ARTICLE 10 -- INCOME

10A -- SSI/SSP PAYMENT STANDARDS

10B -- AID TO FAMILIES WITH DEPENDENT CHILDREN STANDARDS

10C -- PUBLIC LAW PAYMENTS INCOME EXEMPTIONS

1. PL 94-385 and PL 97-35 – Home Energy Assistance
2. PL 95-171 – Disaster Assistance
3. PL 96-420 – Payments Distributed Under the Maine Indian Claims Settlement Act of 1980

10D -- SENIOR CITIZENS RENT ASSISTANCE

1. Background
2. Eligibility Requirements
3. Impact on Income

10E -- COST OF IN-HOME SERVICES AS AN INCOME DEDUCTION FOR AGED, BLIND, AND DISABLED-MEDICALLY NEEDY (ABD/MN)

10F -- INCOME IN KIND VALUES AND POLICIES RELATING TO THEIR USE

10G -- TREATMENT OF MONEY RECEIVED FROM NONFAMILY MEMBERS LIVING IN THE HOME

1. Ten Percent of Gross (Title 22 Section 50515(a)(2))
2. Net Profit From Self-Employment (Title 22 Section 50508(a)(4))
3. Income In Excess of Contributor's Share of Household Costs (Title 22 Section 50515(a)(2))

10I -- TITLE II DISREGARD ELIGIBILITY DETERMINATIONS – OBSOLETE, SEE "PICKLE" HANDBOOK

10J -- VETERAN'S BENEFITS

1. Background
2. Referral
3. Client Responsibility

10K -- COMMUNITY PROPERTY INCOME AVAILABLE IN LONG-TERM CARE (LTC) SITUATIONS

10L -- APPLICATION OF THE $30 PLUS ONE-THIRD AND $30 DEDUCTION

10K -- COMMUNITY PROPERTY INCOME AVAILABLE IN LONG-TERM CARE (LTC) SITUATIONS

10L -- APPLICATION OF THE $30 PLUS ONE-THIRD AND $30 DEDUCTION

10M -- INCOME FROM SELF-EMPLOYMENT

10P -- TREATMENT OF VETERAN'S EDUCATIONAL BENEFITS

10Q -- INCOME DEDUCTION FOR PERSONS IN LICENSED BOARD AND CARE FACILITIES

10R -- APPLICATION OF OLD AND CURRENT MEDICAL BILLS TOWARD SHARE OF COST (INCLUDES HUNT V. KIZER PROCEDURES)

SSI/SSP PAYMENT STANDARDS
EFFECTIVE JULY 1, 1977

CATEGORY	LIVING ARRANGEMENTS				
	Independent Living Arrangement	Residing in Household of Another and Receiving Room and Board in Kind	Independent Living Arrangement Without Cooking Facilities	Nonmedical Board and Care	Disabled Minor Residing in Home of Relative
Aged	$296.00	$236.74	$329.00	$343.00	N/A
Disabled	296.00	236.74	329.00	343.00	$241.00
Blind	334.00	274.74	N/A	343.00	N/A
Aged and Aged Spouse	557.00	468.10	623.00	686.00	N/A
Disabled and Disabled Spouse	557.00	468.10	623.00	686.00	N/A
Blind and Blind Spouse	663.00	574.10	N\A	686.00	N/A
Aged and Disabled Spouse	557.00	468.10	623.00	686.00	N/A
Aged and Blind Spouse	625.00	536.10	N/A	686.00	N/A
Blind and Disabled Spouse	625.00	536.10	N/A	686.00	N/A

SSI/SSP -- PAYMENT STANDARDS
EFFECTIVE SEPTEMBER 1, 1978

CATEGORY	LIVING ARRANGEMENTS				
	Independent Living Arrangement	Residing in Household of Another and Receiving Room and Board in Kind	Independent Living Arrangement Without Cooking Facilities	Nonmedical Board and Care	Disabled Minor Residing in Home of Relative
Aged	$307.60	$244.47	$340.60	$354.60	N/A
Disabled	307.60	244.47	340.60	354.60	$258.00
Blind	345.60	282.47	N/A	354.60	N/A
Aged and Aged Spouse	574.40	479.70	640.60	709.20	N/A
Disabled and Disabled Spouse	574.40	479.70	640.60	709.20	N/A
Blind and Blind Spouse	680.40	585.70	N\A	709.20	N/A
Aged and Disabled Spouse	574.40	479.70	640.60	709.20	N/A
Aged and Blind Spouse	642.40	547.70	N/A	709.20	N/A
Blind and Disabled Spouse	642.40	547.70	N/A	709.20	N/A

EFFECTIVE JULY 1, 1978 THROUGH AUGUST 31, 1978

CATEGORY	LIVING ARRANGEMENTS				
	Independent Living Arrangement	Residing in Household of Another and Receiving Room and Board in Kind	Independent Living Arrangement Without Cooking Facilities	Nonmedical Board and Care	Disabled Minor Residing in Home of Relative
Aged	$322.00	$258.87	$358.00	$369.00	N/A
Disabled	322.00	258.87	358.00	369.00	$258.00
Blind	363.00	299.87	N/A	369.00	N/A
Aged and Aged Spouse	602.00	507.30	674.00	738.00	N/A
Disabled and Disabled Spouse	602.00	507.30	674.00	738.00	N/A
Blind and Blind Spouse	714.00	619.30	N\A	738.00	N/A
Aged and Disabled Spouse	602.00	507.30	674.00	738.00	N/A
Aged and Blind Spouse	673.00	578.30	N/A	738.00	N/A
Blind and Disabled Spouse	673.00	578.30	N/A	738.00	N/A

SSI/SSP -- PAYMENT STANDARDS
JULY 1, 1980 THROUGH JUNE 30, 1981

CATEGORY	LIVING ARRANGEMENTS				
	Independent Living Arrangement	Residing in Household of Another and Receiving Room and Board in Kind	Independent Living Arrangement Without Cooking Facilities	Nonmedical Board and Care	Disabled Minor Residing in Home of Relative
Aged	$420.00	$340.67	$464.00	$465.00	N/A
Disabled	420.00	340.67	464.00	465.00	$322.00
Blind	471.00	391.67	N/A	465.00	N/A
Aged and Aged Spouse	773.00	654.00	861.00	930.00	N/A
Disabled and Disabled Spouse	773.00	654.00	861.00	930.00	N/A
Blind and Blind Spouse	905.00	786.90	N\A	930.00	N/A
Aged and Disabled Spouse	773.00	654.00	861.00	930.00	N/A
Aged and Blind Spouse	854.00	628.90	N/A	804.00	N/A
Blind and Disabled Spouse	854.00	735.00	N/A	930.00	N/A

JULY 1, 1979 THROUGH JUNE 30, 1980

CATEGORY	LIVING ARRANGEMENTS				
	Independent Living Arrangement	Residing in Household of Another and Receiving Room and Board in Kind	Independent Living Arrangement Without Cooking Facilities	Nonmedical Board and Care	Disabled Minor Residing in Home of Relative
Aged	$356.00	$286.60	$394.00	$402.00	N/A
Disabled	356.00	286.60	394.00	402.00	$282.00
Blind	399.00	329.60	N/A	402.00	N/A
Aged and Aged Spouse	660.00	555.90	736.00	804.00	N/A
Disabled and Disabled Spouse	660.00	555.90	736.00	804.00	N/A
Blind and Blind Spouse	776.00	671.90	N\A	804.00	N/A
Aged and Disabled Spouse	660.00	555.90	736.00	804.00	N/A
Aged and Blind Spouse	733.00	628.90	N/A	804.00	N/A
Blind and Disabled Spouse	733.00	628.90	N/A	804.00	N/A

SSI/SSP -- PAYMENT STANDARDS

JULY 1, 1981 THROUGH JUNE 30, 1982

CATEGORY	LIVING ARRANGEMENTS				
	Independent Living Arrangement	Residing in Household of Another and Receiving Room and Board in Kind	Independent Living Arrangement Without Cooking Facilities	Nonmedical Board and Care	Disabled Minor Residing in Home of Relative
Aged	$439.00	$350.77	$486.00	$496.00	
Disabled	439.00	350.77	486.00	496.00	$348.00
Blind	492.00	403.77	N/A	496.00	
Aged and Aged Spouse	815.00	682.67	909.00	992.00	
Disabled and Disabled Spouse	815.00	682.67	909.00	992.00	
Blind and Blind Spouse	958.00	825.67	N\A	992.00	N/A
Aged and Disabled Spouse	815.00	682.67	909.00	992.00	N/A
Aged and Blind Spouse	904.00	771.67	N/A	992.00	N/A
Blind and Disabled Spouse	904.00	771.67	N/A	992.00	N/A

One spouse at home, one spouse in LTC = 1/2 of appropriate couple payment + $25.00

One spouse at home, one spouse in B&C = 1/2 of appropriate couple payment plus B&C payment for one person

JANUARY 1, 1981 THROUGH JUNE 30, 1981

CATEGORY	LIVING ARRANGEMENTS				
	Independent Living Arrangement	Residing in Household of Another and Receiving Room and Board in Kind	Independent Living Arrangement Without Cooking Facilities	Nonmedical Board and Care	Disabled Minor Residing in Home of Relative
Aged	$402.00	$322.67	$445.00	$454.00	N/A
Disabled	402.00	322.67	445.00	454.00	$319.00
Blind	451.00	371.67	N/A	454.00	N/A
Aged and Aged Spouse	746.00	627.00	832.00	908.00	N/A
Disabled and Disabled Spouse	746.00	627.00	832.00	908.00	N/A
Blind and Blind Spouse	877.00	758.67	N\A	908.00	N/A
Aged and Disabled Spouse	746.00	627.00	832.00	908.00	N/A
Aged and Blind Spouse	828.00	709.00	N/A	908.00	N/A
Blind and Disabled Spouse	828.00	709.00	N/A	908.00	N/A

SSI/SSP — PAYMENT STANDARDS

JULY 1, 1982 THROUGH DECEMBER 31, 1982

CATEGORY	LIVING ARRANGEMENTS				
	Independent Living Arrangement	Residing in Household of Another	Independent Without Cooking Facilities	Nonmedical Board and Care	Disabled Minor Residing in Home of Relative
INDIVIDUALS:					
Aged	$451.00	$356.24	$499.00	$510.00	N/A
Disabled	451.00	356.24	499.00	510.00	$263.24
Blind	506.00	411.24	N/A	510.00	N/A
COUPLES:					
Aged or Disabled	838.00	695.87	935.00	1,020.00	N/A
Blind	985.00	842.87	N/A	1,020.00	N/A
Blind/Aged or Disabled	929.00	786.87	N/A	1,020.00	N/A

SSI/SSP -- PAYMENT STANDARDS

JANUARY 1, 1983 THROUGH DECEMBER 31, 1983

CATEGORY	LIVING ARRANGEMENTS			
	Independent Living Arrangements	Residing in Household of Another and Receiving Room and Board in Kind	Independent Living Arrangement Without Cooking Facilities	Nonmedical Board and Care
INDIVIDUALS:				
Aged	$ 461.00	$359.57	$509.00	$ 520.00
Disabled	461.00	359.57	509.00	520.00
Blind	516.00	414.57	N/A	520.00
Disabled Minor	368.00*	266.57	N/A	520.00
COUPLES:				
Aged/Aged	853.00	700.87	950.00	1,035.00
Disabled/Aged	853.00	700.87	950.00	1,035.00
Disabled/Disabled	853.00	700.87	950.00	1,035.00
Blind/Blind	1,000.00	847.87	N/A	1,035.00
Aged/Blind	944.00	791.87	N/A	1,035.00
Disabled/Blind	944.00	791.87	N/A	1,035.00

* This payment amount should be used if the disabled minor resides in the home of a relative.

SSI/SSP -- PAYMENT STANDARDS

JANUARY 1, 1984 THROUGH DECEMBER 31, 1984

CATEGORY	LIVING ARRANGEMENTS			
	Independent Living Arrangements	Residing in Household of Another and Receiving Room and Board in Kind	Independent Living Arrangement Without Cooking Facilities	Nonmedical Board and Care
INDIVIDUAL:				
Aged or Disabled	$ 477.00	$372.34	$528.00	$ 539.00
Blind	535.00	430.34	- - -	539.00
Disabled Minor	378.00	273.34	- - -	539.00
COUPLE:				
Aged or Disabled				
per couple	886.00	728.67	989.00	1,078.00
per person	443.00	364.34	494.50	539.00
BLIND:				
Per couple	1,041.00	883.67	- - -	1,078.00
Per person	520.50	441.84	- - -	539.00
BLIND/AGED OR DISABLED				
per couple	982.00	824.67	- - -	1,078.00
per person	491.00	412.34	- - -	539.00

SSI/SSP -- PAYMENT STANDARDS

JANUARY 1, 1985 THROUGH DECEMBER 31, 1985

	SSI/SSP											
	Independent Living Arrangements			Household of Another			Independent Living Arrangement Without Cooking Facilities			Nonmedical Board and Care		
	Total	SSI	SSP	Total	SSI (FBR)	SSP	Total	SSI (FBR)	SSP	Total	SSI (FBR)	SSP
INDIVIDUAL:												
Aged or Disabled	504.00	325.00	179.00	395.67	216.67	179.00	558.00	325.00	233.00	569.00	325.00	244.00
Blind	565.00	325.00	240.00	456.67	216.67	240.00	.....	.....	.....	569.00	325.00	244.00
Disabled Minor	399.00	325.00	74.00	290.67	216.67	74.00	.....	.....	.....	569.00	325.00	244.00
COUPLE:												
Aged or Disabled												
per couple	936.00	488.00	448.00	773.34	325.34	448.00	1,045.00	488.00	557.00	1,138.00	488.00	650.00
per person	468.00	244.00	224.00	386.67	162.67	224.00	522.50	244.00	278.50	569.00	244.00	325.00
BLIND:												
Per couple	1,099.00	488.00	611.00	936.34	325.34	611.00	.....	.....	.....	1,138.00	488.00	650.00
Per person	549.50	244.00	305.50	468.17	162.67	305.50	.....	.....	.....	569.00	244.00	325.00
BLIND/AGED OR DISABLED												
per couple	1,037.00	488.00	549.00	874.34	325.34	549.00	.....	.....	.....	1,138.00	488.00	650.00
per person	518.50	244.00	274.50	437.17	162.67	274.50	.....	.....	.....	569.00	244.00	325.00

SSI/SSP -- PAYMENT STANDARDS

JANUARY 1, 1986 THROUGH DECEMBER 31, 1986

	SSI/SSP											
	Independent Living Arrangements			Household of Another			Independent Living Arrangement Without Cooking Facilities			Nonmedical Board and Care		
	Total	SSI (FBR)	SSP	Total	SSI (FBR)	SSP	Total	SSI (FBR)	SSP	Total	SSI (FBR)	SSP
INDIVIDUAL:												
Aged or Disabled	533.00	336.00	197.00	421.00	224.00	197.00	590.00	336.00	254.00	601.00	336.00	265.00
Blind	597.00	336.00	261.00	485.00	224.00	261.00	.....	.....	.....	601.00	336.00	265.00
Disabled Minor	422.00	336.00	86.00	310.00	224.00	86.00	.....	.....	.....	601.00	336.00	265.00
COUPLE:												
Aged or Disabled												
per couple	989.00	504.00	485.00	821.00	336.00	485.00	1,104.00	504.00	600.00	1,202.00	504.00	698.00
per person	494.50	252.00	242.50	410.50	168.00	242.50	552.00	252.00	300.00	601.00	252.00	349.00
BLIND:												
Per couple												
Per person	1,162.00	504.00	658.00	994.00	336.00	658.00	.....	.....	.....	1,202.00	504.00	698.00
	581.00	252.00	329.00	497.00	168.00	329.00	.....	.....	.....	601.00	252.00	349.00
BLIND/AGED OR DISABLED												
per couple	1,096.00	504.00	592.00	928.00	336.00	592.00	.....	.....	.....	1,202.00	504.00	698.00
per person	548.00	252.00	296.00	464.00	168.00	296.00	.....	.....	.....	601.00	252.00	349.00

