supplemental Payments (SSI/SSP) due to cost-of-living increases in Social Security Retirement Survivors, and Disability Insurance payments to retain their Medicaid* benefits. The amendment was named after the congressman who sponsored the legislation.

What are the eligibility requirements?

Potentially eligible individuals must meet the following criteria:

- They must have been **entitled** to receive both Social Security and SSI at the same time after April 1977.
- They must be currently eligible for and receiving Social Security.
- They must not be currently eligible for SSI.
- They must be receiving incomes that would qualify them for SSI after deducting all Social Security cost-of-living adjustments received since the last month in which they were eligible for both Social Security and SSI.

Additional information:

For a screening guide for eligibility under the Pickle Amendment, visit:

www.povertylaw.org/advocacy/publications/pickle/pickle-screening.html

* The federal government program that provides medical benefits for low-income individuals is called Medicaid. California calls its state program Medi-Cal.

Other Pathways to Medi-Cal

Program Details

- ✧ Tuberculosis Program.....page 5-1
- ✧ Kidney Dialysis and Related Services.....page 5-2
- ✧ Breast and Cervical Cancer Early Detection Program.....page 5-3
- ✧ Breast and Cervical Cancer Treatment Program.....page 5-4
- ✧ Minor Consent Medi-Cal Program.....page 5-7
- ✧ Former Foster Care Child Programpage 5-9

Who is eligible for programs in this section?

- Low-income individuals who are not eligible for full scope-Medi-Cal but who may be eligible for specific health services under Medi-Cal.

Tuberculosis Program (TB)

Who is this program for?

The TB program is an optional program for individuals who are infected by TB and who do not qualify for federally mandated Medi-Cal programs such as 1931(b), Supplemental Security Income (SSI), Public Assistance or poverty level programs.

What are the eligibility requirements?

Applicants must meet income and resource requirements or must meet all other Medi-Cal requirements and be currently infected with TB. Financial eligibility requirements follow SSI guidelines. For information about the Supplemental Security Income Program and details on SSI eligibility, visit <http://www.ssa.gov/pubs>. Applicants must be residents of California.

How does immigration status affect eligibility?

California residency is a requirement. The program is available only to U.S. citizens and those with satisfactory immigration status. However, there are public health services for undocumented immigrants in their communities that include TB testing and treatment. (See Section 7 for more information.)

What is the cost?

Services are offered at no cost or on a sliding-scale basis.

Are there resource limits?

Resources are items a family may own, such as cars, houses, jewelry, savings or checking accounts, etc. This program takes resources into consideration (see page 2-8).

What benefits are covered?

Services that may be covered include: limited outpatient services, prescription drugs, physician services, outpatient hospital services, laboratory and X-ray services, clinic visits and some case management.

How are services delivered?

The program offers limited outpatient services through participating Medi-Cal clinics and providers on a fee-for-service basis.

How to apply?

Staff at clinics where TB treatment is provided may be able to offer assistance in filling out the required Medi-Cal forms which will be forwarded to Medi-Cal for eligibility determination.

Contact Information:

Contact the Los Angeles Department of Public Health Tuberculosis Control Program at 213-744-6160 or send an e-mail request to: tb@ph.lacounty.gov to find clinic locations.

Kidney Dialysis and Related Services

Who is this program for?

This program offers limited coverage to individuals who need kidney dialysis or related services and who are not covered by other health insurance or government health programs. The program is designed to protect such individuals from high medical costs and make it easier for them to continue working.

What are the eligibility requirements?

This program is for California residents who need kidney disease services and treatment and are not eligible for full scope Medi-Cal because they exceed income or resource limits and do not qualify for disability. Applicants must meet medically needy requirements except for income and resources (see pages 3-7 and 4-4 for medically needy criteria).

How does immigration status affect eligibility?

In order to receive full-scope benefits, applicants must be U.S. citizens or permanent legal residents. There are public health services for undocumented immigrants in their communities that include kidney dialysis and related treatment (see Section 7 for more information).

What is the cost?

There is no co-payment required if the annual combination of counted resources and gross income is less than \$5,000, and there are no co-payments required of those who are working.

Are there resource limits?

Resources are items a family may own, such as cars, houses, jewelry, savings or checking accounts, etc. This program takes resources into consideration (see page 2-8).

How are services delivered?

The program offers limited outpatient services through participating Medi-Cal clinics and providers.

How to apply/contact information:

Visit <http://www.lapublichealth.org> to find clinics in specific areas.

Breast & Cervical Cancer Early Detection Program (BCCEDP)/Every Woman Counts

Who is this program for?

This program provides low income women access to screening and diagnostic services for breast and cervical cancer.

What are the eligibility requirements?

Women may be able to access services if they meet the following requirements:

- Income at or below 200% of the FIG
- 40 years of age or older (for breast exams and mammograms)
- 25 years of age or older (for pap test and pelvic exams)
- Must be California resident
- Not receiving these services through Medi-Cal or other government-sponsored programs
- Have high deductibles or co-payments or if services are not a benefit under their insurance plans

How does immigration status affect eligibility?

Satisfactory immigration status is not required for this program.

What is the cost?

Women who are eligible can receive services at no cost.

Are there resource limits?

Resources are items a family may own, such as cars, houses, jewelry, savings or checking accounts, etc. This program takes resources into consideration (see page 2-8).

How are services provided?

Women must call the number below to be pre-screened for the program; if they appear eligible, the program will send an information packet in the mail containing a list of providers. Final eligibility will be determined during the first visit.

- Women who are diagnosed with breast or cervical cancer through the **Every Woman Counts** program will be “linked” to Medi-Cal’s **Breast and Cervical Cancer Treatment Program**. Free treatment is available to California residents who qualify for the Breast and Cervical Cancer Treatment Program.

How to apply/contact information:

To obtain more information and to determine pre-eligibility, please call BCCEDP Every Woman Counts toll free at 1-800-511-2300, Monday through Friday, 8:30 am to 5:00 pm.

Breast & Cervical Cancer Treatment Program (BCCTP)

Who is this program for?

This program is for low-income women in California with a diagnosis of cervical cancer and low-income women and men in California with a diagnosis of breast cancer. Both state and federal programs offer these services.

Who is eligible?

Federal Program	State Program
<ul style="list-style-type: none"> • Women under 65 years of age 	<ul style="list-style-type: none"> • Women and men of any age*
<ul style="list-style-type: none"> • 200% FIG or under 	<ul style="list-style-type: none"> • 200% FIG or under
<ul style="list-style-type: none"> • Must have diagnosis of breast or cervical cancer 	<ul style="list-style-type: none"> • Must have diagnosis of breast (women or men) or cervical cancer (women)

What are the residency/citizenship requirements?

Federal Program	State Program
<ul style="list-style-type: none"> • Resident of California 	<ul style="list-style-type: none"> • Resident of California
<ul style="list-style-type: none"> • Satisfactory immigration status 	<ul style="list-style-type: none"> • Satisfactory immigration status is not required

What benefits are covered?

Federal Program	State Program
<ul style="list-style-type: none"> • Full-scope Medi-Cal coverage 	<ul style="list-style-type: none"> • Cancer-related services only
<ul style="list-style-type: none"> • Access to screening and diagnostic services 	<ul style="list-style-type: none"> • Access to screening and diagnostic services
<ul style="list-style-type: none"> • Coverage for the duration of cancer treatment • Annual renewal is required 	<ul style="list-style-type: none"> • Up to 18 months coverage for breast cancer treatment • Up to 24 months of coverage for cervical cancer treatment

How are services delivered?

Federal Program	State Program
<ul style="list-style-type: none"> • Providers participating in these programs: <ol style="list-style-type: none"> 1. Breast Cancer Early Detection Program (BCEDP) 2. Family Planning Access Care and Treatment (Family PACT) 3. Breast and Cervical Cancer Control Program (BCCCP) 	<ul style="list-style-type: none"> • Providers participating in these programs: <ol style="list-style-type: none"> 1. Breast Cancer Early Detection Program (BCEDP) 2. Family Planning Access Care and Treatment (Family PACT) 3. Breast and Cervical Cancer Control Program (BCCCP)

What is the cost?

Federal Program	State Program
<ul style="list-style-type: none"> • No cost 	<ul style="list-style-type: none"> • No cost

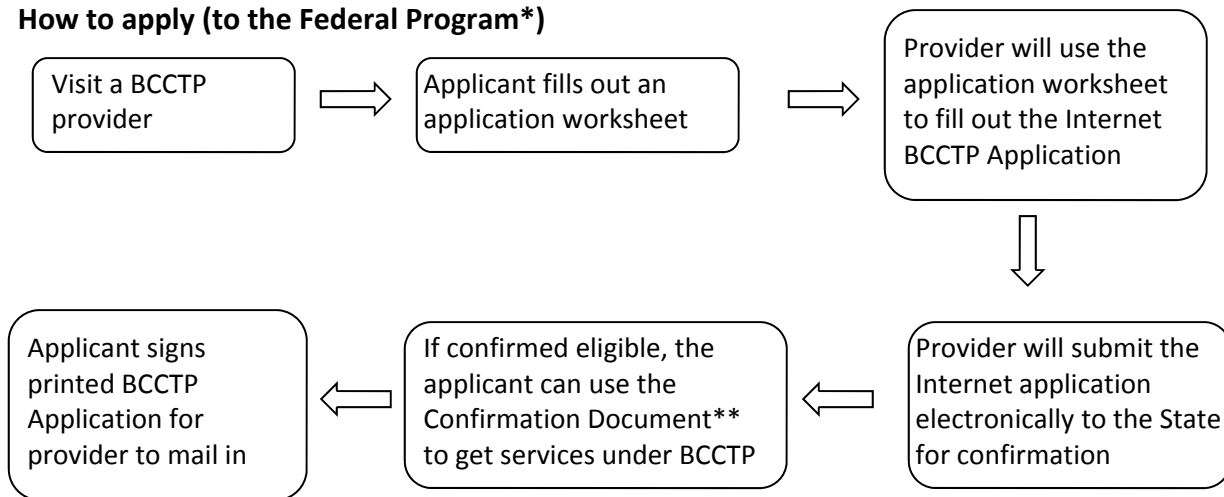
Do resources count?

Federal Program	State Program
<ul style="list-style-type: none"> • No resource limits 	<ul style="list-style-type: none"> • No resource limits

What about other insurance?

Federal Program	State Program
<ul style="list-style-type: none"> • May have other coverage • Medi-Cal pays for services that other coverage does not cover. 	<ul style="list-style-type: none"> • BCCTP may pay for health premiums for other coverage if out-of-pocket costs are more than \$750 per year

How to apply (to the Federal Program*)



* Applicants who are not eligible for the federal program will be screened for the state program by State Eligibility Specialists.

** The Confirmation Document can be used until the Benefits Identification Card (BIC) is received from the State. If the applicant already has a BIC, the existing BIC can be used to get services under BCCTP.

How to apply/contact information:

- Call toll free 1-800-511-2300, the State of California's Cancer Detection Program: *Every Woman Counts* from 8:30 a.m. to 5:00 p.m. Monday through Friday to obtain local phone numbers which can be called to make appointments with local physicians. Phone information is available in English, Spanish, Mandarin, Korean, Cantonese and Vietnamese.
- Call toll free 1-800-824-0088, Monday through Friday, 8:00 a.m. to 5:00 p.m. to speak with BCCTP Eligibility Specialists.
- Visit http://files.medi-cal.ca.gov/pubsdoco/BCCTP/bcctp_m.asp
- Send an e-mail request to: owh@ph.lacounty.gov to receive additional information through the Office of Women's Health in Los Angeles County.
- If applicants qualify for the program, they will be referred to local physicians. If they do not qualify, they will receive referrals for information and low-cost screenings through the Los Angeles Regional Cancer Detection Partnership: *Every Woman Counts*.

