CHAPTER 4

Creating Applications Part Two:

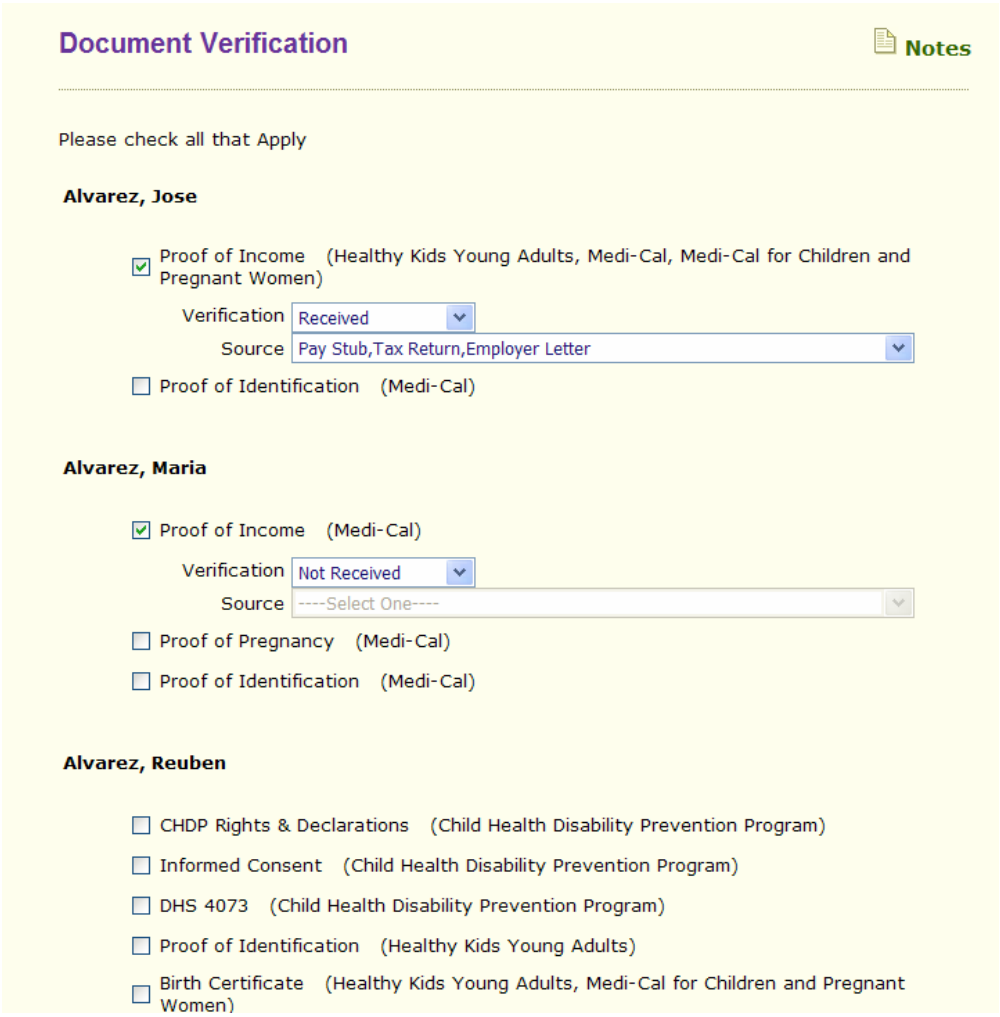
PROGRAM SUBMISSION

Creating Applications Part Two: PROGRAM SUBMISSION

This chapter displays the submission of the applications to each of the programs in San Francisco's version of One-e-App:

- Healthy Kids & Young Adults
- Healthy San Francisco
- Medi-Cal for Children and Pregnant Women (through the Single Point of Entry)
- Healthy Families
- Medi-Cal (to the SF Human Services Agency)
- Child Health and Disability Prevention Program (CHDP)

STEP 7: Program Information

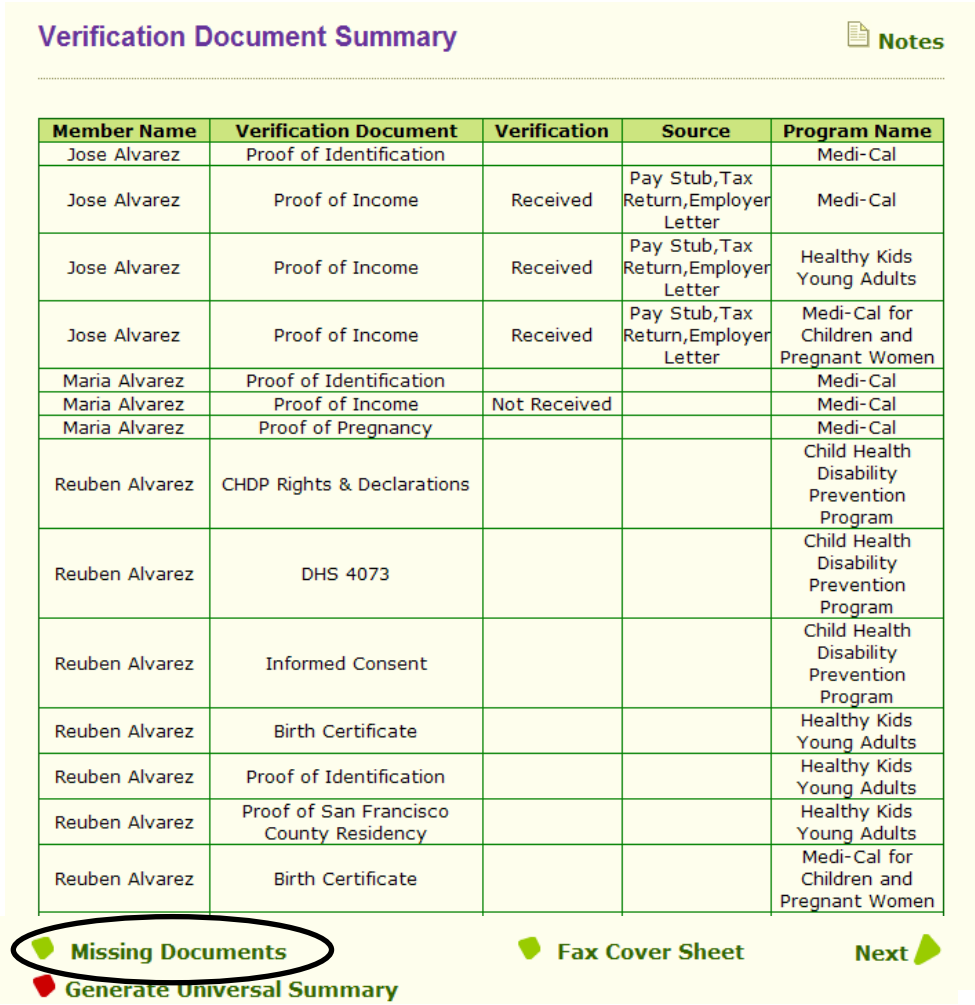


Document Verification

Indicate the status of the required documents for each applicant by checking on the box next to the documentation and indicating the status.

See Appendix C on page 152 for allowable verification documents.

STEP 7: Program Information



Verification Document Summary

Notes

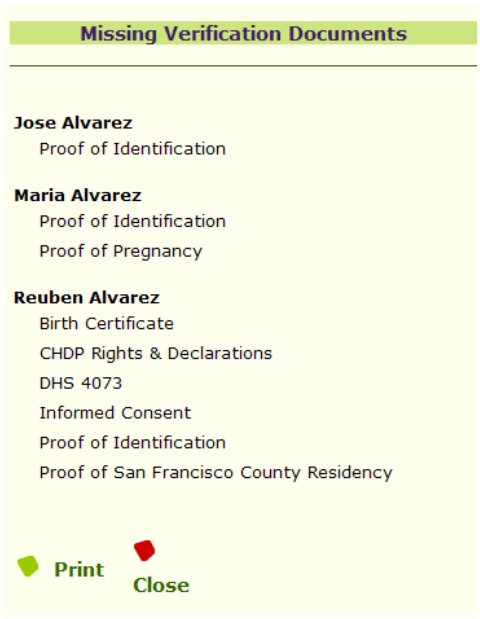
Member Name	Verification Document	Verification	Source	Program Name
Jose Alvarez	Proof of Identification			Medi-Cal
Jose Alvarez	Proof of Income	Received	Pay Stub,Tax Return,Employer Letter	Medi-Cal
Jose Alvarez	Proof of Income	Received	Pay Stub,Tax Return,Employer Letter	Healthy Kids Young Adults
Jose Alvarez	Proof of Income	Received	Pay Stub,Tax Return,Employer Letter	Medi-Cal for Children and Pregnant Women
Maria Alvarez	Proof of Identification			Medi-Cal
Maria Alvarez	Proof of Income	Not Received		Medi-Cal
Maria Alvarez	Proof of Pregnancy			Medi-Cal
Reuben Alvarez	CHDP Rights & Declarations			Child Health Disability Prevention Program
Reuben Alvarez	DHS 4073			Child Health Disability Prevention Program
Reuben Alvarez	Informed Consent			Child Health Disability Prevention Program
Reuben Alvarez	Birth Certificate			Healthy Kids Young Adults
Reuben Alvarez	Proof of Identification			Healthy Kids Young Adults
Reuben Alvarez	Proof of San Francisco County Residency			Healthy Kids Young Adults
Reuben Alvarez	Birth Certificate			Medi-Cal for Children and Pregnant Women

Missing Documents

Fax Cover Sheet

Next

Generate Universal Summary



Missing Verification Documents

Jose Alvarez
Proof of Identification

Maria Alvarez
Proof of Identification
Proof of Pregnancy

Reuben Alvarez
Birth Certificate
CHDP Rights & Declarations
DHS 4073
Informed Consent
Proof of Identification
Proof of San Francisco County Residency

Print

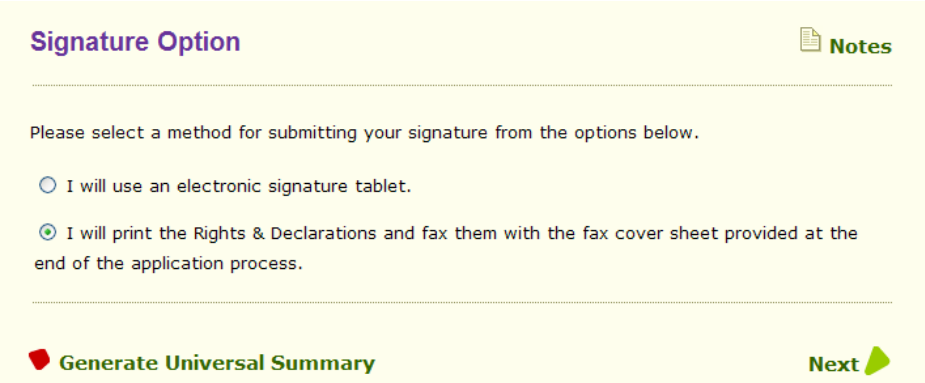
Close

Document Verification

This page shows you a summary of the status of the Verification Documents.

Click on the “Missing Documents” icon for a list of the missing documents to give to the applicant.

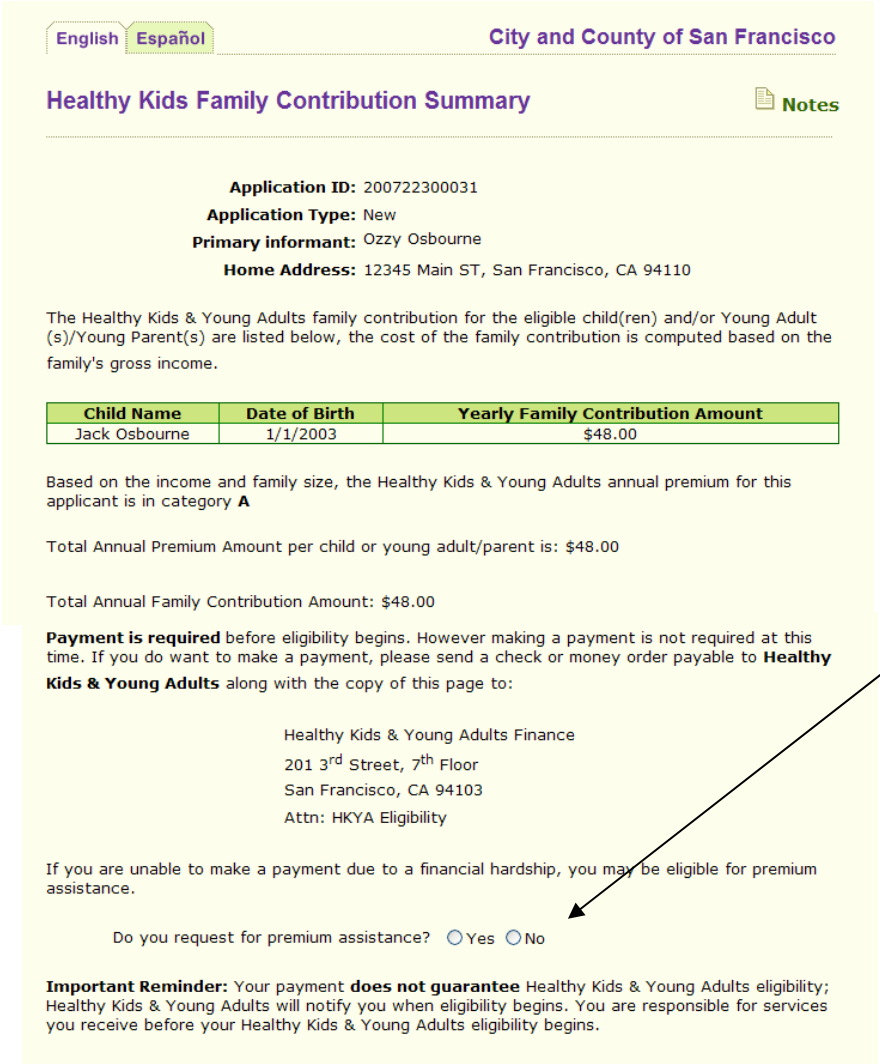
STEP 7: Program Information



Signature Option

Indicate whether the applicant will be signing with an electronic signature pad or printing and manually signing.

STEP 7: Program Information



English Español

City and County of San Francisco

Healthy Kids Family Contribution Summary

Notes

Application ID: 200722300031
Application Type: New
Primary informant: Ozzy Osbourne
Home Address: 12345 Main ST, San Francisco, CA 94110

The Healthy Kids & Young Adults family contribution for the eligible child(ren) and/or Young Adult (s)/Young Parent(s) are listed below, the cost of the family contribution is computed based on the family's gross income.

Child Name	Date of Birth	Yearly Family Contribution Amount
Jack Osbourne	1/1/2003	$48.00

Based on the income and family size, the Healthy Kids & Young Adults annual premium for this applicant is in category **A**

Total Annual Premium Amount per child or young adult/parent is: $48.00

Total Annual Family Contribution Amount: $48.00

Payment is required before eligibility begins. However making a payment is not required at this time. If you do want to make a payment, please send a check or money order payable to **Healthy Kids & Young Adults** along with the copy of this page to:

Healthy Kids & Young Adults Finance
201 3rd Street, 7th Floor
San Francisco, CA 94103
Attn: HKYA Eligibility

If you are unable to make a payment due to a financial hardship, you may be eligible for premium assistance.

Do you request for premium assistance? ○ Yes ○ No

Important Reminder: Your payment **does not guarantee** Healthy Kids & Young Adults eligibility; Healthy Kids & Young Adults will notify you when eligibility begins. You are responsible for services you receive before your Healthy Kids & Young Adults eligibility begins.

Healthy Kids & Young Adults

This is the first of several Healthy Kids & Young Adults pages.

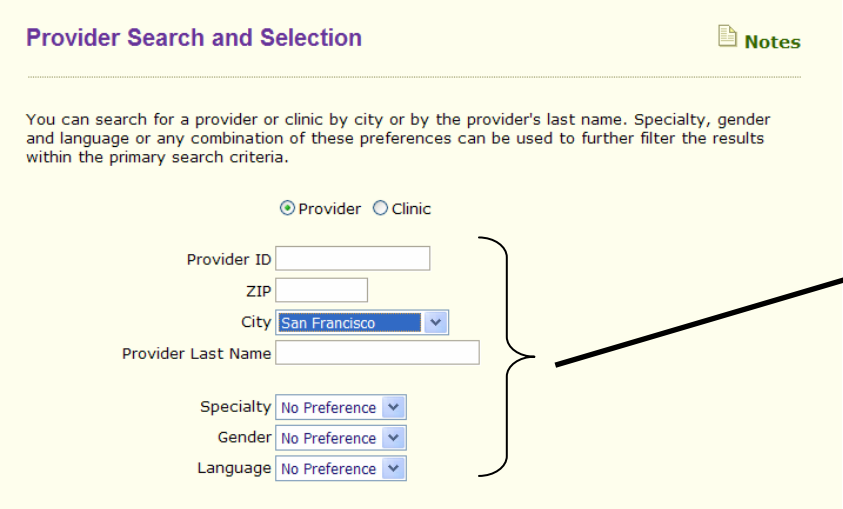
Family Contribution

The following series of screens are for applicants that are submitting an application to the Healthy Kids & Young Adults program.

The first screen is the family contribution page for eligible children and young adults.

Payment is required before eligibility begins. However making a payment is not required at this time. Information is provided if the family is interested in making a payment. There is only one annual payment and premium assistance is available for families with hardships.

STEP 7: Program Information

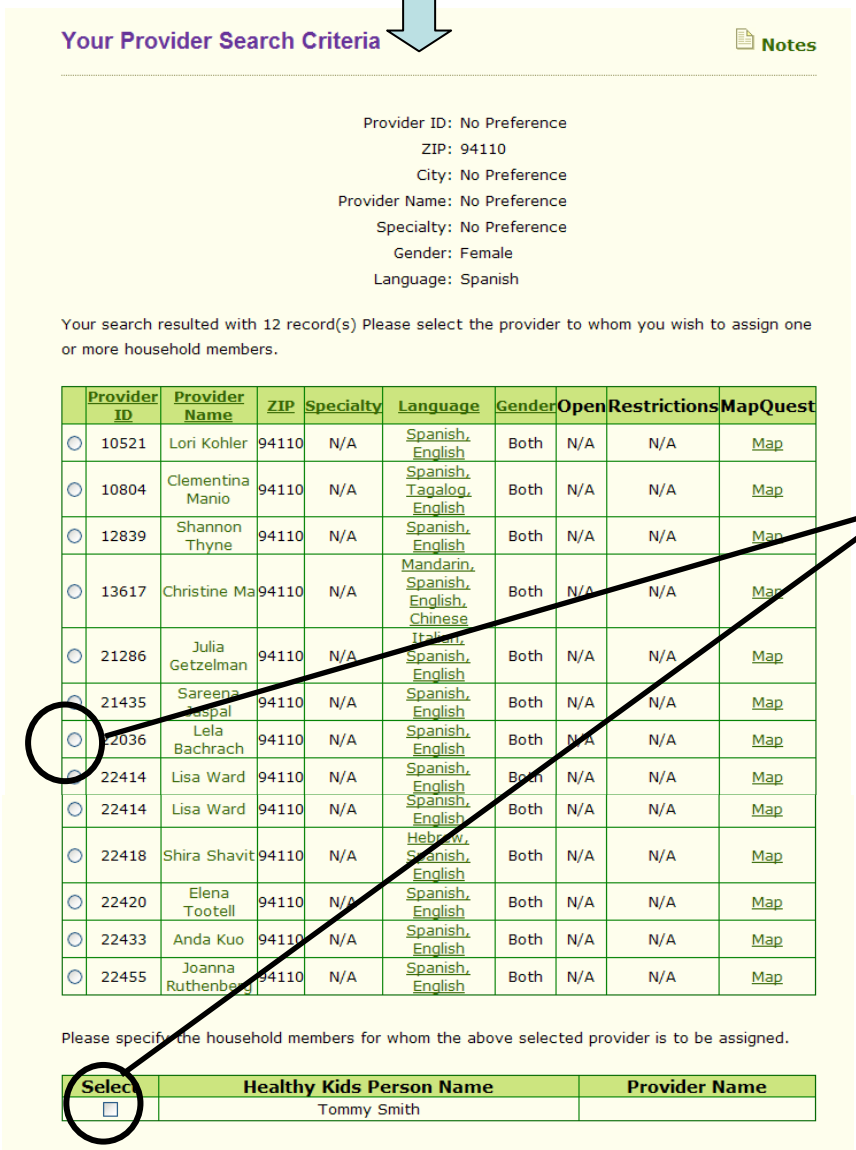


Healthy Kids & Young Adults (cont.)

Provider Selection

The applicant can select a provider OR clinic. You can search for a provider by one or more of the search criteria. Each additional criteria narrows the search results.