SSI/SSP -- PAYMENT STANDARDS

JANUARY 1, 1987 THROUGH DECEMBER 31, 1987

	SSI/SSP											
	Independent Living Arrangements			Household of Another			Independent Living Arrangement Without Cooking Facilities			Nonmedical Board and Care		
	Total	SSI (FBR)	SSP	Total	SSI (FBR)	SSP	Total	SSI (FBR)	SSP	Total	SSI (FBR)	SSP
INDIVIDUAL:												
Aged or Disabled	560.00	340.00	220.00	446.67	226.67	220.00	620.00	340.00	280.00	632.00	340.00	292.00
Blind	627.00	340.00	287.00	513.67	226.67	287.00	.....	.....	.....	632.00	340.00	292.00
Disabled Minor	444.00	340.00	104.00	330.67	226.67	104.00	.....	.....	.....	632.00	340.00	292.00
COUPLE:												
Aged or Disabled												
per couple	1,039.00	510.00	529.00	869.00	340.00	529.00	1,160.00	510.00	650.00	1,264.00	510.00	754.00
per person	519.50	255.00	264.00	434.50	170.00	264.50	580.00	255.00	325.00	632.00	255.00	397.00
BLIND:												
Per couple	1,221.00	510.00	711.00	1,051.00	340.00	711.00	.....	.....	.....	1,264.00	510.00	754.00
Per person	610.50	255.00	355.50	525.50	170.00	355.00	.....	.....	.....	632.00	255.00	377.00
BLIND/AGED OR DISABLED												
per couple	1,152.00	510.00	642.00	982.00	340.00	642.00	.....	.....	.....	1,264.00	510.00	754.00
per person	576.00	255.00	321.00	491.00	170.00	321.00	.....	.....	.....	632.00	255.00	377.00

SSI/SSP -- PAYMENT STANDARDS

JANUARY 1, 1988 THROUGH DECEMBER 31, 1988

	SSI/SSP											
	Independent Living Arrangements			Household of Another			Independent Living Arrangement Without Cooking Facilities			Nonmedical Board and Care		
	Total	SSI (FBR)	SSP	Total	SSI (FBR)	SSP	Total	SSI (FBR)	SSP	Total	SSI (FBR)	SSP
INDIVIDUAL:												
Aged or Disabled	575.00	354.00	221.00	457.00	236.00	221.00	637.00	354.00	283.00	648.00	354.00	294.00
Blind	643.00	354.00	289.00	525.00	236.00	289.00	.....	.....	.....	648.00	354.00	294.00
Disabled Minor	456.00	354.00	102.00	338.00	236.00	102.00	.....	.....	.....	648.00	354.00	294.00
COUPLE:												
Aged or Disabled												
per couple	1,066.00	532.00	534.00	888.67	354.67	534.00	1,190.00	532.00	658.00	1,296.00	532.00	764.00
per person	533.00	266.00	267.00	444.34	177.34	267.00	595.00	266.00	329.00	648.00	266.00	382.00
BLIND:												
Per couple	1,253.00	532.00	721.00	1,075.67	354.67	721.00	.....	.....	.....	1,296.00	532.00	764.00
Per person	626.50	266.00	360.50	537.84	177.34	360.50	.....	.....	.....	648.00	266.00	382.00
BLIND/AGED OR DISABLED												
per couple	1,182.00	532.00	650.00	1,004.67	354.67	650.00	.....	.....	.....	1,296.00	532.00	764.00
per person	591.00	266.00	325.00	502.34	177.34	325.00	.....	.....	.....	648.00	266.00	382.00

SSI/SSP -- PAYMENT STANDARDS

JANUARY 1, 1989 THROUGH DECEMBER 31, 1989

	SSI/SSP											
	Independent Living Arrangements			Household of Another			Independent Living Arrangement Without Cooking Facilities			Nonmedical Board and Care		
	Total	SSI (FBR)	SSP	Total	SSI (FBR)	SSP	Total	SSI (FBR)	SSP	Total	SSI (FBR)	SSP
INDIVIDUAL:												
Aged or Disabled	602.00	368.00	234.00	479.34	245.34	234.00	667.00	368.00	299.00	678.00	368.00	310.00
Blind	673.00	368.00	305.00	550.34	245.34	305.00	N/A	N/A	N/A	678.00	368.00	310.00
Disabled Minor	477.00	368.00	109.00	354.34	245.34	109.00	N/A	N/A	N/A	678.00	368.00	310.00
COUPLE:												
Aged or Disabled												
per couple	1,116.00	553.00	563.00	931.67	368.67	563.00	1,246.00	553.00	693.00	1,356.00	553.00	803.00
per person	558.00	276.50	281.50	465.84	184.34	281.50	623.00	276.50	346.50	678.00	276.50	401.50
BLIND:												
Per couple	1,312.00	553.00	759.00	1,127.67	368.67	759.00	N/A	N/A	N/A	1,356.00	553.00	803.00
Per person	656.00	276.50	379.50	563.84	184.34	379.50	N/A	N/A	N/A	678.00	276.50	401.50
BLIND/AGED OR DISABLED												
per couple	1,238.00	553.00	685.00	1,053.67	368.67	685.00	N/A	N/A	N/A	1,356.00	553.00	803.00
per person	619.00	276.50	342.50	526.84	184.34	342.50	N/A	N/A	N/A	678.00	276.50	401.50

SSI/SSP -- PAYMENT STANDARDS

JANUARY 1, 1990 THROUGH DECEMBER 31, 1990

SSI/SSP

	Independent Living Arrangements			Household of Another			Independent Living Arrangement Without Cooking Facilities *			Nonmedical Board and Care		
	Total	SSI (FBR)	SSP	Total	SSI (FBR)	SSP	Total	SSI (FBR)	SSP	Total	SSI (FBR)	SSP
INDIVIDUAL:												
Aged or Disabled	630.00	386.00	244.00	501.34	257.34	244.00	698.00	386.00	312.00	709.00	386.00	323.00
Blind	704.00	386.00	318.00	575.34	257.34	318.00				709.00	386.00	323.00
Disabled Minor	499.00	386.00	113.00	370.34	257.34	113.00				709.00	386.00	323.00
COUPLE:												
Aged or Disabled												
per couple	1,167.00	579.00	588.00	974.00	386.00	588.00	1,303.00	579.00	724.00	1,418.00	579.00	839.00
per person	583.50	289.50	294.00	487.00	193.00	204.00	651.50	289.50	362.00	709.00	289.50	415.50
BLIND:												
Per couple	1,372.00	579.00	793.00	1,179.00	386.00	793.00				1,418.00	579.00	839.00
Per person	686.00	289.50	396.50	589.50	193.00	396.50				709.00	289.50	419.50
BLIND/AGED OR DISABLED												
per couple	1,295.00	579.00	716.00	1,102.00	386.00	716.00				1,418.00	579.00	839.00
per person	647.50	289.50	358.00	551.00	193.00	358.00				709.00	289.50	419.00

SSI/SSP -- PAYMENT STANDARDS

JANUARY 1, 1991 THROUGH DECEMBER 31, 1991

	SSI/SSP											
	Independent Living Arrangements			Household of Another			Independent Living Arrangement Without Cooking Facilities			Nonmedical Board and Care		
	Total	SSI (FBR)	SSP	Total	SSI (FBR)	SSP	Total	SSI (FBR)	SSP	Total	SSI (FBR)	SSP
INDIVIDUAL:												
Aged or Disabled	630.00	407.00	223.00	501.34	271.34	230.00	698.00	407.00	291.00	709.00	407.00	302.00
Blind	704.00	407.00	297.00	575.34	271.34	304.00				709.00	407.00	302.00
Disabled Minor	499.00	407.00	92.00	370.34	271.34	99.00				709.00	407.00	302.00
COUPLE:												
Aged or Disabled												
per couple	1,167.00	610.00	557.00	974.00	406.67	567.33	1,303.00	610.00	693.00	1,418.00	610.00	808.00
per person	583.50	305.00	278.50	487.00	203.34	283.66	651.50	305.00	346.50	709.00	305.00	404.00
BLIND:												
Per couple	1,372.00	610.00	762.00	1,179.00	406.67	772.23				1,418.00	610.00	808.00
Per person	686.00	305.00	381.00	589.50	203.34	386.16				709.00	305.00	404.00
BLIND/AGED OR DISABLED												
per couple	1,295.00	610.00	685.00	1,102.00	406.67	695.33				1,418.00	610.00	808.00
per person	647.50	305.00	342.50	551.00	203.34	347.66				709.00	305.00	404.00

SSI/SSP -- PAYMENT STANDARDS

JANUARY 1, 1992 THROUGH DECEMBER 31, 1992

	SSI/SSP											
	Independent Living Arrangements			Household of Another			Independent Living Arrangement Without Cooking Facilities			Nonmedical Board and Care		
	Total	SSI (FBR)	SSP	Total	SSI (FBR)	SSP	Total	SSI (FBR)	SSP	Total	SSI (FBR)	SSP
INDIVIDUAL:												
Aged or Disabled	645.00	422.00	223.00	511.34	281.34	230.00	713.00	422.00	291.00	724.00	422.00	302.00
Blind	719.00	422.00	297.00	585.34	281.34	304.00				724.00	422.00	302.00
Disabled Minor	514.00	422.00	92.00	380.34	281.34	99.00				724.00	422.00	302.00
COUPLE:												
Aged or Disabled												
per couple	1,190.00	633.00	557.00	989.33	422.00	567.33	1,326.00	633.00	693.00	1,441.00	633.00	808.00
per person	595.00	316.50	278.50	494.66	211.00	283.66	663.00	316.50	346.50	720.50	316.50	404.00
BLIND:												
Per couple	1,395.00	633.00	762.00	1,194.33	422.00	772.33				1,441.00	633.00	808.00
Per person	697.50	316.50	381.00	597.16	211.00	386.16				720.50	316.50	404.00
BLIND/AGED OR DISABLED												
per couple	1,318.00	633.00	685.00	1,117.33	422.00	695.33				1,441.00	633.00	808.00
per person	659.00	316.50	342.50	558.66	211.00	347.66				720.50	316.50	404.00

AID TO FAMILIES WITH DEPENDENT CHILDREN MINIMUM BASIC STANDARD OF ADEQUATE CARE EFFECTIVE JANUARY 1, 1981

Size of Family Budget Unit (FBU)	Minimum Basic Standard of Adequate Care
1	$ 231
2	386
3	470
4	577
5	667
6	751
7	827
8	913
9	1,000
10	1,087

Plus $9 for each additional needy person

AID TO FAMILIES WITH DEPENDENT CHILDREN PAYMENT LEVEL EFFECTIVE JANUARY 1, 1981

Size of Family Budget Unit	Payment Level
1	$ 227
2	374
3	463
4	550
5	628
6	706
7	775
8	844
9	912
10 or more	981

10B—AID TO FAMILIES WITH DEPENDENT CHILDREN STANDARDS

AID TO FAMILIES WITH DEPENDENT CHILDREN MINIMUM BASIS STANDARD OF ADEQUATE CARE EFFECTIVE JULY 1, 1981 - JUNE 30, 1983

Size of Family Budget Unit (FBU)	Minimum Basic Standard of Adequate Care
1	$ 248
2	408
3	506
4	601
5	686
6	771
7	846
8	922
9	1,000
10	1,087

Plus $9 for each additional needy person

AID TO FAMILIES WITH DEPENDENT CHILDREN PAYMENT LEVEL EFFECTIVE JULY 1, 1981 - JUNE 30, 1983

Size of Family Budget Unit	Payment Level
1	$ 248
2	408
3	506
4	601
5	686
6	771
7	846
8	922
9	996
10 or more	1,071

10B—AID TO FAMILIES WITH DEPENDENT CHILDREN STANDARDS

AID TO FAMILIES WITH DEPENDENT CHILDREN MINIMUM BASIS STANDARD OF ADEQUATE CARE EFFECTIVE JULY 1, 1983 - JUNE 30, 1984

Size of Family Budget Unit (FBU)	Minimum Basic Standard of Adequate Care
1	$ 258
2	424
3	526
4	625
5	713
6	802
7	880
8	959
9	1,040
10	1,130

Plus $9 for each additional needy person

AID TO FAMILIES WITH DEPENDENT CHILDREN PAYMENT LEVEL EFFECTIVE JULY 1, 1983 - JUNE 30, 1984

Size of Family Budget Unit	Payment Level
1	$ 258
2	424
3	526
4	625
5	713
6	802
7	880
8	959
9	1,036
10 or more	1,114

10B—AID TO FAMILIES WITH DEPENDENT CHILDREN STANDARDS

AID TO FAMILIES WITH DEPENDENT CHILDREN MINIMUM BASIS STANDARD OF ADEQUATE CARE EFFECTIVE JULY 1, 1984 - JUNE 30, 1985

Size of Family Budget Unit (FBU)	Minimum Basic Standard of Adequate Care
1	$ 272
2	448
3	555
4	660
5	753
6	847
7	920
8	1,013
9	1,094
10	1,176

Plus $10 for each additional needy person

AID TO FAMILIES WITH DEPENDENT CHILDREN PAYMENT LEVEL EFFECTIVE JULY 1, 1984 - JUNE 30, 1985

Size of Family Budget Unit	Payment Level
1	$ 272
2	448
3	555
4	660
5	753
6	847
7	920
8	1,013
9	1,094
10 or more	1,176

10B--AID TO FAMILIES WITH DEPENDENT CHILDREN STANDARDS

AID TO FAMILIES WITH DEPENDENT CHILDREN MINIMUM BASIS STANDARD OF ADEQUATE CARE EFFECTIVE JULY 1, 1985 - JUNE 30, 1986

Size of Family Budget Unit (FBU)	Minimum Basic Standard of Adequate Care
1	$ 288
2	474
3	587
4	698
5	796
6	895
7	982
8	1,071
9	1,161
10	1,261

Plus $11 for each additional needy person

AID TO FAMILIES WITH DEPENDENT CHILDREN PAYMENT LEVEL EFFECTIVE JULY 1, 1985 - JUNE 30, 1986

Size of Family Budget Unit	Payment Level
1	$ 288
2	474
3	587
4	698
5	796
6	895
7	982
8	1,071
9	1,156
10 or more	1,243

10B–AID TO FAMILIES WITH DEPENDENT CHILDREN STANDARDS

AID TO FAMILIES WITH DEPENDENT CHILDREN MINIMUM BASIS STANDARD OF ADEQUATE CARE EFFECTIVE JULY 1, 1986 - JUNE 30, 1987

Size of Family Budget Unit (FBU)	Minimum Basic Standard of Adequate Care
1	$ 303
2	498
3	617
4	734
5	837
6	941
7	1,032
8	1,126
9	1,220
10	1,325

Plus $12 for each additional needy person

AID TO FAMILIES WITH DEPENDENT CHILDREN PAYMENT LEVEL EFFECTIVE JULY 1, 1986 - JUNE 30, 1987

Size of Family Budget Unit	Payment Level
1	$ 303
2	498
3	617
4	734
5	837
6	941
7	1,032
8	1,126
9	1,215
10 or more	1,306

10B--AID TO FAMILIES WITH DEPENDENT CHILDREN STANDARDS

AID TO FAMILIES WITH DEPENDENT CHILDREN MINIMUM BASIS STANDARD OF ADEQUATE CARE EFFECTIVE JULY 1, 1987 - JUNE 30, 1988

Size of Family Budget Unit (FBU)	Minimum Basic Standard of Adequate Care
1	$ 311
2	511
3	633
4	753
5	859
6	965
7	1,059
8	1,155
9	1,252
10	1,359

Plus $12 for each additional needy person

AID TO FAMILIES WITH DEPENDENT CHILDREN PAYMENT LEVEL EFFECTIVE JULY 1, 1987 - JUNE 30, 1988

Size of Family Budget Unit	Payment Level
1	$ 311
2	511
3	633
4	753
5	859
6	965
7	1,059
8	1,155
9	1,247
10 or more	1,340

10B–AID TO FAMILIES WITH DEPENDENT CHILDREN STANDARDS

AID TO FAMILIES WITH DEPENDENT CHILDREN MINIMUM BASIS STANDARD OF ADEQUATE CARE EFFECTIVE JULY 1, 1988 - JUNE 30, 1989

Size of Family Budget Unit (FBU)	Minimum Basic Standard of Adequate Care
1	$ 326
2	535
3	663
4	788
5	899
6	1,010
7	1,109
8	1,209
9	1,311
10	1,423

Plus $13 for each additional needy person

AID TO FAMILIES WITH DEPENDENT CHILDREN PAYMENT LEVEL EFFECTIVE JULY 1, 1988 - JUNE 30, 1989

Size of Family Budget Unit	Payment Level
1	$ 326
2	535
3	663
4	788
5	899
6	1,010
7	1,109
8	1,209
9	1,306
10 or more	1,403

10B–AID TO FAMILIES WITH DEPENDENT CHILDREN STANDARDS

AID TO FAMILIES WITH DEPENDENT CHILDREN MINIMUM BASIS STANDARD OF ADEQUATE CARE EFFECTIVE JULY 1, 1989 - AUGUST 31, 1991

Size of Family Budget Unit (FBU)	Minimum Basic Standard of Adequate Care
1	$ 341
2	560
3	694
4	824
5	940
6	1,057
7	1,160
8	1,265
9	1,371
10	1,489

Plus $14 for each additional needy person

AID TO FAMILIES WITH DEPENDENT CHILDREN PAYMENT LEVEL EFFECTIVE JULY 1, 1989 - AUGUST 31, 1991

Size of Family Budget Unit	Payment Level
1	$ 341
2	560
3	694
4	824
5	940
6	1,057
7	1,160
8	1,265
9	1,366
10 or more	1,468

10B–AID TO FAMILIES WITH DEPENDENT CHILDREN STANDARDS

AID TO FAMILIES WITH DEPENDENT CHILDREN MINIMUM BASIS STANDARD OF ADEQUATE CARE EFFECTIVE SEPTEMBER 1, 1991 - JUNE 30, 1992

Size of Family Budget Unit (FBU)	Minimum Basic Standard of Adequate Care
1	$ 341
2	560
3	694
4	824
5	940
6	1,057
7	1,160
8	1,265
9	1,371
10	1,489

Plus $14 for each additional needy person

AID TO FAMILIES WITH DEPENDENT CHILDREN PAYMENT LEVEL EFFECTIVE SEPTEMBER 1, 1991 - JUNE 30, 1992

Size of Family Budget Unit	Payment Level
1	$ 326
2	535
3	663
4	788
5	899
6	1,010
7	1,109
8	1,209
9	1,306
10 or more	1,403

10C — PUBLIC LAW PAYMENTS INCOME EXEMPTIONS

This section contains information and procedures regarding payments which are received by Medi-Cal-only applicants or beneficiaries pursuant to public laws. Unless otherwise specified, the public law payments in this section are not considered as income for purposes of determining share of cost in accordance with California Administrative Code, Title 22, Section 50528.

