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23A. INTRODUCTION

1. PURPOSE

The Medical Support Enforcement Program provides that as a condition of eligibility for Medi-Cal, applicants, beneficiaries, or caretaker relatives must cooperate in medical support enforcement when there is an absent parent who may be responsible for their dependent child(ren)'s medical care, or in paternity establishment when there is a child born out of wedlock. These referrals for medical support enforcement will be made for all children under age 18 who are recipients of Medi-Cal or for whom Medi-Cal is being sought subject to the referral restrictions in Article 23D.

2. BACKGROUND

Title IV-D of the Social Security Act established the child and spousal support enforcement program. The Federal Deficit Reduction Act of 1989, the Consolidated Omnibus Budget Reconciliation Act of 1985, and the Omnibus Budget Reconciliation Act (OBRA) of 1987 amended sections 1902 and 1912 of the Social Security Act. These legislative changes required that, as a condition of Medi-Cal eligibility, applicants and beneficiaries must cooperate in medical support enforcement and paternity establishment. Assembly Bill 1422 (Chapter 806, Statutes of 1988) added section 14008.6 to the Welfare and Institutions Code to adopt, at the state level, the federal requirements.

Medical Support referrals are made to the Family Support Division/District Attorney (FSD/DA). Under California Civil Code, Section 4726, the court must consider that either the absent parent, custodial parent, or both parents provide medical insurance coverage to the child(ren) when medical insurance is available at no or reasonable cost. Section 4726 also requires the court and FSD/DA to secure health insurance through court and administrative orders in all child and medical support actions. Section 4726.1 permits the court to order the employer of the absent parent or other person providing health insurance to the caretaker parent to enroll the supported child in the available health insurance plan. Welfare & Institutions (W&I) Code, Section 11490, requires that medical insurance information be collected by the county FSD/DA offices and then forwarded to Department of Health Services (DHS).

The FSD/DA is responsible for enforcing medical support, in addition to obtaining information regarding the availability of health insurance when such information is not reported by the county welfare department. Health insurance coverage is required if it is available at no or reasonable cost to the parent(s). Federal regulations define "reasonable cost" health insurance as group or employer related health insurance, regardless of the service delivery mechanism. This includes health maintenance organizations (HMOs) and preferred provider organizations (PPOs).

On August 22, 1996, H.R. 3734, "The Personal Responsibility and Work Opportunity Reconciliation Act of 1996" was signed into law. This legislation was a comprehensive bipartisan welfare reform plan which contains comprehensive child support enforcement measures. All child support orders shall include a provision for the health care coverage of the child; and the definition of "child support" now includes health care as well as monetary support. The law establishes a Federal Case Registry, a National Directory of New Hires to track delinquent parents across state lines, streamlines the voluntary paternity establishment process, and provides for uniform rules and procedures for interstate cases.

Other changes impact the audit process, reporting procedures, review and adjustment, penalties for delinquencies, collection of support from Federal employees including members of the armed forces, voiding of fraudulent transfers, work requirements, liens, reporting to credit bureaus, license suspension, denial of passports for non-payment of support, international support enforcement, data

suspension, denial of passports for non-payment of support, international support enforcement, data matches with financial institutions, medical support orders in all cases, and automated systems changes and funding.

Technical amendments to PRWORA were contained in the Balanced Budget Act (BBA) of 1997. The program requirements of PRWORA and BBA are set forth in State Assembly Bill Nos. 573 (Ch. 270, Stats. 1997) and 1542 (Ch. 270, Stats 1997). This legislation provides for a $50 disregard of the first $50 of any amount of child support collected in a month; cooperation determination language requires that the FSD/DA shall have staff available at any county welfare office to determine cooperation and good cause; written and oral information about the Voluntary Declaration of Paternity shall be given to ea ch applicant/beneficiary who has a child born out of wedlock.

Assembly Bill No. 1832 (Ch. 1062, Stats. 1996) was signed by the Governor on September 28, 1996. This bill provides that health coverage be provided for in child support orders for any child, that voluntary acknowledgments of paternity declaration forms will be mandatorily provided to parents at birth of a child in every hospital and they shall be made available at clinics, courts, county welfare offices and at FSD/DA offices. As of January 1, 1997, the father's name on the birth certificate may be included only if both parents sign a Voluntary Paternity Declaration.

3. **IMPLEMENTATION**

The medical support enforcement regulations for DHS's Medi-Cal program were implemented by county welfare departments on July 1, 1993.

23B. CONDITION OF ELIGIBILITY

1. MEDI-CAL ONLY

The county must inform an applicant for or beneficiary of Medi-Cal only that, as a condition of eligibility, the applicant or beneficiary must:

- Assign to the State the applicant's or beneficiary's rights to any medical support and payments;
- Cooperate in obtaining medical support and payments;
- Cooperate in establishing paternity for a child born out of wedlock for whom aid is requested;
- Cooperate in identifying and locating the absent parent; and
- Provide information about possible entitlement to medical support and payments available through any third party.

Cooperation includes the following:

- Providing the name of the alleged or absent parent, along with other information, if known, such as address, Social Security number, telephone number, place of employment, school, or names and addresses of relatives or associates.
- Appearing at interviews, hearings, and legal proceedings if the applicant or recipient is provided with adequate notice of the interview and does not have good cause not to appear.
- If paternity is at issue, submitting to genetic tests, including tests of child, if necessary.
- Providing any additional information reasonably obtainable by the applicant or recipient necessary to establish paternity or to establish, modify, or enforce a child support order.
- A recipient or applicant shall not be required to sign a voluntary declaration as a condition of cooperation.

If the applicant or beneficiary is found ineligible for Medi-Cal because of the above, this will not affect the child(ren)'s Medi-Cal eligibility. The applicant can withdraw the application, claim good cause (Section 23E), close the case, or become an ineligible member of the Medi-Cal Family Budget Unit (MFBU), but the child(ren) is not denied, discontinued from Medi-Cal for noncooperation of applicant/caretaker relative. If applicant/ caretaker relative chooses not to cooperate, refer the child to the Family Support Division/District Attorney (FSD/DA) for medical support enforcement with whatever information was provided. Section 14008.7 was added to the Welfare and Institutions Code to set out the specific guidelines for noncooperation.

EXAMPLE: Mother with mutual child from present husband and one separate child from another man applies for Medi-Cal for family. She can exclude the separate child with absent parent from MFBU and is not mandated to cooperate with medical support enforcement for that child. She must cooperate ONLY if she is applying for Medi-Cal for the separate child and if she is legally responsible for the separate child. Then, if she does not cooperate, she is to be denied Medi-Cal, discontinued, or made an ineligible member of MFBU. Two children and husband may be granted Medi-Cal, if eligible.

2. VERIFICATION OF DOCUMENTS

The county welfare department is responsible for determining the identity of all applicants for Medi-Cal. For purposes of medical support referrals for health coverage or paternity establishment, the county may be guided by Sections 50167 and 50169(a) of the California Code of Regulations or Article 4W of the Medi-Cal Eligibility Procedures Manual.

As stated in Article 4W, the documents listed below should be used as a reference guide when interviewing Medi-Cal applicants and beneficiaries if the individual is without a California Drivers License or California Iidentification Card (ID) issued from the Department of Motor Vehicles:

1. I.D. that has a picture of the person is preferred
2. U.S. Citizenship or Alien Status Documents (passport)
3. School identification card
4. Birth Certificate
5. A Social Security card or document containing a Social Security number
6. Voter's Registration Card
7. Marriage record
8. Divorce Decree
9. Work Badge, Building Pass
10. Draft Card, Military I.D.
11. Adoption Record
12. Court Order for Name Change
13. Clinic, Doctor-Hospital-Admission Record
14. Church Membership or Baptism-Confirmation Record
15. Vaccination Record
16. Insurance Policy
17. Utility Bills
18. Two pieces of mail received at the applicant's-beneficiary's address
19. Any other documents providing identifying data such as physical description, photographs

NOTE: Not listed above, but which may be needed to prove that though there is an absent parent situation, no referral is necessary, are a death certificate of a deceased parent or a document which proves the absent parent is institutionalized.

3. CalWORKs/Edwards

A recipient of CalWORKs benefits who is discontinued from CalWORKs for refusal to cooperate in child support will NOT receive Edwards Medi-Cal. Under federal and state legislation, Applicants and Recipients of the CalWORKs and Medi-Cal programs must, as a condition of eligibility, assign child and medical support rights to the county and cooperate with the DA in establishing paternity and establishing, modifying, or enforcing a child/medical support order for the child(ren) for whom aid is requested. Under federal law, child support includes monetary support, health care, arrearage or reimbursement, and may include other costs such as fees, interest and penalties, income withholding, attorney's fees, and other relief.

When an Applicant or Recipient Parent or caretaker relative of a child for whom aid is sought refuses or fails to cooperate with the DA in paternity establishment or child/medical support enforcement, this individual remains a member of the Assistant Unit (AU), the AU cash grant is reduced by 25 percent, and this individual will be denied Medi-Cal. If otherwise eligible, the members of the AU are granted or continue to receive Medi-Cal benefits. The Notice of Action will need to state that the AU cash grant will be reduced and the custodial parent will be ineligible for Medi-Cal.

There will be no Edwards for these cases because the custodial parent will not be discontinued or denied CalWORKs. The AU will receive a cash grant. Can Medi-Cal benefits be denied by the CalWORKs county staff? Yes, because medical support is part of the definition of Child Support under federal law as defined above, and the county staff must deny or discontinue Medi-Cal if there is a determination of noncooperation by the FSD/DA and the cash grant is reduced by 25 percent.

Even though the CalWORKs eligibility worker (EW) is responsible for sending the case package of child support forms, the EW is responsible for ensuring that the medical support portions of these forms are filled out correctly for Medi-Cal. If needed, the counties can use the revised forms available in the DHS warehouse.

In child support enforcement actions, the DA may require the absent parent to pay child support payments which are in arrears; that is, the absent parent may also be liable for payments which were not paid or were skipped before the custodial parent applied for CalWORKs and Medi-Cal. In medical support, we start with the time of enforcement of coverage. We do not seek reimbursement for medical expenses up to the point of court-ordered medical support enforcement.

4. MEDS PROCESS FOR RESTRICTION CODE TO DENY OR DISCONTINUE MEDI-CAL IN CALWORKS

970 OR 971 Medi-Cal Ineligible CalWORKs recipient due to noncooperation.

980 or 981 Medi-Cal Ineligible CalWORKs recipient due to noncooperation overlaid with S/URS restriction.

When reporting eligibility to MEDS for CalWORKs clients, it will be necessary to use a restriction code to identify the individual charged with noncooperation when the family's computed grant is subject to the new CalWORKs 25 percent reduction penalty. Since the law requires that the responsible individual be ineligible for Medi-Cal for the period of noncooperation, reporting of this code will change the client's Eligibility Status to "691" or "692":

691 = Health and welfare program other than Medi-Cal/CMSP Eligible Reported Timely.

692 = Health and welfare program other than Medi-Cal/CMSP Eligible Reported Retroactively.

This change will allow counties to continue to report the client as an eligible member of the CalWORKs case while the POS/MOPI health care eligibility message will say "NO RECORDED ELIGIBILITY FOR (MONTH/YEAR)." The anticipated implementation date for this MEDS change is Fall of 1999. **(REMINDER: When 25 percent penalty restriction is removed, Medi-Cal benefits will be restored, and counties should report "000" or "001" in the restriction code to remove the noncooperation restriction.**

5. DEPARTMENT OF SOCIAL SERVICES (DSS) CHILD SUPPORT PROCEDURES

DSS child support procedures are to be found in the following:

- DSS Manual of Policy and Procedures (MPP) Sections 12-100 through 12-908 and 43-200 through 43-205;
- DSS Family Support Division (FSD) Letter No. 94-03, February 10, 1994 Title IV-D Child and Spousal Support Program Procedure Manual.

23C. PATERNITY ESTABLISHMENT

1. PURPOSE

As a condition of Medi-Cal eligibility, an applicant/recipient must cooperate in paternity establishment when there is a child born out of wedlock for whom Medi-Cal is being sought. A referral is made to establish the existence of a father and child relationship and the duty of support. **(NOTE: Remember, no** pregnant woman shall be referred until 60 days postpartum.)

In the case of a child born out of wedlock, an individual is not legally the father unless paternity has been established in a court of law. Paternity establishment is necessary for any child born out of wedlock even if there is an intact family because each parent is assigning his/her rights and the rights of the children for whom they are legally responsible in order to establish linkage for AFDC or Medi-Cal.

Even when a marriage takes place subsequent to the child's conception or birth, it is necessary to establish the paternity of the child. Both federal and state law define out of wedlock as ". . . the biological parents of the child were not married to each other at the time of the child's conception."

When two unmarried adults seek Medi-Cal for themselves and their children but do not cooperate with medical support, then the county must make a medical support referral for the children. A referral should be made whenever a child is born out of wedlock. (Title 22, CCR, Section 50101(b).)

2. PATERNITY ESTABLISHMENT BY DISTRICT ATTORNEY

When a medical support referral is made for paternity establishment, the FSD/DA will obtain the identity of the absent father from the applicant/recipient. State law requires the FSD/DA to investigate the question of paternity and take all necessary steps to obtain a paternity determination; however, no questions on paternity will be asked when paternity is not an issue. But when a Medi-Cal case has been referred for the purpose of paternity establishment, this is all that will be done. When paternity has been established, the case will be closed.

The FSD/DA is not required to establish paternity in any case involving forcible rape, incest, or legal proceedings for adoption if such action is not in the child's best interests. (Title 22, California Code of Regulations, Section 50771.5; Welfare and Institutions Code [W&I Code], Article 7.)

Undocumented children in Aid Code 58 - restricted services are not to be referred for paternity establishment unless the father is a citizen. If the child is a citizen of an Omnibus Budget Reconciliation Act parent applying for the child and the child is receiving full-scope benefits, then a medical support and/or paternity establishment referral should be made.

3. **TIME FRAMES**

Within 90 days of locating the absent father, the FSD/DA will file for paternity or complete service of process to establish paternity or document unsuccessful attempts to serve process. Paternity must be established or the absent parent excluded as a result of genetic tests and/or legal process within one year or the later of successful service of process or the child reaching six months of age. The FSD/DA will file a Motion for Temporary Support whenever the alleged father refuses to stipulate to paternity. A motion will be filed for blood tests at the request of any party in a contested paternity case as appropriate. If the alleged father is excluded by blood tests, the FSD/DA will review the case to determine whether the mother should be deemed as non-cooperative for failure to provide the name of the natural father of the minor child or a case should be opened against a different individual. If another alleged father is identified, the FSD/DA has 90 days after locating this person to file for paternity or complete service of process to determine paternity. The time frames for establishing paternity for subsequent alleged fathers is the same as for the original alleged absent father. (W&I Code, Art. 7)

4. **PATERNITY OPPORTUNITY PROGRAM**

In January of 1995, this program was implemented statewide at all licensed hospitals and clinics with birthing facilities. This program gives new, unmarried parents the opportunity to voluntarily acknowledge paternity (fatherhood) in the hospital by signing a Declaration of Paternity shortly after the birth of the child. This Declaration may be filed with the court to establish paternity. This Declaration will help the child have the same rights that he or she would have if the parents were married:

- The child can have the father's legal name;
- The child can be added to the father's health insurance plan;
- The child will receive father's Social Security or veteran's benefits if the father dies or is disabled; and,
- The child has the right to inherit from the father.

5. **VOLUNTARY DECLARATION OF PATERNITY**

State Assembly Bill (AB) 1832 and federal legislation in H.R. 3734 both mandate that a Voluntary Declaration of Paternity program be implemented in county welfare offices by January 1, 1997.

Upon application for Medi-Cal or redetermination, unmarried parents shall be informed of the availability of the Declaration of Paternity when they are informed about the requirements of medical support and their assignment of rights. They are to be given the option of signing the CS 909 in order to establish paternity. A copy of the brochure which explains the voluntary paternity program (PUB 244 (1/97 revision)), the Information Sheet (CS 910), and the Declaration of Paternity (CS 909) shall be given to the applicants at the same time as they are informed about child and medical support enforcement and are given the CS 196 and other support forms.

Completion of the form is **not mandatory** for Medi-cal eligibility. If the form is not signed, the case will be referred to the Family Support Division/District Attorney (FSD/DA) for paternity establishment. Medi-Cal eligibility should not be denied or delayed if the voluntary declaration is not signed at this time. However, cooperation with and information regarding the children's father must be provided for Medi-Cal eligibility approval. If the parents volunteer, or if the parent applying volunteers, the form may be taken home for signature witnessed by a Notary Public, or both parents may return and sign the form in the presence of a county staff person. If there are any legal questions which are not answered in the brochure or information sheet, then refer the case to the FSD/DA.

If the applicant/beneficiary states that they have signed a Voluntary Declaration of Paternity at a hospital or clinic, ask for a copy of the executed Declaration. If they cannot provide a copy, refer to FSD/DA.

23D. PETITION TO THE COURT

The county must notify each applicant or beneficiary placed in the following aid codes that the California Child Support Enforcement (IV-D) Agencies must, by law, petition to the court to include health insurance coverage in support orders when a child receives Medi-Cal. Referral in aid codes cited below will be for children under 18 with an absent parent or when a child is born out of wedlock. **HOWEVER, NO UNDOCUMENTED CHILDREN, NO PREGNANT WOMEN, AND NO CHILD IN A MINOR CONSENT CASE OR IN HEALTHY FAMILIES PROGRAM WILL BE REFERRED**. Also, referrals for infants will be made after the 60-day postpartum period. In a minor consent case, the child must be in a regular aid code before referral can be made. (For explanation of absent parent situations, please refer to MEPM Article 1-B.)

In situations where the applicant is filing for retroactive Medi-Cal only, no referral will be made. When the absent parent is incarcerated or institutionalized, no referral will be made, but obtain necessary verification and refer upon absent parent's release.

In situations where the absent parent is already providing health insurance, no referral is necessary unless paternity must be established, but all forms must be completed on other health coverage and kept in the file, and a copy of the DHS 6155 sent to DHS. Even though the child is covered by medical insurance, the child can be eligible if all Medi-Cal eligibility requirements are met, and the mother will have linkage based on the child. If the mother does not apply for the child or the child is ineligible for any reason, then the mother becomes ineligible for Medi-Cal because the child cannot be used to link the mother.

A custodial parent can exclude a child from the Medi-Cal application and is not mandated to cooperate with medical support enforcement for that child. The custodial parent must cooperate ONLY if he/she is applying for Medi-Cal for that child and if he/she is legally responsible for the child.

In on-going medical support cases, at redetermination or at any time, if there is any change in the case, it should be reported to the FSD/DA via Form CA 371. The FSD/DA should be advised of any changes in the case which involve a change in status such as discontinuance of eligibility, change in family composition, loss of health coverage, change in income, etcetera. If there are no changes in the case at redetermination, no report to the FSD/DA is necessary.

MEDI-CAL AID CODES

The following aid codes are the ones for which the Medi-Cal Eligibility Worker must refer the children with an absent parent.

3A	20	34	51	67	83
3C	24	37	60	72	
7A	27	47	64	82	

CalWORKs AID CODES

The following aid codes are the ones for which child support referrals, including medical support, should have already been made by the CalWORKs or Foster Care Intake Worker for CalWORKs or foster care cases.

3G	30	33	40	45
3H	32	35	42	

1. PREGNANT WOMEN

Medical support referrals will NOT be made on an unborn child until the end of the 60-day postpartum period of the mother. If the mother of the unborn has other eligible children in the MFBU, a medical support referral for these children will NOT be made until the end of the 60-day postpartum period of the pregnant caretaker parent. If a pregnant caretaker parent has other eligible children in the MFBU with a different absent parent than for the unborn, a medical support referral will NOT be made on the children of the absent or unmarried parent(s) until the end of the 60-day postpartum period of the pregnant caretaker parent.

When a woman with a child(ren) has applied for Medi-Cal but refuses to cooperate in medical support and does not claim good cause, she becomes ineligible for Medi-Cal and designated as an ineligible member of the MFBU. The woman's child(ren) may be eligible for Medi-Cal if otherwise eligible and she has not withdrawn the application or asked to close the case. If this caretaker parent then becomes pregnant and applies for Medi-Cal, she may be eligible until her 60-day postpartum period ends. A referral for the caretaker parent and the new child can be made at the completion of the 60-day postpartum period.