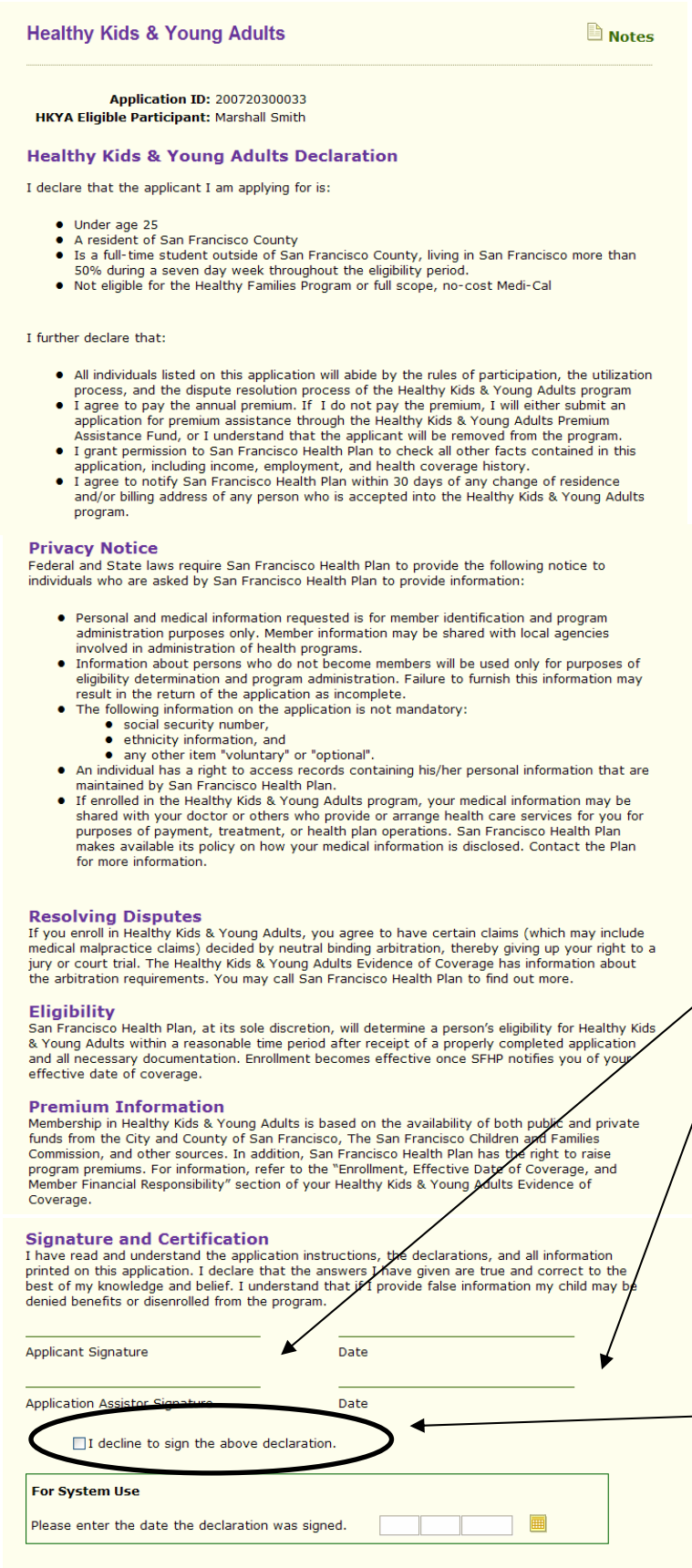
The system will continue to return to this page until all children have an identified provider.



Click on provider or clinic and the household member that will be assigned to that provider.

On the next page, you will receive a Provider Selection Summary which can be printed for the applicant. You may change the provider selection by clicking on the applicant's name in the Provider Search Summary page.

STEP 7: Program Information



Healthy Kids & Young Adults

Notes

Application ID: 200720300033
HKYA Eligible Participant: Marshall Smith

Healthy Kids & Young Adults Declaration

I declare that the applicant I am applying for is:

- Under age 25
- A resident of San Francisco County
- Is a full-time student outside of San Francisco County, living in San Francisco more than 50% during a seven day week throughout the eligibility period.
- Not eligible for the Healthy Families Program or full scope, no-cost Medi-Cal

I further declare that:

- All individuals listed on this application will abide by the rules of participation, the utilization process, and the dispute resolution process of the Healthy Kids & Young Adults program
- I agree to pay the annual premium. If I do not pay the premium, I will either submit an application for premium assistance through the Healthy Kids & Young Adults Premium Assistance Fund, or I understand that the applicant will be removed from the program.
- I grant permission to San Francisco Health Plan to check all other facts contained in this application, including income, employment, and health coverage history.
- I agree to notify San Francisco Health Plan within 30 days of any change of residence and/or billing address of any person who is accepted into the Healthy Kids & Young Adults program.

Privacy Notice
Federal and State laws require San Francisco Health Plan to provide the following notice to individuals who are asked by San Francisco Health Plan to provide information:

- Personal and medical information requested is for member identification and program administration purposes only. Member information may be shared with local agencies involved in administration of health programs.
- Information about persons who do not become members will be used only for purposes of eligibility determination and program administration. Failure to furnish this information may result in the return of the application as incomplete.
- The following information on the application is not mandatory:
  - social security number,
  - ethnicity information, and
  - any other item "voluntary" or "optional".
- An individual has a right to access records containing his/her personal information that are maintained by San Francisco Health Plan.
- If enrolled in the Healthy Kids & Young Adults program, your medical information may be shared with your doctor or others who provide or arrange health care services for you for purposes of payment, treatment, or health plan operations. San Francisco Health Plan makes available its policy on how your medical information is disclosed. Contact the Plan for more information.

Resolving Disputes
If you enroll in Healthy Kids & Young Adults, you agree to have certain claims (which may include medical malpractice claims) decided by neutral binding arbitration, thereby giving up your right to a jury or court trial. The Healthy Kids & Young Adults Evidence of Coverage has information about the arbitration requirements. You may call San Francisco Health Plan to find out more.

Eligibility
San Francisco Health Plan, at its sole discretion, will determine a person's eligibility for Healthy Kids & Young Adults within a reasonable time period after receipt of a properly completed application and all necessary documentation. Enrollment becomes effective once SFHP notifies you of your effective date of coverage.

Premium Information
Membership in Healthy Kids & Young Adults is based on the availability of both public and private funds from the City and County of San Francisco, The San Francisco Children and Families Commission, and other sources. In addition, San Francisco Health Plan has the right to raise program premiums. For information, refer to the "Enrollment, Effective Date of Coverage, and Member Financial Responsibility" section of your Healthy Kids & Young Adults Evidence of Coverage.

Signature and Certification
I have read and understand the application instructions, the declarations, and all information printed on this application. I declare that the answers I have given are true and correct to the best of my knowledge and belief. I understand that if I provide false information my child may be denied benefits or disenrolled from the program.

Applicant Signature _____ Date _____

Application Assistor Signature _____ Date _____

☐ I decline to sign the above declaration.

For System Use

Please enter the date the declaration was signed. ☐☐☐

Healthy Kids & Young Adults (cont.)

Rights and Declarations

Review this document with the applicant, then follow the steps below.

Follow These Steps

1. Print a copy for signing.

2. Have the applicant sign and date. Add your signature and date. Then enter the date it was signed in One-e-App.

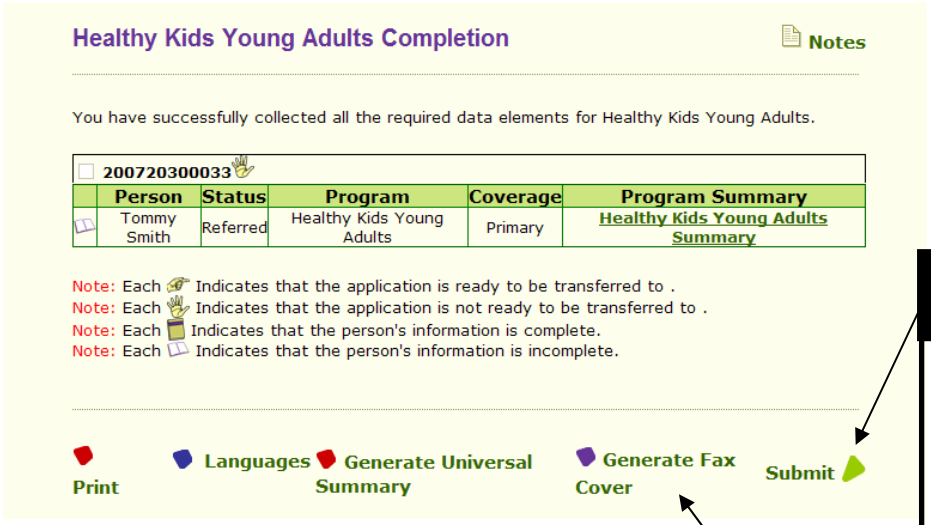
3. Make a copy for the applicant.

4. Fax with other required verification documents.

5. Have applicant mail payment to the San Francisco Health Plan (if applicable).

Applicant can choose to decline to sign the form. This will end the application process.

STEP 7: Program Information

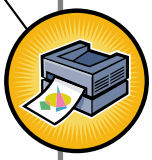


Healthy Kids & Young Adults (cont.)

Completion Page

Submit to Healthy Kids & Young Adults!

You have reached the Healthy Kids & Young Adults Completion Page. Click here to submit the application to the San Francisco Health Plan. Once you fax in the documentation to One-e-App you have completed the application to Healthy Kids & Young Adults.



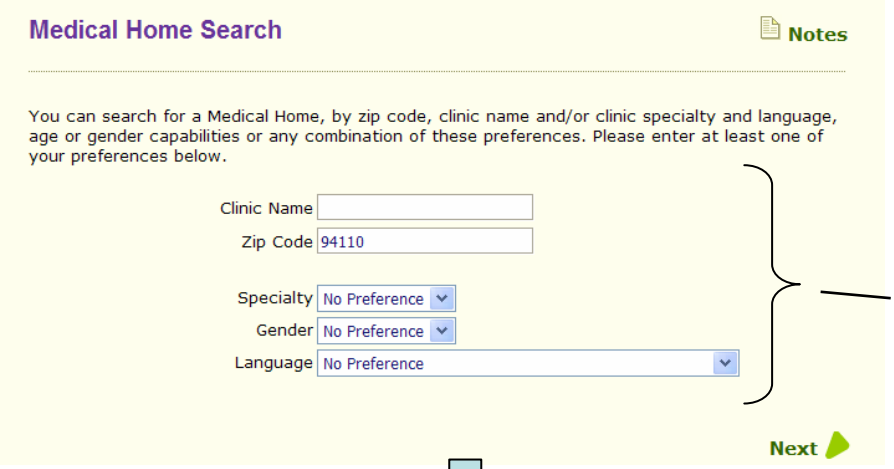
Click on Generate Fax Cover Sheets to print the One-e-App Temporary and Permanent Fax Cover Sheets. See page139 for faxing tips.

HKYA applications that are complete with all required verifications prior to the 25th day of the month (or the business day prior if 25th falls on a weekend or holiday) will be processed to start coverage the 1st day of the following month, if found eligible.

You can generate the Healthy Kids & Young Adults Summary Page by clicking on the Greenlink.

STEP 7: Program Information

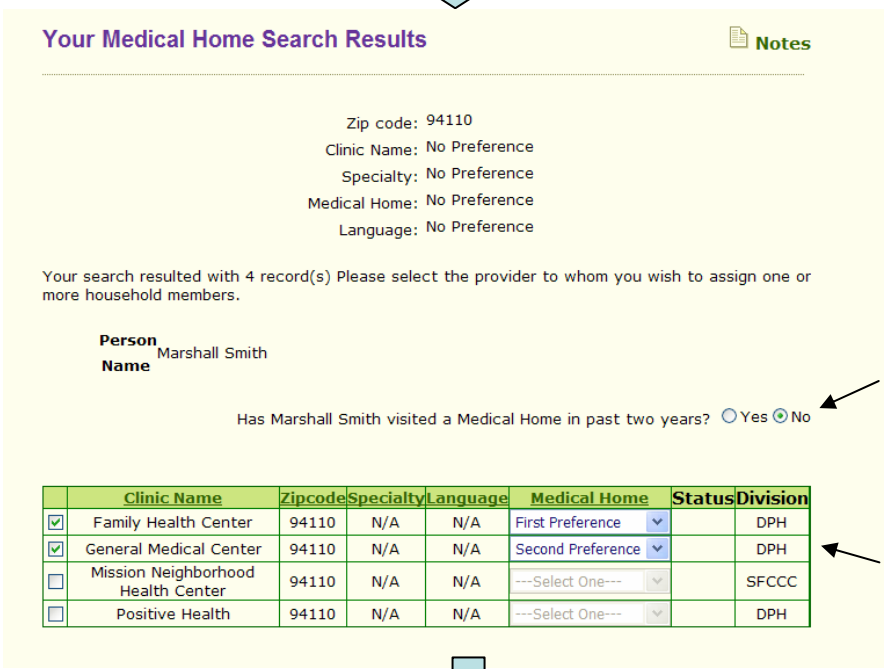
Healthy San Francisco



This is the first of several Healthy San Francisco pages.

Medical Home Selection

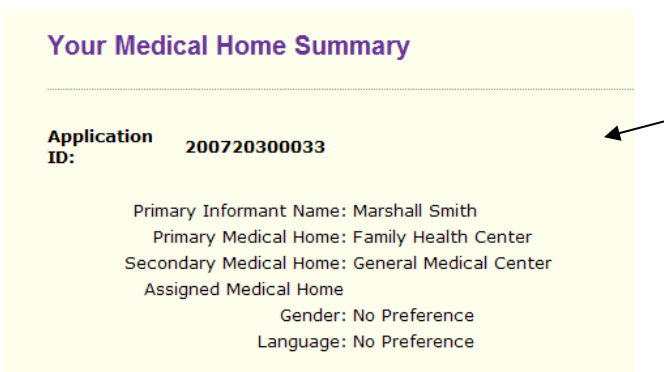
Search for a Medical Home for each applicant by one or more criteria. Each additional criteria narrows the search results further.

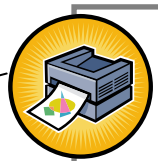


This is a preferential request and is based on availability. See next page for additional information about Medical Home selection.

Indicate whether the applicant has visited a Medical Home in the past two years. If the applicant chooses to they can use that existing clinic as their Medical Home.

Otherwise, select a first and second preference for a Medical Home from the table.





You will see a summary of the selection the applicant made. You can print a copy for the applicant.

Healthy San Francisco (cont.)

Medical Home Assignment

Medical Home Selection
Healthy San Francisco Applicants are required to select a preferred **first and second choice** medical home during One-e-App screening. This is to ensure that individuals can be assigned a medical home if their first choice no longer has availability by the time they officially complete their application. Applicants will have access to information about a medical home to aid them in the selection process, such as location (zip code) or the specific foreign languages spoken by practitioners at a clinic (language). Participants with an existing Healthy San Francisco medical home can maintain their assignment or select an alternative medical home during One-e-App screening.

Medical Home Assignment
An applicant's medical home assignment is finalized when all document and payment (if applicable) are received by Healthy San Francisco. This date can be significantly later than the date of original screening if the applicant does not send in their payment to Healthy San Francisco in a timely fashion. A completed application requires submission of all required documentation and a minimum of the first quarter's payment for those assessed a participant fee. If the applicant's 1st choice medical home is "open," in One-e-App, the applicant is assigned to this site. If the applicant's 1st choice medical home is "closed", the applicant is assigned to their 2nd choice medical home. If both the 1st and 2nd choice medical home requests are "closed", One-e-App will auto-assign a medical home to the participant according to the following logic:

Auto-Assignment Logic (If Applicant's 1st and 2nd Choice Medical Homes are Closed)
If a homeless applicant has selected a DPH medical home, the applicant will be assigned to Tom Waddell. If Tom Waddell is "closed" the applicant will be assigned to General Medical Clinic or Family Health Center. If the applicant is not a homeless individual who selected DPH as a medical home, but has requested a clinic with providers that speak a particular language, the system will assign the participant to an open clinic with providers meeting the applicant's language requirement. If this is not a factor or there is no available open clinic which meets this criterion, the system will assign the participant to a medical home with a patient catchment area which includes the participant's zip code.

Medical Home Re-Assignment Frequency
All participants can select a new medical home choice during annual reenrollment in One-e-App. This medical home change will officially occur on the eligibility date of the participant's reenrollment year. Participants must call Healthy San Francisco customer service to request a medical home change outside of an enrollment. Only those individuals who experience one of the following changes of status can change their medical home assignment outside of an enrollment:
- Change of S.F. resident address
- Participant who was auto-assigned to a medical home
- Participant who explicitly requests assignment to Positive Health
- Pursuit to a grievance

STEP 7: Program Information

English | Español

City and County of San Francisco

Healthy San Francisco Rights and Declarations

Notes

Application ID: 200722300031
HSF Eligible Participant: Ozzy Osbourne

I, **Ozzy Osbourne** , am eligible for the Healthy San Francisco program.I have read and agreed to each of the following:

- I am a current resident of San Francisco City and County.
- I am ages 18-64 or an emancipated minor (includes minors not living in the home of a birth or adoptive parent, a legal guardian, caretaker relative, foster parent, or stepparent).
- I am not currently enrolled or eligible for any full-scope public health insurance program. If I am found eligible for any other full-scope public coverage program, I will be dis-enrolled from Healthy San Francisco.
- I am not enrolled in nor have I dropped employer-sponsored or individual health insurance coverage program within the last 90 days.
- I understand that Healthy San Francisco is ***not*** an insurance program and is only valid at ***pre-approved*** Healthy San Francisco providers. If I obtain care at a non-Healthy San Francisco provider, I understand that I will be responsible for all assessed charges related to my treatment/care.
- I understand that I will be dis-enrolled for the following reasons outlined in the Healthy San Francisco participant guide.
- If I become eligible for public health insurance during the year, gain employer sponsored or individual coverage, or experience a change of income, I will notify San Francisco Health Plan customer service immediately.
- I understand that my eligibility will be reviewed, at minimum, annually. I also agree to undergo eligibility re-screening on request.
- If I am asked to apply for any other public coverage program, I must do so. If I refuse to cooperate when requested to apply for a public coverage program, I will be dis-enrolled and may be responsible for all assessed charges related to my treatment/care.
- I understand that, based on the information I provided for income and liquid assets, I will be charged an annual fee of **$0.00** assessed on a quarterly basis. I understand that I am responsible for paying all Healthy San Francisco participant fees and point-of-service fees.
- I acknowledge that I have received a copy of the Healthy San Francisco participant guide and agree to abide by program terms and conditions.
- I understand that if the information I provide as part of my application is found to be inaccurate, I will be immediately dis-enrolled and may be billed retroactively for all services previously covered under the Healthy San Francisco program.

Signature and Certification

I state that I have read information on this form and have been given the opportunity to discuss any of the above items with an eligibility worker.I declare that the above information is true and correct. Further, by signing below, I authorize County personnel, agents or contractors to verify my eligibility.

Applicant Signature _____ Date _____

Application Assistor Signature _____ Date _____

☐ I decline to sign the above declaration.

For System Use

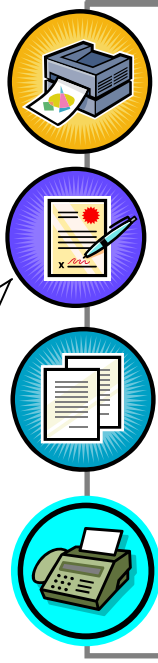
Please enter the date the declaration was signed. 8 12 2007

Healthy San Francisco (cont.)

Rights and Declarations

Review this document with the applicant, then follow the steps below.

Follow These Steps



1. Print a copy for signing.
2. Have the applicant sign and date. Add your signature and date. Then enter the date it was signed in One-e-App.
3. Make a copy for the applicant.
4. Fax with other required verification documents.

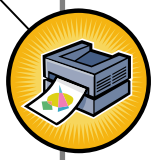
STEP 7: Program Information

Healthy San Francisco (cont.)

Completion Page

Submit to Healthy San Francisco!

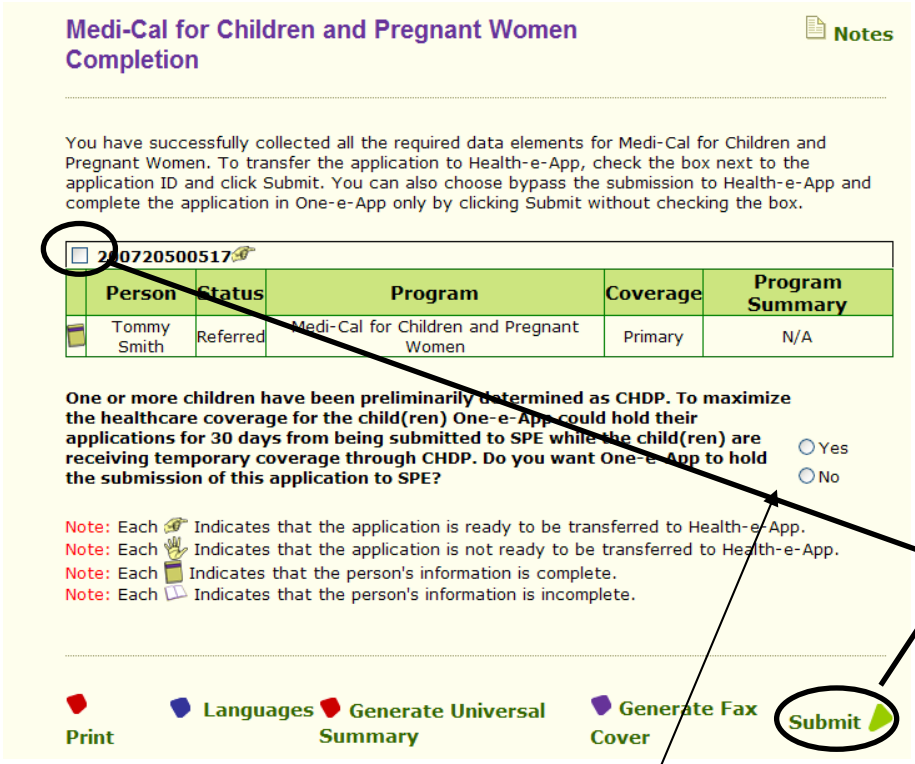
You have reached the Healthy San Francisco Completion Page. Click here to submit the application. Once you fax in the documentation to One-e-App you have completed the application to Healthy San Francisco.