1. PL 94-385 and PL 97-35 — Home Energy Assistance

   PL 94-385 provides for a Low Income Weatherization Assistance Program (LIWAP) through the Department of Energy. PL 97-35 provides for a Low Income Energy Assistance Program (LIEAP) through the Department of Health and Human Services. LIEAP is composed of the Energy Crisis Intervention Program (ECIP) and the Home Energy Assistance Program (HEAP).

   These programs provide payments either to the recipient or to vendors on behalf of the recipient for the purpose of home energy assistance (e.g., heating, cooling, weatherization, blankets, storm doors, etc.). These payments shall not be considered income or resources.

2. PL 95-171 — Disaster Assistance

   PL 95-171 provides for the exemption of any assistance in cash or in kind furnished under federal statute specifically in conjunction with a presidentially declared disaster. The interest payments resulting from a cash disaster assistance payment which is retained for a period of nine months or less (see Procedures, Section 9E, No. 2) are also exempt from consideration as income.

3. PL 96-420 — Payments Distributed Under the Maine Indian Claims Settlement Act of 1980

   Section 9 of PL 96-420 provides that entitlement to or receipt of payment by an individual in accordance with the Maine Implementing Act and the Maine Indians Claims Settlement Fund shall not be considered when determining eligibility or share of cost.

10D—SENIOR CITIZENS RENT ASSISTANCE

This section deals with rental rebates received by Medically Needy (MN) and Medically Indigent (MI) beneficiaries.

1. BACKGROUND

Assembly Bill 2972 (Chapter 1060, Statutes of 1976) amends the Senior Citizen's Property Tax Assistance Law to extend property tax assistance, in the form of rebates, to renters who meet minimum legal requirements. A rebate is granted to renters on the basis that the owner of a rental property uses a portion of the rent to pay the property taxes levied on the rental property. The amount of the rebate is based on the household income of the renter. Further information is available from local Franchise Tax Board offices. The bill became operative for each fiscal year beginning with 1977-78.

2. ELIGIBILITY REQUIREMENTS

To receive a rebate, a beneficiary must:

- Be 62 or older, blind, or disabled;
- Pay $50 or more in rent per month; and,
- Have $13,200 or less of household income.

3. IMPACT ON INCOME

The rebate is considered exempt income in the month received (in accordance with CAC, Title 22, Section 50523). If not utilized in the month received, it becomes property beginning with the first day of the month following the month of receipt.

10E -- COST OF IN-HOME SERVICES AS AN INCOME DEDUCTION FOR AGED, BLIND, AND DISABLED-MEDICALLY NEEDY (ABD-MN)

Under the provisions of Assembly Bill 3398, 1984, the costs of in-home services paid by ABD-MN beneficiaries, who would otherwise require long-term care or board and care placement, may be deducted from the beneficiary's nonexempt income.

I. Criteria for Deductions

Actual out-of-pocket payment for the cost of "in-home services" is an allowable deduction only when all of the following criteria are met:

- The person paying for the services is an ABD-MN applicant or beneficiary.
- The person providing the services is not a family member living in the home. Family members are spouses, parents, and children under 21 years of age.
- The applicant's/beneficiary's need for in-home services is supported by a physician's statement, which specifies that without such services, the individual would require institutionalization, i.e., long-term care or board and care placement.
- An in-home supportive services (IHSS) evaluation has been made verifying the propriety of the services being received. A completed IHSS Needs Assessment (SOC 293) must be on file.
- The applicant/beneficiary must provide verification of the actual amount spent on "in-home services". Types of verification include:
  - Written contract between the applicant/beneficiary and the provider;
  - A receipt from the provider which includes the hours of service and the amount received; and
  - A completed IHSS provider/beneficiary agreement.

II. Computation of Deductions

The amount of the deductions should be computed based on the number of hours and types of services authorized by the IHSS assessment and the actual amount the individual paid for the services. If the individual pays for more hours or for services other than indicated by the needs assessment, deduct only the amount paid for authorized hours/services.

Example

The IHSS assessment indicates that the individual requires ten hours of services each month. This authorized number of hours is to be compared with the total number of hours actually being provided and the amount being paid by the individual should be prorated accordingly.

In this instance, if the individual were paying $100 per month for the ten-hour service, the full $100 would be considered a deduction. However, if the individual were paying $100 per month and receiving 20 hours of service, only $50 can be allowed for a deduction.

The authorized deduction is applied to the client's net nonexempt income. (The deduction is to be entered on line 9, column 3, of the MC 176M.)

III. Special Aid Code

All ABD-MNs receiving the in-home services income deduction will be assigned Aid Code 65. This will enable state and county staff to monitor the number of such cases and develop a methodology for reimbursing any increased county administrative costs associated with medically needy IHSS assessments.

IV. Identification of Potentially Eligible Beneficiaries

A. Referrals From IHSS Staff

The majority of persons entitled to this deduction will be those who were previously denied IHSS benefits because their income is sufficient to purchase the needed services. In these instances, the IHSS worker will have obtained the needed medical verification and determined the amount of hours required prior to referring the client to Medi-Cal intake staff.

Should either of these items be absent, the Medi-Cal worker must immediately contact the IHSS worker to obtain the needed verification.

If necessary, a formal IHSS referral may be made.

B. Persons Who Have Not Applied for IHSS but Are Applying for ABD-MN

1. Persons Who Wish to Have Eligibility for IHSS Determined

- Counties are to follow existing internal procedures for IHSS referrals.

- If the applicant is denied IHSS benefits due to excess income, counties are to follow procedures indicated above. Any person approved for IHSS will automatically receive a Medi-Cal card under the IHSS program.

2. Persons Who Wish to Have Eligibility Determined Under the Medically Needy Program With the Cost of In-Home Services as an Income Deduction

- If an ABD-MN applicant or beneficiary requests the IHSS income deduction, advise him/her of the required physician's statement regarding the necessity of board and care or long-term care placement if "in-home services" were not received. For applicants, continue processing Medi-Cal eligibility. If eligibility is determined and the physician's statement has not been received, compute the share of cost without the IHSS deduction and assign appropriate 1X, 2X, 6X aid code; include a statement on the approval Notice of Action that the cost of "in-home services" has not been allowed because the required physician's statement has not been received (Title 22, California Administrative Code (CAC), Section 50551.6). Do not deny or delay Medi-Cal eligibility solely due to nonreceipt of a physician's statement.

  Once a physician's statement is received, refer the individual to the IHSS unit for a needs assessment. (For persons applying as disabled who are having disability determined via a disability evaluation referral, wait until disability has been established before making the IHSS referral. This will limit the IHSS referrals to those persons whom we know are appropriate IHSS referrals.) When the IHSS needs assessment has been completed, determine the appropriate amount, if any, to be deducted when determining the share of cost. The first month in which the deduction should be applied is the month in which the request for the deduction is made, providing the applicant/beneficiary provides the necessary verification in a timely manner. Otherwise, the deduction should be applied commencing with the month in which the necessary verification is received.

V. Redeterminations for Persons Receiving the "In-Home Services" Income Deduction

As part of the annual redetermination for persons receiving the "in-home services" income deduction, make a referral for an IHSS needs assessment redetermination as required by Title 22, CAC, Section 50169 (d) (6). If the needs assessment has changed, make the necessary changes in the beneficiary's share of cost, sending a Notice of Action as appropriate.

10F — INCOME IN KIND VALUES AND POLICIES RELATING TO THEIR USE

1. VALUE OF INCOME IN KIND EFFECTIVE	7/1/87	7/1/86	3/1/86	*7/1/81
a. Housing				
1 person	$139	$135	$128	$111
2 persons	188	183	174	150
3 persons	205	200	190	163
4 or more persons	216	211	201	173
b. Utilities, Including Telephone				
1 person	$ 31	$ 30	$ 29	$ 25
2 persons	34	33	31	26
3 persons	36	35	33	28
4 or more persons	37	36	34	29
c. Food				
1 person	$ 78	$ 76	$ 72	$ 62
2 persons	166	162	154	133
3 persons	212	207	197	169
4 persons	261	254	242	209
5 persons	316	308	293	252
6 persons	366	357	340	293
7 persons	408	398	379	327
8 persons	447	436	415	358
9 persons	490	478	455	391
10 or more persons	531	518	493	424
d. Clothing				
1 person	$ 25	$ 24	$ 23	$ 20
2 persons	45	44	42	37
3 persons	69	67	64	56
4 persons	92	90	86	74
5 persons	115	112	107	92
6 persons	136	133	127	110
7 persons	162	158	150	129
8 persons	181	176	167	144
9 persons	207	202	192	165
10 or more persons	227	221	210	181

* NOTE: From September 1, 1982 to January 31, 1983, the income in kind values for a non-ABD-MN recipient when all other family members are PA were as follows:

Housing	— $75	Food	— $67
Utilities	— $13	Clothing	— $19

VALUE OF INCOME IN KIND EFFECTIVE	1/1/81	7/1/80	7/1/79	7/1/77
a. Housing				
1 person	$102	$104	$ 90	$ 78
2 persons	137	140	121	105
3 persons	149	152	132	115
4 or more persons	158	162	140	122
b. Utilities, Including Telephone				
1 person	$ 23	$ 23	$ 20	$ 17
2 persons	24	24	21	18
3 persons	26	27	23	20
4 or more persons	27	28	24	21
c. Food				
1 person	$ 57	$ 58	$ 50	$ 43
2 persons	122	125	108	94
3 persons	155	158	137	119
4 persons	191	195	169	147
5 persons	231	236	204	177
6 persons	268	274	237	206
7 persons	299	306	265	230
8 persons	328	335	290	252
9 persons	358	366	317	275
10 or more persons	388	391	343	321
d. Clothing				
1 person	$ 18	$ 18	$ 16	$ 14
2 persons	34	35	30	26
3 persons	51	52	45	39
4 persons	68	69	60	52
5 persons	84	85	74	64
6 persons	101	103	89	77
7 persons	118	120	104	90
8 persons	132	135	117	102
9 persons	151	155	134	116
10 or more persons	166	170	147	128

The maintenance need chart for the period September 1, 1982 to January 31, 1983 (see Procedure Section 11B) shows a maintenance need of $204 for a non-ABD-MN beneficiary when all other family members are PA recipients. This figure was computed by dividing the maintenance need for two non-ABD-MN persons ($408) in half.

However, under regulation CAC, Title 22, Section 50511, if all needs (housing, food, utilities, and clothing) were provided to a beneficiary, that beneficiary would have received $218 of in-kind income. If this beneficiary was a non-ABD person and all other family members were PA recipients, he or she would have had a share of cost of $14 even though he or she had no income other than income in kind.

Therefore, in All County Welfare Directors Letter No. 82-46, the Department asked the counties to use the above in-kind income amount for a non-ABD-MN beneficiary when all other family members are PA recipients.

2. POLICIES RELATING TO INCOME IN KIND

Following in question and answer format are issues frequently raised regarding the application of income in kind.

Question: A person owns a mortgage protection insurance policy. The insurance company is now paying the mortgage payments due to the person's disability. Is there income in kind for housing?

Answer: No. Income in kind occurs only when an entire item of need is contributed. Since the person has paid and is paying premiums on the insurance policy, the entire item of need is not being contributed.

Question: Is it possible for income in kind to be attributed to only a portion of the Medi-Cal Family Budget Unit (MFBU)?

Answer: Yes. Generally, for an entire item of need to be contributed, the contribution would be for all members of the MFBU. However, there are instances in which only certain members of the MFBU are being provided an item of need, or are being provided that need item by someone other than a financially responsible relative. The most common occurrences of this are:

- An unmarried minor parent lives with the parents; parents provide free room and board to minor parent and the minor parent's born children. Income in kind is attributed only to the minor parent's children as her parents are a financially responsible relative of the minor parent.

- An 18-21-year-old with income lives with parent and parent's friend. The friend provides free room and board for the parent but charges the 18-21-year-old a monthly amount for room and board. The child uses his/her income to pay for the room and board. Since none of the parent's income is being used for rent, utilities, or food and clearly the amount paid by the child is for his/her own room and board, income in kind is attributed only to the parent.

Question: When is income in kind for clothing used?

Answer: Since items of clothing may not be obtained every month, income in kind for clothing is based upon the source of clothing when it is obtained. Income in kind for clothing is attributed to a member of the MFBU only if all clothing obtained by/for that person is contributed by someone other than a financially responsible relative.

Example (income in kind for clothing is attributed): A mother states she never spends any money on clothing for herself and her children. All of their clothing and footwear are donated to her by friends, neighbors, and her church. In this case, income in kind for clothing is attributed to the MFBU on a monthly basis.

Example (income in kind for clothing is not attributed): A mother states that she generally purchases the clothing for herself and her children. During the month of application, she purchased no clothing for the family, but her daughter received a new dress as a birthday present from an aunt. Even though the only item of clothing obtained during the month was contributed by someone other than a financially responsible relative, no income in kind for clothing is attributed to the daughter because all of her clothing is not contributed.

Question: When is income in kind attributed to an unborn?

Answer: Income in kind for housing, utilities, or food is attributed to the unborn only when the mother has the item contributed by someone other than a financially responsible relative. Income in kind for clothing would be attributed to an unborn if the mother stated that all of the infant's clothing and diapers will be contributed by someone other than a financially responsible relative once the child is born.

10G — TREATMENT OF MONEY RECEIVED FROM NONFAMILY MEMBERS LIVING IN THE HOME

Medi-Cal regulations provide three methods for determining net income from monies received for housing from nonfamily members living in the home of Medi-Cal applicants or beneficiaries. The following describes the circumstances under which each method is applicable.

1. Ten Percent of Gross (California Administrative Code (CAC), Title 22, Section 50508 (a) (3))

   This method is used when both of the following conditions exist:

   a. A business license is not required.

   b. The individual who receives the income routinely provides lodging, board, etc., to nonfamily members; i.e., if the nonfamily member currently in the home were to leave, the individual would seek another such lodger, etc., for additional income.

   EXAMPLE: Mr. and Mrs. A are Medi-Cal applicants. They live near a college and routinely rent their spare room to students. They do not have a business license and do not report the income as self-employment. At time of application, however, their adult daughter (considered to be not a family member under the Medi-Cal eligibility determinations) is using the room and is paying them $80 per month. The A's state that if the daughter were to leave, they would try to find someone else to rent the room.

   The net monthly income in this instance is $8.00 (10 percent of $80).