Partnered for Progress
4929 Wilshire Blvd., Suite 810
Los Angeles, CA 90010
Phone: (323) 549 – 0800
Email: info@partneredforprogress.org

Minor Consent Program

Who is this program for?

This program allows minors up to 21 years of age to access certain Medi-Cal benefits on their own without their parents' consent.

What are the eligibility requirements?

Minors must be California residents under the age of 21, living with their parents or away at school but supported by their parents financially. Parents' income is not considered and parents are not informed about the applications. There are no Social Security number or pregnancy verification requirements.

Note: Minors 14-21 years of age who meet the following criteria must apply on their own for full-scope Medi-Cal:

- not living at home,
- not receiving any financial support from their parents,
- not claimed by parents as tax dependents, and
- handling their own financial affairs.

How does immigration status affect eligibility?

Immigration status does not matter.

What benefits are covered?

- Services are limited to treatment for sexually transmitted diseases; drug and alcohol abuse, family planning, sexual assault, pregnancy and pregnancy-related issues, and mental health outpatient care (see the chart below for benefits covered according to age group).
- Babies born to mothers on Minor Consent Medi-Cal are "deemed eligible" for 12 months for Medi-Cal coverage after birth. The babies are automatically eligible for full-scope Medi-Cal during this time period.
- Teens can get pre-approved services for mental health services for six months with letters from mental health professionals.

	Under age 12	Age 12 and older
Benefits	<ul style="list-style-type: none">• Pregnancy and pregnancy-related services• Family planning services• Sexual assault services	<ul style="list-style-type: none">• Pregnancy and pregnancy-related services• Family planning services• Sexual assault services• Sexually transmitted diseases treatment• Drug and alcohol abuse treatment• Mental health outpatient care

What is the cost?

There is generally no cost unless the minor reports significant income and resources.

What about other insurance?

Minors can qualify for Minor Consent even if they are covered by private insurance or already have regular Medi-Cal. Those teens would have separate cards for Minor Consent in addition to their Medi-Cal Benefit Identification Card (BIC).

How to apply?

Minors fill out regular Medi-Cal applications and also short forms for Minor Consent at their local DPSS offices or with on-site eligibility workers. **A new short form needs to be filled out each month treatment is needed**, except for mental health services. Teens will need a letter from a mental health professional explaining that they meet certain conditions for getting mental health services and how long treatment will be needed. The applicant will still have to complete the short form each month to update their eligibility. Individuals over 18 years of age or emancipated minors can apply for regular Medi-Cal on their own.

Former Foster Care Children (FFCC) Program

Who is this program for?

This program is for certain former foster care children to continue their Medi-Cal benefits after transitioning out of the foster care program.

What are the eligibility requirements?

Certain children in foster care, in most cases, are automatically eligible for full-scope Medi-Cal until their 21st birthday.

There are no income or resource requirements for this population.

Certain foster care children who remain in foster care on or after their 18th birthday are eligible for Medi-Cal when they later leave foster care until their 21st birthday under the FFCC Program.

NOTE: To be eligible for Medi-Cal children must reside in California.

Undocumented children/Kin-Gap/emancipated minors are not eligible for the program. Incarcerated children or those residing in residential treatment facilities are also not eligible for FFCC but may be eligible when they are released.

Contact Information:

For more information or to receive an application for Medi-Cal, call 1-888-747-1222. Call the Medi-Cal Health and Nutrition hotline at 1-877-597-4777, visit <http://dps.lacounty.gov> or visit a local Department of Public Social Services office or visit www.medi-cal.ca.gov for more information on Medi-Cal programs.



Assistor Tips!!!

- Children receiving Medi-Cal under FFCC need to make certain Medi-Cal has their current address, and they must respond to annual contacts from their Medi-Cal eligibility worker who will ask if they want to continue coverage. At annual review, the only requirement for continued coverage is to prove California residency and age.

Health Resources for Special Populations

Program Details

- ✧ **Pregnancy-Related Coverage**
 - ◆ **Medi-Cal for Pregnant Women**.....page 6-1
 - ◆ **Comprehensive Perinatal Services Program (CPSP)**.....page 6-3
 - ◆ **Access for Infants and Mothers (AIM)**.....page 6-4
 - ◆ **Child Delivery Plan**.....page 6-6

- ✧ **Family Planning, Access, Care and Treatment Program**page 6-7

- ✧ **In Home Supportive Services (IHSS)**.....page 6-8

- ✧ **Genetically Handicapped Person Program (GHPP)**.....page 6-9

- ✧ **Veteran Services**.....page 6-10

- ✧ **HIV/AIDS Services**.....page 6-11

- ✧ **Mental Health Services**.....page 6-12

- ✧ **Drug and Alcohol Treatment and Tobacco Control Programs**.....page 6-13

- ✧ **IMPACT program**.....page 6-14

Who is eligible for programs in this section?

- Uninsured low- and middle-income pregnant women
- Adults seeking family planning services
- Aged or disabled adults needing support services at home
- Individuals who have genetic handicaps who need help with medical costs
- Veterans or reservists seeking health services
- Los Angeles County residents who are in need of:
 - treatment for HIV or AIDS
 - mental health services
 - drug or alcohol treatment
 - smoking cessation programs
 - need drug or alcohol treatment
- Low-income men diagnosed with prostate cancer

Pregnancy Related Coverage

Medi-Cal for Pregnant Women

Who is this program for?

This program provides pregnant women with medical services during pregnancy and for 60 days postpartum.

What are the eligibility requirements?

Pregnant women who are California residents with family incomes at or below 200% FIG are eligible to receive services at no cost.

How does immigration status affect eligibility?

Satisfactory immigration status or verified U. S. citizenship is not required to receive services.

What benefits are covered?

Women with satisfactory immigration status or verified U. S. citizenship are eligible for comprehensive medical services. Women without satisfactory immigration status or verified U.S. citizenship are eligible for pregnancy-related services only.

A California law signed on October 7, 2005 expanded eligibility for preventive dental benefits to women with pregnancy-only Medi-Cal coverage, including women who are on Presumptive Eligibility Medi-Cal (see page 6-2) or Minor Consent Medi-Cal (see page 5-7). Therefore, all pregnant women are now eligible for preventive dental care regardless of their Medi-Cal aid codes. All pregnant women also qualify for emergency dental services.

The following pregnant women are eligible to receive Medi-Cal for 60 days following birth under the 60-Day Postpartum Program:

- Those who had a share of cost when they were pregnant
- Those who were no longer eligible for benefits when their pregnancies ended
- Those who had no other basis for Medi-Cal eligibility when their pregnancies ended

How are services delivered?

Pregnant women with full-scope Medi-Cal will enroll in managed care health plans and receive services from Medi-Cal providers under those plans. Pregnant women who are eligible for pregnancy-related services only will receive services under fee-for-service Medi-Cal (see page 2-4 for more details on fee-for-service and managed care delivery methods).

What is the cost?

Pregnant women with family incomes at or below 200% FIG can receive services at no cost. Pregnant women with incomes above 200% FIG will have a share of cost under Medi-Cal. Also, if their incomes are between 200% and 300% FIG, they may be eligible for the Access for Infants and Mothers (AIM) program described on page 6-4.

What happens when the baby is born?

Babies born to women under Medi-Cal are automatically deemed eligible and qualify for full-scope Medi-Cal up to their first birthday. If the family does not complete their Annual Redetermination prior to the child's first birthday, the family must fill out the Annual Redetermination paperwork at the child's first birthday to determine whether the child is still eligible for no-cost Medi-Cal. If the family fails to comply with the Annual Redetermination for

Pregnancy Related Coverage

their coverage prior to the child's first birthday

Are there resource limits?

No, resources are not counted to receive pregnancy related only services.

How to apply:

Interested applicants can find district DPSS offices in their areas by looking in their local white pages under County Government to request mail-in applications, apply by phone or make appointments. For a list of local DPSS offices or an application visit: <http://dpss.lacounty.gov>. They may also apply online: <https://www.dpss.lacounty.gov>. In order to avoid delaying care, they may want to locate a Presumptive Eligibility Provider (see Assistor Tips below) or ask about applying for Medi-Cal at the clinics or hospitals where they are seeking care.

Contact Information:

For more information or to receive an application for Medi-Cal, call 1-888-747-1222. Call the Medi-Cal Health and Nutrition hotline at 1-877-597-4777, visit <http://dpss.lacounty.gov> or visit a local Department of Public Social Services office or visit www.medi-cal.ca.gov for more information on Medi-Cal programs.



Assistor Tips!!!

- **Presumptive Eligibility (PE):** PE provides temporary, immediate Medi-Cal coverage to low-income pregnant women who have no health insurance or Medi-Cal coverage. PE providers will provide pregnancy-related care during the month a woman applies for PE through the end of the following month. To continue coverage, the woman must apply for Medi-Cal. Eligibility will continue once she has applied and until Medi-Cal makes an eligibility determination. Women with family income at or below 200% FIG who believe they are pregnant are eligible for PE.

Many Medi-Cal providers are also PE providers. A pregnant woman may contact Medi-Cal providers to determine if they are PE providers or to get a referral to a PE provider in her area. Whether or not the woman's Medi-Cal application is approved, providers are reimbursed for services provided. However, PE does not pay for labor and delivery.

The following are some services covered under PE:	The following are not covered by PE:
<ul style="list-style-type: none">➤ Specific ambulatory walk-in prenatal care➤ Prescription drugs for conditions related to pregnancy➤ Outpatient abortion procedures➤ Limited preventive dental services	<ul style="list-style-type: none">➤ Labor and delivery➤ Inpatient care (i.e. hospitalization)➤ Family planning services

Pregnancy Related Coverage

Comprehensive Perinatal Services Program (CPSP)

Who is this program for?

This program is for low-income pregnant women on Medi-Cal who need prenatal care and support services to help ensure positive pregnancy outcomes and healthy babies.

What are the eligibility requirements?

CPSP is available to all pregnant women enrolled in Medi-Cal.

How does immigration status affect eligibility?

Individuals without satisfactory immigration status are eligible to receive services.

What benefits are covered?

CPSP provides comprehensive prenatal care, health services, and parenting and nutritional education. If needed, other optional services such as psycho-social assessment and referral, child birth education, Big Brother/Big Sister Program, CPR, case coordination and other support services are also available. Services are provided up to 60 days after the baby is born.

How are services delivered?

Services are provided by CPSP-certified obstetrical Medi-Cal providers who include CPSP services in their practices.

What is the cost?

There is no cost for this program.

Contact information:

Call 213-639-6419 to obtain a list of CPSP providers.

For additional information, visit <http://www.cdph.ca.gov/programs/CPSP/Pages/default.aspx>.

Additional resources for pregnant women:

211 LA County: For information and referrals related to prenatal health care and social services, call 2-1-1 or visit: www.211LACounty.org.

WIC: WIC is the Special Supplemental Nutrition Program for Women, Infants and Children that offers health care services and nutritional education for high-risk, low-income pregnant women (up to 185% FIG). WIC can also provide vouchers for food for infants and help eligible women find health care providers. For more information please call 1-888-942-9675.

Pregnancy Related Coverage

Access for Infants & Mothers (AIM)

Who is this program for?

This program covers low-income pregnant women whose family incomes are too high to qualify for no-cost Medi-Cal.

What are the eligibility requirements?

In order to qualify for AIM, pregnant women must have monthly family incomes between 200 and 300% FIG. At the time of application, they must be no more than 30 weeks pregnant. Women who are uninsured for their pregnancies, have insurance that does not cover pregnancy-related care, or have high maternity deductibles (over \$500), may be eligible for this program.