If a caretaker parent has a child(ren) and has cooperated with medical support requirements, but then becomes pregnant, the medical support referral process should not be interrupted. The pregnancy should be reported to the FSD/DA, but no referral on the new child should be made until the 60-day postpartum period ends. The rule in on-going medical support cases is if there is any change in the case, it should be reported to the FSD/DA via Form CA 371. The FSD/DA should be advised of any changes (e.g., discontinuance from CalWORKs, new Medi-Cal case).

An unmarried/absent parent may apply for Medi-Cal and medical support services for the caretaker parent at the hospital if the caretaker parent is unable to fill out an application. Under Title 22, CCR, Section 50143, if a person is unable to file an application for Medi-Cal, "(2) a person who knows of the applicant's need to apply" may file the application. An unmarried/absent parent would qualify under this definition.

2. OBRA REFERRALS

If the caretaker parent or mother is undocumented and her children are also undocumented, no medical support referral will be made. If the caretaker parent/mother is undocumented and the children are citizens, a medical support referral will be made. No undocumented children will be referred for either medical support enforcement or paternity establishment.

If the caretaker parent has both OBRA children and citizen children and requests that both be referred for medical support enforcement, the county will only make a referral on the citizen children. Medical support enforcement referrals will not be made on OBRA children.

3. **CONTINUING ELIGIBILITY**

Under this program, infants born to Medi-Cal eligible women are automatically "deemed eligible" for one year, provided they continue to live with their mother and the mother remains eligible for Medi-Cal, or would remain eligible if she were still pregnant. For purposes of medical support enforcement, the father/absent parent still has a legal responsibility for the health and welfare of his children and, at the end of the 60-day postpartum period, a medical support referral must be made.

4. **FOSTER CARE CHILDREN**

The CalWORKs or Foster Care Intake Workers will make child support referrals, including medical support for all foster care children. Medical support enforcement referrals will not be done by the county Medi-Cal Eligibility Worker on foster care children. Foster care children are automatically eligible for Medi-Cal after utilizing whatever other health coverage is available. This is clarified in Section 903 of the Welfare & Institutions Code, Liability for Costs of Support. This section prohibits any imposition of medical costs upon the natural parent(s) until the county has first exhausted any eligibility the child may have under private insurance coverage, standard or medically indigent Medi-Cal coverage, and the Robert W. Crown California Children's Services Act. If there are any costs over and above 100 percent of the average Medi-Cal payment that are not covered under any of the coverages listed, the county may choose to impose those costs.

5. **ADULT CHILDREN**

"Adult children" are individuals in Medi-Cal between the ages of 14 to 18 years of age who are not living in the home of a parent or caretaker relative and who do not have a parent, caretaker relative, or legal guardian handling any of their financial affairs or 18 to 21, and who do not have a parent, caretaker relative or legal guardian handling any of their financial affairs (Sec. 50014). The parents do not claim the children as dependents in order to receive a tax credit or deduction for state or federal income tax purposes. Under 42 Code of Federal Regulations (CFR) 435.222, the State of California may provide Medi-Cal benefits to individuals under age 21 who would be eligible for cash-based Medi-Cal but do not qualify as dependent children. These "adult children" **WILL NOT BE REFERRED** for Medical Support Enforcement. Aid Codes 82 and 83 will be reinstated to the referral list because medically indigent children who are not "adult children" will be referred.

Under Medi-Cal regulations, individuals under 21 years of age (not disabled or blind) and living in the home of a caretaker relative are considered children and are eligible for Medi-Cal.

Under new Medi-Cal regulations if a married individual under the age of 21(not disabled or blind) is living in the home of his/her parents, regardless of whether or not he/she is claimed as a tax dependent, this individual is considered a child for budget purposes and financial responsibility.

If the applicant is an unmarried minor parent (14-18 years of age with a child), who is living on his/her own and does not want to cooperate with medical support , do not deny or discontinue him/her for noncooperation, but do refer the child for medical support enforcement.

If the applicant is an unmarried minor parent (14-18 years of age with a child) and is living with a parent or caretaker relative, do not deny or discontinue the parent for noncooperation, but refer the child. If the parent or caretaker relative is using the linkage with minor for Medi-Cal benefits, then the parent or caretaker relative must cooperate with medical support enforcement or be discontinued or denied Medi-Cal benefits.

If a mother is under 21 but over 18, and living on her own, she must cooperate because an individual 18 years of age or older is considered an adult under the Family Code.

Disabled Adult Children under the Pickle program are at least 18 years of age or older. They will not be referred for medical support enforcement. Referrals are for those under 18.

Disabled children who have been placed in an institution through a guardianship are not to be referred for medical support enforcement.

6. **TRANSITIONAL MEDI-CAL OR FOUR-MONTH CONTINUING MEDI-CAL**

No transitional Medi-Cal cases are to be referred. This includes children in aid codes 39, 54, and 59. These families were initially on CalWORKs and lost their cash grant due to increased earnings, increased hours of employment, or increased allocation of child/spousal support payments. Transitional Medi-Cal or Four-Month Continuing Medi-Cal is provided to these families as an aid in helping them become self-sufficient. If they apply for Medi-Cal Only at the end of their transition period, they should be treated as a new case and a referral should be made.

7. **DECEASED ABSENT PARENT**

No medical support enforcement referral will be initiated for deceased absent parents. However, sufficient substantiation of the fact that the absent parent is deceased is required.

8. **CALIFORNIA ALTERNATIVE ASSISTANCE PROGRAM**

This program allows individuals who qualify for Aid to Families with Dependent Children, Family Group (CAAP-AFDC [FG]) or Aid to Families with Dependent Children, Unemployed Parent Group (CAAP-AFDC[U]) to decline the federal cash grant and instead receive child care assistance and Medi-Cal.

9. **VOLUNTARY DECLARATION OF PATERNITY**

Upon application for Medi-Cal, unmarried parents shall be informed of the availability of the Declaration of Paternity, and given the option of signing the CS 909 in order to establish paternity. A copy of the brochure which explains the voluntary paternity program (PUB 244 (1/97 Revision)), the Information Sheet (CS 910), and the Declaration of Paternity (CS 909) shall be given to the applicants. Completion of the form is **not mandatory** for Medi-Cal eligibility. If the form is not signed, the case will be referred to the Family Support Division/District Attorney (FSD/DA) for paternity establishment. Medi-Cal eligibility **should not be denied or delayed** if the voluntary declaration is not signed at this time. However, cooperation with and information regarding the children's father must be provided for Medi-Cal eligibility approval. If the parents volunteer, or if the parent applying volunteers, the form may be taken home for signature witnessed by a Notary Public, or both parents may return and sign the form in the presence of a county staff person. If there are any legal questions which are not answered in the brochure or information sheet, then refer the case to the FSD/DA.

Appropriate copies of the completed Declaration along with the CA 2.1Q should be sent to the FSD/DA, who will forward the Declaration to the State Office of Vital Records. If there are any questions regarding legal issues that are not answered by the brochure or information sheet, refer the case to the FSD/DA. You may inform the parents that the signed Declaration may be rescinded by either parent by filing a rescission with the State Office of Vital Records within 60 days of execution or by a judicial proceeding.

MINOR PARENTS: When either parent is a minor, the Declaration of Paternity does not establish paternity until 60 days after both minor parents are emancipated or 60 days after the eighteenth birthday of both minors, whichever occurs first.

REFERRAL TO FSD/DA: If the Declaration of Paternity is signed by both parents, DO NOT REFER to the FSD/DA for paternity establishment. The signed Declaration should be sent with other documentation and a note on the CA 371 that the Declaration has been signed and is attached. The Declaration of Paternity will have the same force and effect of law as a judgment rendered by a court.

10. HEALTHY FAMILIES PROGRAM

Healthy Families is a new health care coverage program for low-income, uninsured children only which offers medical, dental, and vision coverage for a small premium to children who are one year to 19 years of age and whose families earn too much to qualify for no-cost Medi-Cal but do not earn enough to afford private health coverage. They will not be referred for medical support enforcement, but the FSD/DA may provide absent parents the opportunity to purchase this health coverage for their children as medical support. Applications for Healthy Families may be made through a mail-in application or through the county welfare department.

EXAMPLES:

1. An intact family applies for Medi-Cal, but requests Healthy Families coverage for a stepchild. Because Healthy Families eligibility determinations cannot be made on MEDS at present, the child will be covered under Medi-Cal until Healthy Families approval is confirmed. No referral to the FSD/DA should be made on this child. Medical Support enforcement cooperation requirements do not apply in Healthy Families program. Healthy Families is a children-only program.

2. Custodial Parent applies for Medi-Cal and is eligible. The Custodial Parent cooperates with medical support enforcement and referral is made to the FSD/DA. The FSD/DA contacts the absent parent and informs him/her about the Healthy Families Program, and that low-cost health coverage can be obtained for the children. The FSD/DA may provide the absent parent with the Healthy Families application, and the absent parent may apply for this health care for his children.

EXAMPLES:

1. Woman with three children declares father is deceased and provides birth certificate for children, death certificate for father, and marriage certificate.

   a. Marriage occurred after birth of children and father's name is not on birth certificates. **Question:** Do we do paternity referral? **Response:** Yes. Children born out of wedlock.

   b. Marriage occurred after birth of children and father's name is on birth certificates. **Question:** Do we do paternity referral? **Response:** Yes. Mother may declare he is rightful father and that is why he is on birth certificates, but birth certificate alone does not establish paternity.

   c. Marriage occurred before birth of all children and father's name is not on birth certificates. **Question:** Do we do paternity referral? **Response:** No. Children were not born out of wedlock. Presumption is deceased person is father.

   d. Marriage occurred before birth of children and father's name is on birth certificate. **Question:** Do we refer since we have a death certificate? Must the FSD/DA validate the death for us? **Response:** No referral. He is not absent; he's deceased.

   e. Same as Number d, but woman claims that at least one of the children has a father other than the man named on the death certificate. **Question:** Would a referral be sent on this new man even though we have a death certificate on the father? **Response:** Refer if there is no name on birth certificate, but use your best judgment since children were not born out of wedlock.

   f. Death of husband occurred over nine months before the birth of child(ren), and woman claims he is father. Question: Would referral be made on child(ren)? Response: Yes, child(ren) was born out of wedlock.

2. Woman with one child applies and is granted benefits. Prior to completing the approval action, she calls the EW and advises that she has moved to County A. EW completes the disposition and processes for an intercounty transfer (ICT) to County A. **Question:** Case should be referred for medical support if she had stayed in County B, but since she is in County A physically, are we required to send the medical support referral to County B FSD/DA as part of the regulations even knowing that they will be closing because of the change in county address? **Response:** In this case, make sure County A is aware of need for medical support referral in County A in the ICT documents. Since case will be in County A, County A must make the referral.

3. Woman with two children applies and is granted benefits for one month only. Case requires cooperation with medical support. **Question:** At point that benefits are approved and cooperation with medical support referral is okay, do we send the medical support referral to the FSD/DA knowing that the case is closed and that they will do nothing with it. Seems to be a workload that is unnecessary. **Response:** If woman requests child and medical support, then refer. If a woman requests medical support enforcement and is willing to request child support enforcement services also, she may be referred to FSD/DA. If woman wants medical support enforcement services only, she can only receive this service if she is

continuing on Medi-Cal. However, since there is no retro enforcement, do not refer unless she specifically wants medical support and child support enforcement services.

4. Woman with two children is working and has health insurance available through her employer. Question: Will the FSD/DA pursue medical support from the mother/custodial parent (CP)? Response: No. Federal regulations require the FSD/DA to pursue medical support from the absent parent/noncustodial parent, not the CP. Although the court has discretion to order the CP to provide health coverage for the dependent children, the FSD/DA is not required to enforce it.

23E. GOOD CAUSE FOR NONCOOPERATION

The applicant or beneficiary may claim good cause for noncooperation in establishing paternity, medical support payments, or identifying third party liability if he/she feels there is a risk of emotional or physical harm to himself/herself or a child(ren) if a referral is made for medical support enforcement. The county must determine if the applicant or beneficiary, in fact, has good cause for failure to cooperate with medical support requirements. (No provision exists for a finding of good cause when the applicant or beneficiary refuses to assign to the State his/her rights to medical support, payments, care, and services.) If the county determines that good cause does not exist (Form CA 51), then the applicant or beneficiary should be given an opportunity to withdraw the application, close the case, or be designated as an ineligible member of the Medi-Cal Family Budget Unit (MFBU) (California Code of Regulations, Title 22, Sections 50155 and 50379).

If good cause is claimed, Medi-Cal is granted pending the good cause determination if the applicants are otherwise eligible. Once good cause is established, it continues unless the mother/caretaker parent rescinds the claim for good cause and is able to cooperate with medical support enforcement. Review at redetermination to determine if circumstances have changed. It is not necessary to process another claim for good cause.

The CA 51 Good Cause Claim for Noncooperation form calls for statistical reporting.

1. COOPERATION

The Family Support Division/District Attorney's (FSD/DA) office shall have staff available in person or by telephone at every county welfare office and shall interview each applicant to obtain information necessary to establish paternity, and establish, modify, or enforce a support order. The FSD/DA shall make the determination of noncooperation, and, in making this finding, it shall take into consideration:

- The age of the child for whom support is sought;
- The circumstances surrounding conception of the child;
- The age or mental capacity of the parent or caretaker of the child for whom aid is being sought; and
- The time that has elapsed since the parent or caretaker last had contact with the alleged father or absent parent.

Cooperation is defined as including:

- The name of the alleged parent or absent parent, and other information about that person if known, including the names and addresses of relatives or associates;
- Submitting to genetic tests, including tests of the child;
- Address;
- Social Security number;
- Telephone number or numbers;
- Place of employment or school;
- Appearing at interviews and court hearings.

The caretaker parent has the right to refuse to cooperate in medical support enforcement for himself/herself and for the child(ren). If this occurs, the caretaker parent is denied or discontinued from Medi-Cal, but the child(ren) may be granted Medi-Cal or continues to receive Medi-Cal, if otherwise eligible, and the caretaker parent does not withdraw the child(ren)'s application. The county would refer the child(ren) for medical support services. Assignment of right is an automatic process

of Medi-Cal eligibility. (Welfare and Institutions Code, Section 14008.6.) The caretaker parent can withdraw the application or close the case if he/she does not want a medical support referral on the child(ren).

- When an applicant/custodial parent does not agree to assign their rights to medical support or establish paternity and does not claim good cause, deny Medi-Cal to the custodial parent and refer the children for medical support enforcement.

- When an applicant/custodial parent agrees to assign their rights and signs the Medi-Cal application, but does not wish to cooperate with the FSD/DA in paternity establishment or identification of medical support and does not claim/have good cause, deny Medi-Cal to the custodial parent and refer the children for medical support enforcement.

- When an applicant/custodial parent agrees to assign their rights, signs the application and agrees to cooperate in paternity establishment and identification of medical support, refer the case to the FSD/DA for medical support enforcement.

- When an applicant/custodial parent agrees to assign their rights and signs the Medi-Cal application but states that he/she has good cause not to cooperate, do not refer the case to the DA until good cause determination can be made, or you may indicate on the CA 371 that good cause has been claimed. The FSD/DA will not begin any action on the case until the good cause determination has been made. Information from the FSD/DA can be requested in making the determination of good cause, but the county welfare department no longer needs to request an independent evaluation of the good cause claim from the DA. If the good cause claim is denied, the case will be referred to the FSD/DA for medical support enforcement. If the good cause claim is valid, the applicant or recipient should be referred to appropriate community, legal, medical, and support services.

- Cooperation determinations will be done by the FSD/DA. Medi-Cal county staff must work with the FSD/DA in determining procedures for accomplishing a cooperation determination. The county will not discontinue any applicant/custodial parent until it receives a statement/document from the FSD/DA which specifies the circumstances of the individual's failure or refusal to cooperate in medical support enforcement. The county shall then review and verify the evidence that the applicant/custodial parent failed or refused to cooperate without good cause. If this is correct, the county must discontinue the individual from Medi-Cal benefits and refer the children for medical support enforcement.

- If the applicant/recipient comes back two months later and agrees to cooperate, do not reinstate applicant/recipient back on Medi-Cal until he/she cooperates with the FSD/DA and brings back a letter of cooperation. Later, if he/she comes in and wants to cooperate and makes an appointment with the FSD/DA's office and the appointment is not until the following month, the applicant/recipient will receive retroactive Medi-Cal for the month in which he/she first made the appointment if it is documented by the FSD/DA in the letter of cooperation.

2. **GOOD CAUSE**

Good Cause shall be determined by the county welfare department. Suspension of child support services will occur as long as good cause exists, and Medi-Cal will not be discontinued or denied until the Good Cause determination has been made. If the applicant/beneficiary did not cooperate without good cause, Medi-Cal will be discontinued or denied to the custodial parent, but not the children unless the application is withdrawn.

GOOD CAUSE DETERMINATION REQUIREMENTS - Good Cause may be determined if the following conditions exist:

- Efforts to establish paternity or establish, modify or enforce a support obligation would increase risk of physical, sexual, or emotional harm to the child for whom support is being sought.

- Efforts to establish paternity or establish, modify, or enforce a support obligation would increase the risk of abuse to the parent or caretaker with whom the child is living.

- The child for whom support is sought was conceived as a result of incest or rape. A conviction for incest or rape is not necessary for this paragraph to apply.

- Legal proceedings for the adoption of the child are pending.

- The applicant/beneficiary is being assisted to resolve the issue of whether to keep or relinquish a child for adoption.

- The applicant/beneficiary is cooperating in good faith but is not able to identify or assist in locating the alleged father or absent parent.

- Any other reason that would make efforts to establish paternity or establish, modify, or enforce a support obligation contrary to the best interests of the child.

EVIDENCE TO SUPPORT GOOD CAUSE CLAIM

- Police, governmental agency, or court records, documentation from a domestic violence program, or a legal, clerical, medical, mental health, or other professional from whom the applicant or recipient has sought assistance in dealing with abuse, physical evidence of abuse, or any other evidence that supports the claim of good cause.

- Statements under penalty of perjury from individuals, including the applicant/beneficiary with knowledge of the circumstances surrounding the good cause claim.

- Birth certificates or medical, mental health, rape crisis, domestic violence program, or law enforcement records that indicate that the child was conceived as the result of incest or rape.

- Court documents or other records that indicate legal proceedings for adoption are pending.

- A written statement from a public or licensed private adoption agency that the applicant/beneficiary is being assisted by the agency to resolve the issue of whether to keep the child or relinquish the child for adoption.

3. **REFERRAL IF GOOD CAUSE CLAIM IS VALID**

If a good cause claim has been approved because of the risk of physical, sexual, or emotional harm to the child for whom support is being sought, then the county may refer these cases to a county or community social services agency, or to the county Mental Health Plan (MHP). (A listing of County MHPs will be in the next revision of Article 6, MEM Procedures.)

4. **NOTICES OF ACTION**

Good cause in medical support is the process by which someone can make a claim that he/she has good cause for not cooperating in medical support enforcement. The claim is documented by filing a CA 51. The Notices of Action (NOA) for good cause are to be used to inform the caretaker parent whether his/her claim has been approved or denied. An applicant may claim good cause if he/she feels that there is a risk of emotional or physical harm to himself/herself or a child(ren) if a referral is made for medical support enforcement. The county will request documentation from the caretaker parent to support the claim of good cause. This information will be sent to the FSD/FSD/DA with the CA 51, and the FSD/DA will investigate further and make a recommendation on the claim. The claim is then returned to the county for a final recommendation of approval or denial of good cause. The applicant is informed of this decision through the NOAs for Good Cause.

(For Notices of Action for Approval or Denial of Good Cause Claims, see Section 23H.)

23F. REFERRAL PROCESS

DHS has adopted the Department of Social Services' (DSS') child support procedures, including the forms and referral process, for the Medi-Cal program. The county welfare department shall refer Medi-Cal Only absent parent cases to the Family Support Division/District Attorney (FSD/DA) for applicable support enforcement services. The county welfare department will also make referrals for paternity establishment services to the FSD/DA when there is a child born out of wedlock. These services will be provided without application or application fee.