You can click on Generate Fax Cover Sheets to print the One-e-App Temporary and Permanent Fax Cover Sheets. See page 139 for faxing tips.

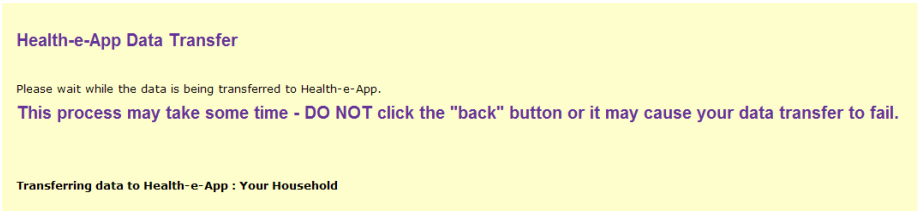
Optional:
You can generate the Healthy San Francisco Summary Page by clicking on the Greenlink.

STEP 8: Health-e-App Data Transfer



Important information regarding CHDP Referrals

If the applicant is also eligible for CHDP, you will see a question asking whether the applicant wants to delay their submission to Health-e-App by 30 days to maximize the length of their coverage. To delay the submission, click Yes. You will be prompted by a tickler in One-e-App to submit the application to Health-e-App in 30 days. Otherwise, click No and the submission will proceed immediately.



Medi-Cal for children and pregnant women

This is the first of several Medi-Cal for Children and Pregnant Women pages. For this program, One-e-App submits using an interface with the Health-e-App website.

Submit to Medi-Cal for children and pregnant women

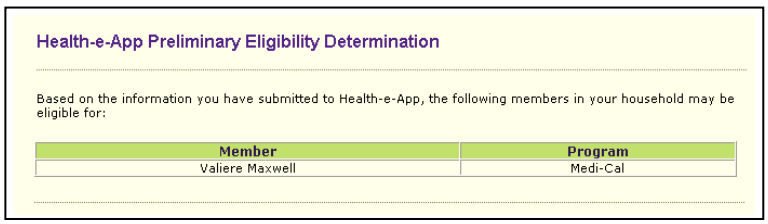
You have reached the Medi-Cal for children and pregnant women Completion page.

Check the box next to the Application ID and then click on "Submit" to send your application to the Single Point of Entry through an interface to the Health-e-App website. If you don't check the box before clicking submit, your application will not be submitted and you will either be navigated to the Main Menu or move to the next program submission process.

The system will go through a data transfer process that is interactive. This may take a few minutes. For problems with data transfers, refer to the Health-e-App Data Transfer Error on page x.

At the end of the submission process, you will see the Health-e-App fax cover sheet to print. Once you fax in the required documentation to Health-e-App you have completed the application process. It is also strongly recommended to fax documents into One-e-App for storage. See faxing tips on page 139.

STEP 8: Health-e-App Data Transfer



Medi-Cal for Children and Pregnant Women

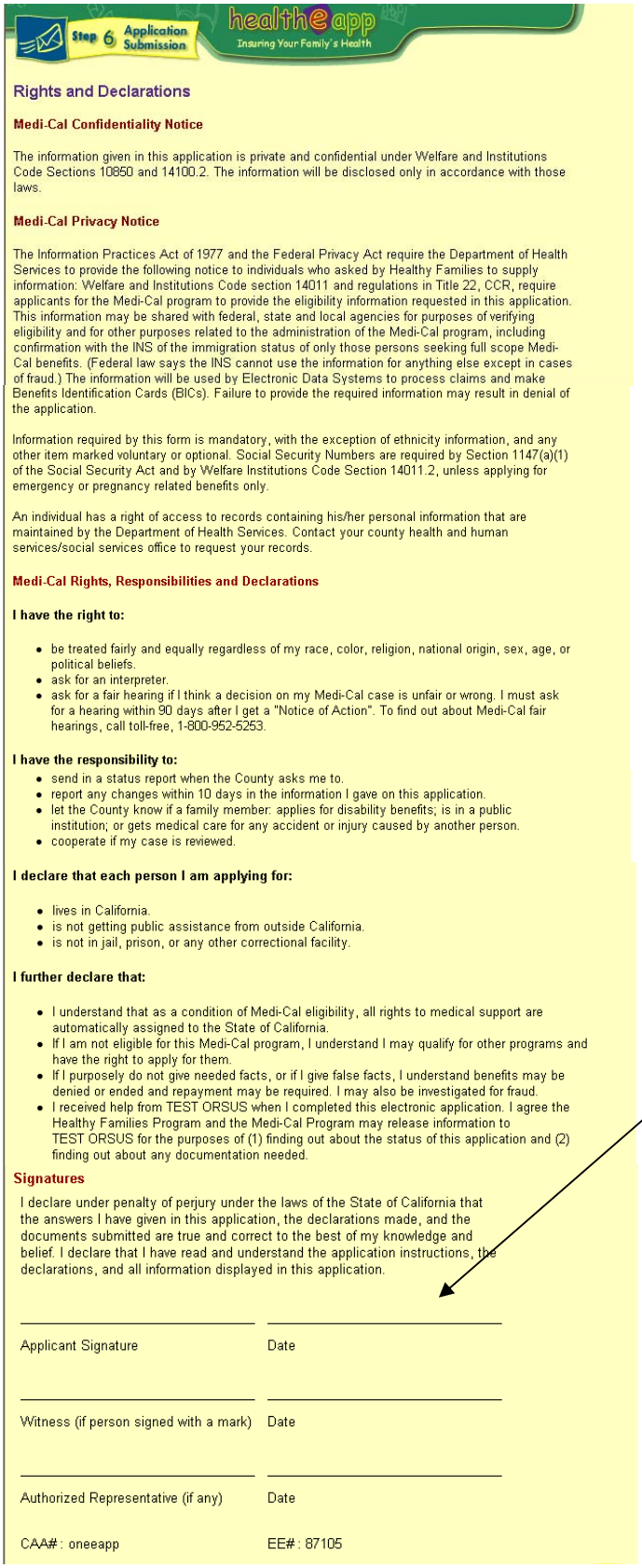
IMPORTANT: At this point, you are viewing and interacting with pages from the Health-e-App website but you are still working in One-e-App.

The system will ask if any people listed below want Medi-Cal and gives one last chance to add a household member.

The system will list the household members and the programs for which they are potentially eligible.

When you click “next” you will begin the consent and signature process for Medi-Cal.

STEP 8: Health-e-App Data Transfer



Step 6 Application Submission

healthe app
Insuring Your Family's Health

Rights and Declarations

Medi-Cal Confidentiality Notice

The information given in this application is private and confidential under Welfare and Institutions Code Sections 10850 and 14100.2. The information will be disclosed only in accordance with those laws.

Medi-Cal Privacy Notice

The Information Practices Act of 1977 and the Federal Privacy Act require the Department of Health Services to provide the following notice to individuals who asked by Healthy Families to supply information: Welfare and Institutions Code section 14011 and regulations in Title 22, CCR, require applicants for the Medi-Cal program to provide the eligibility information requested in this application. This information may be shared with federal, state and local agencies for purposes of verifying eligibility and for other purposes related to the administration of the Medi-Cal program, including confirmation with the INS of the immigration status of only those persons seeking full scope Medi-Cal benefits. (Federal law says the INS cannot use the information for anything else except in cases of fraud.) The information will be used by Electronic Data Systems to process claims and make Benefits Identification Cards (BICs). Failure to provide the required information may result in denial of the application.

Information required by this form is mandatory, with the exception of ethnicity information, and any other item marked voluntary or optional. Social Security Numbers are required by Section 1147(a)(1) of the Social Security Act and by Welfare Institutions Code Section 14011.2, unless applying for emergency or pregnancy related benefits only.

An individual has a right of access to records containing his/her personal information that are maintained by the Department of Health Services. Contact your county health and human services/social services office to request your records.

Medi-Cal Rights, Responsibilities and Declarations

I have the right to:

- be treated fairly and equally regardless of my race, color, religion, national origin, sex, age, or political beliefs.
- ask for an interpreter.
- ask for a fair hearing if I think a decision on my Medi-Cal case is unfair or wrong. I must ask for a hearing within 90 days after I get a "Notice of Action". To find out about Medi-Cal fair hearings, call toll-free, 1-800-952-5253.

I have the responsibility to:

- send in a status report when the County asks me to.
- report any changes within 10 days in the information I gave on this application.
- let the County know if a family member: applies for disability benefits; is in a public institution; or gets medical care for any accident or injury caused by another person.
- cooperate if my case is reviewed.

I declare that each person I am applying for:

- lives in California.
- is not getting public assistance from outside California.
- is not in jail, prison, or any other correctional facility.

I further declare that:

- I understand that as a condition of Medi-Cal eligibility, all rights to medical support are automatically assigned to the State of California.
- If I am not eligible for this Medi-Cal program, I understand I may qualify for other programs and have the right to apply for them.
- If I purposely do not give needed facts, or if I give false facts, I understand benefits may be denied or ended and repayment may be required. I may also be investigated for fraud.
- I received help from TEST ORSUS when I completed this electronic application. I agree the Healthy Families Program and the Medi-Cal Program may release information to TEST ORSUS for the purposes of (1) finding out about the status of this application and (2) finding out about any documentation needed.

Signatures

I declare under penalty of perjury under the laws of the State of California that the answers I have given in this application, the declarations made, and the documents submitted are true and correct to the best of my knowledge and belief. I declare that I have read and understand the application instructions, the declarations, and all information displayed in this application.

Applicant Signature _____ Date _____

Witness (if person signed with a mark) _____ Date _____

Authorized Representative (if any) _____ Date _____

CAA#: oneeapp EE#: 87105

Medi-Cal for Children and Pregnant Women (cont.)

These are the Rights and Declarations pages for this program. Follow the steps below.

Follow These Steps

1. Print a copy for signing.

2. Have the applicant sign and date. Add your signature and date.

3. Make a copy for the applicant.

4. Fax with other required verification documents.

STEP 8: Health-e-App Data Transfer

Medi-Cal for Children and Pregnant Women (cont.)

The primary informant/applicant needs to certify that the application was completed free of charge.

This screen also allows the applicant to provide consent for release of information to the Healthy Families Program. This gives the Application Assistor the ability to work with Healthy Families on behalf of the applicant. This consent will last until Healthy Families enrolls the child into the program.

Follow These Steps

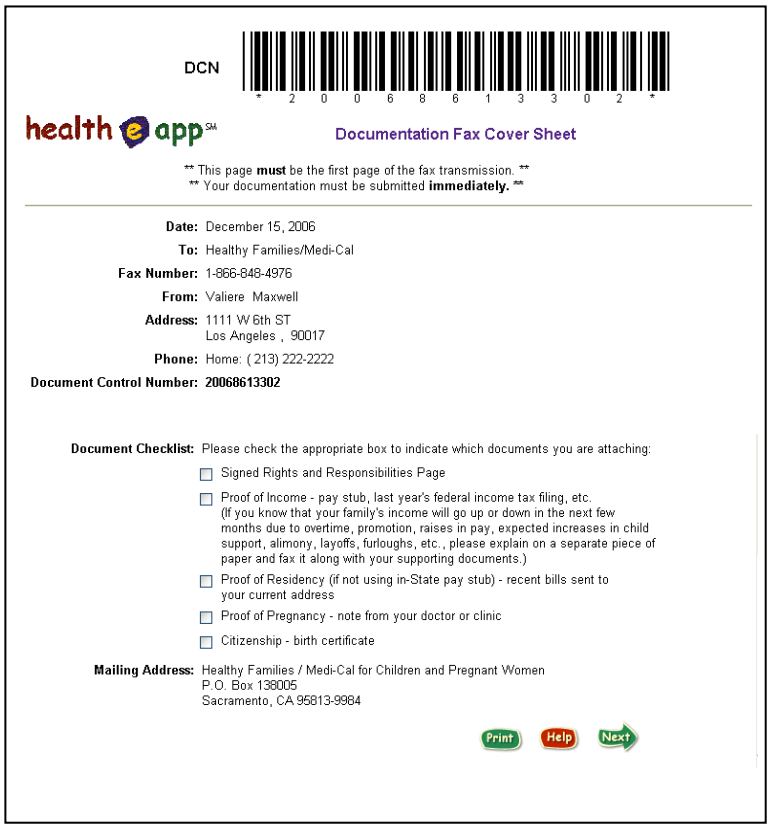
1. Print a copy for signing.

2. Have the applicant sign and date. Add your signature and date.

3. Make a copy for the applicant.

4. Fax with other required verification documents.

STEP 8: Health-e-App Data Transfer



DCN * 2 0 0 6 8 6 1 3 3 0 2 *

health e app℠ Documentation Fax Cover Sheet

** This page **must** be the first page of the fax transmission. **
** Your documentation must be submitted **immediately.** **

Date: December 15, 2006
To: Healthy Families/Medi-Cal
Fax Number: 1-866-848-4976
From: Valiere Maxwell
Address: 1111 W 6th ST
Los Angeles , 90017
Phone: Home: (213) 222-2222
Document Control Number: **20068613302**

Document Checklist: Please check the appropriate box to indicate which documents you are attaching:

- ☐ Signed Rights and Responsibilities Page
- ☐ Proof of Income - pay stub, last year's federal income tax filing, etc. (If you know that your family's income will go up or down in the next few months due to overtime, promotion, raises in pay, expected increases in child support, alimony, layoffs, furloughs, etc., please explain on a separate piece of paper and fax it along with your supporting documents.)
- ☐ Proof of Residency (if not using in-State pay stub) - recent bills sent to your current address
- ☐ Proof of Pregnancy - note from your doctor or clinic
- ☐ Citizenship - birth certificate

Mailing Address: Healthy Families / Medi-Cal for Children and Pregnant Women
P.O. Box 138005
Sacramento, CA 95813-9984

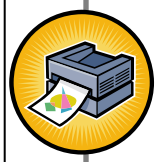
Print Help Next

Medi-Cal for Children and Pregnant Women (cont.)

You will be navigated to the Health-e-App Fax Cover Sheet. This should automatically happen after you have completed the printing and signing of Rights and Declarations.

If you are not navigated to the Health-e-App Fax Cover Sheet, you can access it from the One-e-App Menu.

Follow These Steps

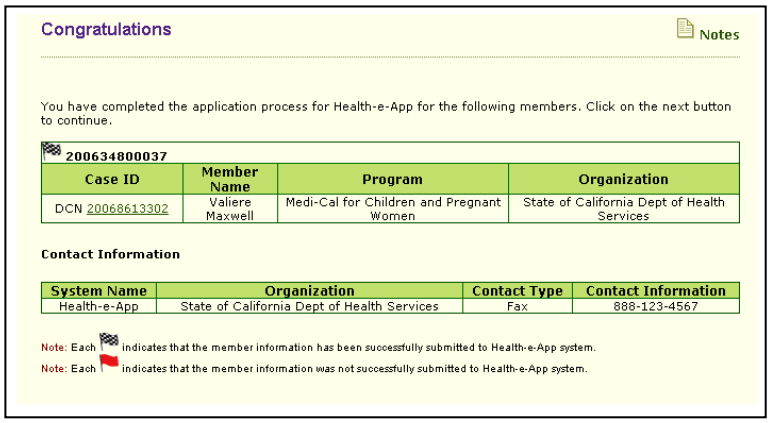


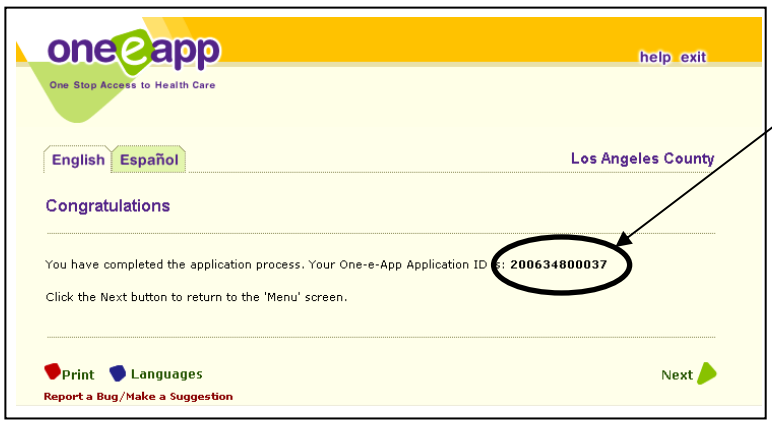
1. Print a copy. Check off the items that are being included on the cover sheet.
2. Assemble required documentation and write the DCN number on each document faxed to help keep documents from getting lost when faxed to Health-e-App.

3. Fax with other required verification documents to Health-e-App using the fax number on the coversheet. **FAX WITHIN 24 HOURS OF SUBMITTING.**
4. For storage, fax into One-e-App using the One-e-App fax cover sheet.

See page 139 for faxing tips.

STEP 8: Health-e-App Data Transfer





Medi-Cal for Children and Pregnant Women (cont.)

This screen will indicate if the application was successfully submitted to Health-e-App.

A state contact number for Medi-Cal or Healthy Families is provided if the applicant was found potentially eligible.

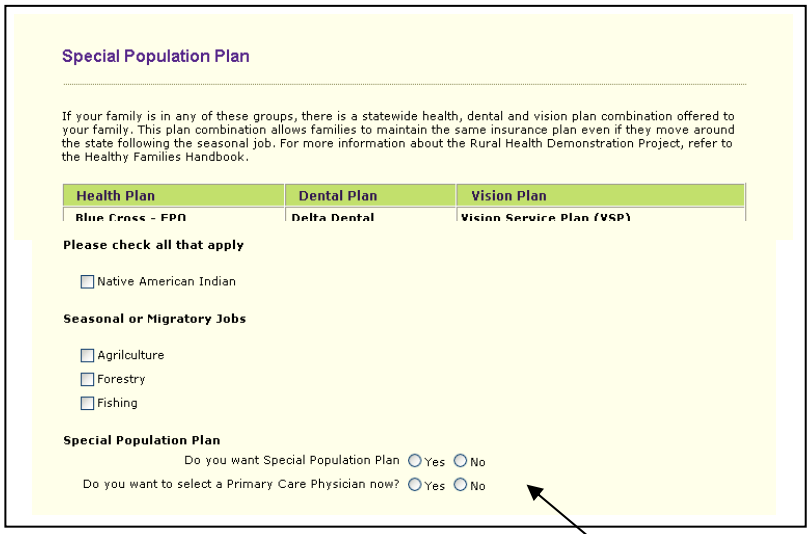
Once you have completed the submission process a Health-e-App Application Summary is generated and will pop up on the screen.

Congratulations! You have completed the application process!
The application ID number is listed on this screen. An application ID is a Unique Identifier that can assist you in locating the application again in the One-e-App system.

You will be navigated back to the main menu when you click on ***Next***.

STEP 8: Health-e-App Data Transfer

Healthy Families



This is the first of several Healthy Families Pages.

Special Population Plan

Within Healthy Families there is a special insurance plan called the ***Special Population Plan*** which offers health, dental and vision coverage for American Indians and families employed in seasonal jobs in agriculture, fishery, or forestry.

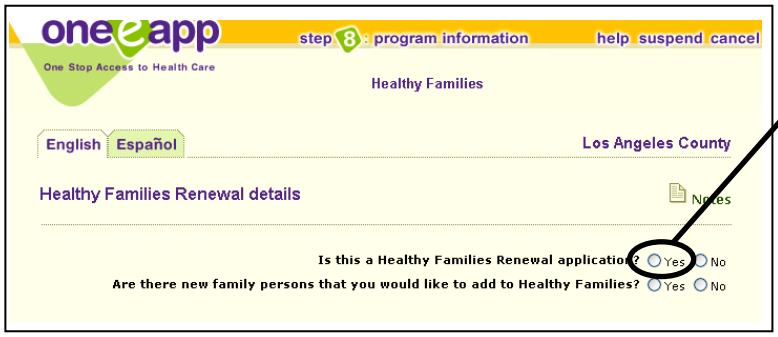
This plan combination is available statewide (see ***Resources***).

It allows families to keep the same health plans even if they move around the state.

Indicate whether this applicant is a part of a Special Population Plan.

STEP 8: Health-e-App Data Transfer

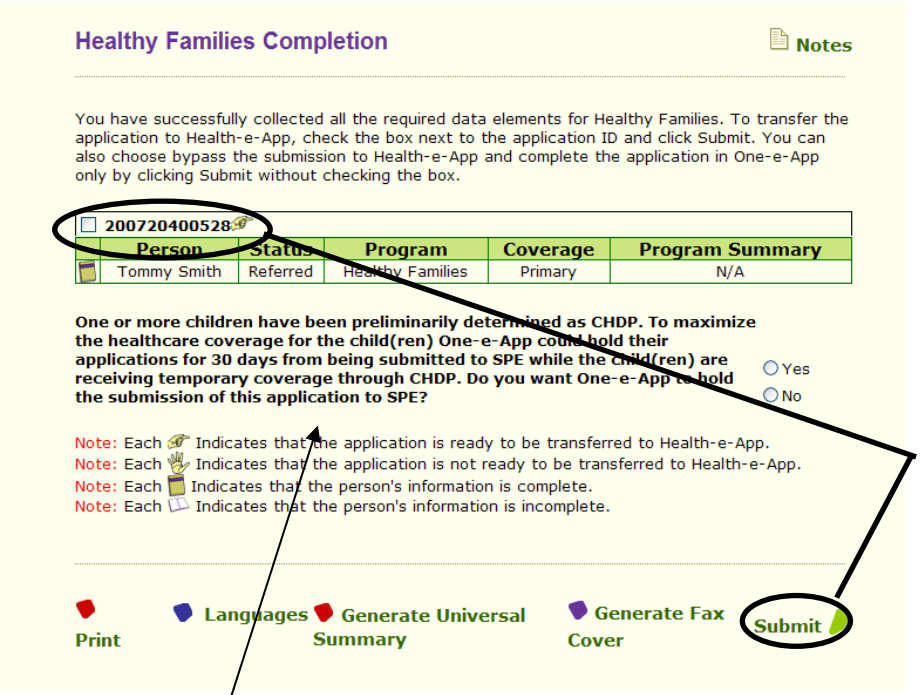
Healthy Families (cont.)