How does immigration status affect eligibility?

Immigration status does not matter.

What benefits are covered?

- AIM provides coverage for medically necessary care from the date of enrollment until 60 days after the end of the pregnancy. AIM will pay for pregnancy-related expenses up to \$125 incurred up to 40 days before the enrollment date as long as the request for payment was made within 90 days of the date the application was received.
- AIM does not provide dental coverage.

How are services delivered?

The choice of health plans varies by county. Plans available to Los Angeles County women (except Catalina Island) are Health Net HMO and Blue Cross HMO.

What is the cost?

The cost for the program is 1.5% of annual family income after program deductions. There are no co-payments or deductibles. Payments can be made on a monthly basis or up-front when submitting the application.

Do resources count?

Resources do not count for this program.

What happens after the baby is born?

Babies born to AIM mothers may be eligible for the Healthy Families Program until their 2nd birthdays. Women on AIM receive an Infant Registration Form 1-3 months prior to their expected due date to enroll the newborn into the Healthy Families Program. Families will be required to pay separate monthly premiums for the newborn's coverage through the Healthy Families Program. The amount of the monthly premium depends on the family's income, Family size, and health plan in which the newborn will be enrolled. The monthly premium will be between \$4 and \$24 for each child. The maximum monthly premium cost for a family ranges from \$8 to \$72. The coverage for the newborn is good for one year. After one year, the family will receive Annual Eligibility Review paperwork that will use the AIM income guidelines (200% - 300% FIG) to determine whether the baby is still eligible for Healthy Families. At the

Pregnancy Related Coverage

baby's second Annual Eligibility Review, the Healthy Families Program income guidelines will be used to determine eligibility (200%-250% FIG).

How to apply:

Application is by mail and applications are available in English, Spanish or Chinese. Visit the MRMIB website for an application and for more information: <http://www.mrmib.ca.gov>.

Women can also request an application and additional information by calling toll free 1-800-433-2611.

Pregnancy Related Coverage

Child Delivery Plan

The Child Delivery Plan covers labor and delivery at a hospital operated by Los Angeles County for pregnant women living in Los Angeles County. Under this plan the woman must pay \$2,000 within seven (7) days after leaving the hospital. The woman does not have to apply for Medi-Cal; however, each mother must apply for Medi-Cal for her baby. The epidural injection is covered by the plan.

To qualify for this plan, women must be unable to pay for the full cost of their medical care and have charges that Medi-Cal, Medicare or private insurance will not cover.

If a woman is less than 30 weeks pregnant, she should find out whether she is eligible for no-cost Medi-Cal or AIM for her pregnancy care. If she is over 30 weeks pregnant, the Child Delivery Plan may assist her in paying for her labor and delivery.

Contact information

Low-income pregnant women can contact their local Los Angeles County operated hospital for additional information or call the toll free information line at 1-800-378-9919.

Family Planning, Access, Care and Treatment Program (Family PACT)

Who is this program for?

Family PACT is a federal and state funded program offering family planning and related services to low-income California men and women and teens for the purpose of preventing unplanned pregnancy and promoting reproductive health.

What are the eligibility requirements?

This program is for low-income men under age 60 and low-income women under age 55 able to become pregnant or cause a pregnancy. Gross family income must be at or below 200% FIG. Coverage is good for one year, but applicants need to confirm eligibility at each visit by verifying information such as income and family size.

How does immigration status affect eligibility?

Satisfactory immigration status is not required.

What benefits are covered?

Services include family planning education and counseling, sexually transmitted disease screening and treatment, contraception including sterilization and emergency contraception, pregnancy testing, limited infertility services, cervical cancer screening and HIV testing.

How are services delivered?

Family PACT providers confirm eligibility by sending applications to the State. The applicants receive Health Access Program Cards from their providers to use at Family PACT visits. The cards can also be used with the Breast Cancer Early Detection Program (BCEDP) and some other health programs.

What is the cost?

There is no cost for those who qualify.

Do resources count?

Resources do not count for this program.

What about other insurance?

The program is for adults who are not covered by Medi-Cal or Medicare. Adults are not eligible for Family PACT if they have other insurance that covers family planning unless they have high out-of-pocket expenses in the form of deductibles or co-payments. If an adult has other health insurance but a barrier to access exists, this person may be eligible for Family PACT services. A barrier to access is when a client's insurance does not assure provision of services to a client without his or her spouse, partner or parents being notified or informed.

How to apply?

Interested men and women can make appointments with Family PACT providers in their areas.

Contact information: Call 1-800-942-1054 for the names and locations of local providers. For more information about the program, visit www.familypact.org.

In-Home Supportive Services (IHSS)

Who is this program for?

This program can help blind, aged or disabled individuals pay for in-home services such as shopping, cooking, and personal care, thus helping individuals remain in their homes.

What are the eligibility requirements?

The need for services is evaluated at a home interview conducted by a county social worker. State guidelines determine the types of services to be provided. Family, friends and health providers can offer supporting information. Income requirements are the same as those for the Supplemental Security Income program (SSI).

IHSS cases are funded by one of three programs in California: Personal Care Services Program (PCSP), IHSS Residual Program or IHSS Plus Waiver. PCSP covers those who are eligible for full-scope Medi-Cal, while the other programs cover individuals who meet IHSS eligibility requirements but who are not eligible for full-scope Medi-Cal.

If approved, the disabled individual will receive notification on the types of services and number of hours authorized for those services. They could include personal care, household tasks and certain paramedical services.

How are services delivered?

Individuals must hire someone to provide the approved services. These persons can be friends or family members or the individual may choose to have services provided by county contracted IHSS providers. The State issues checks for all individual provider payments.

What is the cost?

Those who meet SSI income requirements do not pay for IHSS services. Those who meet resource limits but whose incomes are over the SSI limits will pay for a portion of their IHSS services, depending on income.

Do resources count?

Yes, resources count for this program.

How to apply?

Interested individuals need to schedule in-home interviews.

Contact information:

Call the local DPSS office for scheduling. For questions, call 1-888-678-4477. For assistance and applications, call 1-888-944-4477.

Note: Make certain that clients and providers fill out the required timesheets each month. If the clients are using county-contracted IHSS providers, they should contact their social workers to find out the hourly rate charged.

Genetically Handicapped Persons Program (GHPP)

Who is this program for?

GHPP is a state-funded program that can help individuals with genetic diseases pay for medical costs, including equipment and medication.

What are the eligibility requirements?

The program is open to California residents 21 years of age or older. Persons under 21 may be eligible for California Children's Services (CCS). If a specific condition is not covered under CCS, an individual under 21 can apply to GHPP. Examples of genetic handicaps are cystic fibrosis, sickle cell disease and hemophilia. All applicants must complete an application.

How does immigration status affect eligibility?

Satisfactory immigration status is not required.

What benefits are covered?

GHPP covers a variety of services, including hospital inpatient and outpatient, pharmaceutical and dental, physical therapy, medical equipment and certain home health services.

How are services delivered?

Services are provided through GHPP approved hospitals, specialists and community physicians who work with a Special Care Center that includes medical, nursing, social work and other health professionals who specialize in treating GHPP eligible conditions.

What is the cost?

There are no income eligibility requirements, but families with adjusted gross incomes above 200% FIG pay an enrollment fee and treatment costs based on a sliding scale according to family size and income.

Do resources count?

Resources do not count for this program.

What about other insurance?

Applicants may be required to apply for Medi-Cal if they appear to be eligible. If clients have Medi-Cal, Medicare or private insurance, those providers must be billed first and GHPP will pay only for services not covered by those plans. Those with Medi-Cal managed care need to first obtain approval for medical services through their plans. GHPP pays for case management, referrals to specialists and other services often not covered by other insurance.

How to apply

Call 1-800-639-0597 or 1-916-327-0470 or visit:

<http://www.dhcs.ca.gov/services/ghpp/Pages/Apply.aspx>.

You can also write to:

Genetically Handicapped Persons Program
MS 8100, P.O. Box 997413, Sacramento, CA 95899-7413

Contact information:

An informational brochure is available on the website: www.dhs.ca.gov/pcfh/cms/ghpp.

Veteran Services

The Department of Veteran Affairs (VA) provides an enhanced healthcare benefits plan to all veterans regardless of income.

Who is eligible?

Eligibility is based solely on active military service in the Army, Navy, Air Force, Marines, or Coast Guard (or Merchant Marines during WWII), and that the veterans were discharged under honorable conditions. Reservist and National Guard members called to active duty may also qualify for VA health care benefits. Certain veterans must have completed 24 continuous months of service to be eligible.

What benefits are covered?

Comprehensive preventative and primary care, outpatient and inpatient services are covered. Mental health services including screening and treatment are also available to eligible veterans.

What about benefits for family members?

The Civilian Health and Medical Program of VA (CHAMPVA) provides reimbursement for most medical expenses of eligible family members.

What does it cost?

Depending on income levels, some services may be provided at no cost. Enrollment fees and co-payments may apply in some cases.

For more information about CHAMPVA visit:

<http://www.va.gov/hac/forbeneficiaries/champva/champva.asp>.

Contact information:

For more information on participating healthcare facilities in your area, call 1-877-222-8387. The Veterans Administration also runs an ambulatory care hotline: 1-877-251-6733.

Information on health care benefits for veterans is available through Veterans Health Administration website at <http://www.va.gov/health/default.asp>.

HIV/AIDS Services

The Los Angeles County Public Health Department's Office of AIDS Programs and Policy offers several no- or low-cost health care services to individuals with AIDS and HIV diagnoses.

Who is eligible?

Eligibility requirements vary by program and service provider. An HIV-positive diagnosis or AIDS diagnosis may be required to receive services. Formal assessment is based on the State Office of AIDS guidelines and determines what types of services clients may be eligible for. Most programs offered in Los Angeles County require participants to be Los Angeles County residents. Some programs and provider clinics require that clients be residents of specific geographical areas within Los Angeles County.

How does immigration status affect eligibility?

For most services, satisfactory immigration status is not required.

What benefits are covered?

A wide range of services are offered depending on need. Services may include: screening, testing, treatment, service coordination, case management, psychological counseling, respite care, and crisis intervention.

How are services delivered?

HIV and AIDS services fall under the direction of the Los Angeles County Department of Public Health Office of AIDS Programs and Policy. There are many organizations that offer services throughout Los Angeles County (see contact information below).

What is the cost?

Fees may apply for services depending on the provider. Some programs are offered at no cost for those who cannot afford to pay.

What about other insurance?

Most providers accept Medi-Cal patients or patients with private insurance. Patients enrolled in a managed care plan must receive pre-authorization before being seen. Upon authorization, the managed care plans will be billed for services rendered.

Contact information:

To receive more information on services for HIV/AIDS:

- Visit HIV L.A.'s website: <http://www.hivla.org>. This website allows the user to view the various types of services offered and lists service providers by geographical location.
- Visit California HIV/AIDS Service Referrals website: <http://cdcnpin.org/ca/>. This site is designed to help users find HIV testing, prevention, care & treatment, and support services in their local area.
- Contact the AIDS Drug Assistance Program (ADAP) by calling 1-888-575-2327 or visit <http://www.dhs.ca.gov/ps/ooa/Programs/CARE/adap.htm>

Mental Health Services

The California Department of Mental Health provides free mental health treatment for Medi-Cal recipients. Other individuals may also be eligible for services. The Los Angeles County Department of Mental Health also provides clients with case management and support services to assist them in living within their communities.

What is the cost?

Medi-Cal recipients may be eligible for services at no cost. Other eligible participants may be charged based upon a sliding scale, depending on income or ability to pay. Mental health providers and therapists can request a fee waiver if it would cause the participant hardship.