All new applicants for Medi-Cal in the appropriate aid codes will be referred **within two days** of the Medi-Cal eligibility determination for medical support enforcement services. No referral is to be made until a Medi-Cal determination is approved. Existing cases will be referred at the time of redetermination. These redeterminations will be face-to-face for proper notification and forms completion by the beneficiary. The county welfare department will inform Aid to Families with Dependent Children (AFDC) recipients of changes related to medical support enforcement. Whenever the county becomes aware that an on-going case is an absent parent situation or there is a child born out of wedlock, a medical support referral should be made. Do not wait for redetermination if there is a change in the case.

Please notify the applicant or beneficiary if he or she receives direct payment for medical support for services which were paid for by Medi-Cal. Payments made in this situation should be forwarded to DHS. If payments are not forwarded to DHS, the Department's Third Party Liability Branch will pursue reimbursement from him or her. (Further information can be found in Section 23M.)

Each applicant for Medi-Cal with an absent parent or a child born out of wedlock will be advised of child support services available through the FSD/DA. If a Medi-Cal applicant indicates all child support services are wanted, the case should be handled in the same manner as a non-aid case, except that medical support is assigned to the State. All current child support collected on behalf of Medi-Cal only families must be paid to the family in accordance with the State's non-AFDC policy.

1. FORMS REFERRAL

For application and referral of Medi-Cal cases to the IV-D agencies, the county shall use the following forms:

- **MC 219 (Cover Sheet) (7/96) and MC 210 (11/96)** - Applicant is advised of rights regarding medical support enforcement referrals and third party liability. A copy is given to applicant; the original is placed in file. If the applicant refuses to sign and cooperate, then a notice of action denying Medi-Cal is sent to applicant.

- **Health Insurance Questionnaire (DHS 6155, 10/90 or later)** - Applicant fills out form if there is other health coverage available through the absent parent. County sends a copy both to DHS Third Party Liability Branch and to the FSD/DA.

- **Child/Spousal and Medical Support Notice and Agreement (CA 2.1 Notice and Agreement (12/89))** - Applicant reviews and signs the agreement. If this form is not signed and good cause is claimed, a CA 51 (Child Support - Good Cause Claim for Noncooperation) must be completed and sent to the FSD/DA with evidence of good cause. If form is signed, then medical support process begins and all documents are sent to FSD/DA via CA 371.

- **Child Support Questionnaire (CA 2.1 Q Support Questionnaire (8/96))** - Applicant fills out form, and original is sent to the FSD/DA within two days. The FSD/DA may set up interview with applicant if form is not complete.

- **Child Support - Good Cause Claim for Noncooperation (CA 51 (3/93))** - If applicant claims good cause for failure to cooperate with medical support enforcement requirements, applicant must fill out the form and send the original with evidence of good cause to the FSD/DA. The FSD/DA will return it to the county with a recommendation. The county will make a final decision and, if good cause is denied, the county will give the applicant an opportunity to withdraw the application, close the case, or be designated as an ineligible member of the MFBU. The county will send a copy of the CA 51 to the FSD/DA with the final determination.

- **Child Support Enforcement Program Notice (CS 196 (5/95))** - A copy shall be given to all applicants who claim Medi-Cal for children with absent parent. This is an information notice which explains child and medical support enforcement program, services available, and rights of applicant.

- **Referral to District Attorney (CA 371 (3/93))** - This is a cover sheet to transmit absent parent information to FSD/DA (one form for each absent parent). The county sends a CA 371 to the FSD/DA with originals of CA 2.1 Questionnaire, CA 51 when good cause is claimed (with evidence), and DHS 6155. This form is used to convey any information regarding the status of the case back and forth between the county and the FSD/DA.

- **Medical Insurance Form (DHS 6110 10/91)** - Applicant fills out this form if there is other health coverage available through the absent parent. The FSD/DA sends the form to DHS Third Party Liability Branch. DHS will then send a copy to county welfare department.

- **Attestation Statement (CS 870)** - The FSD/DA will use the CS 870 to give the applicant an opportunity to attest (swear), under penalty of perjury, that he or she has provided all available information regarding the absent parent. A determination of noncooperation cannot be made without giving the applicant the opportunity to complete this form.

- **Establishing Paternity for You and Your Child (PUB 244 (1/97 Revision))** - An eight-panel brochure that explains what paternity is and how a mother, father, and child will benefit from having paternity established. The brochure can be used in conjunction with the Declaration of Paternity or may be used to provide general information about the program without the Declaration of Paternity.

- **How a Declaration Can Help You and Your New Baby (CS 910 1/97)** - A one-page informational sheet for unmarried parents that provides a brief summary of the paternity declaration process. Parents should be given this form along with the Declaration of Paternity. This is a two-sided form with the English version on one side and the Spanish version on the reverse.

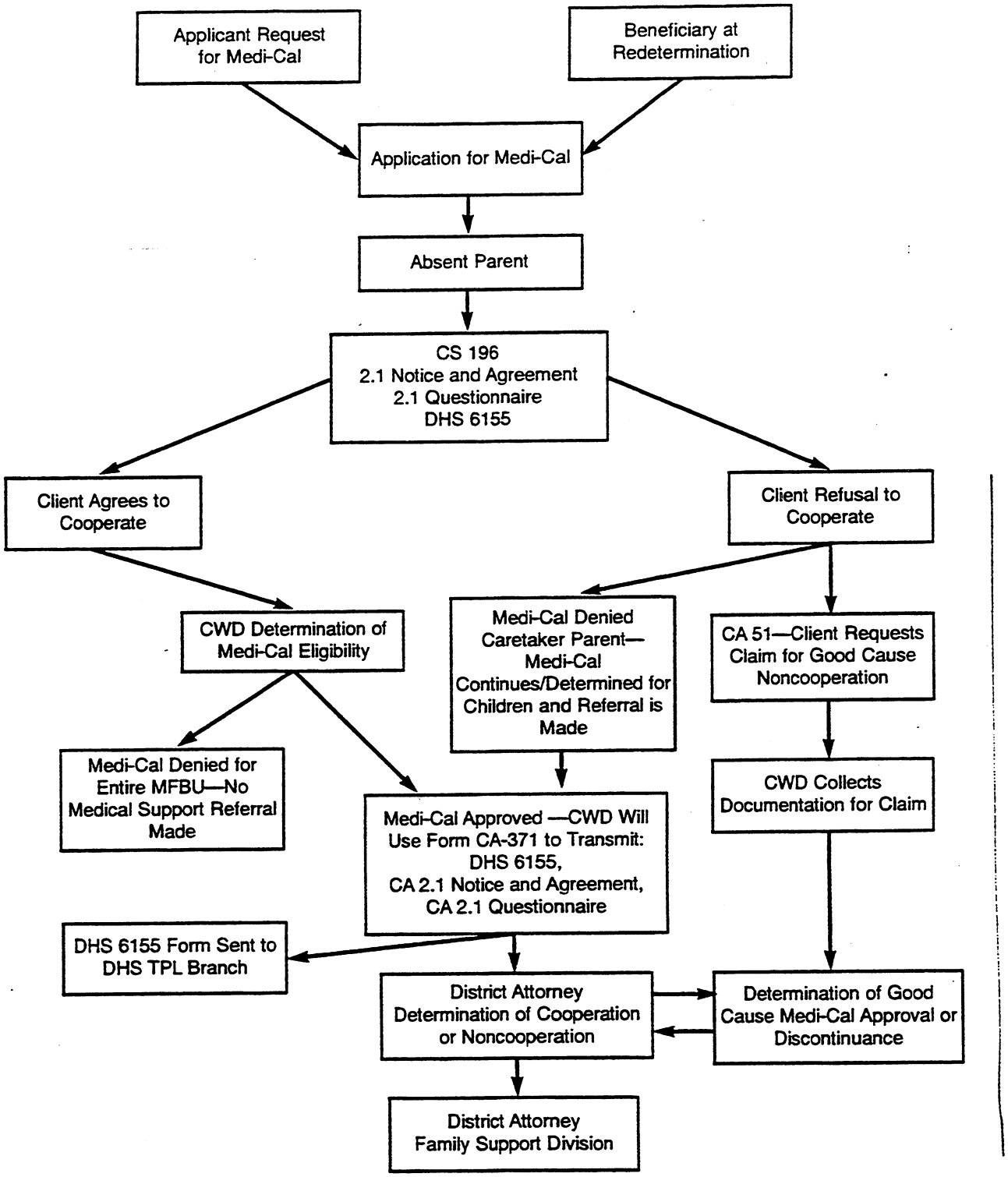
- **Declaration of Paternity (CS 909 1/97)** - A four-part carbonized (NCR) form that when completed, witnessed and officially filed is an acknowledgment of paternity. This form has a blue informational coversheet which contains the heading, **IMPORTANT NOTICE TO UNMARRIED PARENTS**, and an explanation of the purpose of the form. The second page contains instructions for completing and distributing the form. The original is sent to the State Office of Vital Records. The third copy of the Declaration is sent to the local FSD/DA. Copies 1 and 2 are given to the parents. A photocopy may be made for the case file.

NOTE: The county must ask the applicant or beneficiary to state whether he or she wants child support, medical support, or both, and must indicate services requested on the CA 2.1 Questionnaire and on the CA 371. The CA 371 will be used by the county and FSD to communicate subsequent changes or additional information on the case. **THE COUNTY MUST EMPHASIZE TO THE APPLICANT OR BENEFICIARY THAT, FOR RECEIPT OF MEDI-CAL ONLY, CHILD SUPPORT SERVICES ARE AVAILABLE BUT NOT MANDATORY, AND THAT REFUSAL OF CHILD SUPPORT SERVICES WILL NOT AFFECT MEDI-CAL ELIGIBILITY (CS 196 AND CA 2.1).**

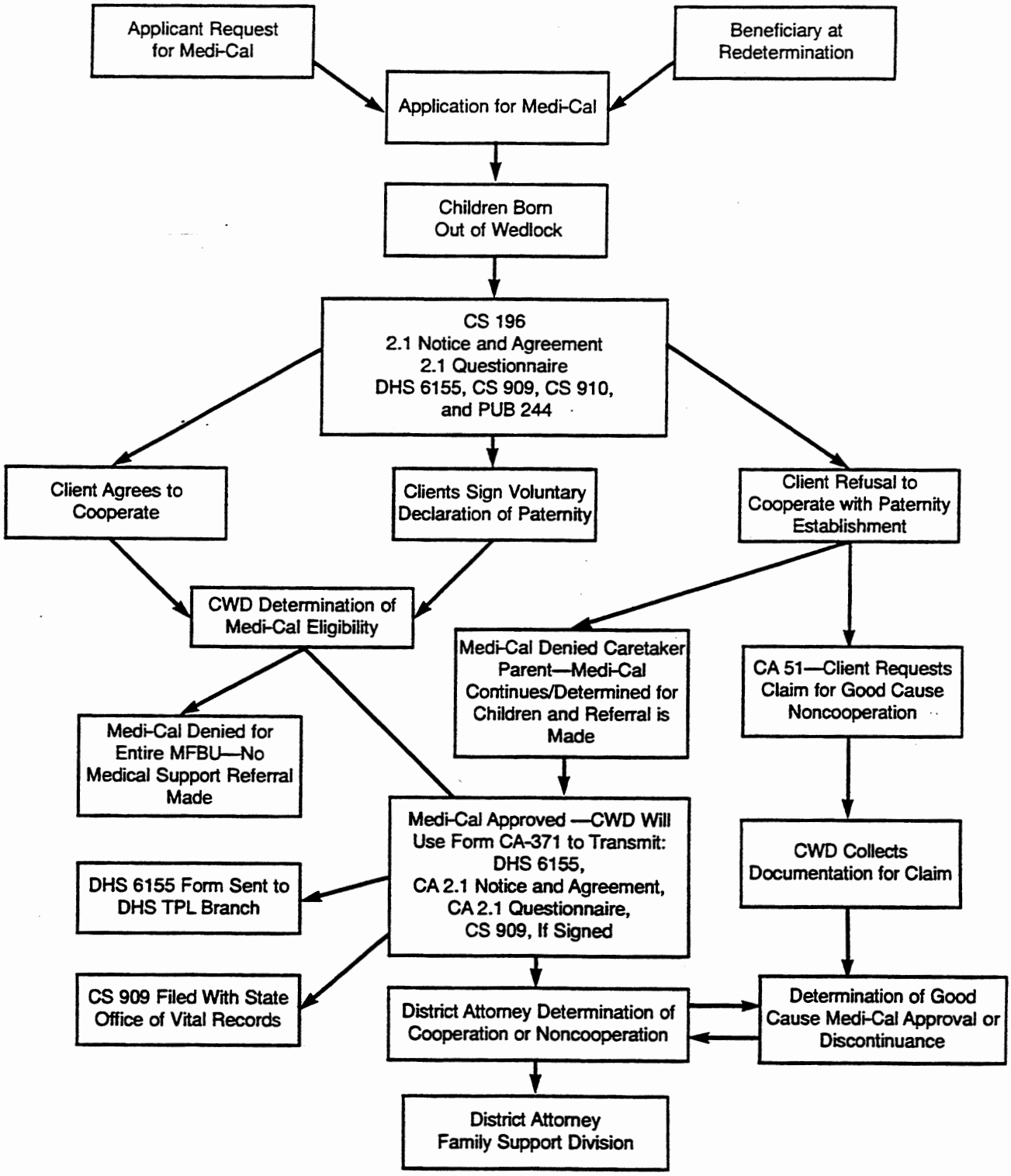
NOTE: Voluntary Paternity Establishment: Send signed Declaration to the State Office of Vital Records. Send copy of Declaration with a CA 371 that it is attached and has been signed.

(The above forms are available in the DHS warehouse, except the for the Voluntary Paternity Declaration forms, which are available through the DSS warehouse. Copies of the forms are shown in Section 23J.)

FORMS REFERRAL CHART—ABSENT PARENT



FORMS REFERRAL CHART—PATERNITY ESTABLISHMENT



23G. HEALTH INSURANCE ASSIGNMENTS, COST SHARING AND MEDI-CAL COPAYMENTS

As a condition of eligibility for Medi-Cal, a beneficiary must assign to the State his or her rights, and the rights of any other Medi-Cal eligible for whom he or she can legally make an assignment, to medical support, health insurance payments, or other third party payments for medical care. This assignment is completed automatically as part of the application process.

The Medi-Cal beneficiary must cooperate with the county and Department of Health Services in obtaining medical support or payments, and cooperate in identifying and providing information to assist medical providers and the State in pursuing third parties who may be liable to pay for medical care and services. Identification of a Medi-Cal beneficiary's other health coverage enables the State to cost avoid medical services and/or to recover from insurance funds previously paid to a provider.

1. HEALTH INSURANCE COST-SHARING

In addition to Medi-Cal, a Medi-Cal beneficiary may also have private health insurance. The private health insurance plan may require a deductible, copayment, and/or coinsurance amount. (A medical support custodial parent is not liable for these charges).

Following are definitions of deductibles, copayments, and coinsurance:

Deductibles

A deductible is the expense that must be incurred by an insured or otherwise covered individual before an insurer will assume any liability for all or part of the remaining cost of covered services. Deductibles are generally fixed dollar amounts and are usually tied to some reference period over which they may be incurred, e.g., $100 per calendar year, benefit period, or spell of illness.

Copayments

A copayment is a type of cost sharing whereby an insured or covered person pays a specified flat amount per service (e.g., $5 per prescription; $10 per office visit). Copayment is incurred at the time the service is received.

Coinsurance

Coinsurance is a cost-sharing requirement under a health insurance policy which provides that the insured will assume a percentage of the costs of covered services. The policy provides that the insurer will reimburse a specified percentage (usually 80 percent) of all or certain services above any deductible. The percent paid may be applied only to a "reasonable" charge. The insured is then liable for the remaining percentage of covered costs and may be liable for charges above those deemed reasonable, until the maximum amount stipulated under the insurance policy is reached.

2. LIABILITY FOR INSURANCE COST SHARING

A provider may not require the beneficiary to pay insurance copayments, deductibles, coinsurance or charges above those deemed reasonable if the provider takes the Beneficiary Identification Card (BIC) and uses it to obtain proof of eligibility through the Automated Eligibility Verification System (AEVS) or bills Medi-Cal.

According to State law, when a provider elects to verify Medi-Cal eligibility using a BIC, a photocopy of a paper identification card or a paper card label, the provider has obtained proof of eligibility and has agreed to accept the patient as a Medi-Cal patient and be bound by the rules and regulations of the Medi-Cal program. And having obtained eligibility verification, the provider must not bill the recipient for all or part of the charge of a Medi-Cal covered service except to collect the Medi-Cal copayment or Share of Cost. Providers must not bill recipients for private insurance cost-sharing amounts such as deductibles, coinsurance or copayments.

Under Federal law (42 U.S.C. Sec. 1396A(25)) health insurance belonging to a Medi-Cal recipient in a child or medical support enforcement case is used as follows:

The provider of service will bill MEDI-CAL. MEDI-CAL will pay the provider of service. Then MEDI-CAL will seek repayment from the other health coverage. The recipient will not be liable for any insurance cost-sharing amount (coinsurance or deductible) unless a MEDI-CAL share of cost must be met. If the other health insurance is a Prepaid Health Plan (PHP) or a Health Maintenance Organization (HMO), the recipient must use the plan facilities for regular medical care. Out of area services or emergency care should also be billed to the PHP/HMO.

In instances where the other health coverage is an HMO, the provider may not seek reimbursement nor attempt to obtain payment for the cost of those covered health care services from the Medi-Cal eligible which are included in the Medi-Cal program's scope of benefits. Medical support beneficiaries are not liable for any copayments or deductibles. (CCR, Title 22, Sec. 51002(a); W&I Code Sec. 14019.4.)

23H. NOTICES OF ACTION

1. **Notices of Action and Speed Letters**

Two formal Notices of Action (NOA) and two Speed Letters for the Medical Support Enforcement Program will be provided to the counties. They are entitled as follows:

- Medi-Cal Notice of Action - Denial of Medi-Cal Benefits for Noncooperation in Medical Support Enforcement
- Medi-Cal Notice of Action - Discontinuance of Medi-Cal Benefits Due to Denial of Good Cause Claim For Noncooperation in Medical Support Enforcement
- Speed Letters - Approval of Good Cause Claim For Noncooperation in Medical Support Enforcement - One approves Claim and FSD/DA will not proceed with support enforcement; One approves Claim, but FSD/DA will proceed with support enforcement

2. **NA BACK 7**

In order to simplify the notice to Medi-Cal Only applicants when Medi-Cal is denied for reasons other than for conditions of medical support, the Child Support paragraph on Form NA Back 7 which is on the back of all Notices of Action will be amended to read:

> "Other information
>
> "Child and/or medical support: The District Attorney's office will help you collect child support even if you are not on cash aid. There is no cost for this help. If they now collect child support for you, they will keep doing so unless you tell them in writing to stop. They will send you any current support money collected. They will keep past due money collected that is owed to the county."

23I. OTHER HEALTH COVERAGE OBTAINED THROUGH MEDICAL SUPPORT ENFORCEMENT

This section provides an overview for the Family Support Division/District Attorney's (FSD/DA) offices in the processing of the DHS 6110 Medical Insurance Form. Item 1-e, Transmittal Letter, and Item 2, County Welfare Department Action, and Item 3-a, Notification, however, describe the county welfare department's role in this process.

1. FSD/DA REPORTING HEALTH INSURANCE COVERAGE

a. Reporting

The availability of health insurance in Medi-Cal eligible family support cases must be reported to Department of Health Services' (DHS) Third Party Liability Branch, Health Insurance Section (HIS). The method used by the FSD/DA's offices to report the availability of health insurance is the DHS 6110 Medical Insurance Form. As part of any court order and family support determination, the parents, employer of the absent parent, other third party providing health insurance to the absent parent, or FSD/DA's office will complete a DHS 6110 form. The DHS 6110 identifies the availability of medical insurance coverage for the dependent child(ren) on public assistance or for whom Medi-Cal is being sought.

b. Procedures

The FSD/DA will:

1. Secure a completed DHS 6110 form for any action against the absent parent in a public assistance case or enforcement proceeding;

2. Ensure the DHS 6110 form is properly completed; and

3. Forward the completed form to DHS for processing.

c. Monitoring, Verifying and Enforcing

The FSD/DA will establish a monitoring system that will ensure that the DHS 6110 forms are completed and returned from the parents, employers, or other third parties who are requested to provide the health insurance information. In addition, verifying the health insurance information will ensure that all dependent children reported to DHS are eligible for coverage under the absent parent's health plan. This information is then used to cost avoid the health insurance benefits or collect from insurance carriers medical payments made by the Medi-Cal program. The FSD/DA must take appropriate action to ensure the responsible parent's obligation to obtain or maintain health insurance for the child(ren) is upheld.

d. Notifying Custodial Parents

The FSD/DA, in all child support and medical support cases, is required to provide the custodial parent with the absent parent's health insurance information.

e. **Transmittal Letter**

After DHS uses the health insurance information provided on the DHS 6110 form to update HIS and MEDS, a transmittal letter and the DHS 6110 form is sent to the appropriate county welfare department for inclusion in the beneficiary's case file.