One-e-App does not process **Healthy Families Renewals** electronically; the system will generate a pre-populated renewal form to print and mail to the Healthy Families Program.

See page 103 for more information.

STEP 8: Health-e-App Data Transfer



Important information regarding CHDP Referrals

If the applicant is also eligible for CHDP, you will see a question asking whether the applicant wants to delay their submission to Health-e-App by 30 days to maximize the length of their coverage. To delay the submission, click Yes. You will be prompted by a tickler in One-e-App to submit the application to Health-e-App in 30 days. Otherwise, click No and the submission will proceed immediately.

Healthy Families (cont.)

When you reach this screen you are ready to submit your application to Health-e-App.

Submit to Healthy Families

You have reached the Healthy Families Completion page.

Check the box next to the Application ID and then click on "Submit" to send your application to the Single Point of Entry through an interface to the Health-e-App website. If you don't check the box before clicking submit, your application will not be submitted and you will either be navigated to the Main Menu or move to the next program submission process.

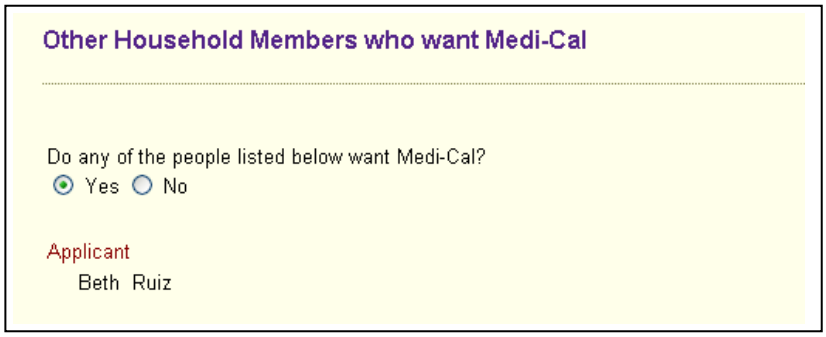
The system will go through a data transfer process that is interactive. This may take a few minutes. For problems with data transfers, refer to the Health-e-App Data Transfer Error on page x.

At the end of the submission process, you will see the Health-e-App fax cover sheet to print. Once you fax in the required documentation to Health-e-App you have completed the application process. It is also strongly recommended to fax documents into One-e-App for storage. See faxing tips on page 139.

You will see a Data Transfer Pop Up each time a section of the application is transferred into the Health-e-App system.

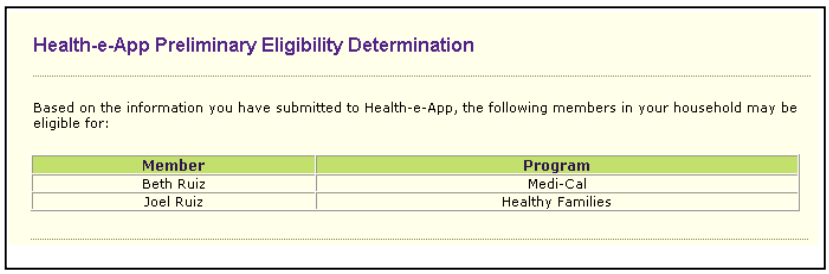
STEP 8: Health-e-App Data Transfer

Healthy Families (cont.)



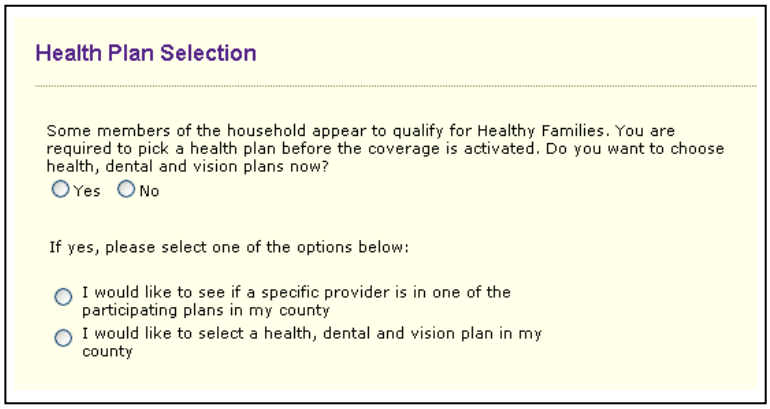
IMPORTANT: At this point, you are viewing and interacting with pages from the Health-e-App website but you are still working in One-e-App.

The Health-e-App system will ask if any people listed below want Medi-Cal. This screen gives a final opportunity to add a household member.



The Health-e-App system will list the household members and the programs for which they are potentially eligible.

STEP 8: Health-e-App Data Transfer



Healthy Families (cont.)

Health Plan Selection

The applicant can choose a health plan or a specific provider at this time or wait and contact Healthy Families later. If the applicant does not choose and does not contact Healthy Families, Healthy Families personnel will contact the family.

Applicants can search for a specific provider or health plan.

If families who do not make a choice cannot be reached by phone (within 20 days, with four attempts) or in writing, the child will be defaulted into the Community Plan for that county so that health coverage can start. The family can change plans within the first 90 days, with no questions asked.

STEP 8: Health-e-App Data Transfer

Please select a health, dental, and vision plan:

For those individuals potentially eligible for Healthy Families, please select a health plan below.

HEALTH PLANS			
Select	Plan Name	Plan Rate	Phone Number
○	KAISER PERMANENTE	$ 7	(800) 464-4000
○	BLUE SHIELD - HMO	$ 7	(800) 424-6521
○	SAN FRANCISCO HEALTH	$ 4	(800) 288-5555
○	BLUE CROSS - HMO	$ 7	(800) 845-3604
○	HEALTH NET	$ 7	(888) 231-9473

DENTAL PLANS		
Select	Plan Name	Phone Number
○	WESTERN DENTAL	(800) 805-8000
○	SAFEGUARD DENTAL	(800) 880-3080
○	DELTA DENTAL	(877) 580-1042
○	ACCESS DENTAL	(888) 849-8440

VISION PLANS		
Select	Plan Name	Phone Number
○	EYE MED VISION CARE	(513) 492-3541
○	SAFEGUARD VISION	(949) 425-4301
○	VISION SERVICE PLAN	(800) 877-7239

Do you want to select a primary care physician now? ○ Yes ○ No

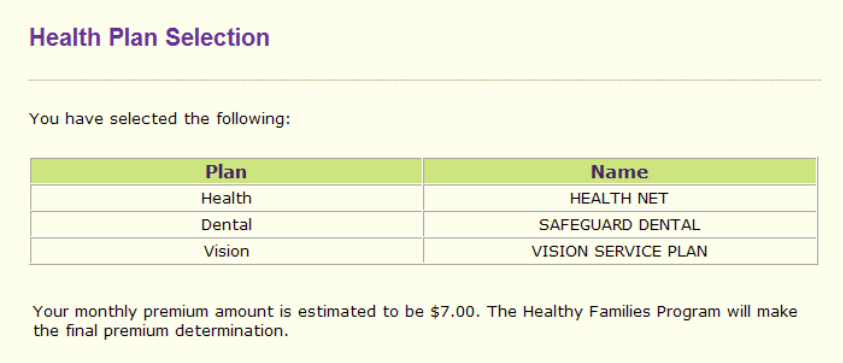
Healthy Families (cont.)

Health Plan Selection (cont.)

Applicants will be able to select their health, dental and vision plan from the list.

STEP 8: Health-e-App Data Transfer

Healthy Families (cont.)

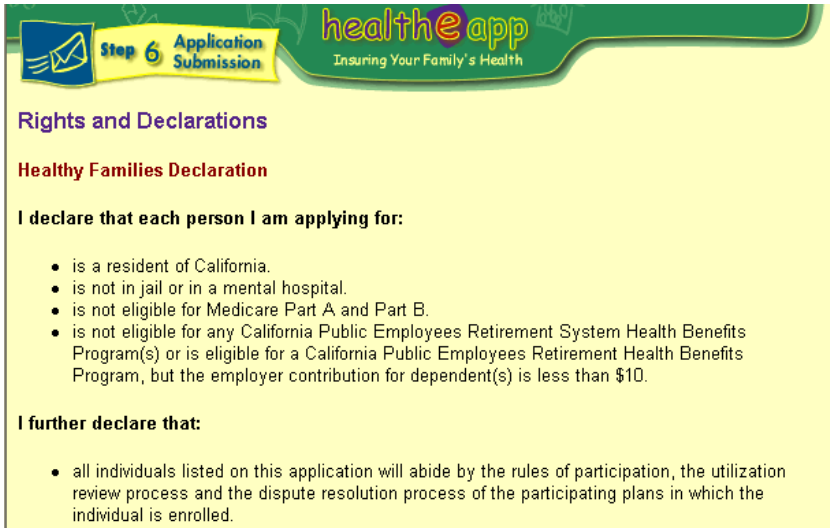


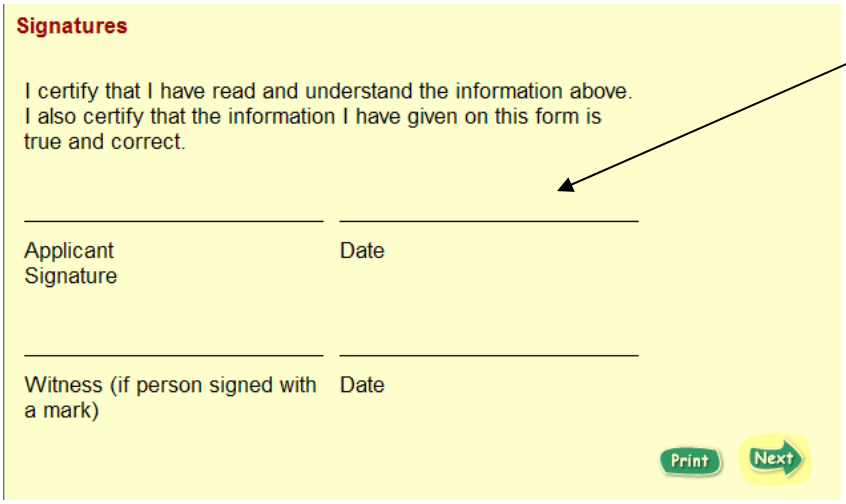
Health Plan Selection (cont.)

Review the plans that the applicant has selected and confirm that they are correctly listed on screen.

The system will give an estimate of the premium payment based on the health plan selected. The Healthy Families program will make the final premium determination. Coverage may start without payment and families will be billed.

STEP 8: Health-e-App Data Transfer





Healthy Families (cont.)

Healthy Families Rights and Declarations

This is the Healthy Families Rights and Declarations page. Review with the applicant and then follow the steps below.

Follow These Steps

1. Print a copy for signing.

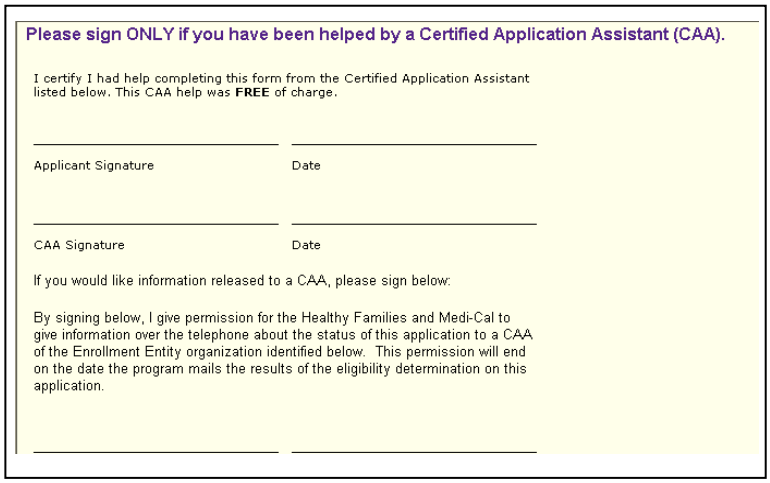
2. Have the applicant sign and date.

3. Make a copy for the applicant.

4. Fax with other required verification documents.

STEP 8: Health-e-App Data Transfer

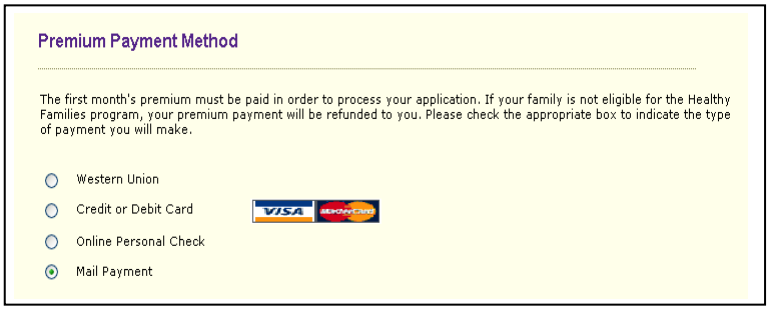
Healthy Families (cont.)



CAA Assistance Page

The applicant will need to certify that the application was completed free of charge.

This screen also allows the applicant to provide consent for release of information to the Healthy Families Program. This gives the Applicant Assistor the ability to work with Healthy Families on behalf of the applicant. This consent will last until Healthy Families enrolls the child into the program.



Premium Payment Page

Indicate the method for paying the premium. See payment options below.

There are four ways to pay premiums in the Healthy Families program:

1. Payments may be made by mail with a Personal Check, Cashiers Check, or Money Order. Make checks out to the "Healthy Families Program".

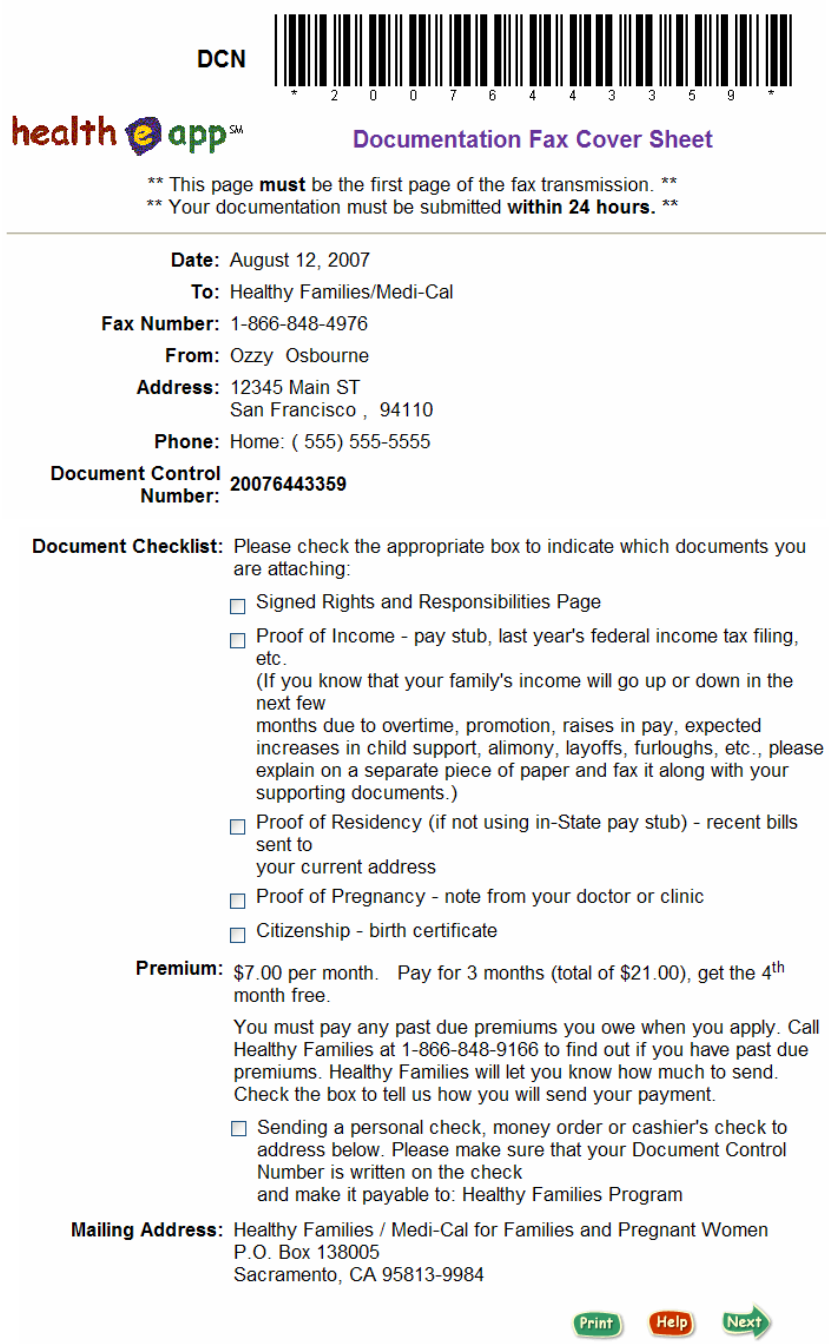
Mail payments to:
Healthy Families
P.O. Box 537019
Sacramento, CA 95853-7019

2. Payments may be made by cash in person at certain Western Union Convenience Pay Locations. Call 1(800) 354-0005, option 5, to find a Western Union near you. There is no charge for this service.

3. Payments may be made by Credit or Debit Card online or by phone. Click on the link to pay online or call 1(888) 256-6167 to pay over the phone.

4. Payments taken electronically from the applicant's banking account with Electronic Fund Transfers (EFT). To pay by EFT follow the steps on the back of monthly statements received once enrolled in Healthy Families.

STEP 8: Health-e-App Data Transfer



DCN *2007644335*

health e app℠ Documentation Fax Cover Sheet

** This page **must** be the first page of the fax transmission. **
** Your documentation must be submitted **within 24 hours.** **

Date: August 12, 2007
To: Healthy Families/Medi-Cal
Fax Number: 1-866-848-4976
From: Ozzy Osbourne
Address: 12345 Main ST
San Francisco , 94110
Phone: Home: (555) 555-5555
Document Control Number: **20076443359**

Document Checklist: Please check the appropriate box to indicate which documents you are attaching:

- ☐ Signed Rights and Responsibilities Page
- ☐ Proof of Income - pay stub, last year's federal income tax filing, etc.
  (If you know that your family's income will go up or down in the next few
  months due to overtime, promotion, raises in pay, expected increases in child support, alimony, layoffs, furloughs, etc., please explain on a separate piece of paper and fax it along with your supporting documents.)
- ☐ Proof of Residency (if not using in-State pay stub) - recent bills sent to
  your current address
- ☐ Proof of Pregnancy - note from your doctor or clinic
- ☐ Citizenship - birth certificate

Premium: $7.00 per month. Pay for 3 months (total of $21.00), get the 4th month free.

You must pay any past due premiums you owe when you apply. Call Healthy Families at 1-866-848-9166 to find out if you have past due premiums. Healthy Families will let you know how much to send. Check the box to tell us how you will send your payment.

- ☐ Sending a personal check, money order or cashier's check to address below. Please make sure that your Document Control Number is written on the check
  and make it payable to: Healthy Families Program

Mailing Address: Healthy Families / Medi-Cal for Families and Pregnant Women
P.O. Box 138005
Sacramento, CA 95813-9984

Print Help Next

Healthy Families (cont.)

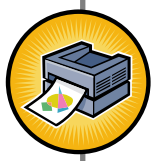
Health-e-App Fax Cover Sheet

You will be navigated to the Health-e-App Fax Cover Sheet. This should automatically happen after you have completed the printing and signing of Rights and Declarations.

If you are not navigated to the Health-e-App Fax Cover Sheet, you can access it from the One-e-App Menu.

The Fax Cover Sheet will list the amount of premium payment along with the mailing address.

Follow These Steps



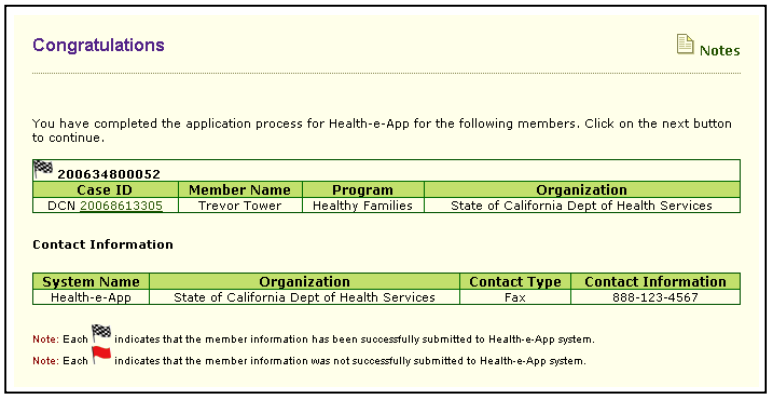
1. Print a copy. Check off the items that are being included on the cover sheet.
2. Assemble required documentation and write the DCN number on each document faxed to help keep documents from getting lost when faxed to Health-e-App.

3. Fax with other required verification documents to Health-e-App using the fax number on the coversheet. **FAX WITHIN 24 HOURS OF SUBMITTING.**
4. For storage, fax into One-e-App using the One-e-App fax cover sheet.

See page 139 for faxing tips.