Contact Information:

For referrals to outpatient health programs in a specific area, call 1-800-854-7771. For more information visit the County of Los Angeles Department of Mental Health website at <http://dmh.lacounty.gov>.

Other Programs:

Adults, as well as children, who are disabled with developmental delays, autism, cerebral palsy, or epilepsy, may qualify for health care services and case management through California's Regional Centers. California residents who are undocumented may also be eligible for services.

There are seven Regional Centers in Los Angeles County. Referral information for these centers can be found at <http://www.arcanet.org/locations.html>.

Drug and Alcohol Treatment and Tobacco Control

Programs and costs for drug and alcohol treatment vary by program in Los Angeles County. Some programs offer outpatient services and others are residential programs. There is also outpatient treatment for homeless clients. Individuals with Medi-Cal or CalWORKs can ask their social workers for referrals.

The Resource Center at the California Department of Alcohol and Drug Programs maintains a comprehensive collection of alcohol, tobacco, and other drug prevention and treatment information. This information is provided to all California residents at no cost through a Clearinghouse, a full-service Library, Internet communication links, and a telephone information and referral system. These services can be accessed by letter, fax, Internet, e-mail, telephone, or in person during the business hours of 8:00 a.m. to 4:30 p.m., Monday through Friday, excluding state holidays. Contact information for the Resource Center can be found at http://www.adp.state.ca.us/RC/rc_sub.shtml.

Contact Information:

Call the Alcohol and Drug Program Administration at 1-800-564-6600 to obtain a list of community assessment centers and services.

Many hospitals, HMOs, clinics and health departments offer smoking cessation programs. Call 213-351-7890 for information about locations that offer stop smoking services in Los Angeles County or visit <http://www.lapublichealth.org/tob/>.

The California Smokers' Help line offers one-on-one telephone counseling at 1-800-NO-BUTTS. Help is available in English, Spanish, Mandarin and Cantonese, Vietnamese and Korean.

Improving Access, Counseling & Treatment (IMPACT)

Who is this program for?

IMPACT provides high quality prostate cancer treatment to low-income California men with little or no health insurance. IMPACT is operated under contract by the University of California, Los Angeles.

What are the eligibility requirements?

Men may be able to access services if they meet the following requirements:

- 18 years of age or older
- California resident
- Have a diagnosis of prostate cancer
- Income at or below 200% of the FIG
- Underinsured and have NO insurance coverage for cancer treatment; or NO medical insurance, and do not qualify for Medicare or Medi-Cal

What benefits are covered?

Cancer treatment for up to 12 months includes; chemotherapy, hormone therapy, brachytherapy, radical prostatectomy, external beam radiation therapy and nurse case manager services and short-term individual and joint counseling services.

What is the cost?

Men who are eligible can receive services at no cost.

How are services provided?

Men must call the number below to be pre-screened for the program; if eligible, IMPACT will pay for prostate cancer treatment for up to 12 months for qualified individuals. Treatment is available throughout California. If you qualify, you will be referred to participating doctors in your neighborhood.

How to apply/contact information:

To obtain more information and to be pre-screened for eligibility, please call **IMPACT** at 1-800-409-8252 to speak with an eligibility specialist. You can also obtain more information by visiting: www.california-impact.org.

Health Programs for Los Angeles County Residents

Program Details

- ✧ **Outpatient Reduced-Cost Simplified Application (ORSA).....page 7-1**
- ✧ **Ability to Pay (ATP).....page 7-3**
- ✧ **Community Partners.....page 7-5**
- ✧ **Pre-Payment Planpage 7-6**
- ✧ **Healthy Way LA (HWLA).....page 7-7**
- ✧ **Out-of-County Discount Payment Plan.....page 7-8**
- ✧ **Dental and Vision Services.....page 7-8**
- ✧ **Tuberculosis Services.....page 7-9**
- ✧ **Kidney Dialysis and Post Polio Plans.....page 7-10**

Who is eligible for programs in this section?

- Low-income uninsured Los Angeles County residents who need medical services and help paying for them
- Los Angeles County residents who need kidney dialysis, tuberculosis or post polio treatment and who are not eligible for those services under Medi-Cal
- Low-income uninsured individuals in need of medical services and assistance paying for them at Los Angeles County operated hospitals who are not Los Angeles County residents

Outpatient Reduced-Cost Simplified Application (ORSA)

Who is this program for?

ORSA will help pay for outpatient medical care at hospitals run by Los Angeles County, including emergency room visits, clinic visits, tests and medicines. Eligible patients may also use ORSA for care at County Comprehensive Health Centers (CHC), Health Centers (HC) and Multi-Service Ambulatory Care Centers (MACC) clinics.

What are the eligibility requirements?

Los Angeles County residents who are low income and do not have health insurance or a program that pays for outpatient medical care may be eligible for ORSA. Family income must be at or below 133% FIG in order to obtain no cost services. Those with incomes over 133% may still qualify by paying a liability (patients' portion of the cost) for visits. Applicants must provide acceptable proof of address to receive ORSA.

If individuals appear to be eligible for Medi-Cal, they must complete the Medi-Cal application and cooperate in the application process before they are able to apply for ORSA. If individuals appear to be eligible for Medi-Cal but do not want to apply, they will not be able to apply for ORSA. However, they may use the Pre-Payment Plan (see page 7-6).

Note: LA County uses the term Federal Poverty Level (FPL) to determine income guidelines for their programs; however the income amounts are equal to the FIG.

How does immigration status affect eligibility?

Satisfactory immigration status is not a requirement.

What benefits are covered?

ORSA covers outpatient medical care, tests, and medications at no-cost or low-cost. ORSA cannot be used for inpatient medical care.

How are services delivered?

Services are provided through Los Angeles County operated hospitals including emergency room visits, Comprehensive Health Centers, Health Centers and Multi-Service Ambulatory Care Centers. A copy of the ORSA agreement and clinic card is needed every time patient goes to a County hospital based clinic or any County clinic.

NOTE: Hospital emergency departments must provide emergency care to everyone regardless of immigration status or ability to pay.

What is the cost?

Under ORSA care is provided at no cost for individuals on General Relief (GR) or if, after income deductions, their monthly income is at or below 133% FIG, which is equal to \$1,207 per month for a family of one. If net income is greater than 133% FIG, the liability varies, depending on family size, resources, income and income deductions.

Are there resource limits?

Resources are items a family may own, such as cars, houses, jewelry, savings or checking accounts, etc. There are no resource limits; however, certain resources, (e.g., cash on hand, stocks, bonds, and checking/savings accounts, etc.) are counted to determine a liability if the net income is greater than 133% FIG.

What about other insurance?

Children and adults who have other coverage (e.g., Medi-Cal, Medicare, Healthy Families, private insurance, CCS, TRICARE, Family PACT, Cancer Detection Program Every Woman Counts, etc.) which pay for outpatient medical care are not eligible to ORSA.

NOTE: As of July 2009 Los Angeles County Residents receiving full-scope Medi-Cal may qualify for ORSA for those benefits Medi-Cal will no longer cover. These changes affect only the Multi-Service Ambulatory Care Centers (MACC), Comprehensive Health Care Centers (CHC) and Health Centers (HC).

How to apply:

County hospital or clinic financial staff can assist applicants with screening. Most applicants will only have to provide information about family size, income, and some of their expenses. The ORSA agreement is good for one year. At the end of one year, individuals will have to renew their coverage. Mail-in renewal is available. If eligible, applicants will be able to use ORSA at DHS facilities. Applicants who do not want Medi-Cal cannot apply for ORSA or the Public-Private Partnership (PPP) program described on page 7-5.

Contact/additional information:

Call 1-800-378-9919 or visit http://www.ladpss.org/dpss/health_care/pdf/ORSA-Centers.pdf to obtain names and locations of Los Angeles County DHS facilities where ORSA applications are taken. For more information visit: <http://www.ladhs.org>.



Assistor Tips!!!

- Most people will only have to provide verification information for family size, income and some expenses when applying for ORSA.
- Recipients must save income and expenses verification for six months from the month of application in the event that the applicant is randomly selected to provide verification.
- ORSA is good for one year. At the end of one year, the recipient will have to renew.
- Patients can apply for ORSA within one year of the time they receive outpatient medical care. If it has been longer than one year since they have received care and the bill has not been paid, ask clinic financial staff with help applying for Ability-to-Pay (ATP) to help pay for that bill (see page 7-3).

Ability-To-Pay Plan (ATP)

Who is this program for?

ATP will help pay for all types of care at Los Angeles County hospitals and hospital-based clinics, including inpatient and outpatient hospital care, emergency room visits, tests, and medications.

What are the eligibility requirements?

Children and adults who use Los Angeles County facilities and are not eligible for full-scope Medi-Cal benefits, County Mental Health Services, TRICARE, or California Children's Services (CCS) can apply for ATP. Persons eligible for restricted Medi-Cal may qualify for ATP to cover non-emergency services only. Patients who receive General Relief always get care at no-cost under ATP. Individuals who appear to be eligible for Medi-Cal must complete the Medi-Cal application and cooperate in the process before being able to apply for ATP.

NOTE: ATP can be used if applicants have other insurance that does not pay for certain needed services or if they have high deductibles under their insurance plans.

How does immigration status affect eligibility?

Satisfactory immigration status is not a requirement.

What benefits are covered?

ATP covers both inpatient and outpatient medically necessary services, including prenatal and maternity care and medications. If family members qualify for ATP at no cost, they can also get medications at no cost. If they qualify for ATP at a reduced cost, they can get medications at no extra cost.

How are services delivered?

Services are available at all Los Angeles County-run hospitals and hospitals' outpatient clinics, Comprehensive Health Centers, Health Centers and Multi-Ambulatory Care Centers. A copy of the ATP agreement and clinic card must be provided at each visit.

What is the cost?

Services under ATP are either no-cost or low-cost. The amount that may have to be paid is based on unearned/earned income, earned income deductions, other allowable deductions that include medical insurance, childcare costs and child or spousal support payments made and family size.

Are there resource limits?

Resources are items a family may own, such as cars, houses, jewelry, savings or checking accounts, etc. Resources do not count toward income for ATP, however 1/12 of the value of certain resources, (e.g., cash on hand, stocks, bonds, and checking/savings accounts, etc.) is **ADDED** to countable monthly income. If the combined income/property is over the income limits for either Clinic or Hospital Care, the ATP worker will figure the ATP obligation amount.

What about other insurance?

Individuals must use any medical benefits they have, such as private insurance or outpatient Medicare, before they can use ATP. ATP will cover a deductible for private insurance, but does not

cover the Medicare deductible or coinsurance or Medi-Cal Share of Cost (SOC).

NOTE: Effective March 1, 2011, patients admitted to a Los Angeles County hospital must be evaluated for the Healthy Way L.A. (HWLA) program prior to being evaluated for ATP. The patient must cooperate with the HWLA program's requirements to see if the patient can be helped by this program.

If the patient does not cooperate with the HWLA application process, he/she will not be eligible to the ATP program.

How to apply:

Applicants can ask for a financial screening appointment at one of the County hospitals. For inpatient hospital care, a person must apply each time they go into a County hospital. The application is good for a stay of up to one month. For outpatient County hospital based clinic care, a person only needs to apply once each year.

Contact information:

Call 1-800-378-9919 to obtain names of Los Angeles County facilities where ATP applications are taken or visit: http://dpss.lacounty.gov/dpss/health_care/adults/ability_to_pay_locations.cfm; or for more information please visit: http://www.ladpss.org/dpss/health_care/adults/atp.cfm.



Assistor Tips!!!

- Enrollees must report changes in income and family size by calling the facility where they first applied.
- ATP has an appeals process if an individual disagrees with the ATP amount they must pay. That process begins with an individual completing and returning the Appeals Section of the Determination form within 10 days of determination.