2. **COUNTY WELFARE DEPARTMENT ACTION**

When the DHS 6110 form and transmittal letter are received from DHS, each county welfare department will take the following actions:

a. Place the DHS 6110 form in the beneficiary's case file.

b. Change the OHC designator in the case file to correspond with the OHC indicator code on MEDS. There is no need to update MEDS because DHS assumes responsibility for updating MEDS in all medical support cases.

c. If the custodial parent of the beneficiary contacts the county to question the health insurance coverage for the dependent child(ren) specified on the Automated Eligibility Verification System (AEVS), explain that the coverage is being provided by the absent parent under court order for child support, and instruct the beneficiary to use the insurance coverage before using Medi-Cal if it is an HMO. If not an HMO, instruct the beneficiary to use the Beneficiary Identification Card (BIC), and Medi-Cal will bill the other health coverage.

3. **LAPSES IN HEALTH COVERAGE**

a. **Notification**

The FSD/DA requests employers of absent parents, county welfare departments, and/or other groups offering health insurance coverage to notify the FSD/DA if there has been a lapse in insurance coverage. In turn, the DHS Health Insurance Section is responsible for ensuring that all FSD/DA's are informed quarterly of any lapses or changes in absent parent health insurance coverage. The FSD/DA will be paid an incentive fee of $50 for each case where the absent parent's health insurance coverage has lapsed and is re-obtained. The re-obtained health insurance should be reported on the DHS 6110 form along with a note on the top of the form stating "**RE-OBTAINED**."

b. **Enforcement**

The FSD/DA will take appropriate action, civil or criminal, to enforce the obligation to obtain health insurance when there has been a lapse in insurance coverage or failure by the responsible parent to obtain insurance as ordered by the court.

4. UTILIZATION OF HEALTH COVERAGE

a. Post Payment Recovery/Pay and Chase

Under Federal Law (42 U.S.C. Section 1396a(25)) health insurance belonging to a Medi-Cal beneficiary in a child or medical support enforcement case is used by the following method, also referred to as "pay and chase":

The provider of service will bill Medi-Cal. Medi-Cal will pay the provider of service. Thereafter, Medi-Cal will seek reimbursement from the other health coverage.

(NOTE: NO CUSTODIAL PARENT AND NO CHILD WHO HAVE AGREED TO COOPERATE WITH MEDICAL SUPPORT ENFORCEMENT ARE TO BE CHARGED A CO-PAYMENT OR DEDUCTIBLE FROM A HEALTH INSURANCE PROVIDER. MEDI-CAL WILL PAY THE CO-PAYMENT AND/OR DEDUCTIBLE (See Article 23G-1 and G-2).)

b. Cost Avoidance

When the other health insurance is a Prepaid Health Plan (PHP) or a Health Maintenance Organization (HMO), however, the dependent must utilize the plan's facilities for regular medical care. Out of area services or emergency care for such dependents are billed to the PHP/HMO. Again, no custodial parent is to pay co-payments and/or deductibles in these instances.

5. DISTRICT ATTORNEY HEALTH INSURANCE INCENTIVE

a. Policy

Effective October 1, 1993, the California Department of Social Services (CDSS) began paying the FSD/DAs an incentive of $50/case for reporting health insurance coverage obtained as a result of enforcement activities for dependent children. Health insurance includes any third party insurance policy that provides coverage or benefits payable for:

Scope Code	Service Type	Services Covered
O	Outpatient	Hospital outpatient (e.g., lab work or physical therapy)
I	Inpatient	Hospital stays
M	Medical	Medical doctor visits
P	Prescriptions	Prescription drugs
L	Long-term care	Long-term care (e.g., nursing home) or coverage for a specific illness (e.g., cancer)
D	Dental	Dental coverage
V	Vision	Vision care

(NOTE: Health insurance does not include insurance coverage for automobile insurance, indemnity policies or periodic benefits for disability, hospitalization or income protection, coverage limited to a specific circumstance (e.g., accidental injury or dismemberment), Medicare, or Medi-Cal capitated health care plans and initiatives. For a more comprehensive list, please refer to the Medi-Cal Eligibility Manual, Article 15A.)

b. **Reporting Process**

DHS will use the obtained health insurance coverage information reported by the FSD/DA on the Medical Insurance Form (DHS 6110) and provide CDSS with a quarterly county-by-county listing of the number of health insurance carriers which have been added to their computer system. The county-by-county list will be used by CDSS to pay health insurance incentives to the FSD/DAs for the health insurance carrier information reported to DHS and provided to Aid to Families with Dependent Children, Foster Care, and Medically Needy Only custodial parents.

CDSS will pay these incentives to FSD/DAs on a quarterly basis. If the health insurance coverage information provided by the FSD/DA was previously known by DHS, the duplicate health insurance carrier information will not be counted, and the DHS 6110 form will be destroyed by DHS.

DHS will, however, return to the initiating county the DHS 6110 forms that are rejected because they cannot be entered into the Health Insurance System (HIS). The rejected documents will be returned weekly with a cover letter explaining the rejection reason. (See Section 23J-15 for a copy of the rejection letter.)

The causes for rejection include:

- No MEDS record found: Eligibility has not, as yet, been established on MEDS. The county welfare department must establish Medi-Cal eligibility before re-submission of the DHS 6110.
- Medi-Cal eligibility not established: The record was found on MEDS, but not eligible for Medi-Cal. Re-submit the DHS 6110 only after the county welfare department has determined the case to be eligible for Medi-Cal.
- Incomplete/Illegible form: The DHS 6110 was incomplete or illegible. Re-submit the DHS 6110 after completing or rewriting the items highlighted on the form.
- Other: Non-Codeable Insurance: Insurance could not be coded into the DHS HIS for other reasons (i.e., out of country carrier, initial report of an HMO with a termination date prior to submission, life insurance, etc.)

For additional information on DA Health Insurance Incentives, see FSD/DA Letter No. 93-24 (November 5, 1993.)

23J. MEDICAL SUPPORT FORMS

State of California—Health and Human Services Agency

Department of Health Services

HEALTH INSURANCE QUESTIONNAIRE

Please provide all the information requested and return this form to your eligibility worker. Use and attach a copy of your insurance policy, membership card, or any other aid to help complete this questionnaire. PLEASE TYPE OR PRINT. DO NOT ABBREVIATE. Additional instructions and information collection and access are on the reverse. If you have any questions about completing this form or require Spanish translation, call toll-free 1-800-952-5294 (8:00 a.m. to 5:00 p.m.).

COMPLETE THIS FORM FOR ANY HEALTH INSURANCE, INCLUDING MEDICARE SUPPLEMENTS, PREPAID HEALTH PLANS/HEALTH MAINTENANCE ORGANIZATIONS, OR CHAMPUS. HAVING PRIVATE HEALTH INSURANCE DOES NOT AFFECT YOUR MEDI-CAL ELIGIBILITY. HOWEVER, FAILURE TO REPORT OTHER HEALTH INSURANCE MAY BE CAUSE FOR TERMINATION OF YOUR MEDI-CAL ELIGIBILITY.

Case name	FOR COUNTY USE ONLY	STATE USE ONLY	
Case address	Worker number	Verified by	
	Date	Date	Initials
	Worker telephone number ( )	Date	Initials
☐ Initial Intake ☐ Redetermination ☐ HIPP	Optional: Disenrollment number	Scope	CC number

SECTION I: Beneficiary Information *LIST ALL PERSONS, INCLUDING UNBORNS, ON MEDI-CAL AND COVERED BY HEALTH INSURANCE POLICY*

OHC	Beneficiary Name (First, Middle, Last)	Social Security Number	Sex	Date of Birth	14-DIGIT MEDI-CAL NUMBER: Co. Code	Aid Code	Case Number	FBU	Pers No
		– –							
		– –							
		– –							
		– –							
		– –							
		– –							

SECTION II: Health Insurance Information

1. What is the name and address of your health insurance company? Include street number, city, state, and ZIP. Do not use abbreviations.
   Name _____
   Address _____
   City, State, ZIP _____
2. Do you have to obtain medical services from a specific facility or a group of providers? (PHP/HMO/PPO) ☐ Yes ☐ No
3. Where do you send your claims?
   Name _____
   Address _____
   City, State, ZIP _____
4. What is the full name, address, phone number, and SSA number of individual employee, union member, or person to whom the insurance policy was issued?
   Name _____ Social security number _____
   Address _____ Telephone number ( )
   City, State, ZIP _____ Absent parent? ☐ Yes ☐ No
5. What is the policy number? _____
6. What are/were the dates of your policy? Beginning date _____ Ending date (if applicable) _____
   ☐ Medical coverage available through employer, but has not been applied for
7. Premium amount, $ _____ ☐ Monthly ☐ Quarterly ☐ Yearly
   How are premiums paid? ☐ By insured to insurance carrier ☐ By employer ☐ By payroll deduction
8. Give name, address, and telephone number of union, employer, group, organization, or school.
   Name _____ Local or group number _____
   Address _____ Telephone number ( )
   City, State, ZIP _____
9. Does any covered beneficiary have an acute, chronic, or pre-existing illness that requires him/her to see a physician? ☐ Yes ☐ No
   If yes, please specify the illness. _____
10. Does your health insurance provide or pay for: (Check all that apply.)
    ☐ Hospital outpatient (i.e., lab work/physical therapy) ☐ Prescription drugs ☐ Long-term care/nursing home
    ☐ Hospital stays ☐ Dental care ☐ Only specific illness (i.e., cancer)
    ☐ Doctor visits ☐ Vision care Type of illness _____
11. Is the policy a Medicare Supplement? ☐ Yes ☐ No

Remarks.

"By signing this document, I hereby authorize the California Department of Health Services to obtain, if needed, any information regarding my private health insurance coverage, including payments and/or benefits for medical care made in my behalf, to be used in determining whether the Department will pay my private health insurance premium."

Signature of applicant	Home telephone	Work telephone	Date
	( )	( )	

RETURN COMPLETED FORM TO: THIRD PARTY LIABILITY BRANCH, MS 4719, P.O. BOX 997422, SACRAMENTO, CA 95899-7422

Original—State Copy—County File Copy—Beneficiary

DHS 6153 (9/04)

INSTRUCTIONS

Section I: Beneficiary Information

List the names (first, middle, last) of all persons on Medi-Cal and covered by the health insurance policy Also, list each person's Social Security number, sex and date of birth If any person listed is expecting a child, on the last available line, put "unborn" in the name section and the expected date of arrival in the date of birth section. Enter Medi-Cal numbers, if known, otherwise, your eligibility worker will complete that section.

Section II: Health Insurance Information

Item No 1· Enter the full name and mailing address of your insurance company (Include street address and/or P O Box, city, state, and ZIP) DO NOT USE ABBREVIATIONS!

Item No 2 Check the appropriate box if you have to obtain medical services from a specific facility or a group of providers (Prepaid Health Plans [PHP], Health Maintenance Organizations [HMO], Preferred Providers Organizations [PPO])

Item No 3· Enter the complete name and mailing address where your health insurance claims are sent Only complete if different from the answer to Item No.1

Item No 4 Enter the full name, mailing address, telephone number, and social security number of the individual, employee, union member, retired employee, or person to whom the insurance policy is or was issued (insured) Check the appropriate box for an absent parent.

Item No 5 Enter the number the insurance company needs to identify the policy. This number is sometimes called: subscriber, certificate, account, employee, group, and local number

Item No 6· Enter the date (month/day/year) the insurance policy began and date terminated If known, enter the policy lapse dates, and check the box if medical coverage is available through an employer which has not been applied for

Item No 7 Enter the premium amount, check the box if they are paid per month quarter or year, and how the premiums are paid Check appropriate box(es)

Item No 8: If the policy is purchased through a union, employer group, organization, or school, enter the name, address, telephone number, local or group number, if known.

Item No 9. Check the box "YES" or "NO" if any covered beneficiary has an acute or chronic pre-existing illness that requires him or her to see a physician Specify the illness

Item No 10 Read and check items which apply to your insurance coverage.

Item No 11. Read and check yes or no.

Signature Section Please sign the form and give your home and/or work telephone number If you do not have a telephone please put a message number in the home telephone box Also enter the date when you completed this form

IMPORTANT: As a condition of eligibility, all Medi-Cal beneficiaries shall assign rights to medical insurance, support, or other third-party payments to the Medi-Cal program and shall cooperate with the California Department of Health Services in obtaining medical support or payments. The assignment of rights to benefits is effective only for services paid for by the Medi-Cal program. Assignment of medical rights allows the California Department of Health Services to recover funds from health insurance companies or funds when the Medi-Cal program pays for medical services which should have been billed to such other health insurance coverage Please note that in order to comply with the Federal Privacy Act (42 USC Section 552a), your social security number and any information you provide may be used to contact insurance companies, employers, providers of health care services, and county agencies to determine the extent of available health insurance. Under Welfare and Institutions Code, Section 14100 2, any submitted information is considered confidential and disclosed only as necessary for Medi-Cal program administration purposes.

INFORMATION COLLECTION AND ACCESS

Sections 50761 and 50763 of Title 22, California Code of Regulations (CCR), requires recipients to report other health coverage to which they are entitled.

The information requested is necessary to make possible the recovery of health insurance or other contractual or legal entitlements as provided in Welfare and Institutions Code, Sections 10020 through 10025, 14024, 14103, and 14124 70, from persons liable thereunder

Information concerning your health coverage is maintained by the Chief of the Recovery Branch, by authority of the Welfare and Institutions Code, Section 14011, and Title 22, California Code of Regulations, Section 50769 All information is mandatory.

Section 14023 of the Welfare and Institutions Code provides that any public assistance recipient who has any other contractual or legal entitlement to any health care service and who willfully refuses to disclose this information by withholding important information regarding other medical entitlement is guilty of a misdemeanor Medi-Cal is the payor of last resort. Additionally, Section 50175 of Title 22 (CCR) provides for denial or discontinuance of benefits if the recipient does not cooperate in providing health insurance information

2. CA 2.1

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

CHILD/SPOUSAL AND MEDICAL SUPPORT NOTICE AND AGREEMENT

Assignment and Cooperation Requirements

You must assign to the county any rights you may have to child or spousal support payments while you are receiving Aid to Families with Dependent Children (AFDC) and any rights you may have to medical support to the state while you are receiving Medi-Cal. The receipt of an AFDC check and/or a Medi-Cal card will assign the past and present support rights of all persons for whom you are requesting AFDC and/or Medical Assistance. At your request, the county will provide information to you on the amount of support paid to the county by the absent parent(s).

You must cooperate with the County Welfare Department and the District Attorney:

- In identifying and locating any absent parent in your case;
- In establishing the paternity of any child in your case when necessary;
- In obtaining from any absent parent medical support payments and, if you receive AFDC, child/spousal support payments;
- By turning over to the county district attorney any medical support payments given to you on or after this date; and if you receive AFDC, any child/spousal support payments given to you on or after this date;
- By informing the county about medical coverage or payment for medical services paid by the absent parent on or after this date.

When requested to do so you must:

- Complete the Child Support Questionnaire (Form CA 2.1).
- Complete a statement (CS 870) under penalty of perjury. If you sign the form and you don't give all the facts or you give the wrong information, you could be fined and/or imprisoned.
- Agree to cooperate in the support enforcement process or to claim good cause for refusing to cooperate.
- Appear at the County Welfare Department or District Attorney's Office to sign papers or provide necessary information.

Benefits of Support Enforcement:

Your cooperation may be of value to you and your child(ren) because finding the absent parent and establishing paternity may give you and your child(ren) rights to future social security, veterans, or other benefits. The District Attorney will continue to help enforce support after you go off AFDC or Medi-Cal unless you make a request in writing to the District Attorney to stop.

You have the right:

- To claim Good Cause if you have an acceptable reason for refusing to cooperate in the support enforcement process.
  If you feel that cooperating would not be in the best interests of your child(ren), you may refuse to cooperate and claim Good Cause. The back of this form explains your right to claim Good Cause in more detail. If you think you might have Good Cause, ask your eligibility worker to explain it to you before signing below.

- To show you are cooperating by filling out and signing a statement (CS 870) under penalty of perjury that you have given all the facts you know about the absent parent(s).

Penalty Provision:

If you refuse to assign support rights, if you refuse or fail to turn over to the county any support given to you by the absent parent(s), or if you refuse to cooperate in the support enforcement process without Good Cause, the following will apply.

If you are an applicant/recipient of AFDC:

- You will be ineligible for AFDC, but your child(ren) may still be eligible. Their grant will go to another person called a protective payee who will pay the child(ren)'s living expenses, and
- Your case will be referred to the District Attorney.
- You will be ineligible for Medi-Cal benefits, but your child(ren) may still be eligible.

If you are an applicant/recipient of Medi-Cal Only:

- You will be ineligible for Medi-Cal benefits, but your child(ren) may still be eligible.

Agreement:

☐ I agree to cooperate with the County Welfare Department and the District Attorney as specified above.
☐ I claim Good Cause and refuse to cooperate at this time.
☐ I refuse to assign child/spousal support rights (AFDC).
☐ I refuse to assign medical support rights (AFDC and Medi-Cal only cases).

I understand my rights and responsibilities as described above, including the requirement that I assign support rights to the county. I also understand my right to claim Good Cause.

Signature of Applicant or Recipient _____ Date _____

I certify that I have notified the applicant or recipient of his or her rights and responsibilities by means of this notice and verbally as needed.

Eligibility Worker's Signature _____ Eligibility Worker Number _____ Date _____

CA 2.1 Notice and Agreement (12/89) Required Form - No Substitutes Permitted

SC 50651

YOUR RIGHT TO CLAIM GOOD CAUSE

The only reasons for claiming Good Cause

- Cooperation is expected to result in serious physical harm to the child(ren);
- Cooperation is expected to result in serious emotional harm to the child(ren);
- Cooperation is expected to result in physical harm to you which is so serious that it reduces your ability to care for the child(ren) adequately;
- Cooperation is expected to result in emotional harm to you which is so serious that it reduces your ability to care for the child(ren) adequately;
- The child(ren) were conceived due to incest or forcible rape;
- Court proceedings are going on for the adoption of the child(ren); or
- You are working with a social agency to help you decide whether to place the child(ren) for adoption and the counseling sessions have not gone on for more than three months.

How to Claim Good Cause

If you want to claim Good Cause, you must tell your eligibility worker. You can do this whenever you believe you have Good Cause not to cooperate. You must also complete and sign the Good Cause claim form which your eligibility worker will give to you.

If you claim Good Cause you must:

- Give the County Welfare Department evidence needed to determine if you have Good Cause for refusing to cooperate. (If your reason for claiming Good Cause is your fear of physical harm and it is impossible to obtain evidence, the County Welfare Department may still be able to make a Good Cause determination after investigating your claim.)
- Give the necessary evidence within 20 days of claiming Good Cause. The County Welfare Department will only give you more time when it decides that more than 20 days are required to get the evidence.

What is Acceptable Evidence?

The following are examples of acceptable evidence the County Welfare Department can use to determine if Good Cause exists. If you need help in getting a copy of any of the documents your eligibility worker will help you.

- Birth certificates, or medical or law enforcement records which indicate that the child was conceived due to incest or forcible rape;
- Court documents or other records which indicate that legal proceedings for adoption are pending in court;
- Records which indicate that the absent parent or alleged father might inflict physical or emotional harm on you or the child(ren);
- Medical records which indicate your or your child(ren)'s emotional health history and present health status; or written statements from mental health professionals giving a diagnosis or prognosis on your or your child(ren)'s emotional health.
- A written statement from a social agency confirming that you are being helped to decide whether to place the child for adoption; and,
- Sworn statements from people who know the circumstances of your Good Cause claim. These people could be friends, neighbors, clergymen, social workers and others.