STEP 8: Health-e-App Data Transfer

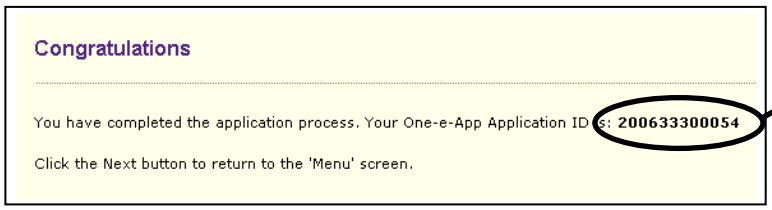
Healthy Families (cont.)



Congratulations Page

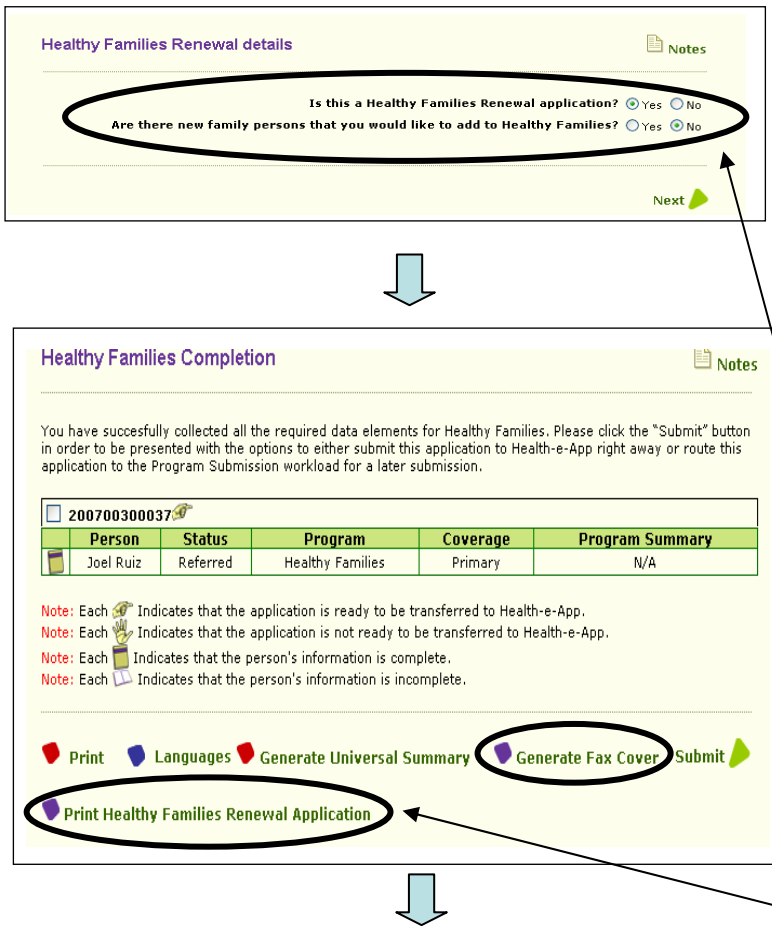
This screen will indicate if the application was successfully submitted to Health-e-App.

A state contact number for Medi-Cal or Healthy Families is provided.



Congratulations!
You have completed the application process! The Application ID number is listed on this screen. An Application ID is a Unique Identifier that can assist you in locating an application in the One-e-App system.

You will be navigated back to the main menu when you click on Next.



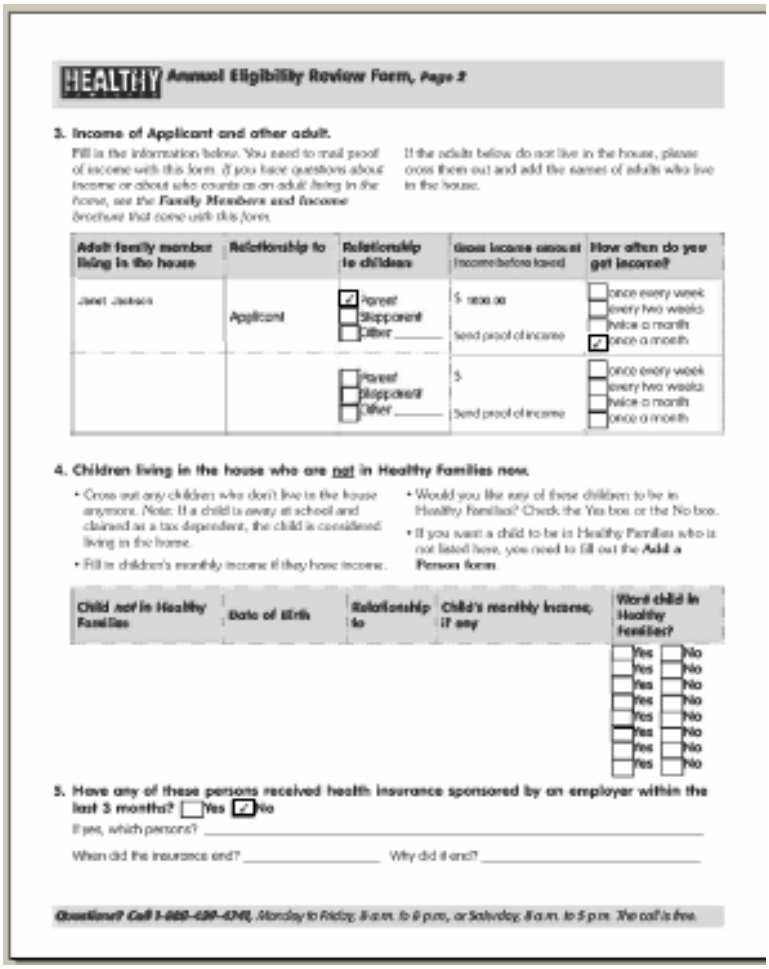
Healthy Families Annual Eligibility Review (AER) & Add a Child Form

The system will provide a Healthy Families AER and/or an Add a Child Form that can be filled out, printed and faxed or mailed to the Healthy Families program. (Please note that Health-e-App does not have the capacity for electronic renewals).

To begin an AER or Add a Child Form, select **"Begin Application"** from the Menu screen. You will enter the information as you would with a new application.

When you get to Step 8, "Program Information", you will indicate that this application is a "Healthy Families Renewal" and/ or indicate if you would like to "add a person (child)" to the Healthy Families case.

When you click "Next" you will be navigated to a Healthy Families Completion screen. You are now able to print out the **Healthy Families Renewal** or **Add a Child Form** by clicking on the "Print Healthy Families Renewal" option.



HEALTHY **Annual Eligibility Review Form,** *Page 2*

3. Income of Applicant and other adult.

Fill in the information below. You need to mail proof of income with this form. *If you have questions about income or about who counts as an adult living in the home, see the* ***Family Members and Income*** *brochure that came with this form.*

If the adults below do not live in the house, please cross them out and add the names of adults who live in the house.

Adult family member living in the house	Relationship to	Relationship to children	Gross income amount (income before taxes)	How often do you get income?
Janet Jackson	Applicant	☑ Parent ☐ Stepparent ☐ Other _____	$ 1800.00 Send proof of income	☐ once every week ☐ every two weeks ☐ twice a month ☑ once a month
		☐ Parent ☐ Stepparent ☐ Other _____	$ Send proof of income	☐ once every week ☐ every two weeks ☐ twice a month ☐ once a month

4. Children living in the house who are not in Healthy Families now.

- Cross out any children who don't live in the house anymore. *Note:* If a child is away at school and claimed as a tax dependent, the child is considered living in the home.
- Fill in children's monthly income if they have income.
- Would you like any of these children to be in Healthy Families? Check the Yes box or the No box.
- If you want a child to be in Healthy Families who is not listed here, you need to fill out the **Add a Person form**.

Child *not* in Healthy Families	Date of Birth	Relationship to	Child's monthly income, if any	Want child in Healthy Families?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

5. Have any of these persons received health insurance sponsored by an employer within the last 3 months? ☐ Yes ☑ No

If yes, which persons? _____

When did the insurance end? _____ Why did it end? _____

Questions? Call 1-888-439-4HF, Monday to Friday, 8 a.m. to 6 p.m. or Saturday, 8 a.m. to 5 p.m. The call is free.

Healthy Families Annual Eligibility Review (AER) & Add a Child Form (cont.)

Follow These Steps

1. Print a copy.

2. Have the applicant sign the form.

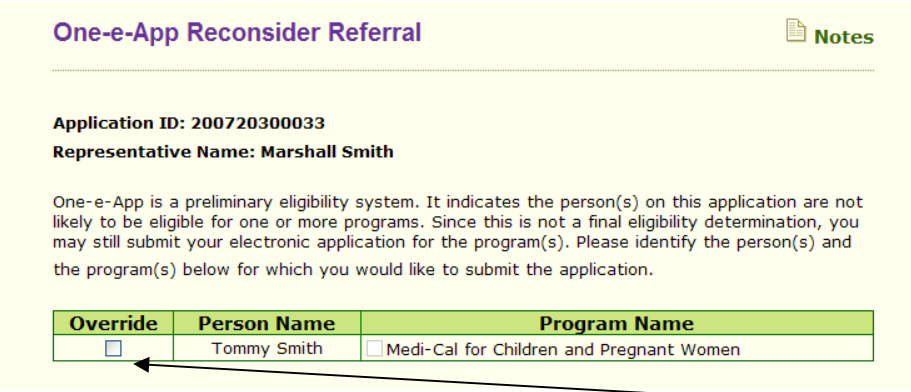
3. Make a copy for the applicant.

4. Mail or fax to Healthy Families. See AER form for instructions.

5. For storage, fax into One-e-App using the One-e-App fax cover sheet.

See page 139 for faxing tips.

STEP 7: Program Information

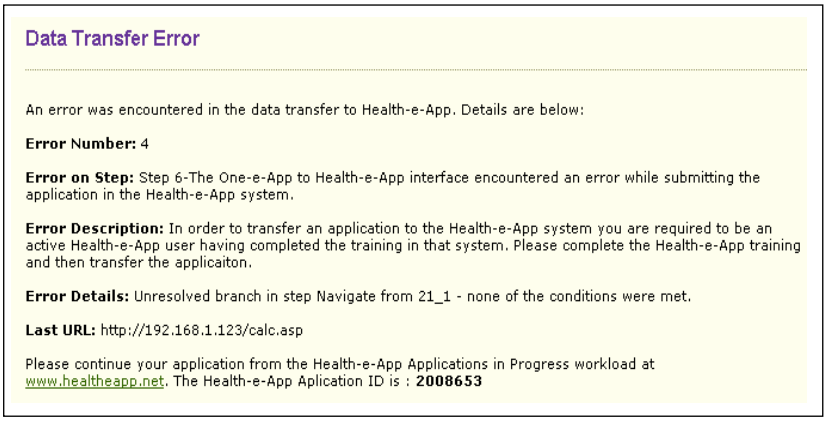


Health-e-App Application Reconsider Referral

If One-e-App determines an applicant to be preliminarily **ineligible** for Medi-Cal for children or pregnant women OR Healthy Families, the applicant may decide that they want to submit the application to Health-e-App anyway for a final determination.

To do this, simply check the box for "Override" (to override the One-e-App system) and process the application through Health-e-App.

STEP 8: Health-e-App Data Transfer



Data Transfer Error

An error was encountered in the data transfer to Health-e-App. Details are below:

Error Number: 4

Error on Step: Step 6-The One-e-App to Health-e-App interface encountered an error while submitting the application in the Health-e-App system.

Error Description: In order to transfer an application to the Health-e-App system you are required to be an active Health-e-App user having completed the training in that system. Please complete the Health-e-App training and then transfer the applicaiton.

Error Details: Unresolved branch in step Navigate from 21_1 - none of the conditions were met.

Last URL: http://192.168.1.123/calc.asp

Please continue your application from the Health-e-App Applications in Progress workload at www.healtheapp.net. The Health-e-App Aplication ID is : **2008653**

Health-e-App

Data Transfer Error

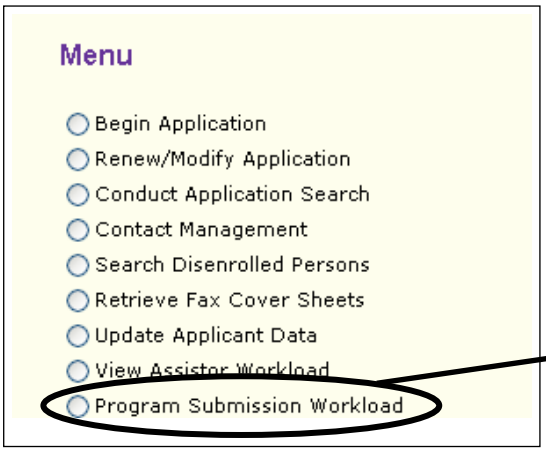
What do I do if you encounter a Health-e-App Transfer Error?

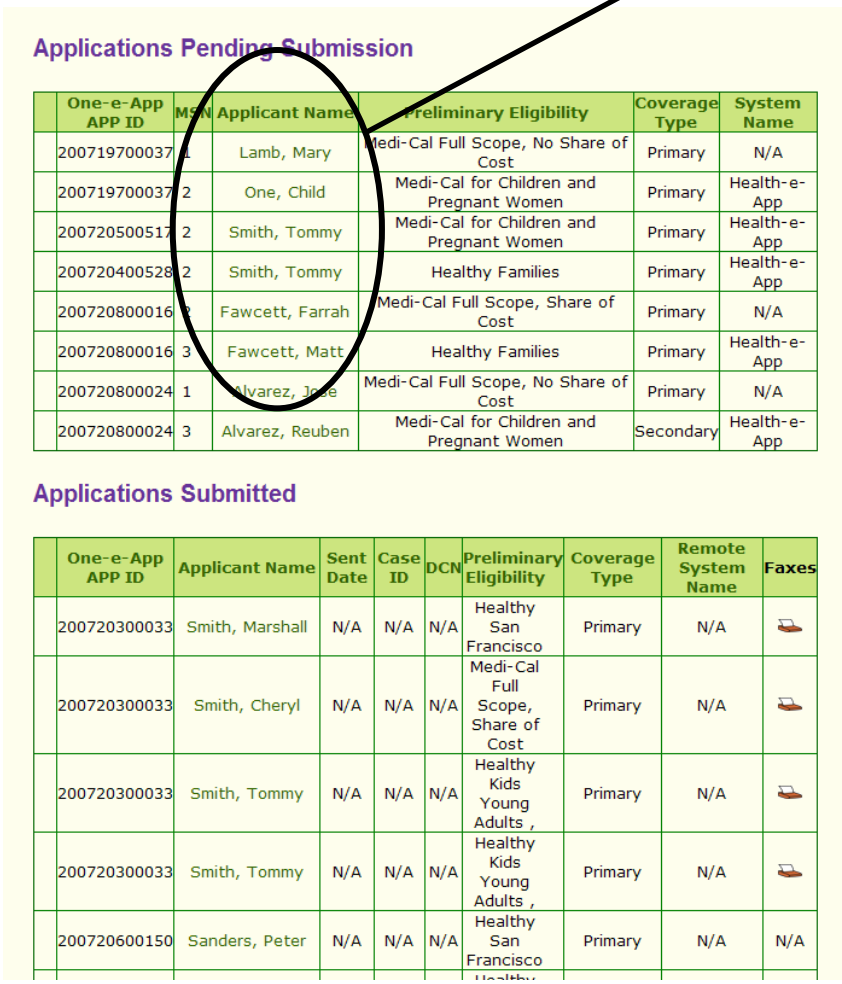
Once the system has completed the data transformation process it will start migrating the application data to the Health-e-App system. When the transfer fails due to System Error and you see a screen like this.

- **Call the One-e-App help desk** and notify them of the error received. Be prepared to give detailed information, including the application ID number and error number (the first line in the screen). You may be instructed to take a screenshot of the error message and e-mail it to One-e-App help desk. (See Using the One-e-App help desk on page 145.)

- If the transfer failed after the Health-e-App password verification, some information may have been sent to Health-e-App. You will need to log in to Health-e-App at www.healtheapp.net, look in your workload, find the application and continue from there.
    - If the reason for the transfer error was your Health-e-App password begin expired, you will need to login in to Health-e-App, **www.healtheapp.net** and have your password reset or you can call the Health-e-App Help Desk at **(866) 861-3443**. Once you have confirmed you new password you must now go to One-e-App and update it there. (See password tips on Page 10).

STEP 8: Health-e-App Data Transfer



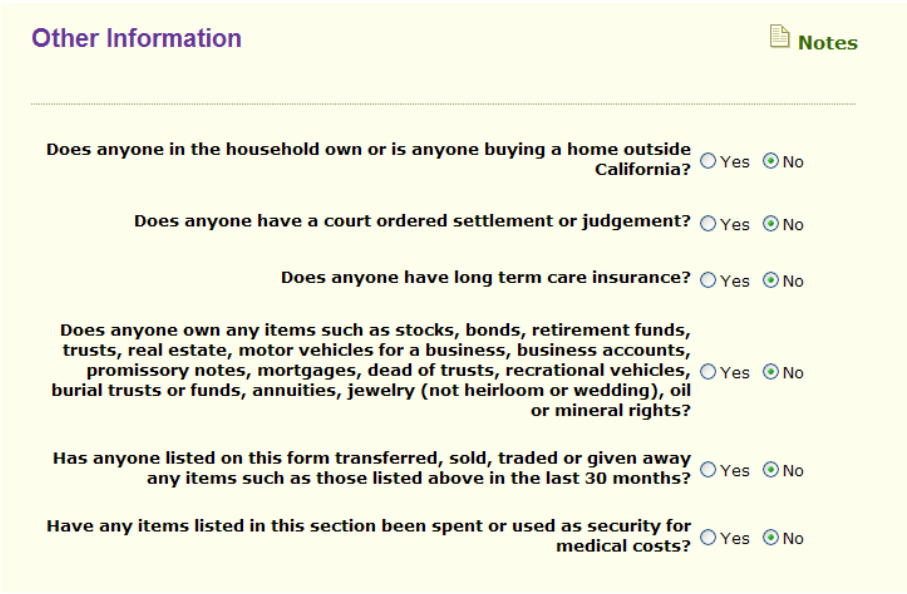


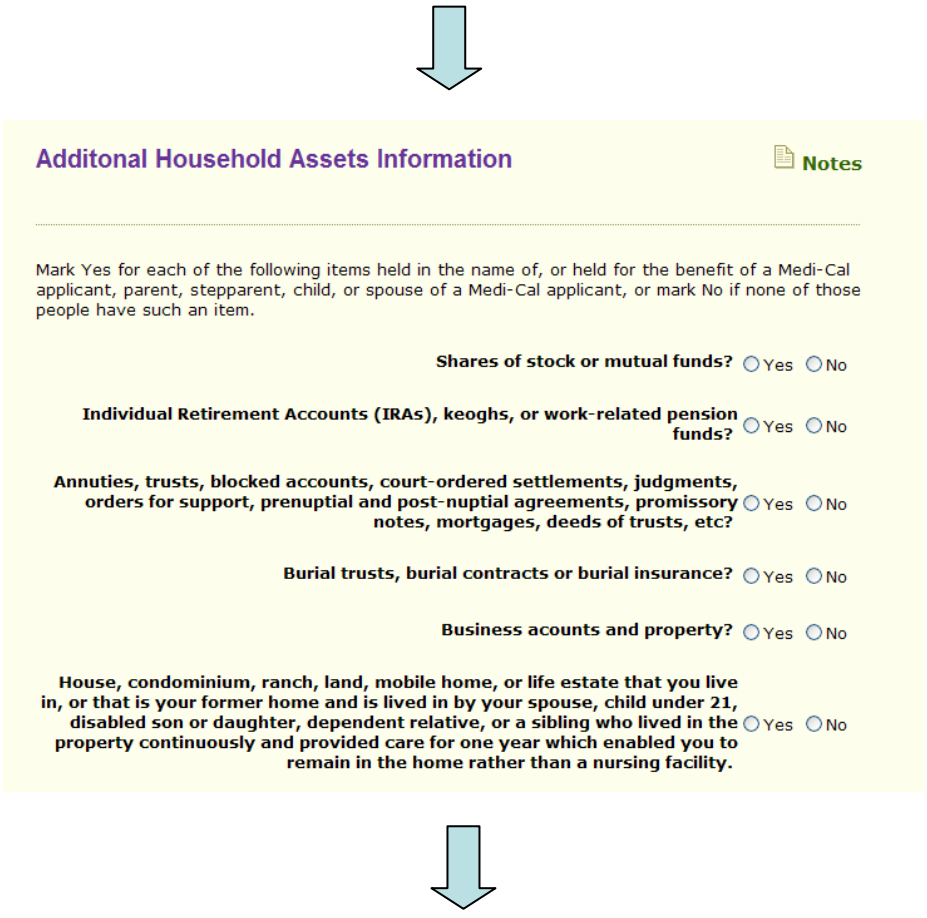
How do I continue to submit an application that was delayed because it was a CHDP child and has not yet been submitted to Health-e-App?

To transfer the application to Health-e-App:

1. Select “Program Submission Workload” from the Menu.
2. On the “Applications Pending Submission” workload, click on the name of each client for whom an application is to be submitted to continue the application submission.

STEP 7: Program Information





Medi-Cal

This is the first of several Medi-Cal pages.

This process produces the documents needed to submit a Medi-Cal application to the San Francisco Human Services Agency.