2. Net Profit From Self-Employment (CAC, Title 22, Section 50508 (a) (4))

   This method, which will probably be rare, is used when <u>either</u> of the following conditions exists:

   a. The individual who receives the income has a business license; or

   b. The individual reports the income for tax purposes as self-employment or the individual considers the income as income from self-employment.

   EXAMPLE: Mrs. B has converted her house into a boarding home. She has a business license, but her yearly total income is so low that she has never bothered completing an income tax return. Her annual gross receipt from the boarding home is $7,000; her annual allowable expenditures are $5,800.

   The net monthly income in this instance is $100 ($7,000 - $5,800 = $1,200 ÷ 12).

3. Income in Excess of Contributor's Share of Actual Costs (CAC, Title 22, Section 50515 (a) (2))

This method is used when both of the following conditions exist:

a. A business license is not required.

b. The individual who receives the income does not routinely provide lodging, board, etc., to nonfamily members; i.e., if the nonfamily member currently in the home were to leave, the individual would not seek another such lodger, etc., for additional income.

EXAMPLE: Mr. and Mrs. C apply for Medi-Cal on behalf of themselves and their one minor child. Mr. C's mother lives with them and gives Mr. C $100 per month to use toward meeting those household costs which directly benefit her. If the mother were not in the home, the C's would not seek another person to move into the home. The C's monthly costs are as follows:

Rent	$250
Utilities	50
Food	200
Total	$500

Since there are 4 persons in the home, the mother's share of the actual costs is $125 ($500 ÷ 4). Since her $100 contribution is less than her share of the actual costs, there is no net income to the C's.

If she instead were contributing $130 per month, then the net income to the C's would be $5.

If the mother lived in a room with its own kitchen, and bought and prepared all her own food, then the mother's share of actual costs would be 1/4 of $300 (rent and utilities) or $75. If the mother were contributing $100/month to the C's, the C's net income would be $25.

NOTE: Regardless of the method which is applicable to a specific case, the county should explain to the clients the manner through which the net income is derived.

10I — TITLE II DISREGARD ELIGIBILITY DETERMINATIONS

NOTE: See the "Pickle" Handbook for eligibility criteria and procedures for determining "Pickle" eligibility for former Supplemental Security Income/State Supplementary Payment recipients.

10J - VETERAN'S BENEFITS

Background

Section 50507 (a) (6) states that veteran's benefits are considered unearned income. These benefits include, among other things, pensions, compensation, educational benefits, and aid and attendance. Both veterans and their dependents are potentially eligible for these benefits.

Of particular importance to the Medi-Cal program are the aid and attendance benefits. Aid and attendance provides cash benefits and medical devices and equipment to veterans and their dependents who are in long-term care or who are unable to care for themselves at home.

Referral

To aid veterans in obtaining the benefits they are eligible to receive, and to ensure that outside sources of income are used before Medi-Cal, the Medi-Cal program is adopting the use of the Veteran's Benefits Referral, form CA 5.

To facilitate the use of the CA 5, the MC 210, Statement of Facts, has been revised to ask for the veteran status of applicants for Medi-Cal. If the answer to Question 31A or B is yes, or Question 32 indicates that a person may be eligible for or has applied for veteran's payments, the CA 5 should be completed if it has not been sent in the past. A CA 5 should also be completed whenever a veteran or veteran's dependent enters long-term care. (See forms section for complete instructions for completion of the CA 5.)

After the CA 5 is completed, it should be sent to the county Veterans Service Office in accordance with the instructions on the CA 5. The Veterans Service Office will return a completed copy of the CA 5 after they have completed their action on the case.

Client Responsibility

If the applicant or beneficiary refuses to cooperate in completing the CA 5 or refuses to cooperate with the county Veterans Service Office, that person is ineligible for Medi-Cal. Per Section 50186, applying for unconditionally available income is a condition of eligibility. Since veteran's benefits are available to eligible veterans upon application, failure to apply for them would be failure to apply for unconditionally available income and would result in ineligibility for the person who refuses to cooperate.

10K — COMMUNITY PROPERTY INCOME AVAILABLE IN LONG-TERM CARE (LTC) SITUATIONS

The following are instructions for Medi-Cal only share-of-cost (SOC) determinations when a beneficiary in LTC is in a separate Medi-Cal Family Budget Unit (MFBU) from his/her spouse living at home.

1. Community Property Income LTC Spouse $_____ (earned) + $_____ (unearned) =	
2. Community Property Income At-Home Spouse $_____ (earned) + $_____ (unearned) =	
3. Total (add lines 1 and 2)	
4. Each Spouse's Community Interest (line 3 divided by 2)	

A. If line 2 is equal to or greater than line 4, the spouse's community property interest is adequately protected.

A1. Use the amount in line 2 plus any separate income of at-home spouse when determining SOC of at-home spouse and allocation from LTC spouse pursuant to 22 California Administrative Code (CAC), Section 50563.

A2. Use the amount in line 1 plus any separate income of LTC spouse when determining LTC SOC.

B. If line 2 is less than line 4, the at-home spouse's community property interest is not adequately protected.

B1. Use the amount in line 4* plus any separate income of at-home spouse when determining SOC of at-home spouse and allocation from LTC spouse pursuant to 22 CAC, Section 50563.

B2. Use the amount in line 4* plus any separate income of the LTC spouse when determining LTC SOC.

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* If the spouse has earnings, the earned and unearned portions of line 4 must be identified to enable the proper income deductions to be applied.

10L -- APPLICATION OF THE $30 PLUS ONE-THIRD AND $30 DEDUCTIONS

This section provides guidance and examples for the proper application of the $30 plus one-third and $30 income deductions set forth in Title 22, California Administrative Code (CAC), Sections 50551.1 and 50553.3. Any reference below to Section 50553.3 applies equally to Section 50551.1.

1. Application of $30 Plus One-Third Deduction

A person is entitled to the $30 plus one-third under Medi-Cal for <u>any month</u> providing he/she was eligible for and receiving an Aid to Families with Dependent Children (AFDC) cash grant in one of the immediately preceding four months and did not receive the subject deduction for four consecutive months under the AFDC cash program. Therefore, depending upon the time between AFDC ineligibility and discontinuance, and the effective date of AFDC-Medically Needy/Medically Indigent (MN/MI) eligibility, the person may be entitled to the $30 plus one-third for one, two, three, or four months, or may not be entitled to the deduction at all.

<u>Example 1-A</u>

A family was discontinued from AFDC effective March 31 due to whereabouts unknown. The family had been receiving the maximum aid payment because there was no income. The family applies for AFDC-MN in July, at which time the only parent in the home is employed full time.

The family is entitled to the $30 plus one-third deduction in July as the person with the earnings received AFDC in one of the four preceding months:

March	April	May	June	July
Terminated AFDC Cash 3/31				Applies Medi-Cal
AFDC	-	-	-	$30+1/3
4	3	2	1	

The family is not entitled to the $30 plus one-third in August because the person with the earnings did not receive AFDC in one of the four preceding months.

March	April	May	June	July	August
				Applies Medi-Cal	
Terminated AFDC Cash 3/31					
AFDC	-	-	-	$30+1/3	No $30+1/3
	4	3	2	1	

Title 22, CAC, Section 50553.3 (a) (1), specifies that the $30 plus one-third shall be applied to a person's earnings when that person was eligible for and receiving an AFDC cash grant in one of the four months immediately prior to the month in which the deduction will be applied.

Example 1-B

A family (mother and two children) was discontinued from AFDC effective January 31, 1985 because the unemployed absent father returned to the home January 17. His Unemployment Insurance Benefits (UIB) combined with her earnings from part-time employment exceeded 185 percent of the AFDC need level. She received the $30 plus one-third deduction for four consecutive months while on AFDC (January was the fourth month of the deduction). When this change in circumstances was reported, the mother indicated that the family was not interested in receiving Medi-Cal-only eligibility. In July, the family applies for AFDC-MN. The mother is still working part time; the father is receiving UIB.

In July, the family is not entitled to the $30 plus one-third deduction for Medi-Cal because the person with earnings did not receive an AFDC cash grant in 1 of the 4 preceding months; furthermore, the $30 plus one-third had been received under AFDC for 4 consecutive months without an intervening 12-month period of not receiving AFDC.

October	November	December	January	February	March	April	May	June	July
				Terminated AFDC Cash 1/31					Applies Medi-Cal
AFDC $30+1/3	AFDC $30+1/3	AFDC $30+1/3	AFDC $30+1/3	-	- 4	- 3	- 2	- 1	No $30+1/3

Example 1-C

A family was discontinued from AFDC effective February 28 because the absent parent, who is the primary wage earner and is full-time employed,

returned to the home on February 16. The other parent also works and had received the $30 plus one-third deduction under AFDC for three months (December-February). The family immediately notified the county of the change and requested Medi-Cal (MI) for the children. The county was able to determine MI eligibility effective March 1, so Edwards v. Myers is not applicable.

In determining the share of cost for the MI children for March, the parent who had been in the AFDC assistance unit is entitled to the $30 plus one-third deduction because he/she had received AFDC cash in one of the four preceding months and had not received the $30 plus one-third for four consecutive months. The earnings of this parent will be subject to the $30 plus one-third through June.

December	January	Terminated AFDC Cash 2/28 February	Applies Medi-Cal March	April	May	June
AFDC $30+1/3	AFDC $30+1/3	AFDC $30+1/3	$30+1/3	$30+1/3	$30+1/3	$30+1/3
		4	3	2	1	

The other parent is not entitled to the $30 plus one-third as he/she has not received AFDC.

2. Application of $30 Deduction

A person who has received the $30 plus one-third for at least four consecutive months in a Medi-Cal Family Budget Unit (MFBU), an AFDC assistance unit, or a combination of both is entitled to the $30 deduction for any month in the immediately following eight consecutive month period. If for some reason the person is not part of the AFDC assistance unit or MFBU and, therefore, does not receive the $30 during some portion of the eight consecutive month period, the person is nonetheless entitled to the deduction for the remaining portion of the period. Likewise, a person who receives the $30 plus one-third one month, but is not entitled to the $30 plus one-third deduction the following month, is not automatically entitled to the $30 deduction for the eight months. The person would have to have received the $30 plus one-third for four consecutive months to be eligible for the $30 deduction.

Example 2-A

The share of cost for August is being determined for the family in example 1-A.

The family is not entitled to the $30 deduction in August, nor any following month, because the $30 plus one-third was not received for four consecutive months in any MFBU or AFDC assistance unit within the last eight months. (Title 22, CAC, Section 50553.3 (c) and (d).)

December	January	February	March	April	May	June	July	August
			Terminated AFDC Cash 3/31				Applies Medi-Cal	
AFDC No Ded.	AFDC No Ded.	AFDC No Ded.	AFDC No Ded.	-	-	-	$30+1/3	No $30+1/3 No $30
			4	3	2	1		
8	7	6	5	4	3	2	1	

Example 2-B

In example 1-B, it was determined that the $30 plus one-third deduction was not applicable to the share-of-cost determination for July.

Now a determination for entitlement to the $30 deduction must be made.

The family is entitled to the $30 deduction because the person with earnings had received the $30 plus one-third deduction for four consecutive months within the last eight months.

October	November	December	January	February	March	April	May	June	July
			Terminated AFDC Cash 1/31						Applies Medi-Cal
AFDC $30+1/3	AFDC $30+1/3	AFDC $30+1/3	AFDC $30+1/3	-	-	-	-	-	$30
	8	7	6	5	4	3	2	1	

The $30 deduction would continue through September at which time the eight consecutive month period would expire.

Example 2-C

The July share of cost for the MI children in example 1-C is being determined.

The parent who had been entitled to the $30 plus one-third deduction is now entitled to the $30 deduction as he/she received the $30 plus one-third as an ineligible member of an MFBU for four consecutive months. The other parent is not entitled to the $30 deduction because he/she has not received the $30 plus one-third for four consecutive months.

December	January	Terminated AFDC Cash 2/28 February	Applies Medi-Cal March	April	May	June	July
AFDC $30+1/3	AFDC $30+1/3	AFDC $30+1/3	$30+1/3	$30+1/3	$30+1/3	$30+1/3	$30
			4	3	2	1	

3. Interaction of the $30 Plus One-Third and $30 Deductions With Edwards v. Myers Month(s) of Eligibility

Pursuant to the Edwards court order, some persons and families receive "no cost" Medi-Cal under Aid Code 38 while their eligibility and share of cost are being determined under another Medi-Cal category. For former AFDC recipients with earnings, the Edwards (Aid Code 38) month(s) of eligibility shall be deemed to be the month(s) in which the $30 plus one-third deduction is received unless the person with the earnings received the $30 plus one-third for four consecutive months under AFDC. In the latter case, the Edwards month(s) would be part of the consecutive eight-month period of the $30 deduction.

Example 3-A

The case situation is the same as in example 1-C.

A family was discontinued from AFDC effective February 28 because the absent parent, who is the primary wage earner and is employed full time, returned to the home on February 16. The other parent also works and had received the $30 plus one-third deduction under AFDC for three months (December-February). The family immediately notified the county of the change and requested Medi-Cal (MI) for the children. In this instance, the county did not have time to determine eligibility

and share of cost under another Medi-Cal program by March 1; so, for the month of March, Medi-Cal cards were issued under Aid Code 38 (Edwards v. Myers). The children's MI eligibility and share of cost are determined effective April 1.

The parent who had been on AFDC cash (now an ineligible member of the MFBU) is entitled to the $30 plus one-third deduction for the months of April, May, and June. He/she is entitled to the $30 for eight consecutive months commencing in the month of July. Since the Edwards month (March) is deemed a $30 plus one-third deduction month, he/she meets the "four consecutive months of $30 plus one-third" test.

Terminated AFDC Cash 2/28 February	Applies Medi-Cal March	April	May	June	July
AFDC $30+1/3	Edwards deemed $30+1/3	$30+1/3	$30+1/3	$30+1/3	$30
	4	3	2	1	

Example 3-B

A 20-year-old woman and child have been receiving AFDC at the maximum payment level as the family has no income. The 22-year-old absent parent, who is employed full time, returns home March 18. The family wants Medi-Cal eligibility. The county has time to discontinue AFDC cash effective March 31, but not to determine Medi-Cal eligibility and share of cost under another Medi-Cal program. The woman and child are issued Medi-Cal cards under Aid Code 38 for the month of March. On April 15, the woman reports she has gone to work part time but will not receive her first paycheck until May 1. The county is able to establish MI eligibility for the woman and child effective May 1.

The woman will be entitled to the $30 plus one-third deduction for the month of May, June, and July. She will not be entitled to the $30 in August. Since she did not have any earnings in the Edwards month of eligibility (April), it cannot be deemed a $30 plus one-third month. As a result, she does not meet the "four consecutive month" test.

December August	January	February	Terminated AFDC Cash 3/31 March	Applies Medi-Cal April	May	June	July	
AFDC $30+1/3 No Ded.	AFDC No Ded.	AFDC No Ded.	AFDC No Ded.	Edwards No Ded.	$30+1/3	$30+1/3	$30+1/3	No $30
			4	3	2	1		
8	7	6	5	4	3	2	1	

Example 3-C

A 20-year-old woman with part-time earnings and her child are receiving AFDC. She has received the $30 plus one-third under AFDC for March, April, May, and June. The full-time employed absent parent (also principal wage earner) returns home June 16. AFDC cash is discontinued June 30. The county does not have time to determine Medi-Cal eligibility by July 1, so the woman and child are issued Medi-Cal cards under Aid Code 38 for July. MI eligibility and share of cost are determined effective August 1.

The woman is entitled to the $30 deduction for the months of August-February.

March	April	May	Terminated AFDC Cash 6/30 June	Applies Medi-Cal July	August	September	October	November	December	January	Februa
AFDC $30+1/3	AFDC $30+1/3	AFDC $30+1/3	AFDC $30+1/3	Edwards	$30	$30	$30	$30	$30	$30	$30
				1	2	3	4	5	6	7	8

10M – DETERMINING NET INCOME FROM SELF-EMPLOYMENT

A. GUIDELINES FOR DETERMINING WHETHER AN INDIVIDUAL IS SELF-EMPLOYED

This section purposes to provide counties with assistance in determining whether an individual is self-employed for purposes of determining their income eligibility for the Medically Needy and Section 1931 programs. While generally it is clear whether an individual is self-employed, there are occasional instances where it can be difficult to determine whether the individual is self-employed or working for another. For example, an individual may be working at a "job" that has characteristics of both self-employment and being in another's employ, such as certain real estate agents or consultants. Counties must exercise their judgment in these matters. To assist counties in making this judgment, several "indicators" of self-employment are listed below.