The County Welfare Department Decides Your Claim

The County Welfare Department will:

- Decide your claim based on the evidence you give, or
- Conduct an investigation to verify and decide your claim. (You may be required to give information such as the absent parent or alleged father's name and address. The County Welfare Department will not contact the absent parent or alleged father without first telling you.)

District Attorney's Participation

The District Attorney may review the County Welfare Department's findings and the basis for a Good Cause determination in your case. If you request a hearing on the issue of Good Cause, the District Attorney may participate in that hearing.

If the County Welfare Department decides you have Good Cause for not cooperating, the District Attorney may try to establish paternity or collect support only if the County Welfare Department decides that this can be done without risk to you or your child(ren). This will not be done without first telling you.

The District Attorney will not pursue child support enforcement activities until the final determination regarding your Good Cause claim has been made by the County Welfare Department.

3. CA 2.1 Q

STATE OF CALIFORNIA – HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

SUPPORT QUESTIONNAIRE

Instructions:

You must answer all questions and fill in all the blanks.
COMPLETE ONE FORM FOR EACH PARENT ABSENT FROM THE HOME OR EACH UNMARRIED FATHER IN THE HOME.
Use ink. Print answer. Check Yes, No, or Unknown.
Use a separate piece of paper if you need more room.

FOR COUNTY USE ONLY	
CWD CASE NAME	FSD CASE NAME
CWD CASE NUMBER	FSD CASE NUMBER
CWD WORKER NAME AND	FSD WORKER NAME AND
TELEPHONE NUMBER ( )	TELEPHONE NUMBER ( )

SECTION 1 - COMPLETE THE FOLLOWING ABOUT YOURSELF

NAME (FIRST, MIDDLE, LAST) | MAIDEN NAME | SEX | BIRTHDATE | BIRTH PLACE | RACE

HOME STREET ADDRESS, APARTMENT NUMBER | CITY | STATE | ZIP | TELEPHONE NUMBER ( )

YOUR RELATIONSHIP TO CHILDREN | YOUR RELATIONSHIP TO ABSENT PARENT/UNMARRIED FATHER IN THE HOME ☐ Spouse ☐ Ex-Spouse ☐ Friend ☐ Other

SECTION 2 - COMPLETE THE FOLLOWING ABOUT THE PARENT ABSENT FROM THE HOME OR UNMARRIED FATHER IN THE HOME

A. NAME (FIRST, MIDDLE, LAST) | SSN | ☐ MALE ☐ FEMALE | BIRTHDATE | BIRTH PLACE

LAST KNOWN STREET ADDRESS, APARTMENT NUMBER | HEIGHT | WEIGHT | EYE COLOR | HAIR COLOR | RACE

CITY | STATE | ZIP | SCARS, BIRTHMARKS, TATTOOS, NICKNAMES, ETC

WHEN WAS THIS ADDRESS CURRENT? | TELEPHONE NUMBER ( ) | WHEN DID YOU LAST HEAR FROM OR GET MAIL FROM THIS PARENT? | DOES THIS PARENT LIVE WITH YOU? ☐ YES ☐ NO

B. WHAT KIND OF INCOME DOES ABSENT PARENT HAVE? ☐ Earnings ☐ UIB/DIB ☐ Social Security ☐ None ☐ Other

LAST KNOWN EMPLOYER | TELEPHONE NUMBER ( )

STREET ADDRESS | TYPE OF WORK

CITY | STATE | ZIP | UNION MEMBER? ☐ YES, UNION NAME ☐ NO ☐ UNKNOWN

WHEN DID THIS PARENT LAST WORK HERE? | UNION ADDRESS

C. DOES THIS PARENT HAVE HEALTH INSURANCE FOR THE CHILDREN? ☐ YES ☐ NO ☐ UNKNOWN | WHO IS COVERED?

NAME OF INSURANCE | POLICY NUMBER | DATE OF COVERAGE

D. PARENTS ARE ☐ NOT MARRIED ☐ MARRIED ☐ SEPARATED ☐ LIVING TOGETHER ☐ DIVORCED WHEN/WHERE:

E. IS THERE A COURT ORDER FOR SUPPORT? ☐ YES ☐ NO ☐ PENDING | AMOUNT ORDERED $ | HOW OFTEN? | DATE OF COURT ORDER | COURT ORDER NUMBER | LOCATION OF COURT (COUNTY & STATE)

HOW DOES THE PARENT PAY? ☐ TO YOU ☐ TO COUNTY ☐ PAYS HOUSEHOLD BILLS ☐ PAYROLL DEDUCTION ☐ OTHER | WHEN DID PARENT LAST PAY? | HOW MUCH? $

F. NAME OF A FRIEND OR RELATIVE OF ABSENT PARENT | RELATIONSHIP TO ABSENT PARENT | TELEPHONE NUMBER ( )

ADDRESS (NUMBER AND STREET) | CITY | STATE | ZIP

G. DOES THIS PARENT OWN ANY MOTOR VEHICLES? ☐ YES ☐ NO ☐ UNKNOWN | MAKE | MODEL | YEAR | LICENSE NO | STATE

H. DOES THIS PARENT OWN A HOUSE, LAND, BUILDINGS, OR BANK ACCOUNTS ☐ YES ☐ NO ☐ UNKNOWN | WHAT/WHERE

I. IS THIS PARENT CURRENTLY ON PROBATION OR PAROLE? ☐ YES ☐ NO ☐ UNKNOWN | WHAT COUNTY OR STATE?

J. HAS THIS PARENT EVER BEEN IN JAIL OR PRISON? ☐ YES ☐ NO ☐ UNKNOWN | IF YES, WHEN/WHERE

K. HAS THIS PARENT EVER BEEN IN THE MILITARY ☐ YES ☐ NO ☐ UNKNOWN | IF YES, WHEN/WHAT BRANCH

SECTION 3 - CHILDREN (IN YOUR HOME) OF THIS ABSENT PARENT OR UNMARRIED FATHER

NAME OF CHILD	M F	SSN	BIRTHDATE	BIRTHPLACE	MC# (FOR COUNTY USE ONLY)
NAME OF CHILD	M F	SSN	BIRTHDATE	BIRTHPLACE	MC#
NAME OF CHILD	M F	SSN	BIRTHDATE	BIRTHPLACE	MC#
NAME OF CHILD	M F	SSN	BIRTHDATE	BIRTHPLACE	MC#

SECTION 4 - SUPPORT ENFORCEMENT SERVICES (MEDI-CAL ONLY)

☐ I don't want other child support enforcement services.

SIGNATURE | DATE

1st Copy - Family Support Division
2nd Copy - County Welfare Department
3rd Copy - Applicant

CA 2.1 (Q) (7/89) Support Questionnaire Required Form-No substitute permitted

4. **CA 51**

STATE OF CALIFORNIA — HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

CHILD SUPPORT — GOOD CAUSE CLAIM FOR NONCOOPERATION
MANTENIMIENTO DE HIJOS — RECLAMACION DE MOTIVO JUSTIFICADO PARA NO COOPERAR

I feel that cooperating in establishing paternity and obtaining support would not be in the best interest of the child(ren) for whom aid is requested because:

I expect it to result in: A) ☐ Physical
B) ☐ Emotional harm to the child(ren).

I expect it to result in: C) ☐ Physical
D) ☐ Emotional harm to me which is so serious that it reduces my ability to adequately care for the child(ren).

E. ☐ The child(ren) were conceived due to incest or forcible rape.

F. ☐ Court proceedings are going on for the adoption of the child(ren).

G. ☐ I am working with a social agency helping me decide whether to place the child(ren) for adoption and the counseling sessions have not gone on for more than three months.

Creo que el cooperar para establecer la paternidad y obtener mantenimiento, no sería de óptimo beneficio para el niño(s) para el cual se está solicitando asistencia porque:

Estoy segura que resultará en daño: A) ☐ físico
B) ☐ emocional daño para el niño(s).

Estoy segura que resultará en daño: C) ☐ físico
D) ☐ emocional para mí el cual es tan grave que reduce mi capacidad para poder cuidar al niño(s) adecuadamente.

E. ☐ El niño(s) fue concebido como resultado de incesto o violación.

F. ☐ Actualmente se está gestionando en la corte la adopción del niño(s).

G. ☐ Estoy laborando con una agencia de servicio social para que me ayude a decidir si coloco al niño(s) para adopción, y las sesiones de orientación no se han llevado a cabo durante más de tres meses.

County Use Only
Sólo para Uso del Condado

CASE NAME

CASE NUMBER

NAME OF CHILD(REN) INVOLVED

ABSENT PARENT INVOLVED

EVIDENCE PROVIDED
☐ No investigation
☐ No evidence provided
☐ Birth certificate
☐ Medical records
☐ Court documents
☐ Social agency letter
☐ Mental health professional letter
☐ Sworn statement from other person
☐ Other

PUTATIVE FATHER CONTACT
☐ Applicant/Recipient informed in advance

Applicant/Recipient:
☐ Provided more evidence
☐ Withdrew application
☐ Requested discontinuance
☐ Requested claim be denied

"I want to claim Good Cause for refusing to cooperate for the reason(s) checked above. I understand that I may be asked to prove that I have Good Cause for refusing to cooperate."

"Quiero invocar un motivo justificado para negarme a cooperar por las razones marcadas arriba. Entiendo que se me puede pedir que demuestre que tengo un motivo justificado para negarme a cooperar."

SIGNATURE OF APPLICANT OR RECIPIENT
FIRMA DEL SOLICITANTE O PERSONA QUE RECIBE LOS BENEFICIOS

DATE
FECHA

DATE PUTATIVE FATHER CONTACTED

County Use Only/Sólo para Uso del Condado

THIS CLAIM IS FOR: ☐ CHILD SUPPORT ☐ MEDICAL SUPPORT

TO DA REPRESENTATIVE

IF APPLICANT/RECIPIENT IS NOT PARENT: INDICATE RELATIONSHIP

DATE OF APPLICATION

PROPOSED DETERMINATION
Good Cause: ☐ does not exist ☐ does exist based on (Enter A, or B, or C . . . from above): _____
COMMENTS:

Support Enforcement:
☐ may ☐ may not proceed without applicant's or recipient's participation

REPLY TO COUNTY WELFARE DEPARTMENT REPRESENTATIVE

WORKER NUMBER

DATE

PROPOSED DETERMINATION
Good Cause: ☐ does not exist ☐ does exist based on (Enter A, or B, or C . . . from above): _____
COMMENTS:

Support Enforcement:
☐ may ☐ may not proceed without applicant's or recipient's participation

DA FILE NUMBER

DA REPRESENTATIVE'S SIGNATURE

TELEPHONE

DATE

FINAL DETERMINATION
Good Cause: ☐ does not exist ☐ does exist based on (Enter A, or B, or C . . . from above): _____
AFDC status at the time of Good Cause determination: ☐ Applicant ☐ Recipient ☐ Medi-Cal Only
☐ Applicant has withdrawn application for AFDC. ☐ Applicant has withdrawn application for Medi-Cal.
☐ This case has been discontinued effective _____. Reason(s):

Support Enforcement:
☐ may ☐ may not proceed without applicant's or recipient's participation

DATE

COUNTY WELFARE DEPARTMENT REPRESENTATIVE SIGNATURE

DATE OF DECISION

SUPERVISOR'S SIGNATURE

DATE OF DECISION

STATISTICAL SUMMARY *(Instructions for completing section are on the back of this page)*

☐ CLAIM OR APPLICATION WITHDRAWN OR AID DISCONTINUED (COMPLETE 1 AND 2 ONLY) — DATE WITHDRAWN

☐ FINAL DETERMINATION (COMPLETE 1-6 IF GOOD CAUSE EXISTS OR 1,2,7, AND 8 IF GOOD CAUSE DOES NOT EXIST) — DATE OF DETERMINATION

1 STATUS AT TIME OF CLAIM
☐ APPLICANT ☐ RECIPIENT _____ (DATE OF CLAIM)

2 WAS CLAIM BASED ON PHYSICAL HARM WITHOUT EVIDENCE? ☐ YES ☐ NO

3. ☐ GOOD CAUSE EXISTS BASED ON: (✓ ONE ONLY).
A ☐ PHYSICAL HARM TO CHILD(REN)
B ☐ EMOTIONAL HARM TO CHILD(REN)
C ☐ PHYSICAL HARM TO CARETAKER
D ☐ EMOTIONAL HARM TO CARETAKER
E ☐ INCEST OR FORCIBLE RAPE
F ☐ LEGAL ADOPTION BEFORE COURT
G ☐ PREADOPTION SERVICES

4 WAS DETERMINATION BASED ON PHYSICAL HARM WITHOUT EVIDENCE? ☐ YES ☐ NO

5 WAS DETERMINATION BASED SOLELY ON EXAMINATION OF EVIDENCE WITHOUT INVESTIGATION? ☐ YES ☐ NO

6 MAY ENFORCEMENT PROCEED WITHOUT APPLICANT/RECIPIENT PARTICIPATION? ☐ YES ☐ NO

7 ☐ GOOD CAUSE DOES NOT EXIST.

8 WAS CLAIMANT AN APPLICANT AT TIME OF CLAIM, BUT A RECIPIENT AT FINAL DETERMINATION? ☐ YES ☐ NO

CA 51 (10/93) REQUIRED FORM — SUBSTITUTE PERMITTED

INSTRUCTIONS

INDIVIDUAL CASE REPORT

The statistical summary section is to be completed when a final claim determination is made or when a claim is withdrawn. A claim is considered withdrawn if the applicant/recipient withdrew the claim; withdrew the application; requested discontinuance; or if the county cancelled or otherwise disposed of the claim before a final determination is made.

CLAIM WITHDRAWN - If claim or application was withdrawn or aid discontinued, check (✓) box and enter date when claim was withdrawn. Complete items 1 and 2 and leave rest of items blank.

FINAL DETERMINATION - If a final determination was made, check (✓) box and enter date when the final determination was made. Complete items 1 - 6 if determined that good cause exists or items 1, 2, 7 and 8 if determined that good cause does not exist.

1. Enter date when claim was made and check (✓) appropriate status box
   - check "applicant" for a new application or restoration.
   - check "recipient" for a redetermination or intercounty transfer.

2. Based on the claim made, determine if YES or NO and check (✓) appropriate box
   - check YES if reason given was physical harm to child and/or caretaker and no evidence was available, i.e., evidence does not exist.
   - otherwise, check NO.

   NOTE: If more than one reason was given and one of the reasons was physical harm to child and/or caretaker, then:
   - check YES if the final determination was based solely on the physical harm to child and/or caretaker without any evidence.
   - otherwise, check NO.

3. If determined that good cause exists, check (✓) box.

3A - 3G. Check (✓) only one box for the good cause circumstance (reason). The good cause circumstance is the one upon which the county's findings determines that good cause exists. If based on more than one circumstance, check the most significant.

4. Based on the final determination that good cause exists, determine if YES or NO and check (✓) appropriate box
   - check YES if based solely on physical harm to child and/or caretaker without any evidence.
   - otherwise check NO.

   NOTE: If checked YES, then item 2 must be checked YES and item 5 must be checked NO.

5. Based on the final determination that good cause exists, determine if YES or NO and check (✓) appropriate box
   - check YES if based on evidence only, i.e., no investigation was conducted
   - otherwise check NO.

   NOTE: If checked YES, then item 2 and 4 must be checked NO.

6. Based on the final determination that good cause exists, determine if YES or NO and check (✓) appropriate box
   - check YES if determined that enforcement may proceed without applicant/recipient participation.
   - otherwise check NO.

   NOTE: If checked YES, then item 2 and 4 must be checked NO.

7. If determined that good cause does not exist, check (✓) box.

8. Based on the final determination that good cause does not exist, determine if YES or NO and check (✓) appropriate box
   - check YES if determined that good cause does not exist but claimant's application or restoration request already had been approved.
   - otherwise check NO.

5. **CS 196**

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY | DEPARTMENT OF SOCIAL SERVICES

CHILD SUPPORT ENFORCEMENT PROGRAM NOTICE

All children have the right to be supported by both parents. Any person, including a noncustodial parent, whether or not (s)he receives public assistance, can apply for support services. Some of the available services are as follows:

- locating the parent(s) for support enforcement purposes;
- establishing paternity;
- establishing a child and/or medical support (health insurance) order;
- enforcing a child and/or medical support order;
- modifying an existing court order for child and/or medical support;
- enforcing a spousal support order in conjunction with a child support order;
- collecting and distributing support payments.

CUSTODY AND VISITATION SERVICES ARE NOT PROVIDED

THE DISTRICT ATTORNEY/FAMILY SUPPORT DIVISION (DA/FSD) PROVIDES SERVICES ON BEHALF OF THE STATE OF CALIFORNIA. THEY DO NOT REPRESENT YOU AND ARE NOT YOUR ATTORNEY. BECAUSE YOU ARE NOT THEIR CLIENT THE INFORMATION YOU PROVIDE IS NOT CONFIDENTIAL UNDER ATTORNEY/CLIENT PRIVILEGE.

The information in the case may be discussed or disclosed to the State, the Department of Social Services, other public agencies that are authorized by law to receive such information, and to the other parent or his/her attorney to the extent required by law. To enroll a child in health insurance may require the release of the child's Social Security Number and mailing address to the other parent's employer or the release of the child's Social Security Number to the other parent.

When you request services, you must cooperate with the DA/FSD by providing any information or documents needed to establish paternity and/or locate the parent and to get support payments for your child. Once the services of the DA/FSD have been requested, the DA/FSD will determine the appropriate action to take. All support payments must be turned over to the DA/FSD.

The DA/FSD is interested in making sure that parents take care of their child support duties. They will ask you to help them work your case. People who receive welfare <u>must</u> help the DA/FSD work their child support case. If you do not give them that help, they probably cannot work your case.

When you apply/receive support services, you are <u>responsible</u> for promptly informing the DA/FSD of any change in circumstances or information. Some examples are as follows:

- child leaves the home;
- address changes (including a move to another State, County or Country) and telephone number changes;
- discontinuance of welfare;
- name change;
- initiation of any divorce or legal proceedings;
- information regarding the noncustodial parent;
- direct receipt of any child, spousal, or family support.

You have the right to seek legal advice from a private attorney or legal aid group at your own expense. If you do hire an attorney, you must report this to the DA/FSD.

Each parent subject to a support order in the State has the right to request that the DA/FSD review his/her support order to determine whether the amount of support should be changed based on statewide criteria. If the amount of support does not meet criteria for change, the DA/FSD must provide to either parent, upon request, information on how either parent can get forms to request the court to modify the amount of support ordered.

The DA/FSD must notify you of the initial date, time and purpose of every hearing for paternity or support. You also have a right to inspect the county clerk's file, except for that information which is not considered public and is legally prohibited by confidentiality requirements.

The DA/FSD will provide you with copies of the most recent order entered in your case.

The DA/FSD is required to obtain the consent of a nonwelfare recipient prior to the filing of a stipulation affecting the support order in which that person is named as a party. The DA/FSD is also prohibited from entering into a stipulation that will reduce the amount of past due support when the recipient is owed support arrearages that exceed unreimbursed public assistance without the recipient's consent.

In general, payments received by the DA/FSD are applied in the following order*:

1. Current monthly support;
2. Interest;
3. Arrearages - first welfare arrears, then non-welfare arrears; and
4. Future obligations.

*Federal and State income tax refunds owed to the noncustodial parent may be intercepted by the DA/FSD. By Federal law, these monies <u>cannot</u> be applied to current child/spousal/family/medical obligations. They must be applied to the arrearages. If a custodial parent has received public assistance, including MEDI-CAL, in the past, the child support debt owed to the State/County will be paid first.

CALIFORNIA DOES NOT CHARGE ANY APPLICATION FEES AND DOES NOT CHARGE FOR THE SERVICES PROVIDED TO APPLICANTS. HOWEVER, SOME STATES DO CHARGE A FEE FOR SERVICES. IF YOUR CASE INVOLVES ONE OF THOSE STATES, THEY MAY DEDUCT THE FEE FROM THE SUPPORT PAYMENTS, OR ADD IT TO THE BALANCE THAT IS OWED. IN ADDITION, IN SOME SITUATIONS, COSTS FOR BLOOD TESTS MAY BE CHARGED.