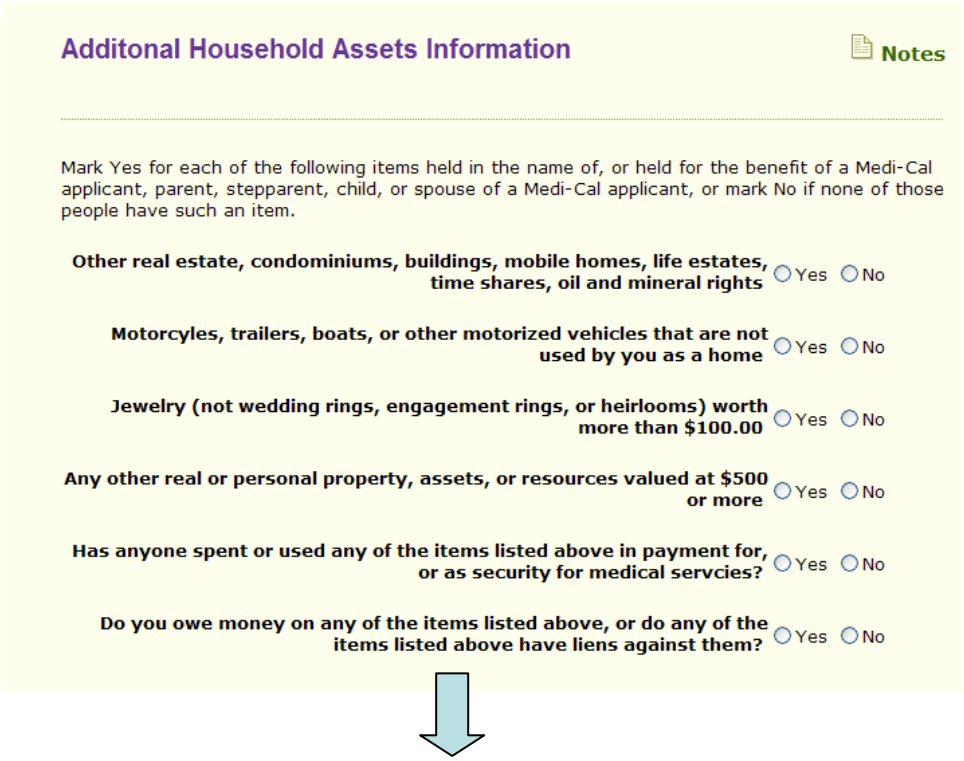
Combined with the One-e-App Universal Application Summary, this process produces the equivalent of the following Medi-Cal forms:

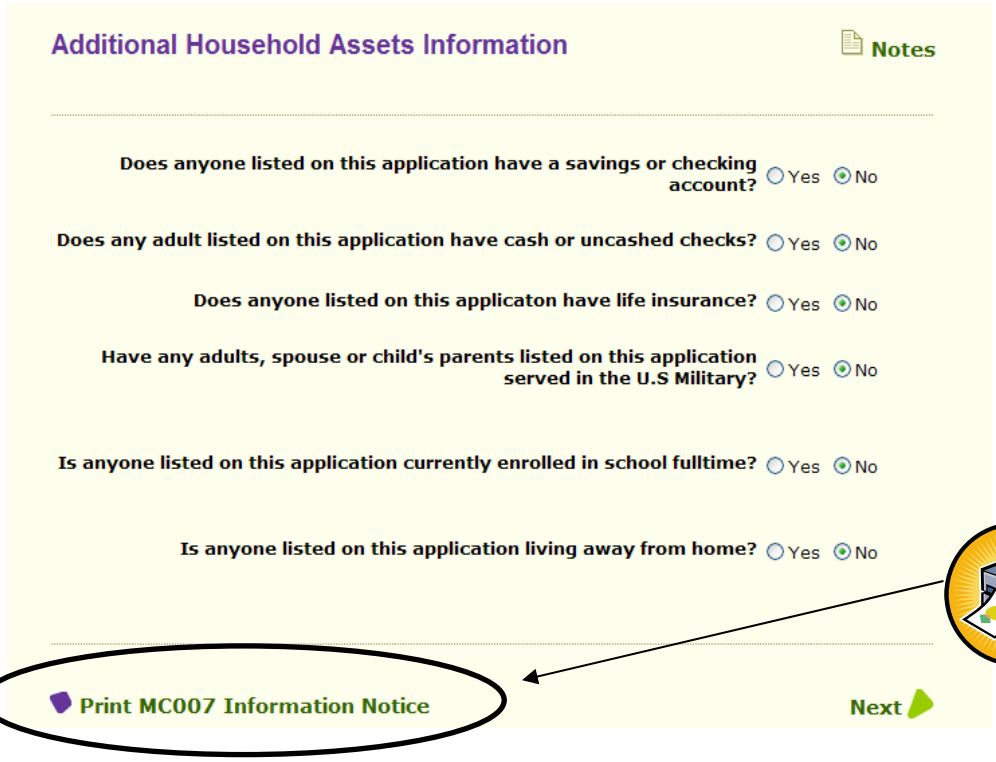
- MC 210
- MC 219
- MC 13
- MC 220
- MC 223
- Non-custodial parent

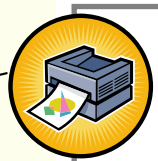
STEP 7: Program Information

Medi-Cal (cont.)

Additional Household Assets questions continued.



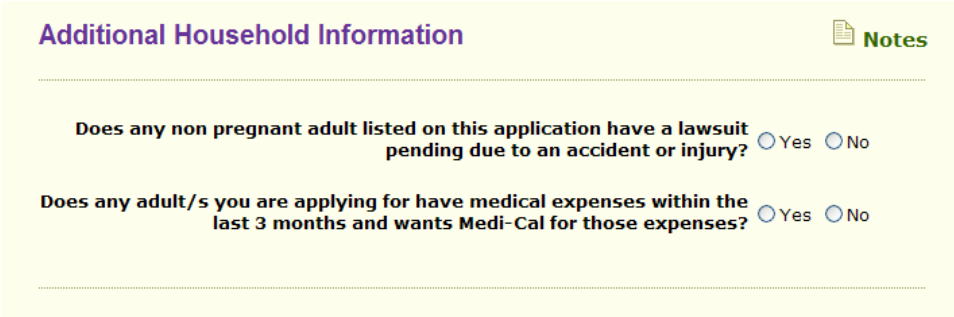




You will need to print a copy of the MC007 Information Notice for the applicant.

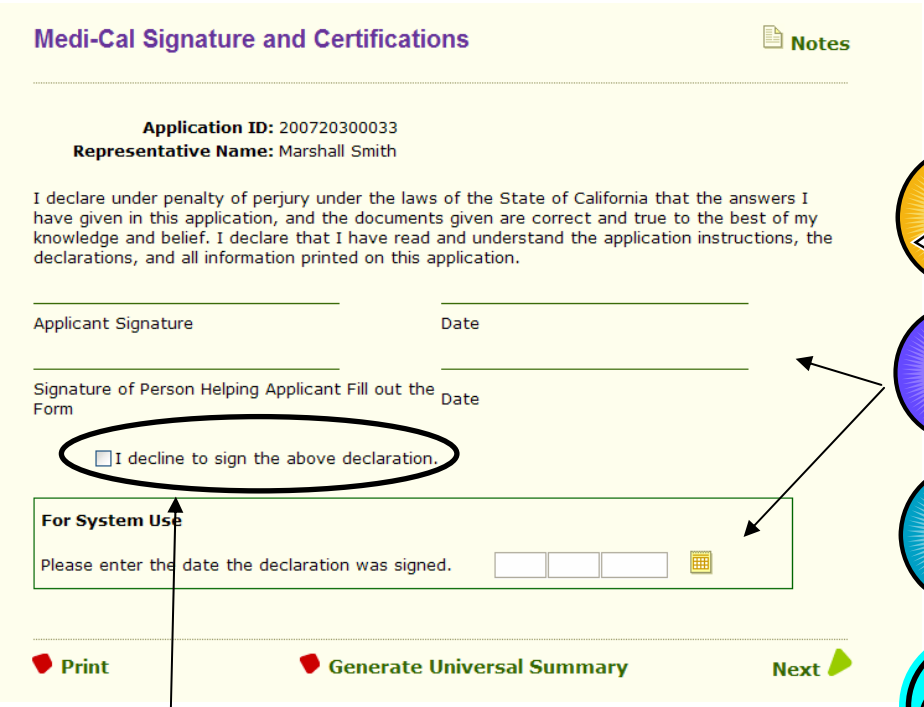
STEP 7: Program Information

Medi-Cal (cont.)



Additional Household questions continued.

STEP 7: Program Information

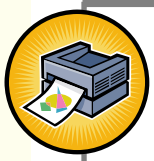


Applicant can choose to decline to sign the form. This will end the application process.

Medi-Cal (cont.)

This is the Medi-Cal signature page validating that the information is correct.

Follow These Steps



1. Print a copy for signing.

2. Have the applicant sign and date. Add your signature and date. Then enter the date it was signed in One-e-App.

3. Make a copy for the applicant.

4. Fax with other required verification documents.

STEP 7: Program Information

Notes

Important Information For Persons Requesting Medi-Cal

Application ID: 200720300033
Representative Name: Marshall Smith

Privacy and Confidentiality Notification
Sections 14011 and 14012 of the Welfare and Institutions Code allow county welfare departments to get certain facts from you to decide if you, or the persons you represent, can get Medi-Cal benefits. You must provide these facts to get Medi-Cal benefits. The information will be used:
1. By the county welfare department to establish first-time and ongoing Medi-Cal eligibility.
2. By Administrative Vendor (AV) to process claims and make Benefits Identification Cards (BICs).
3. By the United States (U.S.) Department of Health and Human Services to make audit and quality control reviews and verify Medicare Buy-In and Social Security Numbers (SSNs).
4. To verify alien status with the U.S. Immigration and Naturalization Service (INS) only for aliens who claim to be lawfully admitted for permanent residence or Permanently Residing in the U.S. Under Color of Law (PRUCOL) or Amnesty Aliens with a valid and current I-688 card. The information the INS receives can only be used to determine Medi-Cal eligibility, and cannot be used for immigration enforcement unless you are committing fraud.
5. By medical services providers and health maintenance organizations to certify eligibility.
6. To identify health insurance coverage and take recovery actions.

Medi-Cal Applicant/Beneficiary Rights, Responsibilities, and Understandings
I have the right to:
1. Ask for an interpreter to help me in applying for Medi-Cal if I have difficulty in speaking or understanding the English language.
2. Request a face-to-face interview with a county representative.
3. Be treated fairly and equally regardless of my race, color, religion, national origin, sex, age, or political beliefs.
4. Apply as a disabled person if I think I am disabled.
5. Receive information about the rules for retroactive Medi-Cal eligibility.
6. Apply for Medi-Cal and to be told in writing whether I qualify for any Medi-Cal program.
7. Review Medi-Cal program rules and regulation manuals if I want to question the basis on which my eligibility is approved or denied.
8. Have all facts that I give to the county welfare department kept in the strictest confidence and to look at those facts during regularly scheduled office hours.
9. Receive an immediate need card, when possible and eligible, if I have a medical emergency or I am pregnant.
10. Receive Medi-Cal, as authorized, while my satisfactory immigration status is being documented and verified, if I am otherwise eligible. Aliens who are lawfully admitted for permanent residence or PRUCOL or Amnesty Aliens with a valid and current I-688 card are in a satisfactory immigration status.
11. Receive information about the Child Health and Disability Prevention Program (CHDP) and the Special Supplemental Food Program for Women, Infants, and Children (WIC), and to ask for help in receiving those services.
12. Receive information about the Personal Care Service Program (PCSP), and to ask for help in receiving those services.
13. Receive information about the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT).
14. Ask for and receive information about the Family Planning Program and be told if I am eligible for those services.
15. Speak to a social worker about other public or private services or resources that I can get.
16. Receive information about Medi-Cal Health Care Plans that my family and I can join to get a doctor and other medical care, and to choose the option I prefer.
17. Lower my share of cost by providing past unpaid medical bills (that I still owe).
18. Reduce my property reserve to within the Medi-Cal property limit by the last day of a month for which I want Medi-Cal, including the month I apply, and to be told how I may spend my excess property.
19. Divide countable (nonexempt) community (MY SPOUSE's AND MY) property by written agreement into equal shares of separate property if ether of us entered a long-term care (LTC) facility before September 30, 1989.
20. Keep a certain amount of countable separate and community property if I enter an LTC facility on or after January 1, 1990. My spouse and I have the right to be told the amount.
21. Have a state hearing if I am dissatisfied with an action taken (or not taken) by the county welfare department or the State Department of Health Services, except actions relating to the Health Insurance Premium Payment (HIPP) and Employer Group Health Plan (EGHP) programs. If I want a state hearing to appeal the decision, I must ask for it within 90 days of the date the Notice of Action (NOA) was mailed to me. If I do not receive a NOA, I must request a hearing within 90 days from the date I discover the action (or inaction) with which I am dissatisfied. The date of discovery is the date I know, or should have known, of the action. The best way to ask for a hearing is to contact the nearest county welfare department.

I have the Responsibility to tell my County Representative within ten days whenever:
1. Income received by me or any member of my family increases, decreases, starts, or stops. This includes income from Social Security Administration (SSA), loans, settlements, or any other source.
2. I plan to change or have already changed my place of residence or mailing address.
3. A person, including a newborn child, whether or not related to me or my family, moves into or out of my home.
4. An absent parent returns to the home.
5. I or a member of my family gives birth, becomes pregnant, or ends a pregnancy.
6. I, my spouse, or any member of my family enters or leaves a nursing home or an LTC facility.
7. I receive, transfer, give away, or sell real or personal property (including money), or when someone gives me or a member of my family such things as a car, house, insurance payments, etc.
8. Have a change in expenses related to my job or education. (For example: child care, transportation, etc.)
11. I or a member of my family becomes physically or mentally impaired (this would include a child in the family).
12. I or a member of my family applies for disability benefits with the SSA, Veterans Administration, or Railroad Retirement.
13. One of my children drops out of school or returns to school.
14. There is a change in the citizenship/immigration status of any family member applying for or receiving Medi-Cal.
15. Health insurance coverage for me or a member of my family changes.

I have the Responsibility to:
1. Complete and return a status report by the date required when requested.
2. Give proof that I am a resident of California.
3. Make a declaration about my citizenship/immigration status.
4. Provide an SSN for myself and/or for any member of my family who has an SSN and wants Medi-Cal benefits. If I am a U.S. citizen, a U.S. national, or an alien in a satisfactory immigration status, I must apply for an SSN and provide it to the county if I do not already have one. If I need to apply for an SSN, I can get help from my eligibility worker, but I must work with the SSA to clear up any questions or my Medi-Cal will be denied or stopped. (Aliens who are not in a satisfactory immigration status and do not have an SSN can get restricted Medi-Cal without applying for an SSN if they meet all the rules.)
5. Apply for any income that may be available to me or any member of my family.
6. Apply for Medicare benefits if I am blind, disabled, have End Stage Renal Disease, or am 64 years and 9 months of age or older and eligible. I am responsible for telling my providers that I have both Medi-Cal and Medicare coverage.
7. Apply for and enroll in any health insurance if that is available to me and my family at no cost. I have the responsibility to remain enrolled in the health plan when Medi-Cal approves payment of plan premiums by the State of California.
8. Report to the county department, and to the health care provider, any health care coverage/insurance I carry or am entitled to use, including Medicare. If I willfully fail to give this fact, I may be guilty of a criminal offense, or may be billed by my provider.

Medi-Cal (cont.)

This is the Medi-Cal Rights and Declarations (MC219 Form). It continues on the next page.

STEP 7: Program Information

8. I have any expenses that are paid for by someone other than myself.
9. I or a member of my family gets a job, changes jobs, or no longer has a job.
10. I have a change in expenses related to my job or education. (For example: child care, transportation, etc.)
11. I or a member of my family becomes physically or mentally impaired (this would include a child in the family).
12. I or a member of my family applies for disability benefits with the SSA, Veterans Administration, or Railroad Retirement.
13. Take my BIC to my medical provider when I am sick or have an appointment. In emergencies when the BIC is not in hand, I must get the BIC to the medical provider when possible.
14. Report to the county department when I receive health care services because of an accident or injury caused by another person's action or failure to act, for which Medi-Cal has been, or may be billed.
15. Cooperate with the State or county in establishing paternity and identifying any possible medical coverage I or my family may be entitled to through an absent parent.
16. Cooperate with the State of California if my case is selected for review by the quality control review team. If I refuse to cooperate, my Medi-Cal benefits will be stopped.

I understand that:

1. Failure to give necessary facts or deliberately giving false facts can result in Medi-Cal benefits being denied or stopped. My case may also be investigated for suspected fraud.
2. The facts I give will be checked by computer with facts given by employers, banks, SSA, Franchise Tax Board, welfare, and other agencies. I will have the right to give proof to correct any facts which are found to be wrong.
3. Aliens who are not in a satisfactory immigration status and do not have an SSN can get restricted Medi-Cal without applying for an SSN if they meet all the rules.
4. Immigration status data given as part of the Medi-Cal application is confidential.
5. Based on my income, I will have to pay or be billed for part of my medical expenses before I can get Medi-Cal.
6. If I do not report changes promptly, and because of this, receive Medi-Cal benefits that I am not eligible for, I may have to repay the State Department of Health Services.
7. If I am receiving Medi-Cal based on disability and I apply for disability benefits from the SSA, and the SSA denies my disability claim, my Medi-Cal may be stopped. If I appeal my SSA denial right away, my Medi-Cal will continue until the SSA makes a final decision. If the SSA allows my claim, then my Medi-Cal benefits will continue. If the SSA does not allow my claim, then my Medi-Cal benefits will stop.
8. As a condition of Medi-Cal eligibility, all rights to medical support and/or payment for medical services for myself and any eligible persons that I have legal responsibility for, are automatically assigned to the State.
9. If medical support is court-ordered from an absent parent for my children, the insurance carrier must allow me to enroll and provide benefits to my children without the absent parent's consent.
10. If I don't apply for or keep no-cost health coverage or state-paid coverage, my Medi-Cal benefits and/or eligibility will be denied or stopped.
11. When I apply for Medi-Cal, I will be evaluated for potential eligibility under other medical assistance programs, including the HIPP and EGHP programs.
12. If I ask a Medi-Cal provider for any services not covered by my non-Medi-Cal health insurance plan, I must give the medical provider a written statement from my health plan saying it does not offer the Medi-Cal-covered services.
13. Medi-Cal providers cannot collect insurance copayment, coinsurance, or deductibles from me unless the payment is used to meet my Medi-Cal share-of-cost and/or copayment.
14. If I am admitted to a nursing facility and I have no intention of returning to my home, the State may impose a lien against my property.
15. After my death, the State has the right to seek reimbursement from my estate for all Medi-Cal benefits I received after age 55 unless I have a surviving spouse (during his or her lifetime), minor children, blind or permanently and totally disabled children, or it would create a hardship for my heirs.
16. After the death of my surviving spouse, the State has the right to claim from the part of his or her estate received from me, all Medi-Cal benefits I received after age 55 up to the amount of property my spouse received from my estate.

Sign and keep for your records.
I hereby state that I have reviewed the information on this form with the county representative and that I fully understand my RIGHTS AND RESPONSIBILITIES to have my eligibility determined for Medi-Cal and to maintain that eligibility.

Applicant Signature _____ Date _____

Signature of Person Helping Applicant Fill out the Form _____ Date _____

☐ I decline to sign the above declaration.

For System Use

Please enter the date the declaration was signed. ☐☐☐

Print | Generate Universal Summary | Next

Applicant can choose to decline to sign the form. This will end the application process.

Medi-Cal (cont.)

- MC219 Form (cont.)

Follow These Steps

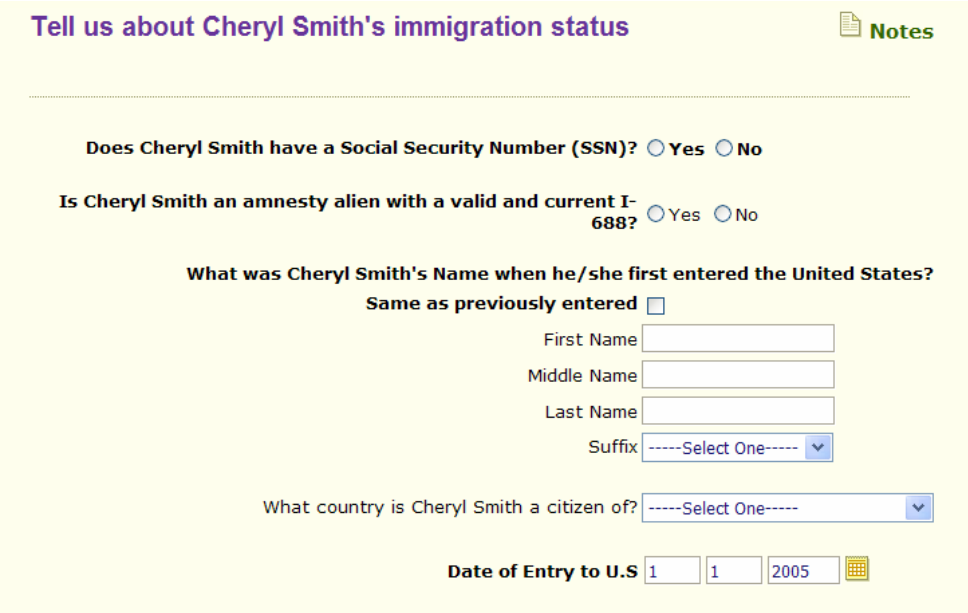
1. Print a copy for signing.