INDICATORS OF SELF-EMPLOYMENT

- The individual defines for himself the scope and nature of his work and daily work activities, including work-duration; and such activities are not supervised or determined by another (except pursuant to a limited term, contractual arrangement*).

- Others assume no, or only limited liability, for the individual's work and for the individual during the course of his/her work (or, if others do assume liability, it is pursuant to an indemnity agreement or other contractual arrangement*).

- The individual does not work at another's facility nor makes substantial use of another's capital; (or, if he/she does, it is pursuant to a limited term, contractual arrangement*)

- The individual's employment requires that he/she own substantial equipment, which is subject to depreciation, and the individual "bargains-for", and receives, compensation which reflects the cost of such depreciation.

- The person or entity files an income tax return attesting that they are self-employed person (e.g. files a Schedule C).

- The person or entity providing compensation to the individual for his/her services does not (and will not) deduct Social Security taxes or federal taxes from the compensation payment.

- Applicable to individuals "selling" services (as opposed to individuals selling goods): The relationship between the "contractor" (the beneficiary) and the contractee is contractual, and changes in the definition or extent of the services provided by the contractor require changes in the contractual agreement. The individual (contractor) exercises a pattern of entering into contractual arrangements* with multiple "contractees" simultaneously, or in succession, and of providing bargained-for, contractually defined services pursuant to an explicit (oral or written) agreement between the individual and the "contractee."

* Contractual arrangement: Provision of goods or services by the individual (a contractor) to another (the "contractee") are contractual if provided pursuant to a "bargained for" agreement in which the individual undertakes to do a specific piece of work, or produce a specified product (as specified in the agreement), for an agreed upon price, within a specific, and limited time period.

It is possible for these indicators to provide conflicting measurements. For example, an individual may not have Social Security or withholding taxes deducted from his compensation and yet the individual is working on another's premises, under another's supervision, subject to another's directions. This scenario may occur where the employment is "under the table." Generally, such an individual would not be considered self-employed.

The county should give consideration to each of the above indicators in conjunction with any other factors that may be pertinent to an individual's job situation. In the case of conflicting measurements, the county must weigh all the indicators and exercise its best judgment. The indicators above are arranged in a hierarchy of perceived importance.

B. DETERMINATIONS OF NET BUSINESS OR SELF-EMPLOYMENT INCOME

1. Medically Needy Program: Determine Net Self-Employ e t Income by subtracting from total business reviews the allowable business deductions per the instructions in Section E below.

2. Section 1931 Program: Instead of determining net business income by subtracting from total business revenue the allowable business deductions per Section B. 1., above, the individual or family may choose that his/her/their net business income be calculated by subtracting from his/her/their total business revenue an amount equal to 40 percent of the total business revenue.

If after being advised by county staff, the individual or family does not indicate his/her/their preferred alternative for computing net business income by the time the county is ready to make a final determination of eligibility, the default method for determining net business income for the Section 1931 program shall be the 40 percent deduction method described in Section B2.

C. COMPUTING NET INCOME FROM SELF-EMPLOYMENT

Section C provides instructions for computing Net Self-Employment Income by subtracting from total business revenue the allowable business deductions.

Section 50505 (Title 22 California Code of Regulations) governs how net income from self-employment is computed. Net self-employment income (business income) is determined by subtracting from the total business revenue those expenses which are "directly related to the production of goods or services, and without which the goods and services could not be produced."

Allowable Expenses: Expenses which are directly related to the production of goods and services, and which are subtracted from business revenue to compute net business income include the following:

1. Material and supply costs;
2. Wages and other benefits paid to employees;
3. Payment for rental of space or equipment;
4. Payment of interest on loans for capital assets or durable goods;
5. Transportation costs to call upon customers or deliver goods;
6. Maintenance and repair costs;
7. Other necessary costs of doing business (e.g. advertising, business dues & publications, and insurance.)
8. Principal and interest payments on capital assets* (equipment, machinery and other durable goods, real estate)*

* Allowable business expenses for Section 1931 program; NOT allowable for MN program.

Expenses Not Allowable: Certain expenses, although connected to business activities, are not considered to be "directly related to the production of goods or services", and cannot be subtracted from business revenue for purposes of determining net business income. These non-allowable expenses include:

1. Entertainment costs;
2. Depreciation;
3. Expenditures to purchase of capital equipment;

4. Payments on the principal of loans used to acquire capital assets or durable goods, **
5. Meals & transportation to and from work.

****Not allowable for MN program, but allowable for Section 1931 program.**

D. VERIFICATION AND RECORDS OF SELF-EMPLOYMENT INCOME

IRS Form Used To Verify Income: This section provides guidelines for the verification and the monthly apportioning of net business income. If the county is using a tax return to verify business income, most of the "business deductions" allowed by the IRS are "allowable" for purposes of determining net business income, except the items list above as non-allowable expenses. Other expenses may not be allowed if they are not related to the business.

If the business was operated throughout the previous year, once the county has determined the net business income for the previous year, apply this previous year's net self-employment income to the current year by apportioning it into the 12 months of the current year by dividing the previous year's yearly net self-employment amount income by 12.

If the county has reason to believe that the business was not operated throughout previous year, the county should determine the number of months in the previous year in which the business was operated and then project the business' yearly revenue and yearly allowable business expenses into the current year by multiplying each by the ratio of 12 (months) divided by the number of months the business was operated in the previous year. After projecting these amounts for the current year, determine net self-employment income for the current year by subtracting from the projected yearly business revenue the projected allowable yearly business expenses. This yearly net self-employment income is then apportioned into the months of the current year by dividing it by 12

Example, the county has a tax return from the previous taxable year from which the county determines there were $12,000 in business revenue and $4000 in allowable business expenses from the previous year. Suppose the county is informed that this business was operational for 8 months of that taxable year. To estimate monthly net business income for the current taxable year (assuming the business will be operational for the entire current taxable year), multiply the $12,000 and $4,000 amounts by the fraction "12/8". The result is a projected $18,000 in yearly business revenue and $6000 in yearly allowable business expenses for the current year. Apportioning these amounts into monthly amounts by dividing them by 12 results in $1500 in monthly total business revenue and $500 in allowable monthly business expenses. Subtracting the $500 in expenses from the $1500 in revenue yields the projected monthly net income from self-employment for the current year of $1000.

County Has Reason To Believe There Should Be An Adjustment: In some situations, last year's tax return may not provide a fair estimate of this year's net business income. If the county has reason to believe that last year's tax return will not provide a reasonably accurate estimate of this year's taxable income, then the county will require the self-employed individual to submit records sufficient to enable the county to estimate net income from self-employment for the current year. See the instructions below for estimating net profit from self-employment when the appropriate IRS tax forms are unavailable or will result in inaccurate estimates of the current year's net self-employment income.

Applicant/Beneficiary Requests Adjustment: An applicant/beneficiary who believes that this year's estimated taxable income based on last year's tax return does not accurately reflect the net income from his business for the current year (due to changes in his/her business' total revenue, or business expenses, or other changes), may request the county to reevaluate his/her net business income based on recent statements of total business revenue and expenses. See the instructions below for estimating net

profit from self-employment when the appropriate IRS tax forms are unavailable or will result in inaccurate estimates of the current year's net self-employment income.

Instructions for Estimating Current Year's Income When the Appropriate Last Year's IRS Tax Forms Are Unavailable or Will Result in Inaccurate Estimates of the Current Year's Net Self-Employment Income. In these cases, the county will evaluate the current year's net business income upon receiving from the applicant/beneficiary the required documentation, including an organized, coherent, readable book keeping record or statement of total business revenues and business expenses for at least the last three months (preceding the month in which the request was made), subject to the next paragraph, and subject to the principles discussed in the two examples which follow below. At the county's prerogative, the applicant/beneficiary must submit verification for the business revenue and business expenses shown in the bookkeeping record statement.

It is the applicant/beneficiary's prerogative to submit more than the three statements identified in the paragraph above if he/she feels it would be helpful in estimating his/her income. It is the counties prerogative to request more than the three statements (and corroborating verification), or to request statements for other than the last three months (and corroborating verification), if the county has a reason to believe that it is likely that a substantially inaccurate estimate of net business income would result without the additional information. The county has flexibility to make adjustments in the requirement in this section that the applicant/beneficiary submit a book keeping record or statement for the "last three months."

Example: An applicant has applied for Medi-Cal in June. The applicant is self-employed providing day-care services and her client base is steady throughout the year. She has bookkeeping statements for her business for February, March and April, but has not yet finished preparing statements for May. The county may accept a book keeping record/statements for February through April.

Difficult Situations: Seasonal or Other Fluctuations in Self-Employment: Not infrequently, these kinds of situations require the exercise of considerable judgment; and counties have discretion regarding the methodology to use to estimate net self-employment income. An example is provided below. Although involved, it embodies one of the more difficult self-employment scenarios ever submitted by a county. This example is a sample of one way for a county to approach the problem of estimating the individual's net self-employment income in a difficult situation such as this.

Example: An applicant has applied for Medi-Cal in May. He owns a small crab boat and fishes from September through December last year. He expects to do the same this year. His catch, and income from it, fluctuates substantially from month to month. From January through March of this year he was unemployed. He was unemployed during this period last year. He owns a logging truck, and from April through August of last year he contracted out to several small logging operations to haul felled logs to their mills. His logging contract tends to produce consistent revenue. He has started his trucking operation in May of this year and expects to repeat last year's work pattern. He doesn't have a tax return from last year. He kept poor records.

To repeat: Estimating self-employment income in these situations is difficult, and counties must exercise their judgment and common sense. There are no simple rules that can replace individual judgment for purposes of ensuring a reasonably accurate estimate of the current year's net business income. Credibility of the applicant is a legitimate consideration in determining the extent of verification to require. In this example, assume the applicant appears credible but a little fuzzy on recalling details. Clearly, getting statements and verification for the last 3 months will not suffice to obtain a reasonable estimate of net business income for the year.

In this example, it is reasonable for the county to require verification of business revenue and expenses for the months in which the applicant was self-employed as a fisherman. What constitutes acceptable verification is also subject to judgment. Bank statements for deposited business revenue and receipts for

business expenses are obviously acceptable. If the applicant has a credible reason for his inability to provide statements and certain business expense receipts, it may be acceptable, for example, to use estimates of monthly catch and price to estimate business revenue, and trip mileage, fuel utilization, and costs to estimate fuel costs.

Because the applicant has started his trucking operation in the month previous to his application, it is reasonable to expect he should be able to produce statements and verification for his trucking business revenue. These may be complemented by statements and verification of revenue and expenses from last year's trucking operation if the applicant indicates that last year's trucking revenue and expenses to date are not representative.

In short, the county must use its judgment when estimating net business income in these situations.

10P — TREATMENT OF VETERANS' EDUCATIONAL BENEFITS

This section contains information regarding the treatment of veterans' educational benefits received by Medi-Cal beneficiaries. The Veterans' Administration (VA) currently provides educational benefits under the GI Bill and the Veterans' Educational Assistance Program (VEAP). Proper treatment of the two types of payments is described below.

1. GI BILL

Background

Eligible veterans who served on active duty in the military prior to January 1, 1977 are entitled to receive educational benefits from the VA under the GI Bill. The veteran can receive up to 45 months of educational assistance. Under the GI Bill, the VA provides all the benefits and the veteran does not make a contribution.

Treatment

The entire amount of educational benefits received under the GI Bill is considered income for educational purposes in accordance with Title 22, California Administrative Code (CAC), Section 50547 (b).

2. VETERANS' EDUCATIONAL ASSISTANCE PROGRAM

Background

The Post-Vietnam VEAP is basically a contribution matching program for persons entering active military service after December 31, 1976. Persons on active military duty voluntarily contribute to the VEAP educational fund. Upon discharge from the military, eligible veterans are entitled to receive educational benefits from the VA. The benefits received under VEAP consist of the veteran's contribution and funds provided by the VA. The VA contributes $2 for every $1 previously contributed by the veteran. The veteran may receive up to 36 months of educational benefits under VEAP.

Treatment

The Post-Vietnam VEAP is funded differently than the GI Bill; therefore, the benefits received by Medi-Cal beneficiaries are treated differently. Only the portion of the VEAP benefits provided by the VA (two-thirds of the benefit) is treated as income for educational purposes in accordance with Title 22, CAC, Section 50547 (b). The veteran's contribution

(one-third of the benefit) is a return of the veteran's own money so it is not to be counted either as an educational benefit or as income or property while the veteran is pursuing an education, even if the veteran currently is not attending school or training. Because the VA does not distinguish between the sources of funding of these benefits when issuing benefit checks, the county must be sure to count only two-thirds of the amount received as income for educational purposes and to exempt the remaining one-third.

The veteran may elect to withdraw his or her contribution, but forfeits entitlement to matching funds from the VA. When a veteran voluntarily withdraws his or her own contribution, the money received should not be counted as income because the funds are a return of the veteran's own money. The veteran's unused contribution to VEAP is counted as property upon withdrawal, since the withdrawal from VEAP means that the funds are no longer earmarked specifically for educational purposes.

ARTICLE 10Q--INCOME DEDUCTION FOR PERSONS IN LICENSED BOARD AND CARE FACILITIES

BACKGROUND

Medi-Cal regulation 50515(a)(3) states, that portion of the monthly income of a medically needy person residing in a licensed board and care facility which is both of the following is unavailable:

- Aid to the facility for residential care and support.
- In excess of the appropriate maintenance need level as determined in accordance with Section 50603.

In the Pettit v. Bontá lawsuit, the court found the Medi-Cal program needed to allow persons in licensed board and care residential facilities the ability to apply incurred expenses for personal care services to their share of cost (SOC). An income deduction of $315 for board and care services is to be allowed unless the income deduction for excess board and care allows for a lower share of cost.

COMPUTATION OF INCOME DEDUCTION

Effective April 1, 2000, individuals in licensed board and care residential facility are to be allowed a $315 personal care services income deduction or the excess board and care deduction for residential care. The income deduction that will result in the lowest share of cost is to be used.

Examples

1. Person in licensed board and care pays board and care in the amount of $750. Beneficiary receives Social Security in the amount of $900. $900 minus $20 Aged Blind or Disabled (ABD) any income deduction leaves a nonexempt income of $880.

   $750 Amount paid for board and care.
   -$600 Maintenance need.
   $150 Excess board and care.

   The standard $315 deduction for personal care services is greater than the $150 excess board and care. Therefore, allow an income deduction of $315.

   $880 Net income.
   -$315 Standard personal care deduction for persons in board and care.
   $565 Income used to determine share of cost.

   $565 Net income after all deductions.
   -$600 Maintenance need.
   0 Share of cost.

2. Person in licensed board and care pays board and care in the amount of $1,300. Beneficiary receives Social Security in the amount of $1,100. $1,100 minus $20 ABD any income deduction leaves a nonexempt income of $1,080.

   $1,300 Amount paid for board and care.
   -$ 600 Maintenance need.
   $700 Excess board and care.

The $700 for excess board and care is greater than the $315 standard deduction for personal care services. Therefore, allow an income deduction of $700.

$1,080 Net income.
-$ 700 Excess board and care.
$ 380 Income used to determine share of cost.

$380 Net income after all deductions.
-$600 Maintenance need.
0 Share of cost.

3. Person in licensed board and care pays board and care in the amount of $850. Beneficiary receives Social Security in the amount of $1,000. $1,000 minus $20 ABD any income deduction leaves a nonexempt income $980.

$850 Amount paid for board and care.
-$600 Maintenance need.
$250 Excess board and care.

The standard $315 deduction for personal care services is greater than the $250 excess board and care. Therefore, allow an income deduction of $315.

$980 Net income.
-$315 Standard personal care deduction for persons in board and care.
$665 Income used to determine share of cost.

$665 Net income after all deductions.
-$600 Maintenance need.
$ 65 Share of cost.

4. Person in licensed board and care pays board and care in the amount of $1,300. Beneficiary receives Social Security in the amount of $1,400. $1,400 minus $20 ABD any income deduction leaves a nonexempt income of $1,380.

$1,300 Amount paid for board and care.
-$ 600 Maintenance need.
$ 700 Excess board and care.

The $700 for excess board and care is greater than the $315 standard deduction for personal care services. Therefore, allow an income deduction of $700.

$1,380 Net income.
-$ 700 Excess board and care.
$ 680 Income used to determine share of cost.

$680 Net income after all deductions.
-$600 Maintenance need.
$ 80 Share of cost.