Community Partners

Who is this program for?

Community Partners is a partnership between the Los Angeles County Department of Health Services (DHS) and various clinics and physicians who have contracts with the County. Through Community Partners, low-income uninsured children and adults can access primary care outpatient services (includes medications) at various provider sites.

What are the eligibility requirements?

Low income people of all ages who have no other health insurance and meet the income guidelines are eligible for Community Partners services. Family income after deductions must be at or below 133% FIG to qualify for no-cost services. Applicants must be Los Angeles County residents.

How does immigration status affect eligibility?

Satisfactory immigration status is not a requirement.

What benefits are covered?

Primary care outpatient services such as office visits for children and adults, women's health care, prenatal care, immunizations, and medications, etc.

How are services delivered?

Services are provided at any neighborhood Community Partners clinic or at any Community Partners provider site.

What is the cost?

Community Partners clinics provide services at no cost if the income is at or below 133% FIG.

Are there resource limits?

Resources are items a family may own, such as cars, houses, jewelry, savings or checking accounts, etc. Resources are not counted for this program.

What about other insurance?

Community Partners is for individuals and families who have no other health insurance.

How to apply?

Applicants can make appointments to apply at any Community Partners clinic or Community Partners site. Applicants are required to sign a one page "Certificate of Indigency" (COI) form and sign a statement that they have no health insurance; they must provide proof of residency in Los Angeles County.

Contact information:

Call 1-800-427-8700 for clinic or doctor's office locations or visit:

http://www.ladhs.org/wps/PA_1_QDN2DSD3005DD02DJ6VQC830G3/DhsSite/AmbulatoryCare/pdf/Clinic%20Status%20List.pdf. For more information please visit: <http://www.ladhs.org> and click on Patient Information/Clinics.

Pre-Payment Plan

Pre-Payment Plan can only be used for outpatient care at Los Angeles County-run hospitals. If the patient pays within seven days of choosing the Pre-Payment Plan, he/she does not have to prove income or family size. This plan does not cover medications. For each outpatient visit the costs are as follows:

Cost	Service/Location
\$60	For prenatal services for the first seven visits, then no cost for the remaining visits. At Health Centers or Comprehensive Health Centers, except Urgent Care Center visits
\$80	At County Hospital Outpatient Clinics and Multi-Service Ambulatory Care Centers except Emergency Room visits
\$80	At Comprehensive Health Center's Urgent Care Centers
\$120	At County Hospital Emergency Rooms
\$400	At Outpatient Surgery Clinics

NOTE: Individuals can apply at any Los Angeles County facility; however, Los Angeles County residency is required. Reduced cost labor and delivery services at Los Angeles County operated hospitals are available through the Child Delivery Plan (see page 6-5).

Contact Information:

Call the toll free information line at 1-800-378-9919.

Healthy Way LA (HWLA)

Who is this program for?

HWLA is a no-cost health care coverage program that provides a range of medically necessary services to low-income uninsured Los Angeles County residents. Services are provided at Health Centers, Comprehensive Health Centers, Multi-Service Ambulatory Care Centers, County hospitals and hospital-based clinics, and Public-Private Partnership clinics.

What are the eligibility requirements?

An individual must be eligible for zero liability ATP, ORSA, COI or GR programs. HWLA eligible persons must not be pregnant and must meet the following criteria:

1. Los Angeles County residency: As proof of Los Angeles County residency, workers verify the current address to establish Los Angeles County residency. Acceptable proof includes valid California Driver's License, California Identification Card, Utility bill, or other document that appears to be valid and establishes residency.
2. Between the ages of 19-64
3. Income at or below 133% of FIG
4. U.S. Citizen/National or Legal Permanent Resident (LPR) for five or more years, and Proof of Identity: Consistent with the Medi-Cal program, U.S. Citizen/National status and Identity verification requirements are based on the Deficit Reduction Act (DRA) of 2005 guidelines.

Each patient is asked to provide their social security number (SSN) as part of the HWLA application process.

How does immigration status affect eligibility?

Applicants must be U.S. Citizens/Nationals or legal permanent residents for at least 5 years and verify their citizenship/national status, legal permanent residence, and identity.

What benefits are covered?

HWLA covers outpatient primary care and preventive services, including early intervention services, health education, and chronic disease management.

How are services delivered?

Services are available at any LA County clinic, County hospital, hospital-based clinics and most Community Partners clinics. Most Community Partners clinics have an agreement with HWLA.

What is the cost?

Services under HWLA are provided at no cost.

What about other insurance?

If patients seem to be eligible for Medi-Cal, HWLA will require the patient to apply. Applicants have to be uninsured for ninety days before applying to Healthy Way LA.

Contact Information

Call HWLA Customer Service at 1-877-333-HWLA or 1-877-333-4952.

Out-of-County Discount Payment Plan

This plan offers a discount on medical care services received at Los Angeles County hospitals and hospital-based clinics to patients who are not Los Angeles County residents. Out-of-county patients with income up to 350% FIG can get a 5% discount on medical care received but they will not have to pay more than what Medi-Cal would pay for the same type of services received. Individuals can apply at LA County hospitals.

Note: The Out-of-County Discount Payment Plan is only available at County hospitals.

Contact Information

Call the toll free information line at 1-800-378-9919. For a listing of hospitals and clinics in Los Angeles County, visit <http://www.ladhs.org>.

Dental Services

Los Angeles residents who do not qualify to receive dental services under Medi-Cal and who are not covered by private insurance may be able to receive services at County medical facilities. Services are not offered at all locations, so patients should inquire at their local clinics and ask for referrals if needed services are not offered there.

Contact Information:

For clinic listings, visit <http://www.ladhs.org>.

Vision Services

The California Vision Foundation offers free comprehensive eye exams and low-cost glasses, if needed, to qualified patients. If glasses are needed, they are provided for a fee of \$20. Qualified individuals will be matched to volunteer optometrists in their area. There may be a waiting period of several months.

What are the eligibility requirements?

Eligibility requirements include the following:

- There must be at least one adult in the household who is employed (full or part-time)
- The individual who is applying must qualify as low-income and unable to pay for eye care.
- The individual who is applying must not have had an exam in the past two years.
- The individual who is applying for the exam has no public or private insurance that covers eye exams.

NOTE: Applications require a \$10 non-refundable administrative fee per person to be processed. Applicants will be notified by mail about their eligibility. Applicants who receive an acceptance letter must call the assigned optometrist to schedule an appointment within 60 days of receiving notice of eligibility.

Contact Information:

To download an application, visit: <http://www.californiavision.org/patients.html> or call 1-800-877-5738 to request an application by mail or fax. California Vision Foundation offers services in other counties in addition to Los Angeles County.

Tuberculosis Services

The following Public Health Centers offer Tuberculosis screening and treatment at no-cost to Los Angeles County residents. For further information on the services provided please contact one of the following centers.

Antelope Valley Public Health Center

335-B East Avenue K-6
Lancaster, CA 93535
(661) 723-4526

Central Public Health Center

241 N. Figueroa Street
Los Angeles, CA 90012
(213) 240-8204

Curtis-Tucker Public Health Center

123 W. Manchester Blvd.
Inglewood, CA 90301
(310) 419-5325

Glendale Public Health Center

501 N. Glendale Ave
Glendale, CA 91206
(818) 500-5750

Hollywood/Wilshire Public Health Center

5205 Melrose Avenue
Los Angeles, CA 90038
(323) 769-7800

Monrovia Public Health Center

330 W. Maple Avenue
Monrovia, CA 91016
(626) 256-1600

Pacoima, CA91331

(818) 896-1903

Pomona Public Health Center

750 S. Park Avenue
Pomona, CA 91766
(909) 868-0235

South Public Health Center

1522 E. 102nd Street
Los Angeles, CA 90002
(323) 563-4053

Torrance Public Health Center

711 Del Amo Blvd.
Torrance, CA90502
(310) 354-2300

Whittier Public Health Center

7643 S. Painter Avenue
Whittier, CA 90602
(562) 464-5350

Pacoima Public Health Center

13300 Van Nuys Blvd.

Kidney Dialysis and Post Polio Plans

Special low-cost plans cover these services through the County of Los Angeles. Persons requiring treatment for Renal Dialysis, Tuberculosis, and Post-Polio related medical services can apply for them at the hospitals and outpatient clinics where treatments are given. Individuals eligible for full-scope no Share of Cost Medi-Cal are not eligible for these special programs.

Application should be made at the center where the treatment is provided. Satisfactory immigration status is not required. These plans are for adults who are not able to pay the full cost of their medical care and who have charges that Medi-Cal, Medicare or private insurance will not pay.

NOTE: Individuals who need kidney dialysis and related treatment or treatment for tuberculosis may qualify for Medi-Cal services described on pages 5-1 and 5-2. Programs described on this page are for Los Angeles County residents who do not meet the income, resource, or immigration status requirements for those programs.

Contact Information:

Call the toll free information line at 1-800-378-9919. For a listing of clinics and services in Los Angeles County, visit <http://www.ladhs.org>.

Government-Sponsored Programs

Program Details

- ✧ **Health Insurance Payment Program (HIPP).....page 8-1**
- ✧ **Consolidated Omnibus Budget Reconciliation Act (COBRA) and California Continuation Benefits Replacement Act (Cal-COBRA)page 8-3**
- ✧ **Major Risk Medical Insurance Program (MRMIP).....page 8-6**
- ✧ **Pre-Existing Condition Insurance Plan (PCIP).....page 8-8**
- ✧ **Health Insurance Portability and Accountability Act (HIPAA)..... page 8-10**

Who is eligible for programs in this section?

- Medi-Cal recipients with high cost medical conditions who need help paying for private health coverage
- Workers facing changes in employment who want to continue medical coverage for themselves or their dependents
- California residents who face problems getting and keeping health coverage or who have high premiums due to pre-existing health conditions

Health Insurance Premium Payment (HIPP) Program

Who is this program for?

The California Department of Health Care Services (DHCS) pays private health insurance premiums for certain Medi-Cal beneficiaries who have high-cost medical conditions. Medi-Cal refers individuals who might be eligible to DHCS for possible participation. There is also a HIPP Program called Care/HIPP that pays insurance premiums for HIV/AIDS patients who are unable to work full time.

What are the eligibility requirements?

To be eligible, applicants must meet all of the following requirements:

- Currently enrolled in full-scope no-cost Medi-Cal or have a share-of-cost;
- Currently have health coverage or access to health coverage through an employer (individual policies, group health plans or self-pay*, COBRA or conversion policies) at the time of application that covers the medical condition for which treatment is needed. HIPP will not pay for new policies nor will it pay premiums for the California Major Risk Medical Insurance Program (MRMIP);
- Not enrolled in a Medi-Cal managed care plan;
- Not enrolled in a County Organized Health Plan;
- Not Medicare eligible; and
- Have disabilities that result in high medical costs, for example, HIV/AIDS. Medical bills are generally required to be greater than twice the monthly premiums, but this requirement may be waived in some cases.

How to apply?

Applications should be submitted early in the month to have premiums paid for the following month. HIPP will not cover current or past premiums. The following items should be included with the application:

- signed and dated copy of a physician's statement of diagnosis
- completed HIPP Referral Form (DHS 6172)
- proof of Medi-Cal eligibility (BIC number)
- copy of latest premium notice and policy booklet

Applications and documentation should be sent to:

Department of Health Care Services, HIPP Program
MS 4719, P.O. Box 997422
Sacramento, CA 95899-7422

Contact information:

For additional information, call 1-866-298-8443 or visit http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx.

***NOTE:** Under self-pay policies, beneficiaries pay a portion of their health care, either through deductibles or by paying out-of-pocket once a cap on benefits is reached, or both.