2. Have the applicant sign and date. Add your signature and date. Then enter the date it was signed in One-e-App.

3. Make a copy for the applicant.

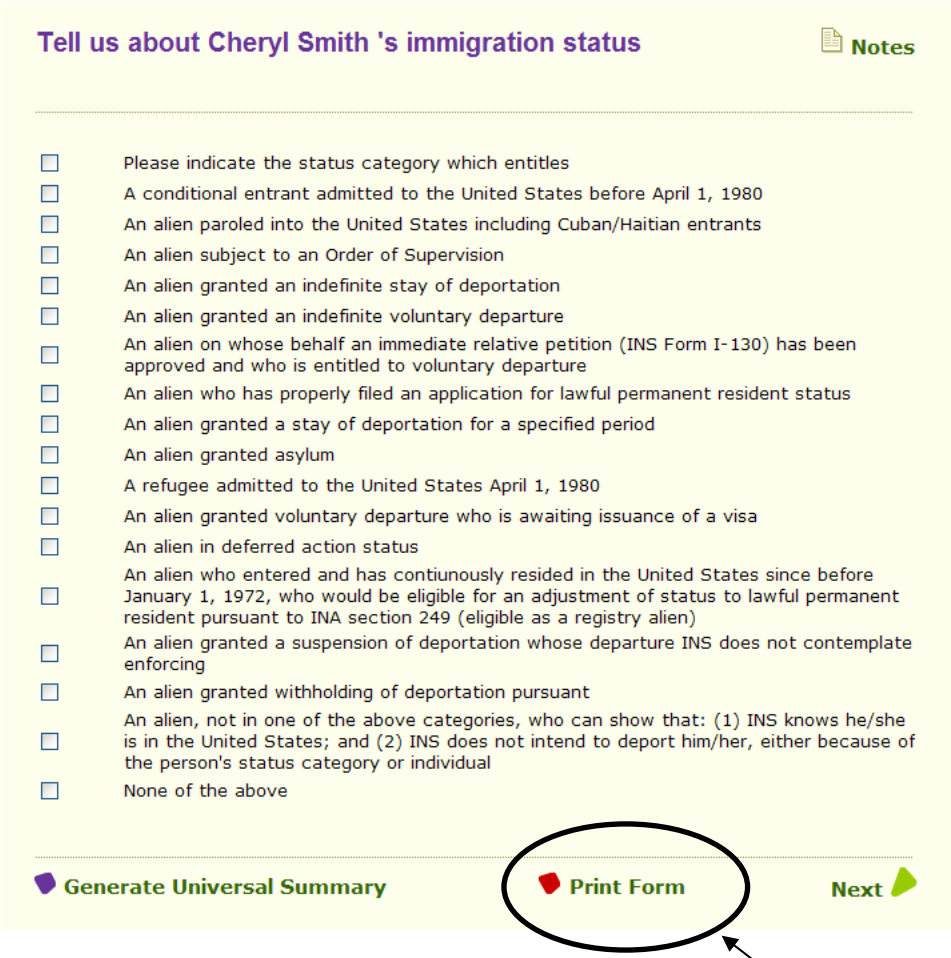
4. Fax with other required verification documents.

STEP 7: Program Information



Medi-Cal (cont.)

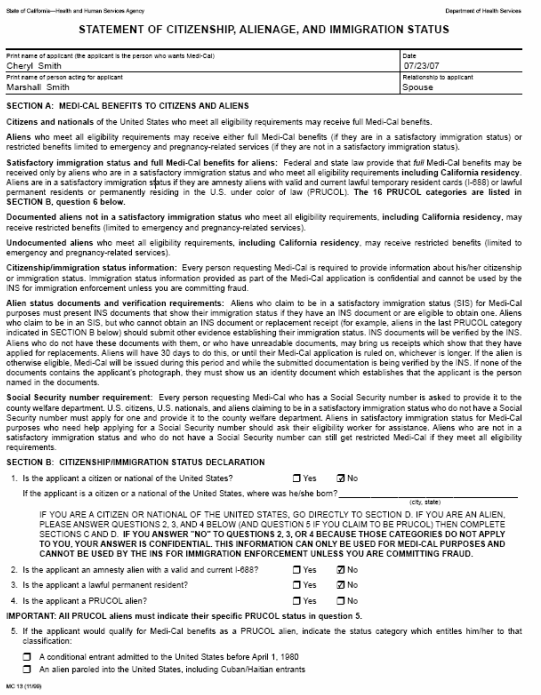
- Medi-Cal Immigration Information



Medi-Cal (cont.)

Medi-Cal Immigration Information (MC13 Form) cont.

These screens will populate the MC13 form for the applicant to print and sign.



State of California—Health and Human Services Agency — Department of Health Services

STATEMENT OF CITIZENSHIP, ALIENAGE, AND IMMIGRATION STATUS

Print name of applicant (the applicant is the person who wants Medi-Cal)	Date
Cheryl Smith	07/23/07
Print name of person acting for applicant	Relationship to applicant
Marshall Smith	Spouse

SECTION A: MEDI-CAL BENEFITS TO CITIZENS AND ALIENS

Citizens and nationals of the United States who meet all eligibility requirements may receive full Medi-Cal benefits.

Aliens who meet all eligibility requirements may receive either full Medi-Cal benefits (if they are in a satisfactory immigration status) or restricted benefits limited to emergency and pregnancy-related services (if they are not in a satisfactory immigration status).

Satisfactory immigration status and full Medi-Cal benefits for aliens: Federal and state law provide that *full* Medi-Cal benefits may be received only by aliens who are in a satisfactory immigration status and who meet all eligibility requirements **including California residency**. Aliens are in a satisfactory immigration status if they are amnesty aliens with valid and current lawful temporary resident cards (I-688) or lawful permanent residents or permanently residing in the U.S. under color of law (PRUCOL). **The 16 PRUCOL categories are listed in SECTION B, question 6 below.**

Documented aliens not in a satisfactory immigration status who meet all eligibility requirements, **including California residency**, may receive restricted benefits (limited to emergency and pregnancy-related services).

Undocumented aliens who meet all eligibility requirements, **including California residency**, may receive restricted benefits (limited to emergency and pregnancy-related services).

Citizenship/immigration status information: Every person requesting Medi-Cal is required to provide information about his/her citizenship or immigration status. Immigration status information provided as part of the Medi-Cal application is confidential and cannot be used by the INS for immigration enforcement unless you are committing fraud.

Alien status documents and verification requirements: Aliens who claim to be in a satisfactory immigration status (SIS) for Medi-Cal purposes must present INS documents that show their immigration status if they have an INS document or are eligible to obtain one. Aliens who claim to be in an SIS, but who cannot obtain an INS document or replacement receipt (for example, aliens in the last PRUCOL category indicated in SECTION B below) should submit other evidence establishing their immigration status. INS documents will be verified by the INS. Aliens who do not have these documents with them, or who have unreadable documents, may bring us receipts which show that they have applied for replacements. Aliens will have 30 days to do this, or until their Medi-Cal application is ruled on, whichever is longer. If the alien is otherwise eligible, Medi-Cal will be issued during this period and while the submitted documentation is being verified by the INS. If none of the documents contains the applicant's photograph, they must show us an identity document which establishes that the applicant is the person named in the documents.

Social Security number requirement: Every person requesting Medi-Cal who has a Social Security number is asked to provide it to the county welfare department. U.S. citizens, U.S. nationals, and aliens claiming to be in a satisfactory immigration status who do not have a Social Security number must apply for one and provide it to the county welfare department. Aliens in satisfactory immigration status for Medi-Cal purposes who need help applying for a Social Security number should ask their eligibility worker for assistance. Aliens who are not in a satisfactory immigration status and who do not have a Social Security number can still get restricted Medi-Cal if they meet all eligibility requirements.

SECTION B: CITIZENSHIP/IMMIGRATION STATUS DECLARATION

1. Is the applicant a citizen or national of the United States? ☐ Yes ☑ No
   If the applicant is a citizen or a national of the United States, where was he/she born? _____ (city, state)

   IF YOU ARE A CITIZEN OR NATIONAL OF THE UNITED STATES, GO DIRECTLY TO SECTION D. IF YOU ARE AN ALIEN, PLEASE ANSWER QUESTIONS 2, 3, AND 4 BELOW (AND QUESTION 5 IF YOU CLAIM TO BE PRUCOL) THEN COMPLETE SECTIONS C AND D. **IF YOU ANSWER "NO" TO QUESTIONS 2, 3, OR 4 BECAUSE THOSE CATEGORIES DO NOT APPLY TO YOU, YOUR ANSWER IS CONFIDENTIAL. THIS INFORMATION CAN ONLY BE USED FOR MEDI-CAL PURPOSES AND CANNOT BE USED BY THE INS FOR IMMIGRATION ENFORCEMENT UNLESS YOU ARE COMMITTING FRAUD.**

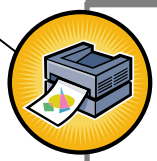
2. Is the applicant an amnesty alien with a valid and current I-688? ☐ Yes ☑ No
3. Is the applicant a lawful permanent resident? ☐ Yes ☑ No
4. Is the applicant a PRUCOL alien? ☐ Yes ☐ No

IMPORTANT: All PRUCOL aliens must indicate their specific PRUCOL status in question 5.

5. If the applicant would qualify for Medi-Cal benefits as a PRUCOL alien, indicate the status category which entitles him/her to that classification:
   - ☐ A conditional entrant admitted to the United States before April 1, 1980
   - ☐ An alien paroled into the United States, including Cuban/Haitian entrants

MC 13 (11/99)

Follow These Steps

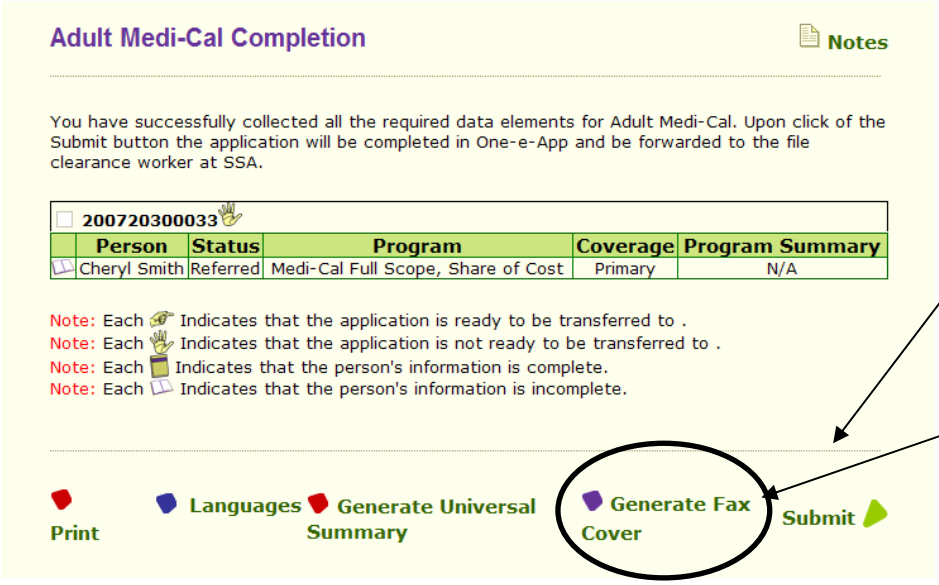


1. Print a copy for signing.

2. Have the applicant sign and date.

3. Make a copy for the applicant.

4. Fax with other required verification documents.



Medi-Cal (cont.)

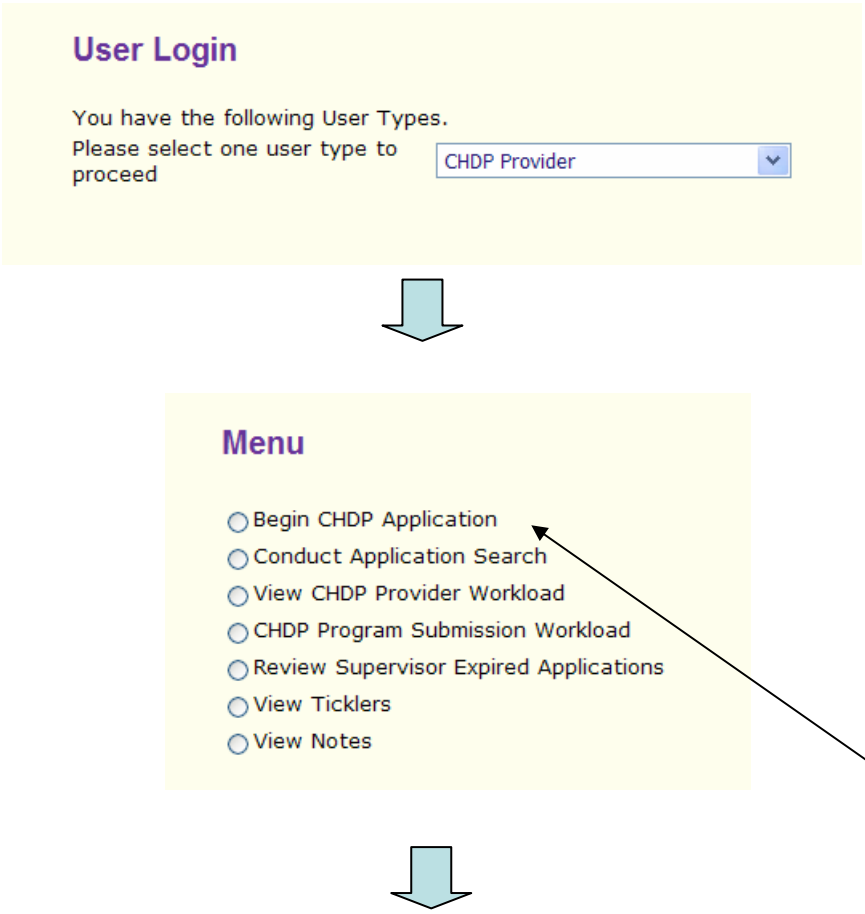
Submit to Medi-Cal!

You have reached the Medi-Cal Completion Page. Click here to submit the application.

Click on the “Generate Fax Cover” to print the One-e-App fax cover sheet. Once you fax in the required documentation to One-e-App you have completed the application. See page 139 for faxing tips.

STEP 7: Program Information

Child Health and Disability Prevention Program (CHDP)



IMPORTANT: This is for users from CHDP Provider agencies who can submit electronic CHDP applications through the State Department of Health's CHDP Gateway.

In order to submit applications to the CHDP Gateway using One-e-App, you must have at least one of the following One-e-App User Types:

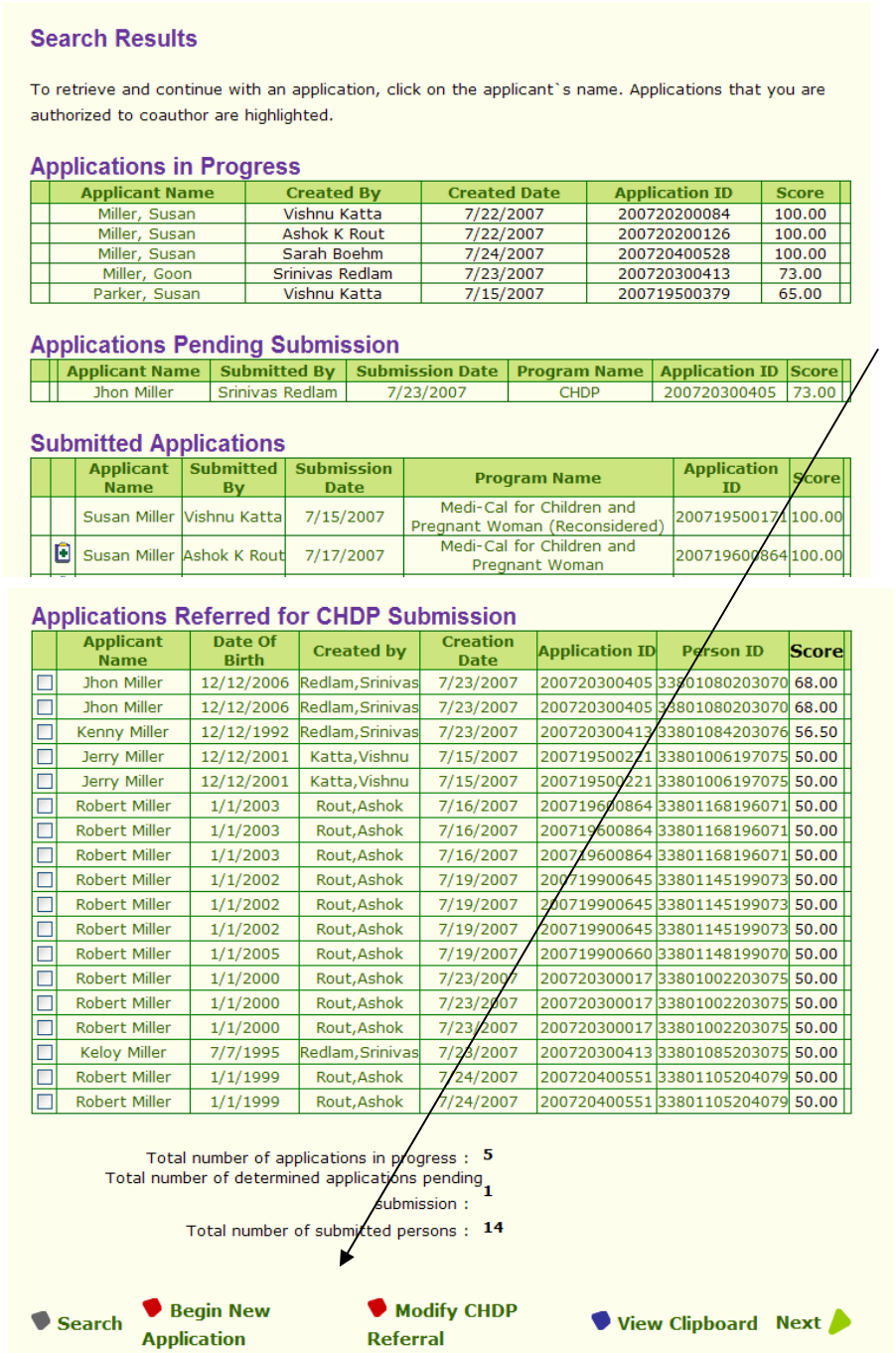
- CHDP Provider (only submits to the Gateway)
- CAA User Type that can submit to the CHDP Gateway

All other users can make referrals to CHDP. See page 67 for the CHDP referral process.

This manual shows the application process from a CHDP Provider User Type perspective. You may also submit to the CHDP Gateway from the Preliminary Eligibility page if you have user permissions to do so.

After logging on as a CHDP Provider User Type, click "Begin CHDP Application" from the Menu. This will prompt you to conduct an application search.

STEP 7: Program Information



Search Results

To retrieve and continue with an application, click on the applicant`s name. Applications that you are authorized to coauthor are highlighted.

Applications in Progress

Applicant Name	Created By	Created Date	Application ID	Score
Miller, Susan	Vishnu Katta	7/22/2007	200720200084	100.00
Miller, Susan	Ashok K Rout	7/22/2007	200720200126	100.00
Miller, Susan	Sarah Boehm	7/24/2007	200720400528	100.00
Miller, Goon	Srinivas Redlam	7/23/2007	200720300413	73.00
Parker, Susan	Vishnu Katta	7/15/2007	200719500379	65.00

Applications Pending Submission

Applicant Name	Submitted By	Submission Date	Program Name	Application ID	Score
Jhon Miller	Srinivas Redlam	7/23/2007	CHDP	200720300405	73.00

Submitted Applications

Applicant Name	Submitted By	Submission Date	Program Name	Application ID	Score
Susan Miller	Vishnu Katta	7/15/2007	Medi-Cal for Children and Pregnant Woman (Reconsidered)	200719500171	100.00
Susan Miller	Ashok K Rout	7/17/2007	Medi-Cal for Children and Pregnant Woman	200719600864	100.00

Applications Referred for CHDP Submission

Applicant Name	Date Of Birth	Created by	Creation Date	Application ID	Person ID	Score
Jhon Miller	12/12/2006	Redlam,Srinivas	7/23/2007	200720300405	33801080203070	68.00
Jhon Miller	12/12/2006	Redlam,Srinivas	7/23/2007	200720300405	33801080203070	68.00
Kenny Miller	12/12/1992	Redlam,Srinivas	7/23/2007	200720300413	33801084203076	56.50
Jerry Miller	12/12/2001	Katta,Vishnu	7/15/2007	200719500221	33801006197075	50.00
Jerry Miller	12/12/2001	Katta,Vishnu	7/15/2007	200719500221	33801006197075	50.00
Robert Miller	1/1/2003	Rout,Ashok	7/16/2007	200719600864	33801168196071	50.00
Robert Miller	1/1/2003	Rout,Ashok	7/16/2007	200719600864	33801168196071	50.00
Robert Miller	1/1/2003	Rout,Ashok	7/16/2007	200719600864	33801168196071	50.00
Robert Miller	1/1/2002	Rout,Ashok	7/19/2007	200719900645	33801145199073	50.00
Robert Miller	1/1/2002	Rout,Ashok	7/19/2007	200719900645	33801145199073	50.00
Robert Miller	1/1/2002	Rout,Ashok	7/19/2007	200719900645	33801145199073	50.00
Robert Miller	1/1/2005	Rout,Ashok	7/19/2007	200719900660	33801148199070	50.00
Robert Miller	1/1/2000	Rout,Ashok	7/23/2007	200720300017	33801002203075	50.00
Robert Miller	1/1/2000	Rout,Ashok	7/23/2007	200720300017	33801002203075	50.00
Robert Miller	1/1/2000	Rout,Ashok	7/23/2007	200720300017	33801002203075	50.00
Keloy Miller	7/7/1995	Redlam,Srinivas	7/23/2007	200720300413	33801085203075	50.00
Robert Miller	1/1/1999	Rout,Ashok	7/24/2007	200720400551	33801105204079	50.00
Robert Miller	1/1/1999	Rout,Ashok	7/24/2007	200720400551	33801105204079	50.00

Total number of applications in progress : 5
Total number of determined applications pending submission : 1
Total number of submitted persons : 14

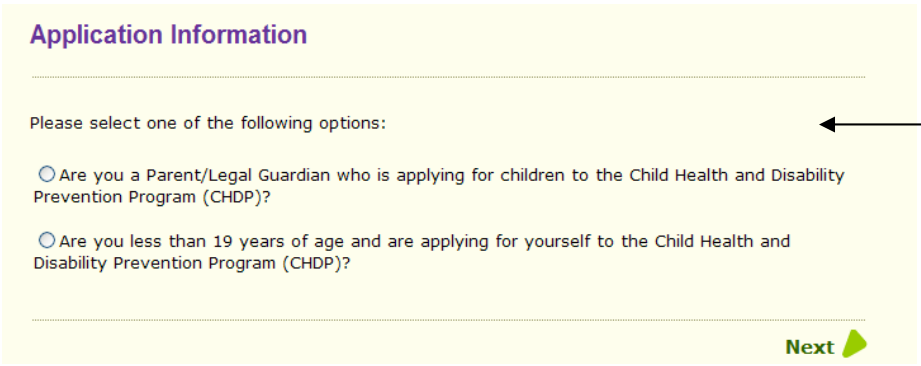
Search | Begin New Application | Modify CHDP Referral | View Clipboard | Next

Child Health and Disability Prevention Program (cont.)