10R -- APPLICATION OF OLD AND CURRENT MEDICAL BILLS TOWARD SHARE OF COST (INCLUDES HUNT V KIZER PROCEDURES)

PART 1: INTRODUCTION AND OVERVIEW OF THE PROVISIONS OF THE HUNT V KIZER LAWSUIT

INTRODUCTION: APPLYING MEDICAL BILLS TOWARD SHARE OF COST BEFORE HUNT V KIZER

Previous to the Hunt v Kizer lawsuit, Medi-Cal individuals could apply toward a particular month's share of cost (SOC) only those medical expenses incurred in the month in which they were being applied toward SOC. Individuals were not permitted to apply medical bills for medical expenses incurred in previous months (old medical bills) toward their SOC for a current month, nor could individuals save medical bills from current months and apply them as old medical bills toward a future month's SOC.

In the early 1990's, the Department of Health Services (DHS), pursuant to its settlement agreement in the Hunt v Kizer litigation, changed its policy to allow "old" medical bills to be applied toward the SOC under certain circumstances. This procedure manual section delineates the current policy and procedures for acceptance and application of old medical bills toward SOC under Hunt v Kizer. These policies and procedures were finalized and originally communicated to counties in All Counties Welfare Director Letter No. 93-63, and were effective October 5, 1993.

SUMMARY OF THE CURRENT HUNT V KIZER RULES ON APPLYING MEDICAL BILLS TOWARD SOC

Individuals are allowed to apply medical bills from previous months (old medical bills) toward their current month's SOC provided these old medical bills were unpaid at the time they were submitted to the county. Individuals are also permitted to save old or current medical bills and apply them as old medical bills toward their SOC in a future (later) month, provided these old medical bills remain unpaid. Individuals are allowed to use credit card or collection agency statements as evidence of medical expenses.

PART 2: APPLYING MEDICAL BILLS TOWARD SOC; OTHER PROVISIONS

I. DEFINITIONS

Current Month: This refers to the current calendar month with respect to the reader. For example, the current month would be whatever month you are in when you read this. The current month changes each month.

Future Month: A future month is any month which is future to the current month.

Previous Month: A previous or past month is any month which occurred prior to the current month.

Current Medical Bills: The term "current medical bill" refers to a medical bill which is/was incurred in the same month (month of eligibility) for which it will be applied toward the individual's SOC. As used in these procedures, the term "current medical bill" does not refer to the bill's chronological age. A medical bill incurred several months ago, and hence chronologically old, is nevertheless considered a current medical bill for the purpose of Hunt if the bill is applied by the individual toward his/her SOC in the same month in which the bill was incurred.

Old Medical Bills: The term "old medical bill," as used in these Hunt Procedures, refers to a medical bill which was incurred in a month previous to the month for which it will be applied toward the individual's SOC.

Old and current medical bills are sometimes treated differently and subject to different requirements for purposes of determining whether they can be applied toward SOC. The most notable difference is that current medical bills may be applied toward SOC whether unpaid or paid, while old medical bills must be unpaid before they can be applied toward SOC. Old medical bills applied toward SOC must be submitted to the county for processing. Some of the Hunt medical-bill qualifying criteria and verification requirements (Section III of these procedures, p. 14), and other requirements, are different for current and old medical bills.

Month In Which A Medical Bill Is Incurred: A medical bill is incurred on the date the medical service or drug is provided. The month in which a medical bill is incurred is the month in which this date of service falls.

Medical Bills Spanning Two Or More Months: In some instances, a medical bill will show a single medical expense for a medical service, such as a hospital stay, which was rendered over multiple days and therefore shows multiple dates of service. A medical bill showing such a multiple-day medical expense spanning more than one month is incurred in each month containing one or more dates of service for that expense. For example, a medical bill showing a single medical expense for a medical service, such as a hospital bed charge, might show the dates of service as March 27, 1992 through April 7, 1992. This medical expense has been incurred in both March and April.

When a medical bill spans two months, a portion of that bill is incurred in each month. If an individual submits such a medical bill to the county, the county must determine how much of the bill was incurred in each month. To calculate the portion of the medical expense that was incurred in the first month the county should first calculate the daily charge for the medical service by dividing the medical expense for that service by the number of dates of service for that expense, and then multiply the daily charge by the number of dates of service falling within the first month. Similarly the amount of the bill

incurred in the second month is the daily charge multiplied by the number of days of service in the second month.

For example, suppose a individual submits to the county for application toward his/her SOC for May 1992 a medical bill which was incurred over a two month period. The medical bill shows a charge of $400 for a four day stay in a hospital that began May 29, 1992 and ended June 1, 1992 billed to the individual. (Assume the rest of the bill was paid by another person).

The portion of this bill incurred in May is found by first calculating the daily charge. The daily charge is $400 (the total amount billed to the individual) divided by 4 (the number of days in the service period). The daily charge is then multiplied by 3 (the number of days of the service period falling in May) to obtain $300 as the amount billed to the individual for May. This $300 is the portion of this bill which may be applied toward the individual's May SOC. (The portion of the bill incurred in June is $100, the product of the $100 daily charge and the one date of service falling in June.)

These multiple-month medical bills may be applied toward SOC in the same way regular bills are. In the above example, if the individual elects not to apply the May portion of the bill toward his/her May SOC, this May portion may be applied toward June's SOC if it meets the Hunt requirements. The June portion of the bill cannot be applied toward May's SOC because this portion of the bill did not exist in May.

Unpaid Old Medical Bills: Unpaid old medical bills are old medical bills which are unpaid at some time in the month in which they are submitted to the county (i.e. the old medical bills have not been paid previous to the month of their submission). If a portion of the old medical bill has been paid, the unpaid portion may still be applied toward the individual's SOC.

Medical Bills and Medical Expenses: Medi-Cal can accept for application toward a individual's SOC only medical bills for bona fide medical expenses. Expenses for medically-related services qualify as bona fide medical expenses if the service was rendered by a State-licensed health-care provider.

Expenses for medically-related equipment, supplies or drugs qualify as bona fide medical expenses if the equipment, supply-item or drug was:

1. Prescribed by a physician as necessary to treat a medical condition and;

2. Is customarily considered by the medical profession as primarily for health care and medical treatment and;

3. Is intended, and will be used, solely for the health care and medical treatment of the individual.

(3. cont.) Medi-Cal presumes that medical expenses for drugs and supplies which are available only through a prescription are necessary to treat a medical condition and that expenses for these items are therefore bona fide medical expenses.

This presumption does not apply to medically-related equipment, drugs and supplies which a physician has prescribed but which are available without a prescription. For drugs, supplies, and medical equipment which have been prescribed, but which are available without a prescription, counties may require, at their discretion, that the individual obtain a statement from the prescribing health-care provider attesting that each of the three above- numbered requirements are satisfied. The statement must include a short description of the condition being treated and must name the drug, supply, or medical equipment which the physician has prescribed.

If the county is uncertain whether the drug or other item is available without a prescription, the county may require that the individual obtain a statement from the provider stating either that the item or drug is available only through a prescription, or attesting that each of the three above-numbered requirements are satisfied.

The county may disallow the application toward SOC of a medical expense for a drug or other item which is available without a prescription despite a provider's statement attesting to the three above-numbered items if the provider's statement is contrary to common sense. For example, a spa would not satisfy condition No. 2 above, despite the provider's statement that this condition is satisfied.

Remedy: The word "remedy" is used in these procedures to denote certain benefits belonging to the Medi-Cal individual which have arisen as a result of the Hunt v Kizer lawsuit (Remedies are described in Section II of these procedures.)

II. APPLYING OLD UNPAID MEDICAL EXPENSES (BILLS) TOWARD SOC

Applying Unpaid Old Medical Bills Toward Share of Cost: An individual may apply an old medical bill toward his/her SOC when all of the conditions below are satisfied.

1. The old medical bill, or the portion of the old medical bill, which will be applied toward SOC was unpaid at some time in the month of its submission to the county (i.e. was not paid previous to the month of submission.) This condition is satisfied if the bill is unpaid at some time during the month of its submission (except where a bill was paid by the individual in a previous month and then "refunded" by the provider in the month of its submission.)

2. The bill is not more than four years old as of the date of its submission. If the bill is more than four years old, it is subject to the Statute of Limitations, and not acceptable toward SOC, unless it falls under one of the exceptions to the Statute of Limitations. (See Section V of these procedures.)

3. The old medical bill satisfies the qualifying criteria (see Section III.A of these procedures), verification requirements (see Section III.B of these procedures) and other applicable conditions discussed in these procedures.

4. An old medical bill submitted for application toward SOC must not have previously been applied toward SOC and must not have been for a medical expense which is subject to payment by the Medi-Cal program.

Individuals may also save and accumulate unpaid medical bills from a current month and then submit these bills as old medical bills toward their SOC in a later month. An old medical bill may also be applied toward a past month IF the bill was incurred previous to that past month and IF the individual had not already met his/her SOC in that past month. These bills cannot be applied to months more than 12 months previous to the month of their submission (months for which a Letter of Authorization would be necessary) unless the individual could qualify for a Letter of Authorization on grounds of administrative error.

III. QUALIFYING CRITERIA AND VERIFICATION REQUIREMENTS FOR CURRENT AND OLD MEDICAL BILLS

A. Qualifying Criteria: This Section lists the criteria which a medical bill must satisfy before the county can apply the bill toward SOC. All the below criteria (Nos. 1-6) apply to UNPAID OLD medical bills. Criteria 3-6 apply to CURRENT medical bills; criteria 1 and 2 do not apply to current medical bills.

1. The old medical bill must be unpaid at some time in the month of the bill's submission to the county (i.e. the bill must not have been paid previous to the month in which it is submitted). To ease administration, the county may consider this requirement satisfied when the bill's date of issuance falls within 90 days of the bill's submission to the county (see also Section III.B.7 of these procedures), unless the individual indicates that the bill has been paid or the county has reason to believe that the bill has been paid since the bill's issuance date.

2. The old medical bill is less than four years old as of the date of the bill's submission, with certain exceptions (see Statute of Limitations, Section V of these procedures.)

3. That portion of the old or current medical bill for which a third party is liable must first be subtracted from the amount billed to the individual.

4. The portion of a current or old medical bill previously used to meet Medi-Cal SOC may not be re-applied toward SOC.

5. The current or old medical bill must be an original bill, an authenticated copy, or an acceptable substitute (see Section VI of these procedures).

6. The current or old medical bill must satisfy the list of verification requirements discussed in this Section, see below.

If completely paid previous to the month of their submission, unpaid old medical bills cannot be applied toward SOC. If partly paid previous to the month of their submission, only the portion of the old medical bill which remains unpaid in the month of submission can be applied toward SOC.

Current medical bills can be applied toward SOC whether paid or unpaid (provided they meet other applicable requirements.)

B. Verification Requirements For Current And Old Medical Bills: Current and old medical bills applied towards an individual's SOC must contain certain items of information. These items are called the medical bill's "verification" requirements. These verification requirements assure that submitted medical bills are accurate and valid. They apply both to current medical bills and to old medical bills, except where noted. The verification requirements which must be satisfied are:

1. Current and old medical bills must show the name and address of the provider who provided the service.

2. Current and old medical bills must show the name of person who received the medical service.

3. Current and old medical bills must contain a short description of the medical service received.

4. Current and old medical bills must show a "Procedure Code" (a medical reference number).

5. Current and old medical bills must show either the provider's Medi-Cal provider identification number, taxpayer identification number, or provider license number.

6. Current and old medical bills must show the date(s) the medical service was provided.

7. Current and old medical bills must show the date on which the bill was issued. If the bill is an unpaid old medical bill, its billing date must be within 90 days of the date the bill is received by the county.

8. Current and old medical bills must show the amount owed solely by the individual and not subject to third party coverage. If the individual has other health care coverage, the amount billed solely to the individual may be demonstrated by a bill which shows the total amount of the bill and a separate amount billed to the individual. If the individual has other health care coverage, and the bill does not show the total amount billed for the service, and a separate amount billed to the

individual, the county may require that the individual obtain a statement from his/her provider or health insurer showing the total amount for the service and the amount for which the individual is solely liable. A statement from the individual's health insurer may include either a statement showing how much the insurer will pay or a check or pay stub from the insurer which properly references the medical service paid for and which shows how much the insurer paid. If the individual does not have other health care coverage, the county may treat the total billed amount as the amount owed solely by the individual.

Some of the numbered verification requirements listed above may be supplied by the individual in a sworn statement (Section VII of these procedures) if they are missing from the medical bill. When an old medical bill fails to meet the qualifying criteria, verification requirements, or other requirements discussed in these procedures, and the individual is unable to cure the deficiency in a manner consistent with the procedures delineated within these procedures, the county must reject the medical bill following the procedures in Section VIII of these procedures.

IV. LIMITATIONS ON USE OF OLD MEDICAL BILLS APPLIED TOWARD SOC

A. Old Medical Bills: Month of Submission and Month of Application. Individuals do not have the right to submit an old medical bill and designate a month several months in the future as the month in which their old medical bill is to be applied toward their SOC. If the individual wants to apply an old medical bill toward his/her SOC in a future month, the county may require the individual to submit the old medical bill in that future month. At its discretion, the county may accept old medical bills for application toward SOC one month in advance.

Individuals may apply old medical bills toward a past month's SOC provided that the individual's SOC was not met in that past month (i.e. the individual was not "certified" eligible"). Such bills must have been incurred previous to that past month. These bills cannot be applied to months more than 12 months previous to the month of their submission (months for which a Letter of Authorization would be necessary) unless the individual would qualify for a Letter of Authorization on the ground of administrative error.

The county should presume that the individual intends to apply an old medical bill in the month in which he/she submits it, unless he/she indicates otherwise. In order to avoid misunderstanding, and potential disputes, the county may require a individual to submit written identification of the past month in which the individual wishes to apply the old medical bill toward his/her SOC. The county may also require written statement from the individual if he/she wishes to apply the old medical bill in the month after the month of submission.

B. Old Medical Bills Applied to Consecutive Months SOC Commencing With Month Of Submission: An old medical bill submitted for application toward SOC which exceeds the individual's SOC for the month in which it is being applied toward his/her SOC,

must continue to be applied toward the individual's, MFBU's, or individual's SOC in consecutive months starting with the month after the bill's submission until the sum of the monthly SOC amounts to which the bill has been applied equals the unpaid amount on the old medical bill which was billed to the individual. Otherwise, large numbers of partially used old medical bills may accumulate in county Medi- Cal case files. Maintaining records on the amounts of each bill not applied toward SOC, and re-evaluation of such bills to assess whether any portion of the bill had been paid since the bill was last used to meet SOC would be extremely time consuming, costly, and complex, and the inevitable misunderstanding between individuals and counties would result in frequent disputes.

C. Prioritizing Old Medical Bills For Application Toward SOC: Although Medi-Cal pays for a very broad range of medical services (covered medical expenses), the individual may submit a medical expense for a medical service which is not subject to payment by the Medi-Cal program either because the medical service or item is not covered by Medi-Cal or because the provider is not a Medi-Cal provider. These kinds of medical services are called non-covered medical services. Although they are non-covered services, they may be applied toward SOC if they are medical services.

If the individual submits multiple medical bills for application toward SOC, and if these medical bills exceed the SOC, counties should advise individuals to select bills for uncovered medical expenses for application toward SOC before selecting covered services. Individuals who seek medical care as Medi-Cal individuals are expected to identify themselves to the provider as Medi-Cal individuals and to inquire with the provider as to whether he/she is a Medi-Cal provider and whether he/she can bill the service to Medi-Cal. The individual who submits medical expenses should therefore know whether the expense is uncovered.

V. STATUTE OF LIMITATIONS FOR OLD MEDICAL BILLS

Only that portion of an old medical bill not paid previous to the month of submission, and for which the individual is still legally liable, may be applied toward SOC. If a medical bill is more than 4 years old, measured from the date of submission, it is presumptively voidable under the applicable Statute of Limitations in California law, and the individual is not legally liable for such a bill. Counties must disapprove these bills, unless the individual can demonstrate that his/her medical bill falls into one of the exceptions to the Statute of Limitations. These exceptions are listed below.

1. The medical expenses has been reduced to judgment in a formal judicial proceeding.

2. There is a contract between the provider of the service and the recipient of the service extending the statute of limitation beyond four years and the bill falls within the contract period.