CS 196 (9/93) (Continued on back)

NOTICE OF COLLECTIONS AND DISTRIBUTION

A Notice of Collections and Distribution of support payments will be mailed to you by the county at least quarterly. The Notice will show you all support which was received and paid out during the specific time period shown on the Notice. You will not receive a Notice of Collections and Distribution if no support was received or paid out.

CHILD SUPPORT COLLECTION OR DISTRIBUTION CONCERNS

If you believe the DA/FSD made a mistake, or took an action with which you disagree about the collection or distribution of a child support payment(s), you have the right to file an informal or formal complaint. To do that, contact the DA/FSD handling your case and ask to speak with the Complaint Coordinator. If you do not want to call the DA/FSD, you can write to the DA/FSD Complaint Coordinator about your concerns.

MEDICAL SUPPORT AND MEDI-CAL

Every child is entitled to a court order that requires either or both parents to provide health insurance if such insurance is available at reasonable cost. In general, the cost of health insurance is assumed to be reasonable if it is employment related group health insurance or other group health insurance. However, in determining reasonable cost, the court will also consider the actual cost of the health insurance.

The DA/FSD will ask the court to establish or modify a child support order which requires the noncustodial parent to provide health insurance if it is available at reasonable cost. The custodial parent may also request that the DA/FSD modify the child support order to include a provision for health insurance. This may affect the amount of the monthly child support obligation. If the noncustodial parent is ordered to provide health insurance coverage, the DA/FSD will contact the noncustodial parent and his or her employer, if necessary, to secure health insurance for the child. After the DA/FSD receives the policy information, a copy will be provided to the custodial parent.

Having private health insurance coverage does not prevent you from having Medi-Cal coverage. If you receive Medi-Cal and have individual or group health private coverage (including dental or vision coverage), you are required by Federal and State law to report this to your local county welfare department, to your health care provider, and/or to the DA/FSD. Failure to provide this information is a misdemeanor. You must report to your welfare worker and/or DA/FSD within ten days when your private health coverage changes or stops. You must also tell your welfare worker and/or the DA/FSD about any court order providing health insurance.

If you are only receiving Medi-Cal benefits, you must cooperate in establishing paternity and obtaining medical support as a condition of continued eligibility for Medi-Cal benefits, unless you have filed and the County Welfare Department has approved a claim of good cause (CA 51) for not cooperating. Also, you will be provided all child support services, unless you notify the DA/FSD that you do not want to receive those services that are unrelated to obtaining medical support and establishing paternity. Obtaining medical support may reduce the amount of child support you receive. In cases where both parents are in the home, the DA/FSD will establish paternity.

Under Federal law [42 U.S.C. Section 1396A (25)] health insurance belonging to a Medi-Cal recipient in a child or medical support enforcement case is used as follows:

> The provider of service will bill Medi-Cal. Medi-Cal will pay the provider of service. Then Medi-Cal will seek repayment from the other health coverage. You will not be liable for any insurance cost-sharing amount (co-insurance, co-payment or deductible) unless a Medi-Cal co-payment or share of cost must be met. The provider may bill you for the service if you do not cooperate in identifying your private health insurance. If your other health insurance is a Prepaid Health Plan (PHP) or a health maintenance organization (HMO), you <u>must</u> use the plan facilities for regular medical care. Except for out-of-area service or emergency care, Medi-Cal will not pay for services rendered by a provider not associated with your PHP/HMO. Out-of-area services or emergency care should be billed to the PHP/HMO.

If you have questions about using your Medi-Cal card, contact your welfare eligibility worker.

6. **CA 371**

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

REFERRAL TO DISTRICT ATTORNEY
(Complete one form for each Absent or Unmarried Parent)

DATE OF REFERRAL

☐ TO ☐ FROM: DISTRICT ATTORNEY (SPECIFY COUNTY)

CASE NAME

AID TYPE/CASE NUMBER

☐ TO ☐ FROM: EW NAME EW NUMBER CWD DISTRICT OFFICE

APPLICANT/RECIPIENT NAME (LAST, FIRST, MIDDLE)

RELATIONSHIP TO CHILD(REN)

A. This case is referred to you because:

- ☐ Action is necessary to obtain
  - ☐ financial support ☐ medical support ☐ paternity.
- ☐ Recipient is receiving direct support payments. Action needed to transfer payments to county.
- ☐ Good Cause has been
  - ☐ claimed ☐ granted ☐ denied (see CA 51 attached).
- ☐ Other (see comments)

B. The following information applies to this case:

- ☐ CA 2.1(O) Questionnaire is attached.
- ☐ Absent parent has health insurance coverage. A copy of the DHS 6155 is attached.
- ☐ Medi-Cal eligibility has not been determined.
- ☐ This is a relinquishment for adoption case.
- ☐ Previously sanctioned: now agrees to cooperate.
- ☐ Child no longer resides with recipient.
- ☐ Child added to TCC, was not on AFDC.
- ☐ Medi-Cal Only; Applicant/Recipient does not want other child support services.
- ☐ Other (see comments)

C. Applicant/recipient has not agreed to:

- ☐ Assign accrued
  - ☐ financial support rights ☐ medical support rights.
- ☐ Cooperate in obtaining
  - ☐ financial support ☐ medical support AND/OR
  - ☐ establishing paternity.
- ☐ Cooperate in establishing Good Cause.
- ☐ Forward support payments.

D. Information from District Attorney (DA) to CWD:

DA FILE NO

- ☐ Applicant/recipient has cooperated in accordance with Federal law.
- ☐ Applicant/recipient has not cooperated in accordance with Federal Law:
  - ☐ Did not appear and/or provide verbal, written or documentary information.
  - ☐ Rescheduled appointment on _____ ☐ kept ☐ failed
  - ☐ Refuses to appear as a witness at court or other hearing.
  - ☐ Refuses to transmit child support payment(s) received directly from the absent parent.
- ☐ Applicant/recipient has claimed Good Cause for refusal to cooperate and has been provided with a Good Cause claim form.
- ☐ This is a notice of renewed cooperation.
- ☐ Paternity ☐ has ☐ has not been established.
- ☐ Support order established.
- ☐ Other (see comments)

E. TYPE OF APPLICATION

☐ NEW ☐ REAPPLICATION ☐ ADD A CHILD ☐ ICT ☐ RENEWAL

ABSENT PARENT'S NAME | DA FILE NUMBER

CHILD'S NAME | DATE OF BIRTH

CHILD'S NAME | DATE OF BIRTH

CHILD'S NAME | DATE OF BIRTH

CHILD'S NAME | DATE OF BIRTH

F. ☐ APPLICANT STATES AID RECEIVED PREVIOUSLY.

SPECIFY TYPE: ☐ CASH AID ☐ MEDI-CAL ONLY ☐ TCC ☐ TMC

PLACE (CITY, COUNTY, STATE) | DATE LAST RECEIVED

G. ☐ INTER-COUNTY TRANSFER/INTERSTATE TRANSFER

FROM (COUNTY/STATE) | PRIOR COUNTY'S DA FILE NUMBER (IF KNOWN)

H. ☐ CASH AID

APPROVAL DATE | ONGOING CASH AID AMOUNT $

DISCONTINUANCE DATE | REASON FOR DISCONTINUANCE/CODE

I. ☐ MEDI-CAL ONLY

DATE MEDI-CAL BEGINS/CONTINUES | DATE DISCONTINUED

REASON FOR DISCONTINUANCE

J. ☐ TRANSITIONAL CHILD CARE

DATE TCC BEGINS | DATE TCC ENDS

Comments

SIGNATURE OF DA REPRESENTATIVE | TITLE | E.W. SIGNATURE | E.W. NUMBER | PHONE | DISTRICT OFFICE

CA 371 (Rev) REQUIRED FORM - SUBSTITUTES PERMITTED

State of California—Health and Human Services Agency

Department of Health Services

MEDICAL INSURANCE FORM

Complete this form only if the children involved in this action are applying for or receiving AFDC or Medi-Cal Send to the California Department of Health Services once the noncustodial parent health insurance coverage for the dependent child(ren) is obtained and verified

Mail to: California Department of Health Services
Other Coverage Unit
MS 4719
P.O Box 997422
Sacramento, CA 95899 7422

FOR COUNTY USE ONLY

Date. _____

PLEASE TYPE OR PRINT (DO NOT ABBREVIATE)

COUNTY INFORMATION (ITEMS 1 THROUGH 3)

1. County | 2 IV D case number | 3. Phone number ( )

CUSTODIAL PARENT INFORMATION (ITEMS 4 THROUGH 10)

4 Name (first) (middle) (last) | 5 Social security number — —

6 Complete street address

City State ZIP code | 7 Home telephone number ( )

8 Name of employer

9 Employer's complete street address

City State ZIP code | 10 Work telephone number ( )

DEPENDENT CHILDREN INFORMATION

11. Dependent children on Medi Cal covered by health insurance (If more space is needed complete another form)

Child's Name (First Middle Last)	Social Security Number	Sex	Date of Birth Month	Day	Year	County Code	Aid Code	Medi-Cal ID Number (Case Number)	F BU	Pers No
	— —									
	— —									
	— —									
	— —									
	— —									
	— —									
	— —									
	— —									
	— —									

NONCUSTODIAL PARENT INFORMATION (ITEMS 12 THROUGH 19)

12 Name (first) (middle) (last) | 13. Date of birth | 14 Social security number — —

15 Complete street address

City State ZIP code | 16 Home telephone number ( )

17 Name of employer

18 Employer's complete street address

City State ZIP code | 19 Work telephone number ( )

HEALTH INSURANCE INFORMATION (ITEMS 20 THROUGH 23)

If additional insurance coverage (medical dental and/or vision) is being provided, please complete the back of this form

20 Health insurance is provided by (check appropriate box)

☐ Noncustodial parent ☐ Custodial parent ☐ Other If other, please state _____ Name _____ Relationship

21 Name of insurance company or union | 21 a Union Local number

22 Complete street address of insurance company or union (address where claims are mailed)

City State ZIP code | 23 Policy number

DHS 6110 (6/04)

24 Type of Coverage Does the health insurance provide or pay for (Check all that apply, if information is available)

- ☐ Hospital outpatient (i e lab work/physical therapy)
- ☐ Hospital stays
- ☐ Doctor visits
- ☐ Long term care/nursing home
- ☐ Prescription drugs
- ☐ Dental care
- ☐ Vision care

ADDITIONAL HEALTH INSURANCE POLICY INFORMATION

DENTAL INSURANCE INFORMATION (Please complete if dental coverage is being provided.)

1 Name of insurance company or union | 1 a Union Local number

2 Complete street address of insurance company or union (address where claims are mailed)

City | State | ZIP code | 3 Policy number

VISION INSURANCE INFORMATION (Please complete if vision coverage is being provided.)

1. Name of insurance company or union | 1 a Union Local number

2 Complete street address of insurance company or union (address where claims are mailed)

City | State | ZIP code | 3 Policy number

MEDICAL INSURANCE INFORMATION (Please complete if additional medical coverage is being provided.)

1 Name of insurance company or union | 1 a. Union Local number

2 Complete street address of insurance company or union (address where claims are mailed)

City | State | ZIP code | 3 Policy number

REMARKS

IMPORTANT: All Medi-Cal eligibles must irrevocably assign the benefits of any contractual or legal entitlement for health care to the California Department of Health Services. Assignment of medical rights allows the California Department of Health Services to code Medi-Cal cards and recover funds from insurance companies when the Medi-Cal program pays for medical services which could be billed to other health insurance plans. IN THE EVENT THAT YOUR PRIVATE HEALTH INSURANCE TERMINATES, NOTIFY YOUR COUNTY WELFARE DEPARTMENT.

INFORMATION COLLECTION AND ACCESS

Information concerning your health coverage is maintained by the Chief of the Recovery Branch, by authority of the Welfare and Institutions Code, Section 14011, and Title 22, California Code of Regulations (CCR), Section 50769 All information is mandatory. The information requested is necessary to effect utilization of health insurance or other contractual or legal entitlements as provided in Welfare and Institutions Code, Sections 10020 through 10025, 11490, 14024, 14103, and 14124.70, with persons liable thereunder. Please note that under the authority of Welfare and Institutions Code, Section 14100 2, and in order to comply with the Federal Privacy Act, Section 7(b), your social security number and all of the information you provide are used for identification in contacting insurance companies, providers of health care services, county agencies, or your legal counsel under the authority of Welfare and Institutions Code, Section 14102.

Sections 50761 and 50763 of Title 22, California Code of Regulations, require recipients to use and report other health coverage to which they are entitled. Additionally, Section 50175 of Title 22 provides for denial or discontinuance of benefits if the recipient does not cooperate in providing health insurance information

Section 14023 of the Welfare and Institutions Code provides that any public assistance recipient who has any other contractual or legal entitlement to any health care service and who willfully refuses to disclose this information by withholding important information regarding other medical entitlement is guilty of a misdemeanor. ***MEDI-CAL IS THE PAYOR OF LAST RESORT.***

DHS 6110 (6/04)

8. **CS 870**

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

ATTESTATION STATEMENT

ATTESTATION TO LACK OF INFORMATION ABOUT THE PARENT(S) OF

_____ COUNTY NAME _____

I, _____ have no additional knowledge of the following information about the parent of the child(ren) named in this attestation:

☐ 1. I do not know the identity of the parent of the child(ren) because: (state reason(s))

☐ 2. I have named _____ as the parent of the child(ren). However, I do not know the parent(s') residence and/or employer because: (state reason(s))

☐ 3. I do not have or know any other information that might assist the District Attorney in identifying or locating the parent of the child(ren), because: (state reason(s) if different)

In signing this attestation, I declare, under penalty of perjury under the laws of the State of California that all the information I have provided is true, correct and complete. I further understand that Federal and State law provide for penalties of fine and/or imprisonment or denial of Public Assistance/Medi-Cal if I do not tell the truth when applying for Public Assistance/Medi-Cal or if I conceal or fail to disclose facts regarding the identity, whereabouts or other information concerning the child(ren)'s parent.

Signed:

_____ Name

_____ Date Signed

Witnessed by:

_____ Family Support Officer

_____ Date Signed

CS 870 (12/89)

9. DHS 6110 REJECTION LETTER

State of California—Health and Human Services Agency

Department of Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

Date: April 16, 2004

«Title» «FirstName» «LastName»
«JobTitle»
«Company»
«County» County
«Address1»
«Address2»
«City», «State» «PostalCode»

DHS 6110 DOCUMENT/INCENTIVE REJECTION

Dear «Title» «LastName»:

The enclosed Medical Insurance Forms (DHS 6110) were not considered for an incentive payment. The specific reason for this is noted on the Blue Tag stapled to the left side of each returned document.

The Department of Health Services is returning these documents to assist «County» county in increasing the valid identification of other health coverage based on the District Attorney Health Insurance Incentive Program that took effect October 1, 1993.

Corrected forms may be resubmitted and will be reconsidered for incentive payments if they are returned to the Department of Health Services at the address provided above.

If you have any questions concerning these documents, please contact Ms. Deborah Colasanti, at (916) 650-0547.

Thank you.

Enclosures

THIRD PARTY LIABILITY BRANCH, HEALTH INSURANCE SECTION, MS-4719, P.O. BOX 997422,
SACRAMENTO, CA 95899-7422
Internet Address: www.dhs.ca.gov

9. DHS 6110 REJECTION LETTER

State of California—Health and Human Services Agency

Department of Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

Date: April 16, 2004

«Title» «FirstName» «LastName»
«JobTitle»
«Company»
«County» County
«Address1»
«Address2»
«City», «State» «PostalCode»

DHS 6110 DOCUMENT/INCENTIVE REJECTION

Dear «Title» «LastName»:

The enclosed Medical Insurance Forms (DHS 6110) were not considered for an incentive payment. The specific reason for this is noted on the Blue Tag stapled to the left side of each returned document.

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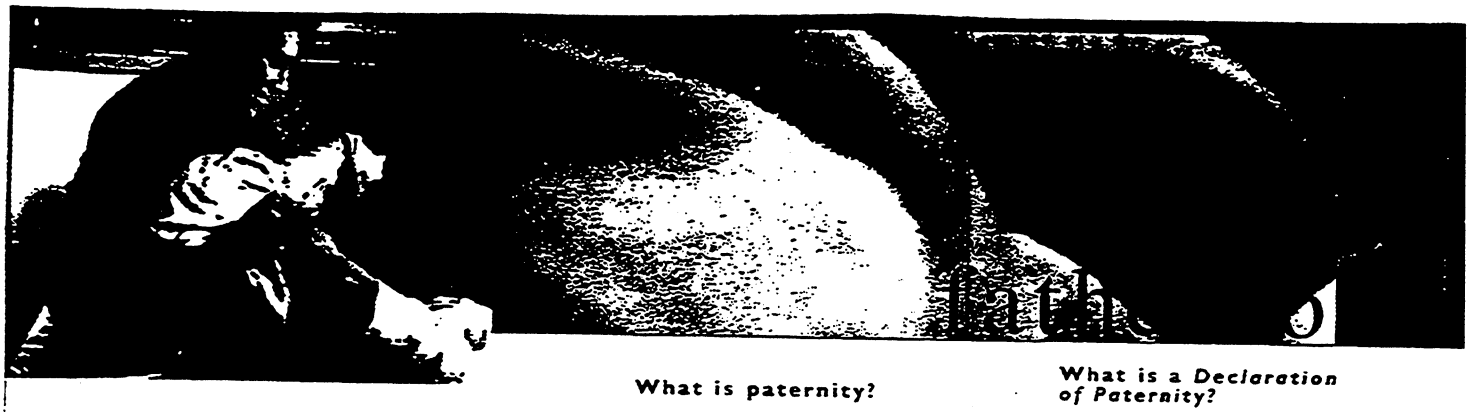
If you have any questions concerning these documents, please contact Ms. Deborah Colasanti, at (916) 650-0547.

Thank you.

Enclosures

THIRD PARTY LIABILITY BRANCH, HEALTH INSURANCE SECTION, MS-4719, P.O. BOX 997422,
SACRAMENTO, CA 95899-7422
Internet Address: www.dhs.ca.gov

10. PUB 244(1/97) - "ESTABLISHING PATERNITY FOR YOU AND YOUR CHILD"



Establishing **Paternity** for You and Your Child

PATERNITY OPPORTUNITY PROGRAM

What is paternity?

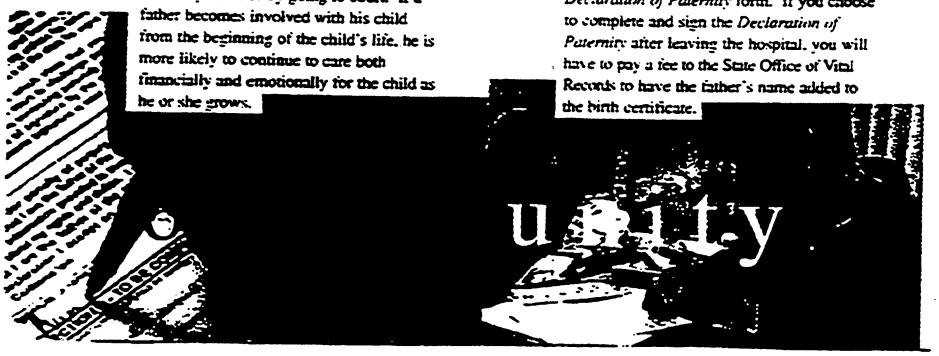
Paternity means fatherhood. Establishing paternity is the legal process of determining the biological father of a child. When parents are married, paternity is usually established automatically. If parents are unmarried, paternity establishment is NOT automatic and the process should be started by both parents as soon as possible for the benefit of the child. Without the establishment of paternity, the father does not have the legal rights or legal responsibilities of a parent. Establishing paternity is necessary before custody, visitation and child support can be ordered by the court. Establishing paternity allows an unmarried father to have his name placed on the birth certificate. Paternity can be established either by signing a *Declaration of Paternity* form or by going to court. If a father becomes involved with his child from the beginning of the child's life, he is more likely to continue to care both financially and emotionally for the child as he or she grows.