Assistor Tips!!!

- If a patient is diagnosed with HIV/AIDS, they could be eligible for the CARE/HIPP Program. The CARE/HIPP Program will pay insurance premiums for patients that are disabled because of HIV and are at risk of losing their health insurance coverage.
 - In order to be eligible for the CARE/HIPP Program, individuals must be:
 - California residents;
 - Disabled by HIV/AIDS;
 - Have assets less than \$6,000;
 - Have incomes less than 400% of the Federal Income Guidelines (FIGs); and,
 - Have a monthly premium payment within the program limits.
- For more information, visit the Office of AIDS website:
<http://www.cdph.ca.gov/programs/aids/Pages/OACAREHIPP.aspx> or call a Benefits Counselor nearest you. To find the nearest Benefits Counselor, please visit the following website:
<http://www.cdph.ca.gov/programs/aids/Documents/CHBenefitsCounsDir.pdf>.

Consolidated Omnibus Budget Reconciliation Act (COBRA) and California Continuation Benefits Replacement Act (Cal-COBRA)

Who is this program for?

COBRA is a program that gives employees and their families an option to continue group health benefits for themselves and their dependents for a specific period of time under special circumstances. COBRA is the name of the federal program and Cal-COBRA (California Continuation Benefits Replacement Act) is California's state program.

What are the eligibility requirements?

Employees of companies with 20 or more employees are covered by federal COBRA which generally provides coverage for up to 18 months. Cal-COBRA is a program for California residents which expands the scope of federal COBRA by providing coverage to:

- employees in companies with 2-19 employees who are therefore not eligible for federal COBRA,
- AND
- employees in companies of more than 20 employees who wish to extend the time period beyond the 18 month time period offered under federal COBRA to up to 36 months.

The length of time employees are eligible to continue receiving COBRA depends on the qualifying event or reason that coverage was lost. Examples of qualifying events for employees or dependents are the following:

- Loss of a job, voluntary or involuntary, unless the reason for termination was for gross misconduct
- Shorter working hours that would result in an employee no longer being eligible to participate in the employer's group health plan
- Eligibility of an employee for Medicare
- No remaining family leave benefits (some circumstances)
- Worker becomes eligible for Social Security Disability Insurance (some circumstances)
- Loss of health benefits by a spouse or dependent due to death, divorce or loss of dependent status

COBRA allows employees who experience one of these qualifying events to continue coverage under their group health plans for a limited time by paying for the coverage out of their own pockets. There are no income requirements for COBRA eligibility. Federal health plans and some church organization health plans are excluded from COBRA requirements.

How does immigration status affect eligibility?

In order to qualify for COBRA or Cal-COBRA, individuals must be legally eligible to work in California.

What is the cost?

The cost to employees under COBRA is no more than 102% of the health plan premium for active employees for the first 18 months (the cost of the coverage for the employee plus an

administrative fee). After 18 months, the cost is no more than 150% of the health premium for active employees. Payment is due **45 days** after electing COBRA coverage. Disabled individuals may be able to have their Cal-COBRA premiums paid through Medi-Cal HIPP or Care/HIPP for HIV/AIDS. Certain employees may be eligible for COBRA premium reduction. Please refer to the COBRA Premium Reduction Fact Sheet.

What benefits are covered?

- COBRA beneficiaries receive the same benefit options as active employees.
- Depending on the qualifying event, the coverage period is either 18 or 36 months. Qualifying events for 36 months are death of an employee, divorce/legal separation, loss of dependent status or Medicare entitlement.
- Individual plans have the option to offer COBRA beneficiaries coverage beyond that which is required under COBRA if they choose to do so. However, non-medical benefits such as vision or dental care under a specialized plan cannot be extended when moving from COBRA to extended coverage under Cal-COBRA.
- Individuals who become eligible for Medicare or who are covered by other health plans are not eligible for Cal-COBRA unless that coverage has pre-existing exclusions that affect the individuals in question.

How are services delivered?

COBRA beneficiaries have the same options for health coverage and the same covered benefits as active employees. In many cases, that will be the same coverage employees had before the qualifying events occurred. COBRA enrollees make their selections during Open Enrollment at the same time as active employees.

What about other insurance?

Individuals can have both Medi-Cal and COBRA, but if they are eligible for both programs, they should consider their situations. If they have a high share of cost, Medi-Cal can actually be more expensive than COBRA. But in cases where there is no share of cost or a low share of cost, since Medi-Cal would pay last, it might be better for the family to enroll in Medi-Cal and not elect COBRA coverage.

How to apply:

Paperwork needs to be completed within **60 days** of the qualifying event or after receiving notice of COBRA rights, whichever is later. Employers need to inform employees within 30 days of a qualifying event that they are eligible for COBRA and should make booklets on COBRA available to all eligible employees.

Contact information:

- For general information on COBRA: <http://www.dol.gov/dol/topic/health-plans/cobra.htm>
- Members of group health plans (HMOs) can call the Department of Managed Care at 1-888-HMO-2219 or visit the website at <http://www.hmohelp.ca.gov>. Employees who have fee-for-service health coverage can contact the Department of Insurance at 1-800-927-4357.



Assistor Tips!!!

- Since premiums are likely to be costly under COBRA, clients may ask why they should enroll in COBRA rather than purchasing private insurance.
 1. For individuals with incomes that are too high to qualify for no-cost Medi-Cal or other low-cost health care options, group health coverage is generally more comprehensive and less expensive than individual health coverage.
 2. COBRA does not take into account pre-existing health conditions, whereas individuals who have pre-existing health conditions may not qualify for individual coverage or may be subject to coverage limitations or exclusions or may have to pay higher than normal premiums.
- Some situations where it might make sense for clients to consider enrolling in COBRA are the following:
 - Client's new job does not offer health insurance.
 - Client's current plan covers dental whereas a private plan may not, so dental expenses could be high without COBRA.
 - Client needs medications that might not be covered under another plan.
 - Client has health conditions that might make it difficult to qualify for an individual plan.
 - Client or covered dependent is pregnant and not eligible for private insurance.
- Employees are responsible for informing their employers in writing within 60 days of the qualifying events that they want to sign up for COBRA. The first premium is due within 45 days of electing coverage. Premium rules are strict. If an employee signs up for COBRA but fails to pay premiums, they will be responsible for the full cost of their medical care.

Major Risk Medical Insurance Program (MRMIP)

Who is this program for?

MRMIP is for California residents who are not able to obtain individual insurance coverage because of pre-existing health conditions. MRMIP can help those who 1) have been denied coverage, have limited coverage or coverage under which certain health conditions are excluded (not covered); or 2) have very high premiums because of those pre-existing health conditions. The program is subsidized by contributions from enrollees and the State of California through tobacco tax dollars.

What are the eligibility requirements?

- Applicants must be residents of California.
- Applicants must not be eligible for Medicare Part A or Part B unless they have a disability.
- Applicants must not be able to purchase health insurance under COBRA or Cal-COBRA, although COBRA or Cal-COBRA enrollees may apply in advance for MRMIP for coverage to begin when their COBRA benefits end.
- Applicants must have been denied coverage under **one** of the following circumstances and submit written proof:
 - They were denied coverage during the previous 12 months.
 - They were offered premium rates that were higher than the rate established by MRMIP.
 - They were members of a group that was denied coverage during the previous 12 months.

What benefits are covered?

- MRMIP enrollees receive comprehensive medical benefits for inpatient and outpatient hospital and physician services. Applicants can call participating health plans or MRMIP or go online to request Evidence of Coverage or a Certificate of Insurance booklet.
- MRMIP benefits cover up to \$75,000 per calendar year and a maximum of \$750,000 per lifetime.
- Individuals who enroll in HMOs (Health Maintenance Organization) will have a 3-month waiting period during which time they will pay no contributions and will not be eligible for services. For those enrolling in PPOs (Preferred Provider Organization), there is a pre-existing period of 3 months during which no services will be provided related to the pre-existing condition. However, contributions are paid during this period. There are some exceptions to the waiting period, including being on a waiting list for MRMIP coverage for over 60 days.
- Subscribers' dependents can also be covered under the plan.
- Subscribers will continue to be enrolled into MRMIP for as long as they are eligible for the program.

How does immigration status affect eligibility?

Immigration status is not taken into consideration.

How are services delivered?

Enrollees will select a plan from those offered in their counties. Participating health plans in Los

Angeles County are Anthem Blue Cross and Kaiser Permanente Southern California (Kaiser Permanente is not available on Catalina Island).

What is the cost?

- MRMIP has an annual household deductible of \$500 that the applicant must pay before MRMIP begins to pay for services.
- Premiums vary by the age of the subscriber, the health provider and the health plan selected. If dependents are included in the coverage, the premium is based on the age of the subscriber.
- Subscribers pay MRMIP established fixed amounts for certain services. If co-payments are required, they cannot exceed 25% of the cost of the covered service, and deductibles cannot exceed \$500 per calendar year per household. Maximum out-of-pocket expenses for services offered by the subscribers' plans and covered by MRMIP are \$2,500 per person per calendar year and \$4,000 per household per calendar year.
- Transfers to other parts of the State or changing to another health plan may affect contribution rates.

What about other insurance?

Medi-Cal beneficiaries can apply for the program but will need to pay premiums and deductibles for coverage under MRMIP, which can be expensive. Medi-Cal will not pay for those costs. Medi-Cal may cover some services that private plans do not, such as dental care.

How to apply:

Interested applicants can request an application from MRMIP at 1-800-289-6574 or download the application from the MRMIB website at <http://www.mrmib.ca.gov>. When applying for MRMIP and/or Pre-Existing Condition Insurance Plan (PCIP), the application will be reviewed for both health care programs to inform the applicant of his/her coverage options. In order for eligibility to be determined for both programs, the applicant must fill out both the MRMIP Application and the PCIP Supplemental Application.

Contact information:

- For more information please visit: <http://www.mrmib.ca.gov/mrmib/MRMIPBRO.pdf>
- MRMIB: <http://www.mrmib.ca.gov>
- Department of Managed Care: <http://www.hmohelp.ca.gov> or call 1-888 466-2219
- Department of Insurance: <http://www.insurance.ca.gov> or call 1-800-927-4357



Assistor Tips!!!

- Make certain that applicants understand about the waiting period, health plan choices, co-payments and deductibles and payment plans.
- Since MRMIP may have a waiting list, anyone who anticipates a loss of coverage should be placed on the waiting list as soon as possible.

Pre-Existing Condition Insurance Plan (PCIP)

The Pre-Existing Condition Health Insurance Plan (PCIP) was authorized by the Patient Protection and Affordable Care Act (ACA) of 2010. PCIP is a federally funded program that was designed to provide coverage to uninsured individuals who have been denied health insurance or who have been offered unaffordable rates.

Who is eligible?

To be eligible for PCIP, applicants must:

- Not have had creditable coverage within the six months prior to application; and
- Have a preexisting condition as evidenced by proof of denial by an insurance carrier within the past 12 months or have been offered coverage above the premium level of the Major Risk Medical Insurance Program (PCIP) PPO rate.
- Be a U.S. Citizen, U. S. National or lawfully residing in the U.S.
- Not enrolled in Medicare Part A & B; or COBRA or Cal-COBRA benefits

How does immigration status affect eligibility for the PCIP program?

Citizenship, U.S. National or Lawfully residing in the U.S. status is a requirement for PCIP.

What are the income limits?

There are no income limits for this program.

Are there resource limits?

PCIP does not take resources into consideration.

What is the cost?