3. The individual has made a payment on the bill within the last four years.

4. There is other reasonable written verification showing the person is still liable for the expense.

VI. SUBSTITUTE MEDICAL BILLS AND OTHER SUPPORTING DOCUMENTATION FOR MISSING VERIFICATION ITEMS

A. Kinds of Medical Expense Statements Which May "Substitute" For The Health-Care Providers Medical Bill: Generally medical bills submitted toward SOC must be formal heath-care provider billing statements or invoices. For purposes of this procedure manual section, these provider billing statements or invoices are "conventional" billing statements. In addition to conventional billing statements, Medi-Cal will also accept as medical bills certain alternative billing statements. These alternatives, called "substitute billing statements," may be credit card billing statements, collection agency billing statements, and other written billing statements by a provider. Before one of these substitute billing statements may be applied toward SOC, they must meet all applicable qualifying criteria (Section III.A of these procedures), verification requirements (Section III.B of these procedures), and other applicable standards (e.g. originality requirement) delineated in these procedures. Qualifying substitute billing statements may be applied toward SOC even though unaccompanied by a conventional provider invoice or billing statement.

B. Credit Card Statements Used As Substitute Medical Bills: When a individual wishes to apply a credit card billing statement which shows a medical expense as a substitute unpaid medical bill toward his/her SOC, he/she must, in addition to satisfying the qualifying criteria, verification and other requirements for old medical bills, demonstrate that the charged medical expense has not been paid previous to the month of submission of the bill. To demonstrate this, the individual must provide credit card statements to the county for every month beginning with the month in which the medical expense was incurred through the month previous to the one in which the credit card statement was submitted to the county. These statements must show that no payments have been made on the charge-card account since the medical expense was incurred.

If any of these subsequent credit-card statements reveal payments made to the charge-card account, the amount of the charged medical expense which may be applied toward SOC must be reduced by a amount commensurate to the amount of the subsequent payment(s). If the individual is unable to provide all of the credit card statements necessary to show his/her payment record since the date of the credit card statement showing the charged medical expense, the county cannot accept the credit card billing statement for application toward the individual's SOC.

Credit card statements applied toward SOC as substitute medical bills need not be dated within 90 days of the submission of the bill (Section III.B.7 of these procedures), nor does the individual need to obtain a statement from the provider stating that the bill is still unpaid. The individual, by demonstrating that he/she has

made no subsequent payments on the charged medical expense, accomplishes the purposes of these two conditions.

Interest charged by the credit card company on a charged medical expense cannot be applied toward SOC.

C. Alternative Billing Statements Which Fail To Qualify As Substitute Medical Bills: When an alternative billing statement fails to qualify as a substitute medical bill, it cannot, by itself, be applied toward SOC. But such alternative billings statements may still be submitted toward SOC in combination with a conventional provider billing statement or invoice in order to supply information missing from the conventional billing statement or invoice. For example, a conventional invoice which cannot be accepted for application toward SOC because certain verification information, such as the billing date, or amount separately billed to the individual, is missing, may be rendered acceptable if accompanied by a credit card or collection agency statement containing the missing information. Alternative billing statements may be used to update the conventional statement in order to meet the 90-day verification requirement.

Before accepting a substitute billing statement submitted for the purpose of augmenting a provider billing statement, the county must determine that the substitute bill is a valid billing statement and that it is a bill for the same service as the conventional provider billing statement or invoice which it augments.

D. Other Supplemental Documentation For Medical Bills Missing Verification Items: A conventional provider billing statement may be supplemented with original supporting documentation such as a handwritten note, signed or initialed by the provider, which provides the verification items missing from the billing statement. Such supplemental documentation cannot be submitted in place of the conventional provider billing statement.

E. Original Medical Billing Statements verses Photocopies: All medical bills, including substitute medical bills, submitted by the individual to the county for application toward the individual's SOC must either be original billing statements, or if photocopies, must be signed, initialed, or signature-stamped by the provider. If not signed, initialed, or signature-stamped by the provider, a medical-bill photocopy may still be acceptable for application toward SOC if there is other, original supporting documentation that corroborates the validity and accuracy of the bill. For example, such corroborative evidence could be a statement from the provider that the bill photocopy is a valid bill and the amount billed to the individual is owed solely by the individual. Such corroborative statements must properly reference the billing statement.

Credit card or collection agency statements must either be original statements or, if copies, be signed, initialed or signature-stamped by the manager of the account and this person must have legal authority to represent the billing organization. Conventional or substitute medical bills which have been altered are unacceptable

except that provider billing statements updated by the provider are acceptable when the provider has signed or initialed the notation which updates the billing statement.

VII. INDIVIDUAL'S AND COUNTY'S OBLIGATION TO OBTAIN VERIFICATION INFORMATION; INDIVIDUAL'S SWORN STATEMENT

A. Individual's Obligation To Obtain Verification Information: Medical bills submitted to the county to meet SOC must satisfy the qualifying criteria and verification requirements (Section III of these procedures) and any other applicable requirements before they can be accepted by the county. The individual is under the obligation to make an effort to obtain verification information missing from the medical bill. The individual has made an effort when he/she has contacted the provider and requested a new bill, acceptable photocopy (see Section VI.E of these procedures), or other acceptable documentation, such as a note from the provider, which contains the missing verification items. Individuals may be required to sign an affidavit stating that they have made such an effort.

When an individual is mentally incapacitated, or comatose, the individual's representative, a conservator, spouse, or other relative, must act on the individual's behalf, and make an effort to obtain verification information missing from old medical bills (see 22 CCR 50163). If such a individual does not have a representative, the county is obligated to assist in obtaining the necessary verification information, see paragraph below.

B. County's Obligation To Assist Individuals In Obtaining Verification Information: If the individual submits a medical bill to the county but has been unable to obtain all the required verification items after having made an effort to do so, the county must assist in obtaining the information subject to the following paragraph.

A county's duty to assist is predicated upon the individual providing an original old medical bill from the provider or a (non-photocopied) acceptable substitute bill. A piece of paper which has no identifying information is not a medical bill. Copies from bookkeeping records are not medical bills. The county may require the individual to furnish the provider's name and telephone number, if these are missing from the medical bill, as prerequisites to the county's assistance in obtaining missing verification information. The county is not required to obtain a medical bill for a individual who claims to have a medical expense but has no medical bill.

A county's assistance may consist of a phone call or letter to a provider requesting that the provider, verbally or in writing, provide the county with the necessary information. When a county obtains verification information needed for a bill from a provider by telephone, the county should note that information on the old medical bill and the eligibility worker noting the information should initial the entry. Approved old medical bills should be kept in the case file.

C. Individual's Sworn Statement: If the individual has made an effort to obtain the missing verification requirements but was unable to do so, and the county was unable to obtain the missing information, the individual may make a written, sworn statement attesting to certain of the verification items. Individuals may attest to verification requirements numbered 1 through 6 in Section III.B of these procedures. Individuals may not attest to verification requirement No. 7, "the date the bill was issued", and verification requirement No. 8, the amount of the bill owed solely by the individual. In those instances where the individual alleges that the date of service for a bill is in the same past month for which he/she wants to apply the medical bills toward SOC, and this date of service does not correspond to the date of the bill, the individual may not attest to this date because it is also the billing date. When the individual may not attest to a verification requirement, he/she must provide verification in the form of an original bill, a signed, initialed or signature-stamped photocopy, or a provider's statement which shows the required information.

Before accepting a individual's sworn statement, the county must determine that the individual has knowledge of the information to which he/she attests. This is especially true when the individual attests to the provider's identification number, the procedure code, or the type of service. If the individual cannot satisfactorily explain how he/she obtained the information, the county may refuse to accept the sworn statement.

VIII. ACCEPTING AND REJECTING MEDICAL BILLS; HUNT NOTICES: "HUNT FIRST DISAPPROVAL LETTER", "HUNT SECOND DISAPPROVAL LETTER," "HUNT MEDICAL BILLS APPROVED LETTER"

A. Rejecting and Accepting Medical Bills For Application Toward A Individual's SOC: A medical bill submitted by the individual may be rejected by the county because it fails to meet one or more of the criteria or requirements enumerated in these procedures or because the bill, in combination with the other bills submitted by the individual, fails to meet the individual's SOC. All rejected medical bills must be returned to the individual. The individual is responsible for keeping these returned bills if the individual wishes to re-submit them at a later date. The individual may re-submit returned bills when he/she has corrected the problem which caused the bills to be rejected. Counties should keep copies of the rejected medical bills. Copies, or ledgers, of bills rejected only because insufficient qualifying medical bills were submitted to meet SOC, might expedite the process of re-evaluating these bills in the event the individual re-submits them at a later date.

Medical bills submitted by the individual are acceptable for application toward the individual's SOC only when such bills meet all the qualifying criteria and verification requirements of these Procedures. If the bills are not acceptable, the county must reject the bills. If the bills are acceptable, and applied toward SOC, counties must keep the original of all such bills and provide a copy of the bills to the individual who submitted them.

When an old medical bill has been previously submitted by the individual and rejected by the county, it may be re-submitted. In such cases, the old medical bill is evaluated for application toward SOC in the month in which it is resubmitted, and not the earlier month of submission, except when the bill has been re-submitted within the 10 day period allowed by the Hunt First Disapproval Letter (see below) or when the medical bill has been re- submitted for application toward SOC in the past month in which the bill was incurred in accordance with 22 CFR Section 50746.

B. Hunt Notices (Approval Letter, First Disapproval Letter, and Second Disapproval Letter): This paragraph is applicable only when a medical bill has been submitted to the county for application toward the individual's SOC. After the county has rejected or accepted the medical bills submitted for application toward SOC, the county is required to notify the individual by issuing the appropriate form letter(s)/notices (discussed below and attached as Exhibit A). The county is required to complete and transmit these forms only when the county is the entity applying the medical bill toward the individual's SOC. The county is not required to complete and transmit these forms when the medical expenses which the individual wants to apply to his/her SOC for the month have been processed by the provider.

C. Hunt Notice For Accepted Medical Bills (Hunt Approval Letter): When the county has determined that a medical bill is acceptable for application toward the individual's SOC, the county shall complete and send to the individual a Hunt v. Kizer "Medical Bills Approved Letter" (Approval Letter). A copy of this Approval Letter is attached as part of Exhibit A. This Approval Letter should be sent within 30 days of the individual's submission of the approved bills. The county must keep copies of these Approval Letters for its files.

D. "Hunt First Disapproval Letter": When the county rejects a medical bill submitted by the individual for application toward his/her SOC, the county must inform the individual of the reason for the rejection, and return the rejected bill to the individual. The individual must then correct the problem before re-submitting the bill.

The county must document rejected medical bills by completing and issuing a "Hunt First Disapproval Letter" (First Disapproval Letter) (attached as part of Exhibit A) to the individual. This First Disapproval Letter will inform the individual which medical bills were rejected and indicate for each rejected bill the reason for its rejection. The individual may resubmit the bill once the reason which caused its rejection is corrected. This First Disapproval Letter must be issued within ten days of the individual's submission of the disapproved medical bills. The county must keep a copy of each First Disapproval Letter which it issues.

To complete this First Disapproval Letter, enter the name of the billing provider, the billing date, and the amount of the bill on the lines indicated on the form. Then on the space provided next to these lines, enter the number(s) corresponding to the numbered paragraphs at the bottom of this form which describe the reason(s) for which the medical bill failed to qualify for application toward SOC. Some of these

numbered paragraphs describe multiple, related items. The blank parenthetical enclosure "( )" after the applicable item should be checked.

E. "Hunt v Kizer Second Disapproval Letter" For Disapproved Old Medical Bills": The individual has 10 days from the issuance date (post-mark date) of the First Disapproval Letter (see above paragraph) to correct the problem which caused the medical bill(s) to be rejected. The county has discretion to increase this 10 day period by a reasonable amount. If the individual fails to correct the problem by submitting replacement medical bill(s) or supporting documentation containing the missing verification information (see Section VI of these procedures, p. 19) where this is appropriate, or by otherwise providing sufficient additional, qualifying medical bills to meet the individual's SOC where this is appropriate, by the end of the 10 day period, the county must complete and issue a "Hunt v. Kizer Second Disapproval Letter" (Second Disapproval Letter) (attached as part of Exhibit A) to the individual. If the individual responds by mail, the 10 days is measure by the post-mark date of the individual's response.

This Second Disapproval Letter, which will be a "Notice of Action" (NOA) advising the individual of his/her rights to a fair hearing, must be issued within 30 days of the end of the above-mentioned 10 day period. The county must keep a copy of each Second Disapproval Letter which it issues.

The First and Second Disapproval Letters serve similar functions: informing the individual that certain medical bills cannot be applied toward SOC until certain problems associated with those medical bills have been corrected. Neither form actually curtails an individual's right to re- submit a medical bill once the problem with that bill has been corrected. Even the issuance of the Second Disapproval Letter does not bar the individual from re-submitting a medical bill once the problem with that bill has been corrected.

When an individual re-submits a medical bill for which the county has previously issued a First and Second Disapproval Letter, and the county rejects the bill for the reason(s) indicated on the previously issued disapproval letters, the county need not re-issue any additional disapproval letters for that bill unless the county discovers that it failed to list in the previously issued disapproval letters all of the reasons for which that medical bill should have been disapproved. If the bill is rejected for a reason not previously indicated, another Second Disapproval Letter must be issued.

IX. PROCEDURES FOR COUNTY PROCESSING OF MEDICAL BILLS UNDER HUNT V KIZER

A. CURRENT Medical Bills MAY Be Brought To County: The individual will generally have his/her current medical bills processed and applied toward his/her SOC by his/her provider using the provider's Point of Service (POS) devices at the time the individual receives the medical service. This device connects with the Medi-Cal centralized eligibility database and immediately registers the individual's incurred

medical expenses with that database and updates the individual's SOC balance for the month.

Individuals have the option of bringing current medical bills to counties for application toward SOC. Individuals obtaining medical services from providers who do not participate in the Medi-Cal program must bring their current medical bills to the county for processing because such providers do not have POS devices and are unable to process their bills.

B. Old Medical Bills MUST Be Brought To The County: Individuals must submit to their county old medical bills which they wish to apply toward their SOC as old medical bills (for definition of current and old medical bills, see Section I of these procedures.) Providers may not process and apply old medical bills toward SOC. Only the county shall process and apply old medical bills toward SOC.

C. County Processing of Medical Bills Brought To Counties: The POS Device Alternative and the "Medi-Cal Eligibility Data Systyem (MEDS) SOC Adjustment" Alternative.

1. Verification Elements:

a. The Procedure Code: All medical bills must contain a procedure code --see Section III.B.4 of these procedures. If the procedure code is missing from a medical bill, the county should make a phone call to the provider and request the procedure code. If obtained, the procedure code must be entered onto the county's copy of the old medical bill. The entry should be initialed by the county worker making the entry. If the procedure code cannot be obtained, notate what effort was made to obtain it.

b. Other Health Care Coverage and the Unreimbursed Amount of the Bill: For any medical bill submitted to the county, only the unreimbursed amount of the bill can be applied toward the individual's SOC. When a individual does not have other health care coverage, and there is no reimbursement to the individual from a third party, the amount which the provider has billed the individual will be the provider's total bill for the service. All of the billed amount can be applied toward SOC.

If the individual submitting the bill has other health care coverage, the county must determine how much of the bill will be paid by the third party before accepting the bill for application toward the individual's SOC. Only that portion of the bill that is not reimbursable (i.e. the amount of the bill that will not be covered by the insurer or other third party) can be applied toward SOC.)

For bills subject to partial payment by a third party, if the provider has entered on the bill both a total amount indicating what the total charge for the service is, and a separate, lesser figure as the amount owed by the individual, the county may apply this lesser amount toward the individual's SOC under the assumption that the provider is billing the individual's insurer for the amount subject to third party payment. If the bill does not show a separate, lesser amount billed to the individual,

the individual must demonstrate how much of the bill will be paid by the third party by submitting: 1) a statement from the provider indicating how much the provider believes will be paid by the insurer, 2) a statement from the insurer indicating how much of the bill will be paid by them, or 3) a check stub from the insurer which properly references the bill being paid and indicates how much was paid. These amounts must be subtracted from the total amount of the bill and the remainder applied toward SOC.

2. POS Method For Applying Medical Expenses Toward SOC: For current and old medical bills submitted to the county for application toward SOC, the county should use its POS devices to register with MEDS the application of the bills toward the individual's SOC. If the medical bill is large relative to the individual's SOC, and would meet the individual's SOC in multiple months (such that it would present tracking or administrative difficulties to use the POS device to apply the bill toward SOC in multiple months) or it would otherwise be a hardship on the county, the county may process these bills by "adjusting" the SOC on MEDS (discussed below). When using this latter method, counties must implement a reminder system that will ensure that the SOC adjustments terminate after the medical bill has been "used up."