What is a *Declaration of Paternity?*

The *Declaration of Paternity* is a legal form that, when signed by both parents, says the man is the legal father. Signing the form will legally establish the man as the child's father without having to go to court. Signing the form allows an unmarried father's name to be placed on his child's birth certificate. Signing a *Declaration of Paternity* is voluntary.

Where can I obtain a *Declaration of Paternity?*

You can obtain a *Declaration of Paternity* form at the hospital or clinic right after your child is born. Signing the form in the hospital is a quick, easy and free way to have the father's name added to his child's birth certificate. Your local registrar of births and deaths' office, county family support or welfare office can also provide you with a *Declaration of Paternity* form. If you choose to complete and sign the *Declaration of Paternity* after leaving the hospital, you will have to pay a fee to the State Office of Vital Records to have the father's name added to the birth certificate.



hts and privileges

How can a *Declaration of Paternity* help you?

When the parents of a child are not married at the beginning of the pregnancy or at the birth of the child, the father is NOT considered a legal parent with rights or responsibilities for the child. To help gain legal rights as the child's father, he can sign the *Declaration of Paternity* form. Sixty days after the form is signed, it will legally establish a parent-child relationship between the child and father, without going to court.

How the child benefits...

By establishing paternity, a child gets the legal rights and privileges of a child born within a marriage. Those rights and privileges may include:

- support from both parents
- legal documentation of who his or her parents are
- access to family medical records
- medical and life insurance coverage from either parent, if available
- inheritance protections
- social security and veteran's benefits, if available
- the emotional benefits of knowing who both parents are

How the father benefits...

Establishing paternity can help the father experience the companionship and emotional rewards that come with spending time with his child. He can enjoy the benefits of paternity which may include:

- legal establishment of parental rights and responsibilities
- having his name added to the child's birth certificate
- the opportunity to give the child his name if both parents choose
- the ability to add the child to his health insurance plan
- the assurance that social security or veteran's benefits are paid to the child in the event of his death or disability, if eligible
- protecting his child's right to inherit from him
- the right to seek custody or visitation, in a court action, and to be consulted about the adoption of the child

How the mother benefits...

Establishing paternity can help a mother by sharing the financial burden and emotional pressure that many single parents experience. Cooperative parenting can provide strong emotional support for the mother, father and child. The mother can also enjoy the benefits of paternity which may include:

- improving financial security for the family
- information about family medical history
- help in sharing the parental responsibilities
- access to medical insurance coverage for the child, if available

Can I rescind or cancel the *Declaration of Paternity* after sign it?

Either parent may cancel the *Declaration of Paternity* by completing a *Rescission of* form. This form must be filed with the Office of Vital Records within 60 days the paternity declaration was signed. T available at the local District Attorney's Support Office or the local registrar of births and deaths' office.

Where do I go if I have more questions?

For more information about the *Declaration of Paternity*, establishing parentage or child support, please contact your local District Attorney's Family Support Office or legal services organization.

emotional support

11. CS 910 (1/97) - 'HOW A DECLARATION CAN HELP YOU AND YOUR NEW BABY'

How a *Declaration of Paternity* Can Help You and Your New Baby

What is a *Declaration of Paternity*?

The *Declaration of Paternity* is a legal document that, when signed by both parents, says the man is the natural father of the child. Signing the *Declaration of Paternity* is voluntary.

How can a *Declaration of Paternity* help us?

When the parents of a child are not married at the beginning of the pregnancy or at the birth of the child, the father may NOT be considered a legal parent with rights or responsibilities for the child.
You can sign the *Declaration of Paternity* to help the father gain legal rights as the child's father. When signed by both parents, the form will legally establish a parent-child relationship between the father and child.

Why should we sign the declaration?

To show your child that you are proud to be his or her parents!
To legally establish the man as the child's father.
To allow the father's name to be added to your child's birth certificate.
To allow your child to be added to the father's health insurance plan.
To make sure that the father's social security or veteran's benefits are paid to your child, if eligible, in case the father dies or is disabled.
To protect your child's right to inherit from his or her father.

What does it mean when we sign the declaration?

After both parents sign the declaration and it is filed with the State Office of Vital Records, it legally establishes a parent-child relationship between the father and the child. Once paternity is established, the father will have the legal rights and financial responsibilities of a parent under California law. Signing this form will give the father parental rights to seek custody or visitation, in a court action, and to be consulted about the adoption of the child.

Can we rescind or cancel the declaration after we sign it?

Either parent may cancel or rescind the *Declaration of Paternity* by completing a form and filing it with the State Office of Vital Records within 60 days from the date the declaration was signed. Rescission forms are available at local District Attorney's Family Support Offices or the local registrar of births and deaths' office.

How do we fill out the declaration?

Sections A and B should be filled out by the parents of the child. The witness will fill out section C. See the instructions on the declaration for more details.

What do we do if we have more questions?

For more information about the *Declaration of Paternity*, establishing parentage or child support, please contact the local District Attorney's Family Support Office or legal services organization.

PATERNITY OPPORTUNITY PROGRAM

CS 910 (1/97)

Cómo una "*Declaración de paternidad*" puede ayudarles a ustedes y a su nuevo bebé

¿Qué es una "*Declaración de paternidad*"?

La "*Declaración de paternidad*" es un documento legal que, cuando está firmado por ambos padres, declara que el hombre es el padre biológico del niño. El firmar la "*Declaración de paternidad*" es voluntario.

¿Cómo puede ayudarnos una "*Declaración de paternidad*"?

Cuando los padres del niño no están casados al principio del embarazo o cuando nace el niño, es posible que el padre NO se considere el padre legal, con derechos y responsabilidades en relación al niño. Ustedes pueden firmar la "*Declaración de paternidad*" para ayudar al padre a obtener los derechos legales como padre del niño. Cuando la declaración está firmada por ambos padres, establece legalmente el parentesco padre-hijo entre el padre y el hijo.

¿Por qué debemos firmar una declaración?

¡Para mostrarle a su hijo que ustedes están orgullosos de ser sus padres!
Para establecer legalmente que ese hombre es el padre del niño.
Para permitir que el nombre del padre se incluya en el acta de nacimiento de su hijo.
Para permitir que se incluya a su hijo en el plan del seguro de salud del padre.
Para asegurarse de que, si reúne los requisitos, se le paguen a su hijo los beneficios del seguro social o los beneficios para veteranos en caso de que el padre muera o quede incapacitado.
Para proteger el derecho que tiene su hijo a heredar del padre.

¿Qué significa el firmar la declaración?

Después de que ambos padres firmen la "*Declaración de paternidad*" y la presenten en la Oficina Estatal del Registro Civil *(State Office of Vital Records)*, quedará legalmente establecido el parentesco padre-hijo entre el padre y el hijo. Una vez que quede establecida la paternidad, el padre tendrá los derechos legales y responsabilidades económicas de un padre, en conformidad con las leyes de California. El firmar esta declaración le dará al padre los derechos típicos de los padres, como el derecho a, por medio de una acción de la corte, tratar de obtener la patria potestad (custodia) del niño o visitas y a que se le consulte en relación a la adopción del niño.

¿Podemos cancelar o anular la declaración después de haber firmado?

Cualquiera de los padres puede anular o cancelar la "*Declaración de paternidad*" completando un formulario y presentándolo en la Oficina Estatal del Registro Civil *(State Office of Vital Records)* antes de que pasen 60 días desde la fecha en que se firmó la declaración. El "Formulario para la anulación de la declaración de paternidad" se puede obtener en la División local de Mantenimiento y Apoyo para Familias de la Oficina del Fiscal del Distrito *(District Attorney's Family Support Division)* o en la oficina local de registro de nacimientos y muertes.

¿ Cómo completamos la declaración?

Los padres del niño deben completar las secciones A y B. El testigo debe completar la sección C. Para obtener más detalles, vea las instrucciones de la declaración.

¿Qué podemos hacer si tenemos más preguntas?

Para obtener más información acerca de la "*Declaración de paternidad*", el establecimiento de la paternidad o el mantenimiento de hijos, por favor comuníquese con la División local de Mantenimiento y Apoyo para Familias de la Oficina del Fiscal del Distrito *(District Attorney's Family Support Division)* o con una organización local de servicios legales.

PATERNITY OPPORTUNITY PROGRAM

CS 910 (ENG/SP) (1/97)

12. CS 909 (1/97) - DECLARATION OF PATERNITY

WHAT IS THE PURPOSE OF A DECLARATION OF PATERNITY?

A declaration of paternity form is used to legally establish the paternity (the father) of a child when the mother and father are not married to each other. It should be signed only by the biological parents of a child who were never married to each other. Signing this form is voluntary.

HOW WILL YOU AND YOUR CHILD BENEFIT IF YOU SIGN THIS FORM?

This form when signed by both parents will:

- Legally establish a parent-child relationship between the father and the child. Your child has the right to know his or her mother and father and to benefit from a relationship with both parents.
- Allow the father's name to be added to the birth certificate. Your child will benefit by having both of your names appear on his or her birth certificate. If the form is signed after the child's birth certificate is prepared, there will be a fee to amend the birth certificate to add the father's name.
- Legally establish the man as the child's father without going to court. This will give the father parental rights such as the right to seek child custody and visitation in a court action and to be consulted about the adoption of the child.
- Make it easier for your child to learn the medical histories of both parents, to benefit from the father's health care coverage, and to receive Social Security or Veterans' dependent or survivor's benefits, if eligible.

WHAT DOES IT MEAN IF YOU SIGN A DECLARATION OF PATERNITY?

- A signed declaration of paternity that states that the man is the father will have the same effect as a court order establishing paternity for the child. If your child does not live with you and a court action is filed, you may be ordered by the court to pay child support. A court action must be filed to deal with the issues of custody, visitation or child support.
- You have the right to a trial in court to decide the issue of paternity; to notice of any hearing on the issue of paternity; to have the opportunity to present your case to the court, including the right to present and cross examine witnesses; to have an attorney represent you; or to have an attorney appointed to represent you if you cannot afford one in an action filed by the District Attorney. By signing this declaration, you are, by your choice, giving up all of these rights.
- If either of you later change your mind about signing the form you must complete a form to rescind or cancel the declaration of paternity and file it with the State Office of Vital Records within 60 days from the date you sign this form. You can get a rescission form from your local Family Support Division, or local office of vital statistics.
- This form may be challenged in court only in the first two years after the child's birth by using blood and genetic tests that prove the man is not the biological father. It also may be overturned if the father or mother is able to prove that he signed the form because of fraud, duress, or material mistake of fact.
- If either or both of you are under the age of eighteen, a declaration of paternity will not establish paternity until sixty days after both of you are age eighteen or are emancipated. If you wish to legally establish paternity before both of you become adults, you should consult an attorney.
- This is a legal document that will establish paternity sixty days from the date of signature. **You do not have to complete or sign this form.** If any part of this form does not make sense to you, talk to your local Family Support Division or a lawyer before signing the form.

OSP 96 88797

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

DECLARATION OF PATERNITY

DISTRIBUTION: ORIGINAL - Vital Records
COPY 1 & 2 - Parents
COPY 3 - Family Support

SECTION A

Child	NAME OF CHILD - FIRST	MIDDLE	LAST
	DATE OF BIRTH	SEX	FOR STATE USE ONLY
Place of Birth	HOSPITAL NAME		COUNTY
Father	NAME OF FATHER - FIRST	MIDDLE	LAST
	SOCIAL SECURITY NO.	DATE OF BIRTH	PLACE OF BIRTH (STATE OR COUNTRY)
	CURRENT ADDRESS (NUMBER, STREET, CITY, ZIP)		
Mother	NAME OF MOTHER - FIRST	MIDDLE	LAST
	SOCIAL SECURITY NO.	DATE OF BIRTH	PLACE OF BIRTH (STATE OR COUNTRY)
	CURRENT ADDRESS (NUMBER, STREET, CITY, ZIP)		
	MAIDEN NAME		

SECTION B - READ OTHER SIDE BEFORE SIGNING

I declare under the penalty of perjury under the laws of the State of California that I am the natural father of the child named on this declaration and that the information provided is true and correct. I have read and understand the rights and responsibilities described on the back of this form. I understand that by signing this form I am waiving those rights and consenting to the establishment of paternity. I am assuming all the rights and responsibilities of the natural father of this child. I wish to be named as the father on the child's birth certificate.

I declare under the penalty of perjury under the State of California that I am the natural mother of the child named on this declaration and that the information provided is true and correct. I have read and understand the rights and responsibilities described on the back of this form. I certify that the man signing this form is the only possible father of this child. I know that by signing this form I am establishing the man named as father as the natural father of this child with all the rights and responsibilities of a natural father under the laws of California. I consent to the establishment of paternity by signing this form.

SIGNATURE OF FATHER	DATE SIGNED	SIGNATURE OF MOTHER	DATE SIGNED

SECTION C - TO BE COMPLETED BY WITNESS AT THE HOSPITAL, AGENCY OR CLINIC (PLEASE PRINT)

DECLARATION WITNESSED BY (SIGNATURE AND PRINTED NAME) | DATE

NAME OF AGENCY (HOSPITAL, CLINIC OR OTHER)

ADDRESS (ADDRESS, CITY AND ZIP CODE)

SECTION D - TO BE COMPLETED BY NOTARY PUBLIC IF NOT WITNESSED ABOVE

State of California

County of_____

On_____before me, _____, personally

appeared_____

_____

personally known to me (or proved to me on the basis of satisfactory evidence) to be the person(s) whose name(s) are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their signature(s) on the instrument the person(s), or the entity on behalf of which the person(s) acted, executed the instrument.

WITNESS by hand and official seal.

CS 909 (1/97)

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

PATERNITY OPPORTUNITY PROGRAM
PATERNITY DECLARATION - INSTRUCTIONS FOR COMPLETION
(THIS FORM IS TO BE COMPLETED BY UNMARRIED PARENTS ONLY)

GENERAL INFORMATION

The attached declaration form is to be used by unmarried parents to declare the father of the child. Paternity means legal fatherhood. Completing and signing this form is voluntary. **THIS IS A LEGAL DOCUMENT. PLEASE CAREFULLY READ THE REVERSE SIDE OF THE FORM BEFORE YOU SIGN IT.** There is important information about what it means to you and your child when you sign this form. In order for the Declaration of Paternity to be valid, both parents must complete and sign this form. The form must be signed in the presence of a witness from the hospital or agency accepting the form. If not signed at a hospital, prenatal clinic or public agency, you must sign the form in the presence of a notary public. If you are an unmarried father and you wish to have your name entered on the child's birth certificate, you must sign this form. Otherwise, you must go to court to establish legal paternity and pay a fee to amend the child's birth certificate to add your name. Please see the information for filing the form for more details.

PLEASE USE BLACK INK WHEN FILLING OUT THE ATTACHED FORM. PRINT ALL INFORMATION, EXCEPT FOR YOUR SIGNATURE. PLEASE PRESS FIRMLY AND PRINT CLEARLY WHEN FILLING OUT THE FORM.

SECTION A

This section is used to identify the mother, father, child and the birth place of the child. You do not have to write down your social security number. The number helps find parents so child support, and other benefits your child may need, may be collected. If you write down your social security number, it will be on any copies made of this form. All other lines in **Section A** must be completed.

SECTION B

In this section, both parents declare that they are the mother and father of the child named on this form. The signature and date signed must be completed by both parents for this form to be legal. **PLEASE READ THE REVERSE SIDE OF THE FORM BEFORE YOU SIGN IT.**

SECTION C

This section is to be completed by the person who is a witness to the parents' signatures on the form. The witness must be an official representative of the hospital or agency accepting the form.

SECTION D

This section is to be completed ONLY when the form is witnessed by a notary public. If parents do not complete the form at a hospital, prenatal clinic or public agency, they can only sign it before a notary public. This section is to be completed and stamped by a notary public.

FILING THIS FORM

When completed at a hospital, the hospital will send the original of this form to the local county registrar, along with the birth record. If your baby is not born in a hospital, this form must be submitted to your local registrar with the birth certificate in order to have the father's name included on the birth record at the time you register the birth. In either case, the local registrar will file the form with the State Department of Health Services, Office of Vital Records, 304 S Street, Sacramento, CA 95814.

If you did not complete this form at the hospital (or when you registered your child's birth), and you want to add the father's name to the birth certificate, you must contact the State Department of Health Services, Office of Vital Records, 304 S Street, Sacramento, CA 95814. They will provide you with the additional forms you need to complete. You will be charged a fee to have your child's birth certificate changed to include the father's name.

If you did not complete this form at the hospital (or when you registered you child's birth), and you do not want to update the birth certificate with the father's name, you may still file this form with the State Department of Health Services, Office of Vital Records, 304 S Street, Sacramento, CA 95814.

Both parents will be given a copy of this form. This form is an important legal record. Parents should keep their copy in a safe place.

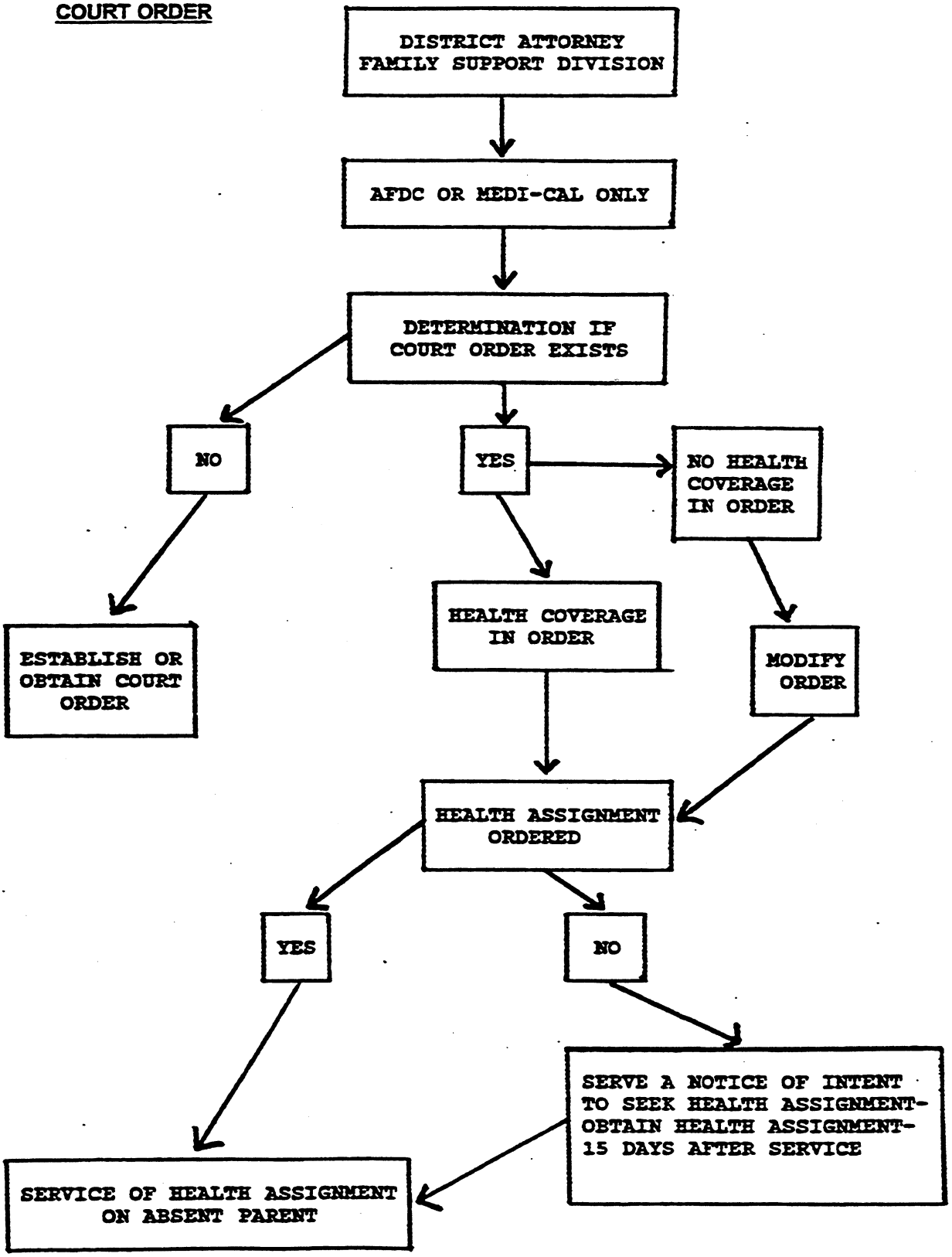
RESCINDING THIS FORM

To rescind or cancel this form, either or both parents must complete and sign a *Rescission Form for the Declaration of Paternity*. This form must be filed with the State Office of Vital Records within sixty days of the date the paternity declaration was signed. To obtain a form to rescind or cancel this form, contact the Family Support Division of your local district attorney's office or your local registrar of births and deaths.