Monthly premium rates for PCIP vary according to age and region (effective until December 31, 2011):

Age band	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
0 – 18	\$ 119	\$ 118	\$ 124	\$ 107	\$ 110	\$ 108
19 – 29	\$ 164	\$ 162	\$ 171	\$ 147	\$ 152	\$ 149
30 – 34	\$ 237	\$ 234	\$ 247	\$ 211	\$ 218	\$ 214
35 – 39	\$ 264	\$ 261	\$ 275	\$ 237	\$ 244	\$ 240
40 – 44	\$ 292	\$ 289	\$ 305	\$ 261	\$ 269	\$ 265
45 – 49	\$ 332	\$ 329	\$ 346	\$ 297	\$ 306	\$ 301
50 – 54	\$ 411	\$ 406	\$ 428	\$ 370	\$ 381	\$ 375
55 – 59	\$ 492	\$ 487	\$ 514	\$ 442	\$ 455	\$ 447
60 – 64	\$ 535	\$ 530	\$ 557	\$ 481	\$ 494	\$ 485
65 – 69	\$ 535	\$ 530	\$ 557	\$ 481	\$ 494	\$ 485
70 – 74	\$ 535	\$ 530	\$ 557	\$ 481	\$ 494	\$ 485
> 74	\$ 535	\$ 530	\$ 557	\$ 481	\$ 494	\$ 485
Region 1 Northern: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, Yuba						
Region 2 Valley: Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, Stanislaus						
Region 3 Bay Area: Alameda, Contra Costa, Marin, San Francisco, San Mateo, Santa Clara						
Region 4 South Coast: Orange, Santa Barbara, Ventura						
Region 5 Los Angeles: Los Angeles						
Region 6 South: Riverside, San Bernardino, San Diego						

Is California residency a requirement?

Applicants must live in California in order to qualify for PCIP.

What about other insurance?

Applicants will not qualify for PCIP if they currently have, or have had, health insurance within the previous 6 months.

How are services provided under PCIP?

MRMIB is responsible for the implementation and operation of PCIP. Maximus is the administrative vendor and HealthNow provides third-party administrator services. PCIP provides all the components of a comprehensive health care plan.

Where can individuals apply?

Persons interested in receiving an application can call the toll free number of 1-877-428-5060 Monday through Friday from 8 a.m. to 8 p.m., Saturdays from 8 a.m. to 5 p.m. or visit the PCIP website to download an application, <http://www.pcip.ca.gov/Home/default.aspx>.

Where can more information be found?

Visit the PCIP website: <http://www.pcip.ca.gov>. Additionally, outreach information is available on the website, under the Outreach Materials tab.

Health Insurance Portability and Accountability Act (HIPAA)

What is HIPAA?

HIPAA is a Federal law passed in 1996. This law protects the rights of all health consumers by giving them rights over their health information and how that information can be used and shared. In addition, the law also offers continuity of coverage protection both for individuals enrolled in group health plans who might otherwise lose their ability to obtain new health insurance or renew existing policies because of pre-existing health conditions.

Who does HIPAA apply to?

The “accountability” sections of the law apply to all health consumers. The “portability” section of the law guarantees continuity of coverage to qualified individuals enrolled in group health plans and also guarantees individual policies to eligible individuals who have no group health plan coverage and who have used up their COBRA or other continuation coverage. Individuals must show proof that they had this type of “creditable coverage” without a significant break (generally 63 days or more) prior to enrolling in a new health plan.

What rights and protections does HIPAA provide?

Since HIPAA is not a health insurance program, the benefits are the rights and protections provided by law which is briefly summarized below.

Accountability-Privacy Issues

- Information in patients’ medical records, conversations among health care providers about patients’ treatment, billing and computer data and most other types of health information are protected by limiting who can receive that information and how it can be used.
- Patients have a right to see and obtain copies of their health records, have misinformation corrected and receive notice of how their health information may be used and shared. They also have the right to give permission on how their information is used for certain purposes, such as marketing.

Portability

- The law protects individuals who are leaving an employment-based plan from losing coverage by limiting the exclusions a new employer can impose for preexisting conditions and prohibits discrimination by an employer against employees and dependents because of certain health conditions.
- The law also guarantees access to individual policies for certain individuals and offers some protections by guaranteeing that those policies can be renewed.

Contact Information:

To learn more about privacy issues under HIPAA, call 1-866-627-7748 to receive a fact sheet called “*Your Health Information Privacy Rights*” or visit <http://www.hhs.gov/ocr/hipaa/>.

For more details on portability of insurance coverage under HIPAA, visit http://www.dol.gov/ebsa/faqs/faq-consumer_hipaa.html.

Resources

- ✧ **Health Resource and Referral Information for Low-Income Los Angeles County Residents.....page 9-1**
- ✧ **Specific Health Services Available to Los Angeles County Adults.....page 9-1**
- ✧ **Health Consumer Information for Los Angeles County Residents.....page 9-3**
- ✧ **Immigration/ Public Charge Informationpage 9-3**
- ✧ **California Health Coverage and Health Services for Adults.....page 9-3**
- ✧ **Health Programs and Services for the Aged, Blind, and Disabled.....page 9-4**
- ✧ **California Departments that Administer Adult Health Programs and Services.....page 9-4**
- ✧ **Private Health Insurance and Services.....page 9-4**
- ✧ **Affordable Care Act Information.....page 9-5**

1. Health Resource and Referral Information for Low-Income Los Angeles County Residents

211 (InfoLine of Los Angeles)

Telephone referral to health and human services organizations in Los Angeles County available 24 hours a day, seven days a week.

2-1-1

CHAMP-Net

Website for the CHAMP Program, offering information on CHAMP trainings, a family resource section, information for health advocates and CAAs, including an eligibility calculator, CAA tutorial, newsletter and access to the current CHAMP manual. For questions please e-mail:

askthetrainers@champ-net.org.

www.champ-net.org

Healthy City

Website that allows users to find services in Los Angeles, search out resources by neighborhood and view health statistics and related information.

www.healthycity.org

Los Angeles County Department of Health Services

Information on free and low-cost health services and a listing of Los Angeles County hospitals & clinics.

1-800-427-8700

www.ladhs.org

Los Angeles County Department of Public Health

Information on free and low-cost public health services and a listing of Los Angeles County public health centers.

www.lapublichealth.org (search by topic)

Los Angeles Department of Public Social Services (Medi-Cal)

1-877-597-4777 (Health & Nutrition)

www.ladpss.org

Medi-Cal Managed Care

Health Care Options 1-800-430-4263

We've Got You Covered

Los Angeles County guide to free and low-cost health care services

Call the County Health & Nutrition Hotline at 1-877-597-4777 for a free copy.

2. Specific Types of Health Services Available to Los Angeles County Residents

HIVLA.org

Online English or Spanish directory of HIV/AIDS related services in Los Angeles County

www.hivla.org or call 1-866-772-2365 (Client Advocacy Services Hotline)

AIDS Drug Assistance Program (ADAP)

Provides assistance obtaining approved medications for HIV positive adults

1-888-575-2327 or visit <http://www.dhs.ca.gov/ps/ooa/Programs/CARE/adap.htm>

Comprehensive AIDS Resources Emergency Health Insurance Premium Payment Program (CARE/HIPP)

This is a financial assistance program designed to pay health insurance premiums for people living with HIV/AIDS

1-800-367-AIDS

<http://www.cdph.ca.gov/programs/AIDS/pages/OACAREHIPP.aspx>

Breast Cancer Early Detection Program (BCEDP)

List of agencies that provide free breast cancer-related services for low and middle income women age 50 and over

1-800-511-2300

<http://www.cdph.ca.gov/programs/cancerdetection/Pages/default.aspx>

Cancer: Partnered for Progress

This organization provides referrals for information and low-cost cancer screenings

www.partneredforprogress.org

Diabetes

Information and links to local programs

www.caldiabetes.org

Family Planning, Access, Care and Treatment (Family PACT)

Family planning services for low income adults without health care coverage

1-800-942-1054

<http://www.cdph.ca.gov/programs/OFP/Pages/default.aspx>

Mental Health

Free or low-cost mental health services

1-800-854-7771

www.dmh.co.la.ca.us

Smoking Cessation; Los Angeles County Tobacco Control Program

For services by geographical area in Los Angeles

1-213-351-7890 or 1-800-No-Butts

www.lapublichealth.org/tob

Veteran Services

1-877-222-8387

<http://www.losangeles.va.gov/>

Women's Health: Office of Women's Health

Services include a mobile clinic outreach program that provides health assessments for low income women

1-626-569-3850

<http://publichealth.lacounty.gov/owh/>

3. Health Consumer Information for Los Angeles County Residents

Center for Healthcare Rights

Serves consumers through direct service programs and policy level advocacy. The center serves Medicare and Medi-Cal enrollees in Los Angeles County as the Los Angeles County Health Insurance Counseling and Advocacy Program (HICAP).

1-800-824-0780

www.healthcarerights.org

Health Consumer Alliance

Health Consumer Hotline at Neighborhood Legal Services provides assistance and information for consumers who have issues or problems relating to health care. The Alliance also publishes helpful brochures on health topics for consumers and advocates.

1-800-896-3203

www.healthconsumer.org

4. Immigration/Public Charge

Coalition for Humane Immigrant Rights of Los Angeles (CHIRLA)

Services include a bilingual Spanish/English hotline for information and referral services that provides access to information for the immigrant community, including rights related to health care

1-888-624-4752

www.chirla.org

Asian Pacific American Legal Center (APALC)

Offers legal services and advocacy programs to the Asian community

213-977-7500

www.apalc.org

5. California Health Coverage and Health Services for Adults

Access for Infants & Mothers (AIM)

1-800-433-2611

<http://www.mrmib.ca.gov> or <http://www.aim.ca.gov>

Breast Cancer Early Detection Program (BCEDP)

1-800-511-2300 for a list of agencies in Los Angeles County

Breast Cancer Control Treatment Program (BCCTP)

1-800-511-2300

<http://www.cdph.ca.gov/programs/cancerdetection/pages/cancerdetectionprogramseverywomancounts.aspx>

Consolidated Omnibus Budget Reconciliation Act (COBRA)

1-888-HMO-2219

www.crbenefits.com/clients/dol_cobra_creative_benefits.htm

www.hmohelp.ca.gov

Department of Health Care Services (Medi-Cal)

www.medi-cal.ca.gov

6. Health Programs and Services for the Aged, Blind, and Disabled

Area Agency on Aging (Los Angeles County)

This is an information and referral agency that helps link seniors and disabled adults to services.
1-213-252-4030 or 1-800-510-2020
<http://aging.lacity.org/>

Genetically Handicapped Person Program (GHPP)

The program helps individuals with genetic diseases pay for medical and related costs.
1-800-639-0597

Health Insurance Premium Payment Program (HIPP)

This is a Medi-Cal program that can help pay high cost medical bills for individuals who have serious illnesses and have private health care coverage.
1-800-952-5294
http://www.dhcs.ca.gov/services/pages/tplrd_cau_cont.aspx

Medicare

Persons 65 years of age or older or individuals receiving social security payments may qualify for Medicare.
1-800-772-1213
www.medicare.gov
www.cahealthadvocates.org (information on Medicare for Californians)

7. California Departments that Administer Adult Health Programs and Services

California Department of Health Care Services (DHCS)

Administers the Medi-Cal Program. The site provides program specific phone numbers, informational brochures and can download a Medi-Cal application.
www.dhcs.ca.gov

Department of Public Social Services (DPSS)

Administers social services programs, including residential care, medical care, mental health care, alcohol and drug treatment services, in-home health/medical care, SSI/SSP, foster care, adoption, daycare licensing and food stamps.
<http://www.ladpss.org/>

Managed Risk Medical Insurance Board (MRMIB)

Administers the Access for Infants & Mothers Program (AIM), the Managed Risk Medical Insurance Program (MRMIP) and the Healthy Families Program for children.
1-916-324-4695
www.mrmib.ca.gov

8. Private Health Insurance and Services

Foundation for Health Coverage Education

California Uninsured Helpline 1-800-234-1317
To order a free booklet *Finding Health Care Coverage in California* which includes information on both public and private health insurance.
www.coverageforall.org

California Department of Insurance

1-800-927-4357 (consumer hotline for insurance-related questions)

<http://www.insurance.ca.gov/>

9. Affordable Care Act Information**HealthCare.gov**

A federal government website helping consumers find the health insurance best suited to their needs, whether it's private insurance for individuals, families, and small businesses, or public programs. It was created to help consumers under the health insurance reform law, the Affordable Care Act.

www.healthcare.gov

CuidadoDeSalud.gov

Spanish-language website version of HealthCare.gov; A federal government website helping consumers find the health insurance best suited to their needs, whether it's private insurance for individuals, families, and small businesses, or public programs. It was created to help consumers under the health insurance reform law, the Affordable Care Act.

www.cuidadodesalud.gov

California Health Care Reform

A State of California website dedicated to helping Californians learn about what state government officials are doing to plan for and administer the changes coming to California's health care system in the months and years ahead as a result of the Affordable Care Act.

www.healthcare.ca.gov

Glossary

Ability to Pay (ATP)

ATP provides medically necessary services at Los Angeles County hospitals or clinics for individuals who cannot afford to pay for their care and are not eligible for full-scope Medi-Cal.