   If the bill exceeds the SOC for the month in which it is first applied, the balance of it must be applied in the next, and consecutive months, until all of the bill has been applied toward SOC. As would be true were the medical bill processed by the provider, once the bill has been applied toward SOC (or, as described in the next subsection, the SOC "reduced" on MEDS), the bill is "used up" and cannot be reapplied toward SOC in any other month. For bills which exceed the individual's monthly SOC, and which must therefore be applied toward SOC in multiple consecutive months, as each portion of the bill is applied toward SOC, it becomes "used up". Bills, or in the case of bills applied over multiple months, portions of such bills, are used up as each bill, or portion thereof, is applied toward SOC (or used to "reduce" SOC), regardless of whether the SOC was met in that month.

3. Processing Medical Bills On MEDS: As mentioned above, as a limited alternative to the recommended method of using the POS to apply medical bills submitted to the county toward the individual's SOC, counties may "reduce" the individual's SOC by means of the county's MEDS terminal. When "adjusting" SOC on MEDS, counties must complete the relevant portions of the MC 176 M form. In the "Underpayment Adjustment Box," column III, line 15, on this form, the county should enter the letters "OMB" for old medical bill, and record the individuals SOC before and after adjustment. This record should be maintained in the case file. When a county manipulates the MEDS SOC figure for a individual, that case must be flagged manually or on MEDS (REDETERM-MONTH) so that the MEDS SOC figure can be reset to the individual's actual SOC at the end of the submitted medical bill's effective period.

   While counties are provided the mechanical alternative of applying medical bills toward the SOC by adjusting the system SOC on MEDS, the case's real SOC is in

fact not changed by this adjustment. Medical expenses do not reduce the SOC. Only reductions in countable income reduce the SOC. Medical expenses are applied to, or used to meet, the SOC. The MEDS SOC adjustment is simply an administrative means to apply medical expenses toward the SOC. When a medical expense is applied toward SOC by making a MEDS SOC adjustment, the MEDS system no longer reflects the case's true SOC. The case's true SOC must of course continue to be tracked by the county so that the MEDS SOC can be reset after the medical bills which the county is applying to the SOC via a MEDS adjustment are "used up."

4. "Zeroing Out the SOC"—No SOC Aid Code: When a county reduces a individual's SOC to zero on MEDS for a particular month, the county must change the individual's aid code for that month to a no-SOC aid code. The certification date for the individual having met his/her SOC should set at the first of the month to enable providers who rendered services to the individual in that month to bill Medi-Cal regardless when in the month the services were rendered.

5. County Retention of Medical Bills: When a medical bill has been accepted by the county for application toward the individual's SOC, the bill and any accompanying documentation must be retained by the county in the case file. Do not return the original bill or supporting documentation to the individual. When a medical bill has been rejected, the county must return the original bill to the individual. The county may photocopy the bill for its files.

   Counties using MEDS to adjust SOC should devise tracking procedures to prevent individuals' from re-submitting old medical bills already applied toward SOC. Copies of medical bills accepted toward SOC must be kept on record so that the Department of Health Services may review them.

X. INFORMING INDIVIDUALS OF THEIR RIGHTS UNDER THE HUNT LAWSUIT: DISTRIBUTING THE MEDI-CAL PAMPHLET

Distributing The Medi-Cal Pamphlet: Counties must provide the Medi-Cal Pamphlet to individuals during the initial eligibility determination for a new case and for cases for which eligibility is being determined for Medi-Cal only for individuals and families who are being (or have been) discontinued from CalWORKs, SSI, or other public programs that conferred Medi-Cal eligibility as an adjunct to their program. Medi-Cal Pamphlets must also be provided to individuals during the Medi-Cal redetermination process for continuing Medi-Cal cases. This pamphlet need not be issued on a monthly or annual basis.

EXHIBIT A: List of Documents

HUNT V. KIZER MEDICAL BILLS APPROVAL LETTER

HUNT V. KIZER FIRST DISAPPROVAL LETTER

HUNT V. KIZER SECOND DISAPPROVAL LETTER

RECORD OF MEDICAL BILLS SUBMITTED AND ACCEPTED FOR APPLICATION TOWARD SHARE OF COST -- HUNT V. KIZER

Note: Camera-ready copies of the documents contained in this Exhibit, including Spanish versions, have been transmitted to counties via an All County Welfare Directors Letter.

STATE OF CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF HEALTH SERVICES MEDI-CAL PROGRAM

;suance Date: _____

County Address

HUNT V KIZER MEDICAL BILL APPROVAL LETTER

Client Address

Case Name: _____
Case Number: _____
District: _____

The medical bill(s) which you submitted were approved and applied toward your Share of Cost in the amount of:

$ _____
Total Share of Cost Credit

ı his amount will be applied toward your Share of Cost for the following months: _____

_____

_____

_____.

For medical bills which are disapproved, if any, you will receive separate notification which will identify which of the medical bills you submitted to the county were disapproved and the reasons for the disapproval.

Please call your Eligibility Worker (EW), below, if you need assistance.

_____	_____	_____	_____
(Eligibility Worker)	(Phone Number))	(County Hours)	(Date)

HK App. Letter (Eng.) (1/01)

STATE OF CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF HEALTH SERVICES MEDI-CAL PROGRAM

Issuance Date: _____

County Address

HUNT V KIZER MEDICAL BILL
FIRST DISAPPROVAL LETTER

Client Address

Case Name: _____

Case Number: _____

District: _____

For Medical Bills Submitted on the following date(s): _____

You brought some medical bills to the county to apply against your Share of Cost (SOC). The county is currently unable to accept some of these medical bills. To determine why the medical bills, listed below, cannot be used, find the number entered on the "Disapproval codes" line (below) next to the listed bill and then read the same-numbered paragraph which follows. These numbered paragraphs are disapproval reasons which tell you why the medical bills which you submitted cannot be used and what you can do to correct the problem.

For disapproval reasons (numbered paragraphs) 1-10 below, you may fix the problem by getting another bill from your provider, or a copy of the bill which is initialed, or signed, or stamped by the provider, or by getting an acceptable statement from an authorized representative of your provider, which shows the missing information. Give this revised bill to your eligibility worker.

If any of your medical bills have been disapproved due to denial reasons 1-6 below, and if you are unable to obtain the information in writing from your provider after you have made the effort to do so, you may be allowed to submit a sworn statement supplying the missing information if you know the missing information.

You must provide the missing information to your eligibility worker no later than 10 days from the post-mark date of the county's request for additional information or the medical bills will be again disapproved. The needed information, and the medical bills for which it is required, is indicated below. If you mail the additional information to the county, the 10 days is measured by the post-mark date of your response.

LISTING OF DISAPPROVED MEDICAL BILLS
(By provider name, date, and amount of bill)

	(Provider name)	(Date of bill)	(Amount of bill)	(Disapproval code(s))
Bill #1	_____	_____	_____	_____
Bill #2	_____	_____	_____	_____
Bill #3	_____	_____	_____	_____
Bill #4	_____	_____	_____	_____

HK Disapp. Letter 1 (Eng) (1/01)

Page 1 Of 2

DISAPPROVAL REASONS

1. The name, and/or the address, of the provider who performed the medical service was missing from the medical bill. Please obtain this information.

2. The name of the person who received the medical service was missing from the medical bill. Please obtain this information.

3. A description of the type of medical service received was missing from the medical bill. Please obtain this information.

4. The Procedure Code (a medical reference number used to identify the kind of service received) is missing from the medical bill. Please obtain this information.

5. The medical bill did not show the provider's identification number. For Medi-Cal providers, please obtain the provider's identification number (I.D.) For providers who are not Medi-Cal providers, please obtain the provider's provider-license number or federal tax I.D. number.

6. The date(s) the service was provided was missing from the medical bill. Please obtain this information.

For the information requested by the items 7-11 below, your sworn statement will not suffice. You must obtain a new bill which contains the information as explained above.

7. The date on which the bill was issued is missing or is not within 90 days of the date the bill was submitted to the county. Please obtain a replacement bill or provider-signed document which shows the bill is dated within 90 days of the date the bill is submitted to the county.

8. The medical bill does not show the current, unpaid balance for which you are solely liable to your provider, or you are no longer liable for the bill. Please obtain a replacement which shows this information unless you are no longer liable for the bill. If you are no longer liable for the bill, it cannot be applied toward your SOC.

9. The submitted medical bill was an unauthenticated copy or was altered. Please obtain an authentic, unaltered replacement.

10. This medical bill has already been applied toward your Share of Cost.

11. This bill does not qualify as a medical expense.

12. The bill was not an unpaid bill.

13. Other: _____

_____

_____

_____

Please call your Eligibility Worker (EW), below, if you need assistance.

_____	_____	_____	_____
(Eligibility Worker)	(Phone Number))	(County Hours)	(Date)

HK Disapp. Letter 1 (Eng) (1/01)

TATE OF CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF HEALTH SERVICES MEDI-CAL PROGRAM

MEDI-CAL NOTICE OF ACTION

Client Address

County Address

Notice date: _____
Case number: _____
Worker name: _____
Worker number: _____
Worker telephone: _____
Worker hours: _____
Notice for: _____

HUNT V KIZER SECOND DISAPPROVAL LETTER

For Medical Bills Submitted on the following date(s):

_____

You previously submitted medical bills to your county for application toward your SOC which were rejected. This will inform you which of these medical bill(s) continue to be disapproved. These disapproved medical bills are listed below. They cannot be used to meet your SOC until you correct the problems with these bills. The reasons(s) for the disapproval is/are listed below.

LISTING OF DISAPPROVED MEDICAL BILLS
(By provider name, date, and amount of bill)

	(Provider name)	(Date of bill)	(Amount of bill)	(Disapproval code(s))
Bill #1				
Bill #2				
Bill #3				
Bill #4				

DISAPPROVAL REASONS

1. Provider's name and/or address missing.
2. Name of person who received the medical service(s) is missing.
3. Description of service is missing.
4. Procedure Code is missing. (The medical Procedure Code is a medical reference number identifying the kind of medical service received.)
5. Provider Medi-Cal provider number, license number, or federal tax identification number is missing.
6. Date(s) on which the medical service was provided is missing.
7. Bill does not show a billing date; or bill was received by the county over 90 days from the date of the bill.
8. Bill does not show amount currently owed solely by the beneficiary; or beneficiary is not liable for part, or all, of the bill.
9. Original billing statement, or acceptable substitute, not provided (bill was altered or unauthenticated copy.)
10. Bill previously used to meet Share of Cost.
11. Bill does not qualify as a medical expense.
12. Bill was not an unpaid bill.
13. Other: _____

A medical bill which has been disapproved may be resubmitted if the missing information is obtained. Please call your Eligibility Worker, below, if you have questions.

(Eligibility Worker)	(Phone Number))	(County Hours)	(Date)

MC 239 HK (1/01)
This action is authorized under the Hunt v Kizer lawsuit.

YOUR HEARING RIGHTS

You have the right to ask for a hearing if you disagree with any county action. You have only 90 days to ask for a hearing. The 90 days started the day after the county gave or mailed you this notice.

If you ask for a hearing before an action on Cash Aid, Medi-Cal, Food Stamps, or Child Care takes place:

- Your Cash Aid or Medi-Cal will stay the same while you wait for a hearing.
- Your Child Care Services may stay the same while you wait for a hearing.
- Your Food Stamps will stay the same until the hearing or the end of your certification period, whichever is earlier.

If the hearing decision says we are right, you will owe us for any extra Cash Aid, Food Stamps or Child Care Services you got. To let us lower or stop your benefits before the hearing, check below:

Yes, lower or stop: ☐ Cash Aid ☐ Food Stamps ☐ Child Care

While You Wait for a Hearing Decision for:

Welfare to Work:

You do not have to take part in the activities.

You may receive child care payments for employment and for activities approved by the county before this notice.

If we told you your other supportive services payments will stop, you will not get any more payments, even if you go to your activity.

If we told you we will pay your other supportive services, they will be paid in the amount and in the way we told you in this notice.

- To get those supportive services, you must go to the activity the county told you to attend.
- If the amount of supportive services the county pays while you wait for a hearing decision is not enough to allow you to participate, you can stop going to the activity.

Cal-Learn:

- You cannot participate in the Cal-Learn Program if we told you we cannot serve you.
- We will only pay for Cal-Learn supportive services for an approved activity.

OTHER INFORMATION

Medi-Cal Managed Care Plan Members: The action on this notice may stop you from getting services from your managed care health plan. You may wish to contact your health plan membership services if you have questions.

Child and/or Medical Support: The local child support agency will help collect support at no cost even if you are not on cash aid. If they now collect support for you, they will keep doing so unless you tell them in writing to stop. They will send you current support money collected but will keep past due money collected that is owed to the county.

Family Planning: Your welfare office will give you information when you ask for it.

Hearing File: If you ask for a hearing, the State Hearing Division will set up a file. You have the right to see this file before your hearing and to get a copy of the county's written position on your case at least two days before the hearing. The state may give your hearing file to the Welfare Department and the U.S. Departments of Health and Human Services and Agriculture. **(W&I Code Sections 10850 and 10950.)**

TO ASK FOR A HEARING:

- **Fill out this page.**
- Make a copy of the front and back of this page for your records. If you ask, your worker will get you a copy of this page.
- **Send or take this page to:**

OR

- **Call toll free: 1-800-952-5253** or for hearing or speech impaired who use TDD, **1-800-952-8349.**

To Get Help: You can ask about your hearing rights or for a legal aid referral at the toll-free state phone numbers listed above. You may get free legal help at your local legal aid or welfare rights office.

If you do not want to go to the hearing alone, you can bring a friend or someone with you.

HEARING REQUEST

I want a hearing due to an action by the Welfare Department of _____ County about my:

☐ Cash Aid ☐ Food Stamps ☐ Medi-Cal

☐ Other (list)_____

Here's Why: _____

_____

_____

_____

_____

_____

☐ **If you need more space, check here and add a page.**

☐ I need the state to provide me with an interpreter at no cost to me. (A relative or friend cannot interpret for you at the hearing.)

My language or dialect is: _____

NAME OF PERSON WHOSE BENEFITS WERE DENIED, CHANGED OR STOPPED		
BIRTH DATE	PHONE NUMBER	
STREET ADDRESS		
CITY	STATE	ZIP CODE
SIGNATURE	DATE	
NAME OF PERSON COMPLETING THIS FORM	PHONE NUMBER	

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

NAME	PHONE NUMBER	
STREET ADDRESS		
CITY	STATE	ZIP CODE

NA BACK 9 (REPLACES NA BACK 8 AND EP 5) REQUIRED FORM - NO SUBSTITUTE PERMITTED

For Medical Bills Submitted: _____
(Month – Year)

(Purpose of form: Counties may want to fill out this form and attach a copy of this form to the copy of the Hunt Approval Notice which the county keeps for its files so that the county knows which medical bills were approved.)

RECORD OF MEDICAL BILLS SUBMITTED AND ACCEPTED FOR APPLICATION TOWARD SHARE OF COST – HUNT V KIZER

Listing of Medical Bills Submitted/Approved:

(Provider Name)	(Date of Bill)	(Date of Service)	(Amount of Bill)
(Provider Name)	(Date of Bill)	(Date of Service)	(Amount of Bill)
(Provider Name)	(Date of Bill)	(Date of Service)	(Amount of Bill)
(Provider Name)	(Date of Bill)	(Date of Service)	(Amount of Bill)
(Provider Name)	(Date of Bill)	(Date of Service)	(Amount of Bill)
(Provider Name)	(Date of Bill)	(Date of Service)	(Amount of Bill)
(Provider Name)	(Date of Bill)	(Date of Service)	(Amount of Bill)
(Provider Name)	(Date of Bill)	(Date of Service)	(Amount of Bill)
(Provider Name)	(Date of Bill)	(Date of Service)	(Amount of Bill)
(Provider Name)	(Date of Bill)	(Date of Service)	(Amount of Bill)
(Provider Name)	(Date of Bill)	(Date of Service)	(Amount of Bill)
(Provider Name)	(Date of Bill)	(Date of Service)	(Amount of Bill)
(Provider Name)	(Date of Bill)	(Date of Service)	(Amount of Bill)
(Provider Name)	(Date of Bill)	(Date of Service)	(Amount of Bill)