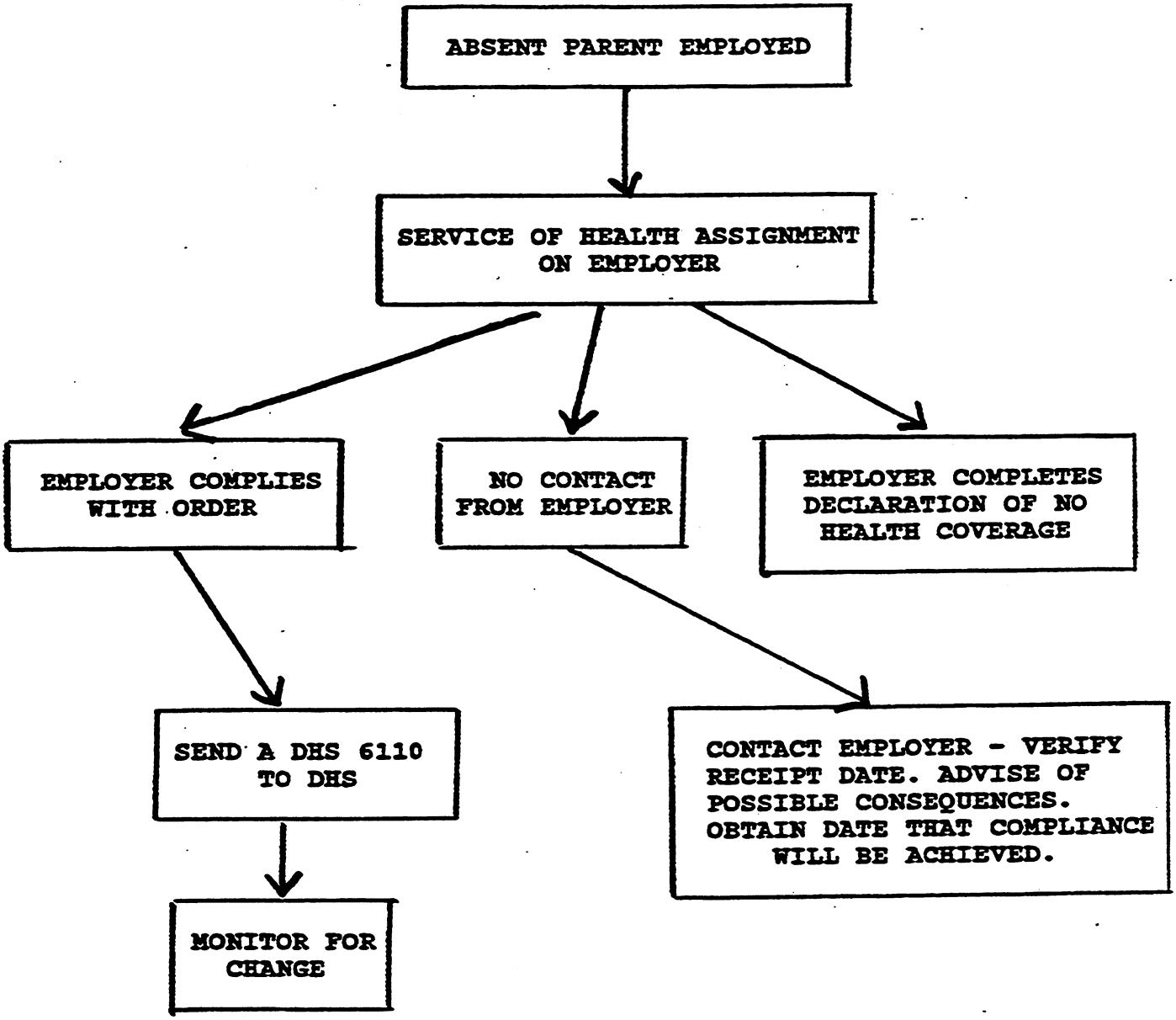
CS 909 (1/97) COVERSHEET

23K MEDICAL SUPPORT ENFORCEMENT PROCESS CHARTS

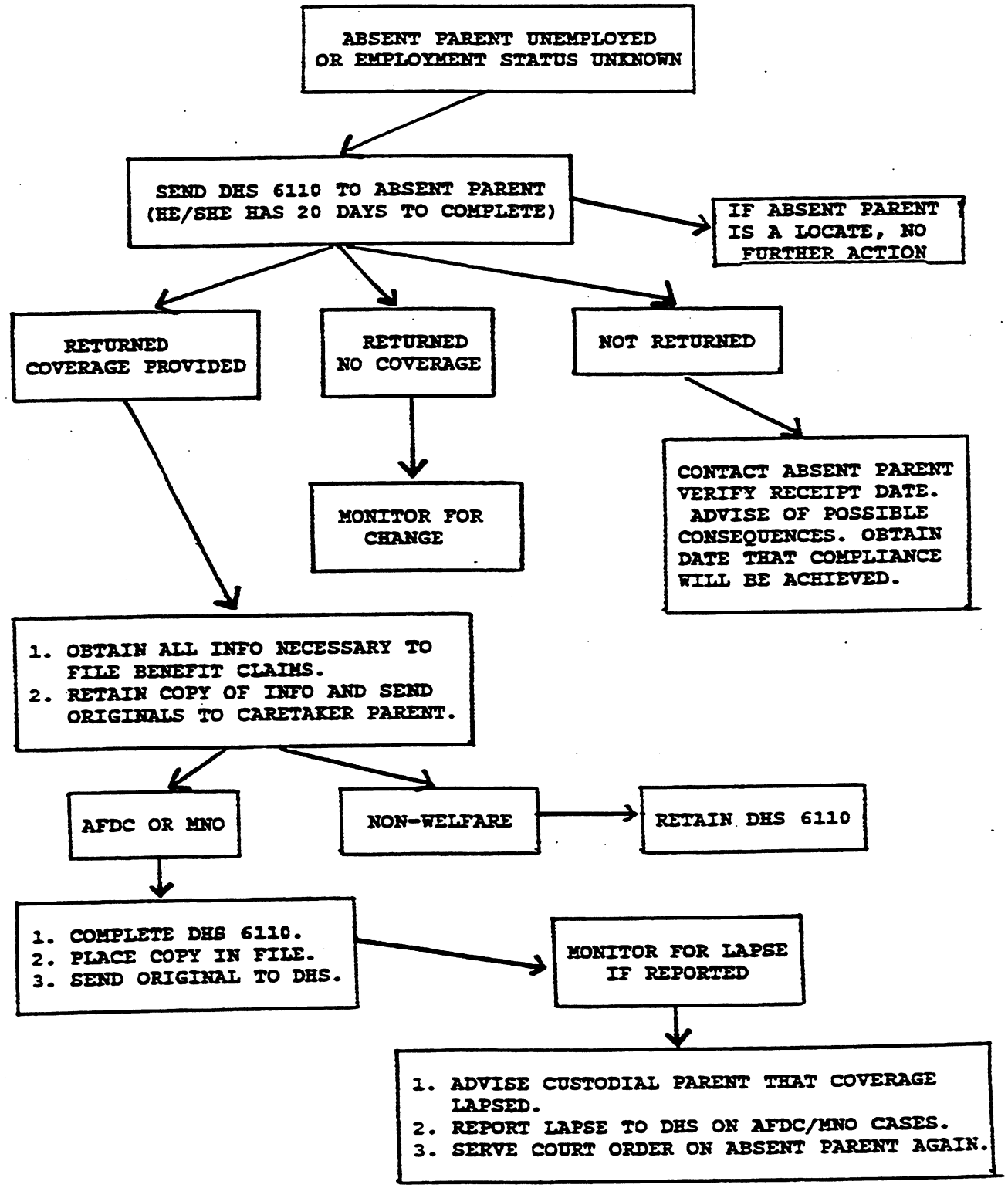
1. COURT ORDER



2. ENFORCEMENT ON EMPLOYED ABSENT PARENT

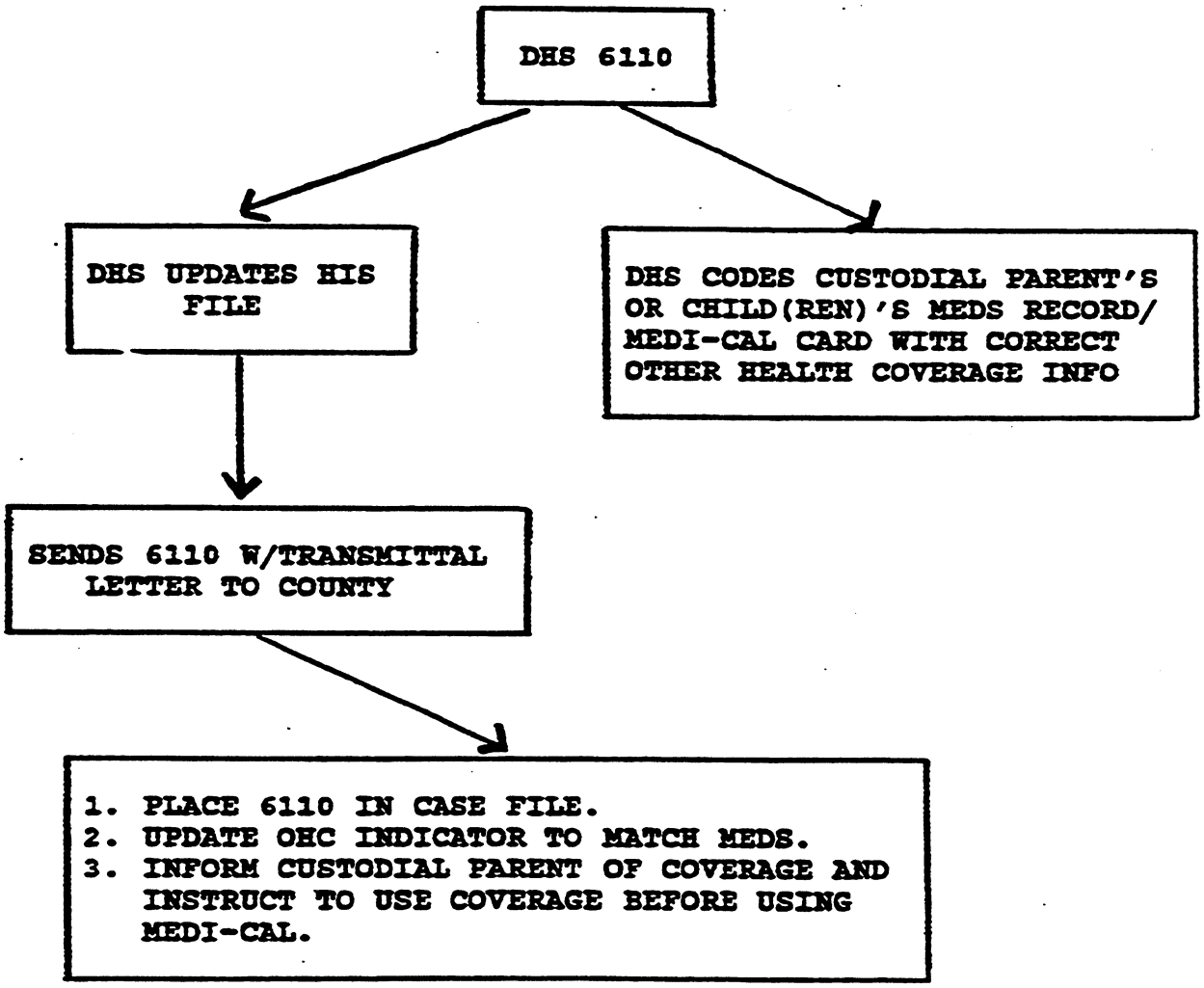


3. ENFORCEMENT ON UNEMPLOYED ABSENT PARENT



4. DHS PROCESSING OF FORM 6110

MEDICAL SUPPORT ENFORCEMENT
DHS PROCESSING OF 6110
AFTER RECEIPT FROM DA/FSD



23L MEDICAL SUPPORT NOTICES OF ACTION

1. NOTICES OF ACTION

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF HEALTH SERVICES

MEDI-CAL
NOTICE OF ACTION
DISCONTINUANCE OF MEDI-CAL BENEFITS DUE TO DENIAL OF GOOD CAUSE CLAIM FOR NONCOOPERATION IN MEDICAL SUPPORT ENFORCEMENT

(COUNTY STAMP)

CASE NO.: _____

DISTRICT: _____

DISCONTINUANCE: _____

_____
(names)

_____

Your Medi-Cal benefits will be discontinued effective the last day of _____.

You do not have good cause for refusing to cooperate in medical support enforcement. Good cause can only be granted when it is decided that cooperating with the District Attorney will result in harm or risk to you or your child(ren).

You may reapply at any time, but you will not receive Medi-Cal benefits until the District Attorney's Office has confirmed that you have cooperated with their office. This action does not affect the Medi-Cal benefits of your child(ren). However, your child(ren)'s case will be referred for medical support enforcement without your cooperation. If you have any questions about this action, please contact your Eligibility Worker.

The regulation which requires this action is California Code of Regulations, Title 22, Sections 50167, 50175, and 50771.5.

_____ (Eligibility Worker) _____ (Date) (____) _____ (Phone)

PLEASE READ THE BACK FOR YOUR HEARING RIGHTS AND OTHER IMPORTANT INFORMATION

MC 268 (11/93)

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF HEALTH SERVICES

MEDI-CAL
NOTICE OF ACTION
DENIAL OF MEDI-CAL BENEFITS FOR NONCOOPERATION IN MEDICAL SUPPORT ENFORCEMENT

(COUNTY STAMP)

CASE NO.: _____

DISTRICT: _____

DENIAL: _____

_____
(names)

You have been denied Medi-Cal benefits because you refused to cooperate in medical support enforcement.

You may reapply at any time, but you will not receive Medi-Cal benefits until the District Attorney's Office has confirmed that you have cooperated with their office. This action does not affect the Medi-Cal benefits of your child(ren). However, your child(ren)'s case will be referred for medical support enforcement without your cooperation. If you have any questions about this action, please contact your Eligibility Worker.

The regulation which requires this action is California Code of Regulations, Title 22, Sections 50167, 50175, and 50771.5.

_____ (Eligibility Worker) _____ (Date) (____) _____ (Phone)

PLEASE READ THE BACK FOR YOUR HEARING RIGHTS AND OTHER IMPORTANT INFORMATION

MC 269 (11/93)

2. **Speed Letters**

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF HEALTH SERVICES

MEDI-CAL
SPEED LETTER
APPROVAL OF GOOD CAUSE CLAIM FOR NONCOOPERATION IN MEDICAL SUPPORT ENFORCEMENT

(COUNTY STAMP)

CASE NO.: _____

DISTRICT: _____

APPROVAL: _____

_____
(names)

The County has decided that you have good cause for not cooperating with the District Attorney Family Support Division in obtaining medical support services from your child(ren)'s absent parent. However, it has been decided that the District Attorney can proceed with your case without harm or risk to you or your child(ren). Your child(ren) will be referred for medical support enforcement without your cooperation.

If you have any questions about this action, please contact your Eligibility Worker.

The regulation which requires this action is California Code of Regulations, Title 22, Sections 50167, 50175, and 50771.5.

_____ (Eligibility Worker) _____ (Date) (____) _____ (Phone)

MC 270 (11/93)

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF HEALTH SERVICES

MEDI-CAL
SPEED LETTER
APPROVAL OF GOOD CAUSE CLAIM
FOR NONCOOPERATION IN
MEDICAL SUPPORT ENFORCEMENT

(COUNTY STAMP)

CASE NO.: _____

DISTRICT: _____

APPROVAL: _____

_____
(names)

The County has decided that you have good cause for not cooperating with the District Attorney Family Support Division in obtaining medical support services from your child(ren)'s absent parent. Therefore, the District Attorney will not proceed with your case.

If you have any questions about this action, please contact your Eligibility Worker.

The regulation which requires this action is California Code of Regulations, Title 22, Sections 50167, 50175, and 50771.5.

_____ (Eligibility Worker) _____ (Date) (____) _____ (Phone)

MC 271 (11/93)

3. NA BACK 7

HEARING RIGHTS

To Ask For a State Hearing

- You only have 90 days to ask for a hearing. The 90 days started the day after we gave or mailed you this notice.
- You have a much shorter time to ask for a hearing if you want to keep your same benefits.

To Keep Your Same Benefits While You Wait For a Hearing

You must ask for a hearing before the action takes place.

- Your Cash Aid will stay the same until your hearing.
- Your Medi-Cal will stay the same until your hearing.
- Your Food Stamps will stay the same until the hearing or the end of your certification period, whichever is earlier.
- Your Transitional Child Care (TCC) will stay the same until the hearing or the end of your eligibility period, whichever is earlier. For all other child care programs, your benefits will NOT stay the same until your hearing.
- If the hearing decision says we are right, you will owe us for any extra cash aid or food stamps you got.

To Have Your Benefits Cut Now

If you want your Cash Aid or Food Stamps cut while you wait for a hearing, check one or both boxes.

☐ Cash Aid ☐ Food Stamps

To Get Help

You can ask about your hearing rights or free legal aid at the state information number.

Call toll free: 1-800-952-5253

If you are deaf and use TDD, call: 1-800-952-8349

You may get free legal help at your local legal aid office or welfare rights group.

Other Information

Child and/or Medical Support: The District Attorney's office will help you collect support even if you are not on cash aid. There is no cost for this help. If they now collect support for you, they will keep doing so unless you tell them in writing to stop. They will send you any current support money collected. They 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 Office will set up a file. You have the right to see this file. The State may give your file to the Welfare Department, the U.S. Department of Health and Human Services and the U.S. Department of Agriculture. (W. & I. Code Section 10850).

BACK 7

HOW TO ASK FOR A STATE HEARING

The best way to ask for a hearing is to fill out this page. Make a copy of the front and back for your records. Then, send or take this page to:

Your worker will get you a copy of this page if you ask. Another way to ask for a hearing is to call 1-800-952-5253. If you are deaf and use TDD, call: 1-800-952-8349.

HEARING REQUEST

I want a hearing because of an action by the Welfare Department of _____ County about my

☐ Cash Aid ☐ Food Stamps ☐ Medi-Cal ☐ Child Care

☐ Other (list) _____

Here's why: _____

☐ Check here and add a page if you need more space.

☐ I want the person named below to represent me at this hearing. I give my permission for this person to see my records or come to the hearing for me.

NAME _____

ADDRESS _____

☐ I need a free interpreter.
My language or dialect is: _____

My name: _____

Address: _____

Phone: _____

My case number: _____

My signature: _____

Date: _____

23M - MEDICAL SUPPORT COLLECTIONS

1. CHECKS

a. If the County Welfare Department, the Family Support Division/District Attorney's office, or a parent (custodial or non-custodial) receives a specific dollar amount for medical services (sum certain) from any third party; an absent parent, or an insurer, it must be forwarded to the Department of Health Services (DHS) for proper distribution.

b. **How to Send:**

1. Two-party checks must be endorsed by the payee prior to forwarding to DHS.

2. The following information must accompany the check(s) for identification purposes.

- Name
- Social Security Number
- Medi-Cal identification number of the dependent child(ren)
- The Explanation of Medical Benefits (EOMB) which identifies the medical services rendered

c. **Where to Send:**

Department of Health Services
Third Party Liability Branch
Recovery Section – OP
MS 4720
P.O. Box 997421
Sacramento, CA 95899-7421

2. INFORMATION ABOUT PAYMENT

If you receive information about a check to an absent parent being cashed, notify DHS in writing at the following address:

Department of Health Services
Third Party Liability Branch
Recovery Section – OP
MS 4720
P.O. Box 997425
Sacramento, CA 95899-7425