Access for Infants & Mothers (AIM)

AIM is a health insurance program for uninsured pregnant women with family incomes that are too high for them to qualify for Medi-Cal.

Aid Codes

Aid Codes are a combination of numbers and letters used by Medi-Cal to identify the qualifications of individuals for Medi-Cal and certain other public benefits programs.

Benefit Identification Card (BIC)

BIC is a card issued by Medi-Cal to be used by beneficiaries when accessing health services.

Blind Work Expense (BWE)

Documented expenses for services or items that are related to one's blindness and needed in order to work. Service animal expenses, transportation to and from work, federal, state, and local income taxes, Social Security taxes, attendant care services, visual and sensory aids, translation of materials into Braille, professional association fees, and union dues are some examples of BWEs.

Breast and Cervical Cancer Control Treatment Program (BCCTP)

BCCTP is a program that provides cancer-related services for low- income California individuals who have a diagnosis of breast or cervical cancer.

Certified Application Assistant (CAA)

CAAs are individuals who have been trained and certified to assist families in applying for Medi-Cal or Healthy Families through the joint mail-in application or through Health-e-App.

Cal-COBRA

California's state program expands the scope of federal COBRA by offering benefits to employees of companies with 2-19 employees and lengthening the eligibility term for employees in companies with 20 or more employees.

California Work Opportunities and Responsibility to Kids (CalWORKs)

Operated by county welfare offices, CalWORKs gives cash aid and services to needy families.

California Children's Services (CCS)

CCS is a State program that provides necessary health care and case management for children who have certain diseases, physical limitations or chronic health problems.

Caretaker Relative

A caretaker relative is a person who provides care and supervision to a child.

Certificate of Indigency (COI)

The form used to determine eligibility for the Public-Private Partnership (PPP) Program.

Children's Health Access and Medical Program (CHAMP)

CHAMP is a project of the National Health Foundation. CHAMP provides training for health advocates and community workers who help low income families enroll in programs that will help pay for their health care.

Community Partners

A partnership between Los Angeles County Department of Health Services and community health providers who are committed to providing outpatient health services to low income uninsured individuals.

Comprehensive Perinatal Services Program (CPSP)

CPSP is a program that provides comprehensive prenatal health services, parenting and nutritional education and other related services for low-income pregnant women on Medi-Cal.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

COBRA allows employees with certain qualifying events to continue health coverage under their group health plans for a limited time by paying for the coverage out of their own pockets.

Countable Unearned Income

Income received from sources for which no paid work activity is performed. Disability benefits such as SSDI, SSI, short term disability insurance, and long term disability insurance; VA benefits; Workers' Compensation; income from a trust or investment; spousal support; dividends, profits, or funds received from any source other than work are all usually considered unearned income.

Deductible

A deductible is the amount of money which the insured party must pay before their medical insurance begins paying for services.

Deemed Eligible

This term refers to eligibility of an individual for a particular program without the need for a formal application. For example, a child born to a woman on Medi-Cal automatically qualifies for Medi-Cal for one year after birth.

Department of Health Services (DHS), Los Angeles County

Los Angeles County public health care system (often called the Safety Net) providing medical, mental health, public health and education services for county residents.

Deprivation

This is an eligibility requirement for certain Medi-Cal programs for families with children. Deprivation occurs when a child lacks parental support because one or both parents are absent, unemployed, underemployed, incapacitated or deceased.

Earned Income Exclusion

Deduction from funds received from sources for which paid work activity is performed.

Exclusions

These are health conditions that a specific insurance plan does not cover.

Exempt Property

For Medi-Cal or other programs that count resources in determining eligibility, certain types of property or resources are not counted and therefore are considered “exempt”.

Family PACT

Family PACT is a state and federally-funded program that provides family planning education and services to low-income California residents.

Federal Income Guidelines (FIG)

These are income figures released annually by the federal government that are used to match family income to eligibility requirements for many healthcare programs. FPL and FIG are used interchangeably.

Federal Poverty Level (FPL)

This is the amount of money the federal government determines is necessary for a family to meet its basic needs. Many healthcare programs are based on the FPL. FPL and FIG are used interchangeably.

Fee-for-service (FFS)

Under this system, a Medi-Cal provider receives a fee from Medi-Cal for each service provided. Fee-for-service Medi-Cal recipients can choose any provider who accepts Medi-Cal. Recipients not under this system are enrolled in a managed care system.

Former Foster Care Children Program (FFCC)

This program allows foster care children to retain their Medi-Cal benefits after leaving foster care until their 21st birthday.

Full-Scope Medi-Cal

Medi-Cal recipients with full-scope Medi-Cal receive comprehensive coverage for all services provided. Individuals with satisfactory documentation are eligible for this type of coverage.

General Income Exclusion

Deduction from funds received from sources for which no paid work activity is performed.

Genetically Handicapped Persons Program (GHPP)

GHPP is a state-funded program helps individuals with genetic diseases pay for medical costs.

Health Care Options (HCO)

HCO is a division of Maximus and is the contractor for managed care plan enrollments, disenrollments and transfers in Los Angeles County.

Health Insurance Premium Payment Program (HIPP)

HIPP is a California Department of Health Care Services program that pays private health

insurance premiums for certain Medi-Cal beneficiaries who have high-cost medical conditions.

Health Maintenance Organization (HMO)

An HMO is a prepaid health plan under which patients receive a set of healthcare services from designated providers in a specific geographical area.

Impairment Related Work Expenses

Documented expenses for services or items that are related to one's impairment and needed in order to work. Wheelchairs, physician visits, co-pays for prescriptions, and other medical expenses are some examples of IRWEs.

In-Home Support Services (IHSS)

IHSS is a program that helps blind, aged or disabled individuals remain in their homes by helping them pay for services such as cooking, shopping and personal care.

Maintenance Need Level (MNL)

MNL is a set of formulas established for Medi-Cal which determine Share-of-Cost amounts. Unlike FIG and FPL amounts which change annually, these formulas have remained constant for more than 10 years.

Major Risk Medical Insurance Program (MRMIP)

This program can help individuals access health coverage who are not able to obtain health coverage or who have very high premiums due to pre-existing health conditions.

Managed Care

Managed care members are enrolled in a specific plan and will generally need to select a medical group or independent practice association to provide their medical services.

Mandatory Participants

Medi-Cal recipients in this category must participate in managed care Medi-Cal as opposed to voluntary participants who may choose between fee-for-service or managed care Medi-Cal.

Medicare

Medicare is the federal health insurance program for people 65 years of age and older and younger individuals who have certain disabilities or permanent kidney failure.

Mid-Year Status Report (MSR)

MSR is a review conducted six months after enrollment to reconsider continued eligibility for certain Medi-Cal beneficiaries.

Minor Consent Medi-Cal

This program allows teenagers up to 21 years of age who live with their parents to access certain confidential Medi-Cal services.

No-cost Medi-Cal

This program covers all services without any payment on the part of beneficiaries.

Open Enrollment

This is an annual time period during which subscribers to health plans may make changes to

their coverage options. Open Enrollment applies to individual and employer-sponsored plans and also public health plans such as Healthy Families.

Out of Pocket Expenses

These are expenses that individuals with health coverage have to pay themselves, generally in the form of deductibles or co-payments.

Outpatient Reduced-Cost Simplified Application (ORSA)

ORSA provides outpatient services including emergency services and medications to individuals who use Los Angeles County facilities and who are not eligible for insurance coverage.

Percentage Programs

These programs provide Medi-Cal benefits with no share of cost to children and pregnant women without taking into account family resources. Percentage refers to the Federal Income Guidelines (FIG), which are used to determine eligibility for the programs.

Permanently Residing Under the Color of Law (PRUCOL)

Individuals with PRUCOL status are legally residing in the U.S. and are known to the United States Citizen Immigration Services (USCIS). They can apply for full-scope, no cost Medi-Cal.

Pre-Existing Condition

An health conditions an individual had before applying for health coverage which may impact his/her ability to obtain coverage or which may be excluded from coverage.

Pre-Existing Condition Insurance Plan (PCIP)

PCIP is a federal program that offers health coverage to medically-uninsurable individuals who live in California. This program is available to individuals who did not have health coverage in the 6 months prior to applying and meet eligibility requirements.

Prepayment

Under this program, Los Angeles County residents can pay a lower, reduced fixed cost for outpatient health services received at County hospitals or clinics if they pay within seven days of receiving treatment.

Presumptive Eligibility (PE)

This program allows certain providers to offer no share of cost prenatal Medi-Cal to low-income pregnant women at the first office visit. Coverage lasts until the end of the second month or until Medi-Cal approves or denies the regular Medi-Cal application filed by the pregnant woman.

Public Assistance

This is a program that provides cash assistance to Low-income individuals. They are automatically eligible for Medi-Cal benefits.

Resources

Resources are things that families own, such as cars, homes and personal property. Bank accounts are also counted as resources. Some health programs take resources into account

when determining eligibility.

Restricted Medi-Cal

Individuals on restricted Medi-Cal are covered only for emergency and pregnancy-related services. This program is available to undocumented individuals who meet eligibility requirements.

Self-Declaration

Some programs allow an applicant to report income or certain other eligibility information without written proof. Other programs may allow self-declaration as a last resort when no other form of documentation is available.

Share of Cost (SOC) Medi-Cal

SOC Medi-Cal beneficiaries are required to pay a certain amount each month out of pocket for their medical expenses before Medi-Cal pays for services.

Sneede

Sneede refers to a lawsuit that affects the way that Medi-Cal determines rules for property and income for some families that have stepparents, unmarried couples and/or children with their own income or property.

Supplemental Security Income/State Supplemental Payment (SSI/SSP)

SSI/SSP is a cash payment from the state and federal government for the elderly and disabled to help them meet their basic needs.

Transitional Medi-Cal (TMC)

TMC provides up to 12 months of no cost Medi-Cal to families who have lost eligibility for CalWORKs or Medi-Cal 1931(b) due to employment or increased earnings.

Two-Plan Model

Medi-Cal managed care is organized under this model in some counties including Los Angeles County. Mandatory participants in managed care enroll in either a Commercial Plan or a Local Initiative.

Voluntary Participants

These Medi-Cal beneficiaries may choose to enroll either in a managed care plan or participate in fee-for-service Medi-Cal.