The search results page will show all applications in progress, pending submission and submitted. It will also show applications that have been referred by a CAA to a CHDP Provider for submission to the Gateway.

You can choose either Begin a new CHDP Application or Modify an CHDP Referral by clicking on the appropriate icon.

STEP 7: Program Information

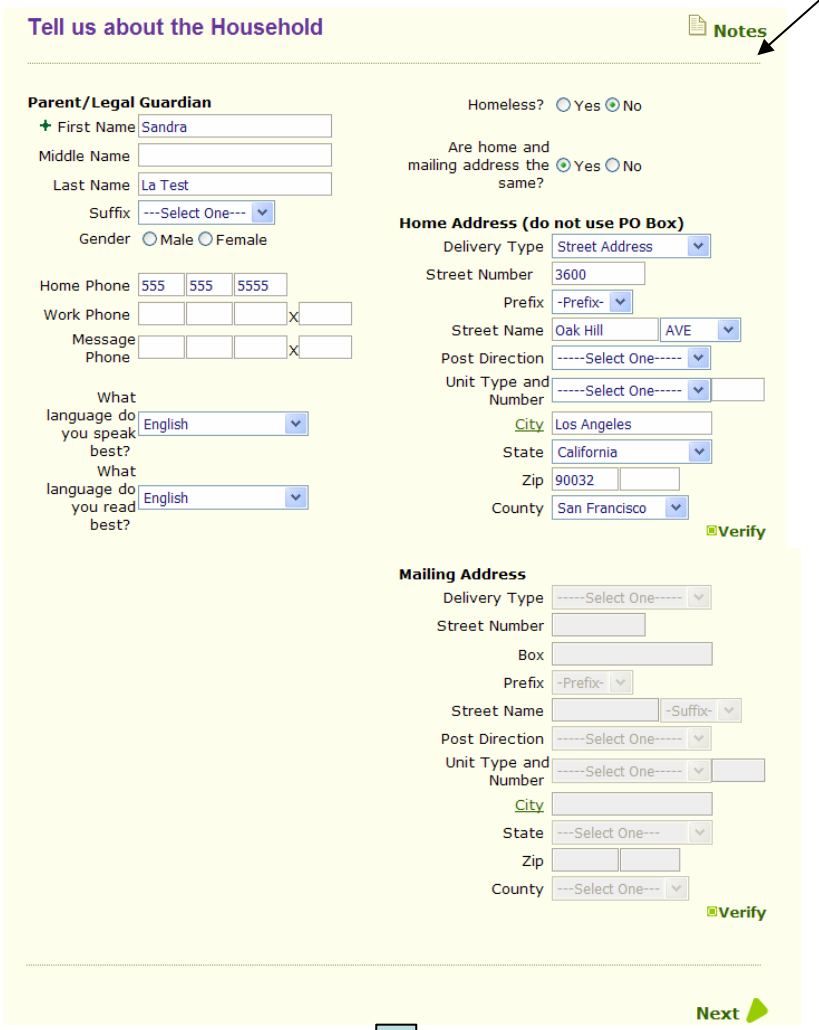


Child Health and Disability Prevention Program (cont.)

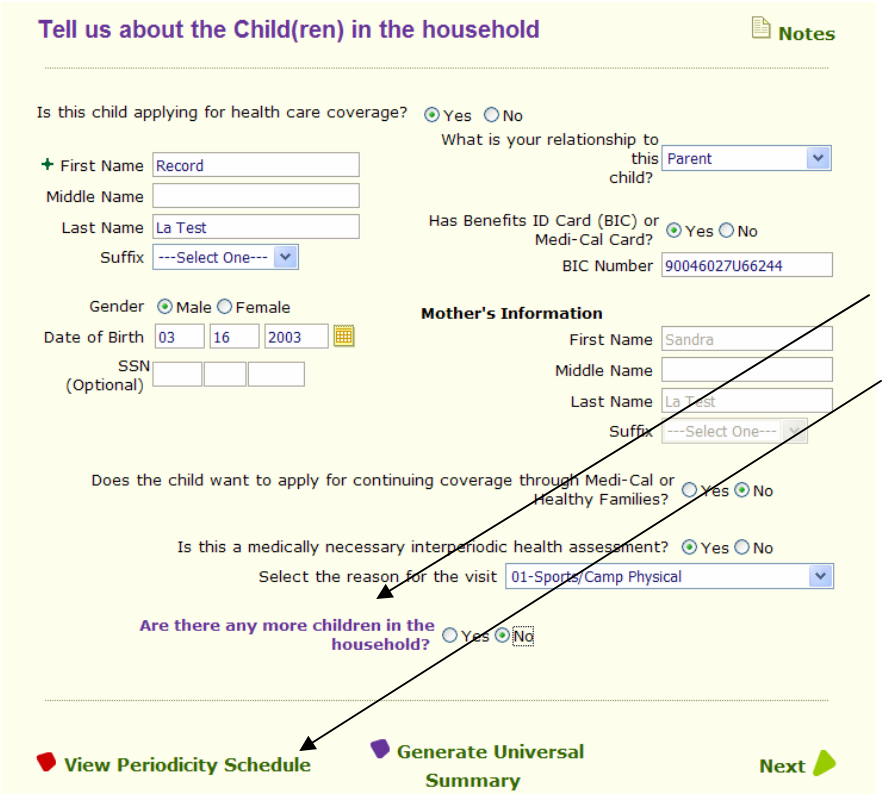
This is the first screen of the application asking whether they are a Parent/Legal guardian or a person under 19 years old applying for CHDP coverage. CHDP requires the primary informant to be one of these options.

Note: This differs from the Primary Informant for the CAA access that can be anyone whether they are a member of the household or not.

The next screen is the demographic page for the Parent/Legal Guardian.



STEP 7: Program Information

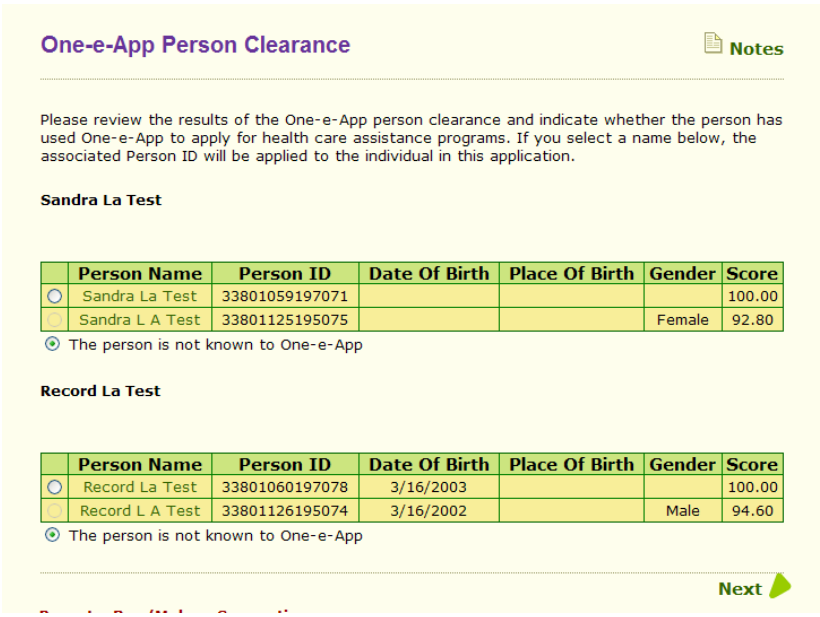


Child Health and Disability Prevention Program (cont.)

This screen collects the demographic information for the child. There are also some additional CHDP Gateway questions.

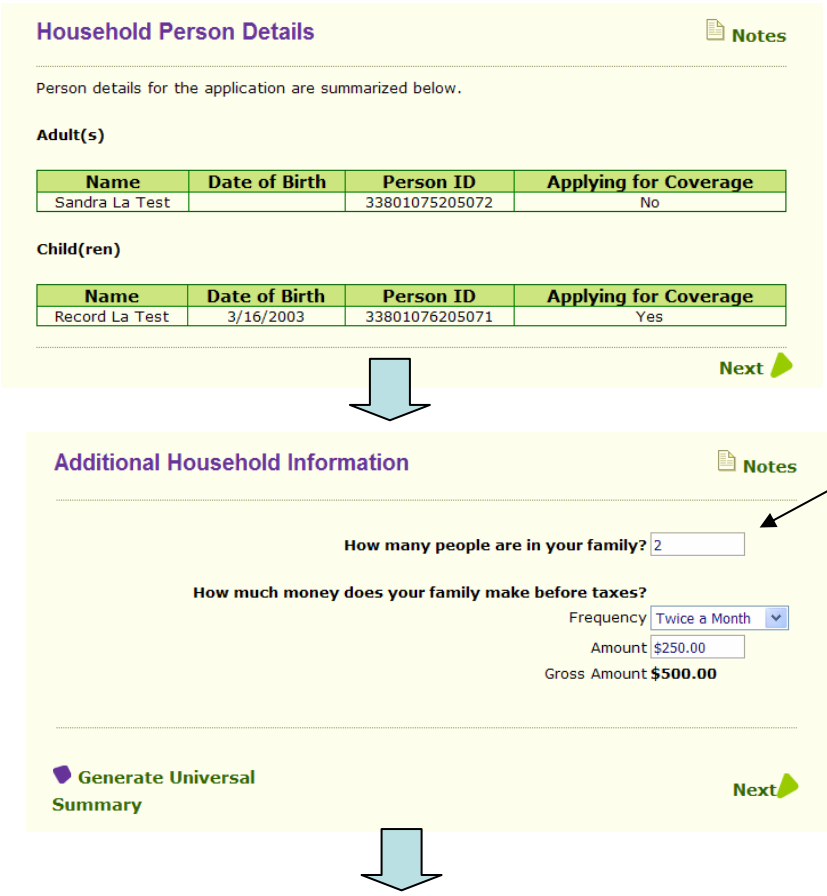
Indicate whether there are any more children in the household here.

Click here to view the Periodicity Schedule.



This the person clearance screen. If you find a match, check the button next to the individual, otherwise check the button to indicate they are not known to One-e-App.

STEP 7: Program Information



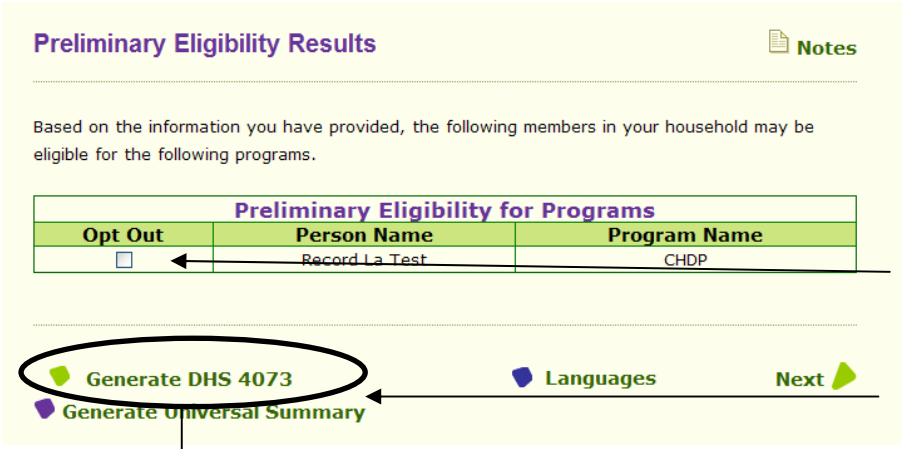
Child Health and Disability Prevention Program (cont.)

This page shows a summary of the household members and who is applying for coverage.

On the Additional Household Information page, enter the number of family members on this page and the family income before taxes.

Click “Calculate” to show the preliminary eligibility page.

STEP 7: Program Information

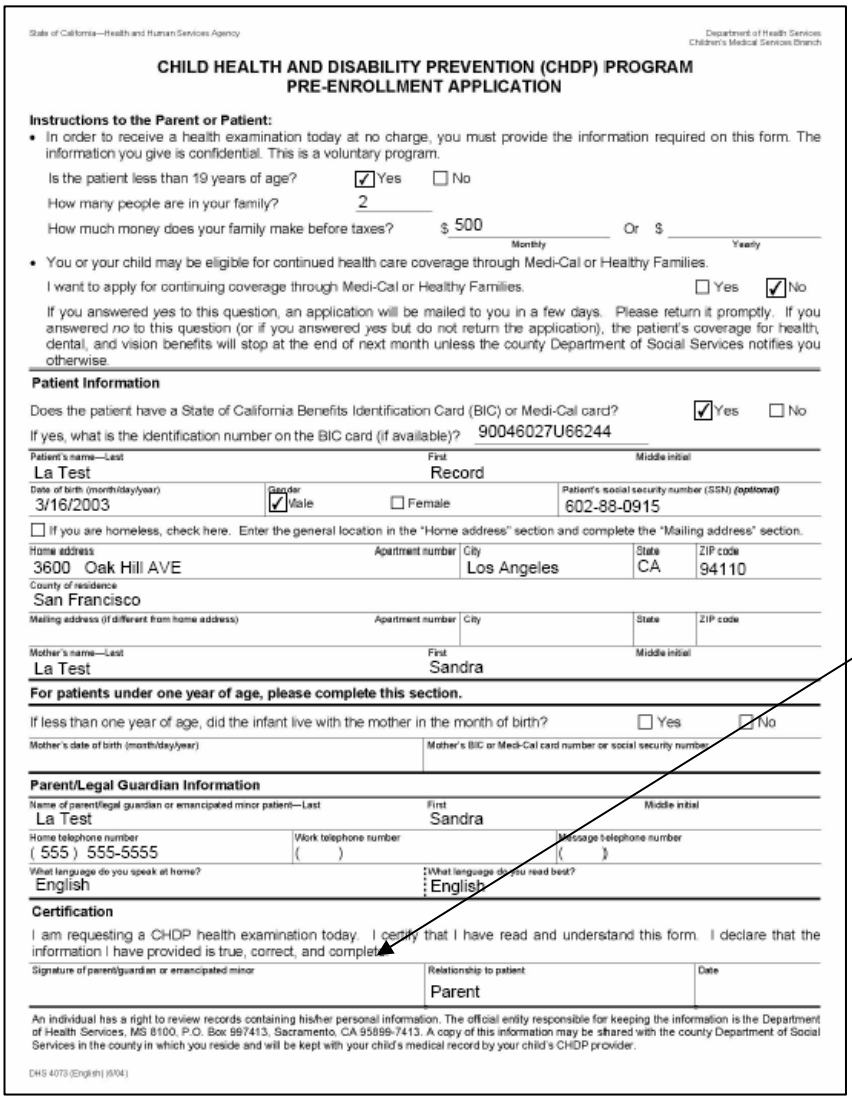


Child Health and Disability Prevention Program (cont.)

This page shows the preliminary eligibility results for the applicants.

An applicant can choose to "Opt Out" of applying for this program by checking this box. An application will not be submitted.

You must print the DHS 4073 form from this page before proceeding. The system will pre-populate this form with data you entered so far.



State of California—Health and Human Services Agency — Department of Health Services, Children's Medical Services Branch

CHILD HEALTH AND DISABILITY PREVENTION (CHDP) PROGRAM
PRE-ENROLLMENT APPLICATION

Instructions to the Parent or Patient:

- In order to receive a health examination today at no charge, you must provide the information required on this form. The information you give is confidential. This is a voluntary program.

Is the patient less than 19 years of age? ☑ Yes ☐ No

How many people are in your family? 2

How much money does your family make before taxes? $ 500 (Monthly) Or $ _____ (Yearly)

- You or your child may be eligible for continued health care coverage through Medi-Cal or Healthy Families.

I want to apply for continuing coverage through Medi-Cal or Healthy Families. ☐ Yes ☑ No

If you answered yes to this question, an application will be mailed to you in a few days. Please return it promptly. If you answered *no* to this question (or if you answered *yes* but do not return the application), the patient's coverage for health, dental, and vision benefits will stop at the end of next month unless the county Department of Social Services notifies you otherwise.

Patient Information

Does the patient have a State of California Benefits Identification Card (BIC) or Medi-Cal card? ☑ Yes ☐ No

If yes, what is the identification number on the BIC card (if available)? 90046027U66244

Patient's name—Last	First	Middle initial
La Test	Record	

Date of birth (month/day/year)	Gender	Patient's social security number (SSN) (optional)
3/16/2003	☑ Male ☐ Female	602-88-0915

☐ If you are homeless, check here. Enter the general location in the "Home address" section and complete the "Mailing address" section.

Home address	Apartment number	City	State	ZIP code
3600 Oak Hill AVE		Los Angeles	CA	94110

County of residence: San Francisco

Mailing address (if different from home address)	Apartment number	City	State	ZIP code

Mother's name—Last	First	Middle initial
La Test	Sandra	

For patients under one year of age, please complete this section.

If less than one year of age, did the infant live with the mother in the month of birth? ☐ Yes ☐ No

Mother's date of birth (month/day/year)	Mother's BIC or Medi-Cal card number or social security number

Parent/Legal Guardian Information

Name of parent/legal guardian or emancipated minor patient—Last	First	Middle initial
La Test	Sandra	

Home telephone number	Work telephone number	Message telephone number
(555) 555-5555	( )	( )

What language do you speak at home?	What language do you read best?
English	English

Certification

I am requesting a CHDP health examination today. I certify that I have read and understand this form. I declare that the information I have provided is true, correct, and complete.

Signature of parent/guardian or emancipated minor	Relationship to patient	Date
	Parent	

An individual has a right to review records containing his/her personal information. The official entity responsible for keeping the information is the Department of Health Services, MS 8100, P.O. Box 997413, Sacramento, CA 95899-7413. A copy of this information may be shared with the county Department of Social Services in the county in which you reside and will be kept with your child's medical record by your child's CHDP provider.

DHS 4073 (English) (6/04)

Follow These Steps

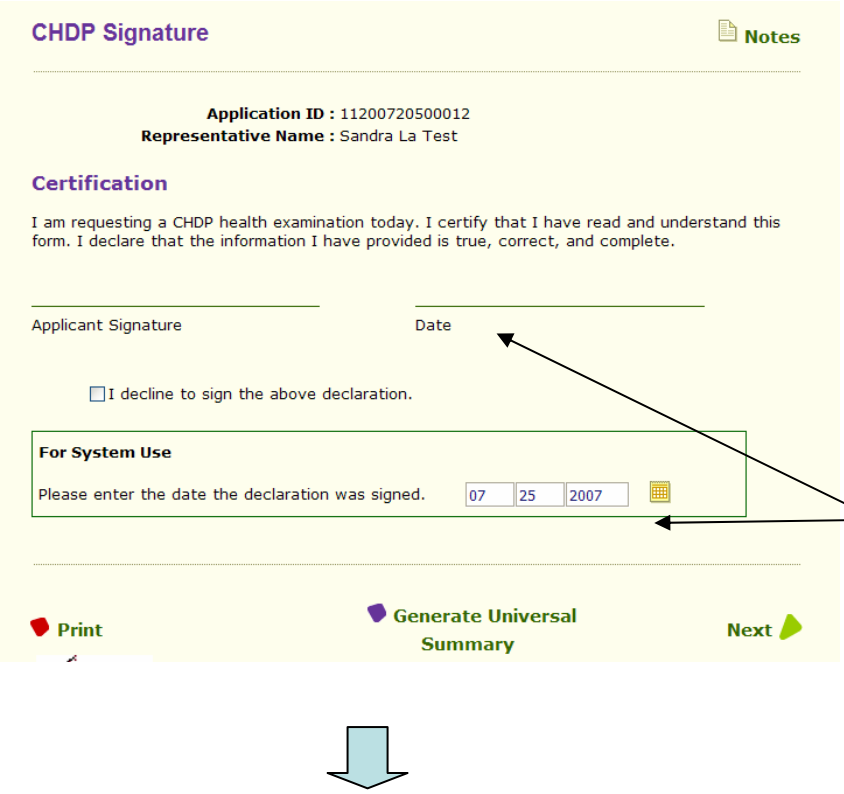
1. Print a copy for signing.

2. Have the applicant sign and date.

3. Make a copy for the applicant.

4. Fax with other required verification documents into One-e-App.

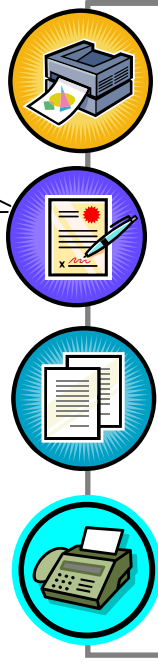
STEP 7: Program Information



Child Health and Disability Prevention Program (cont.)

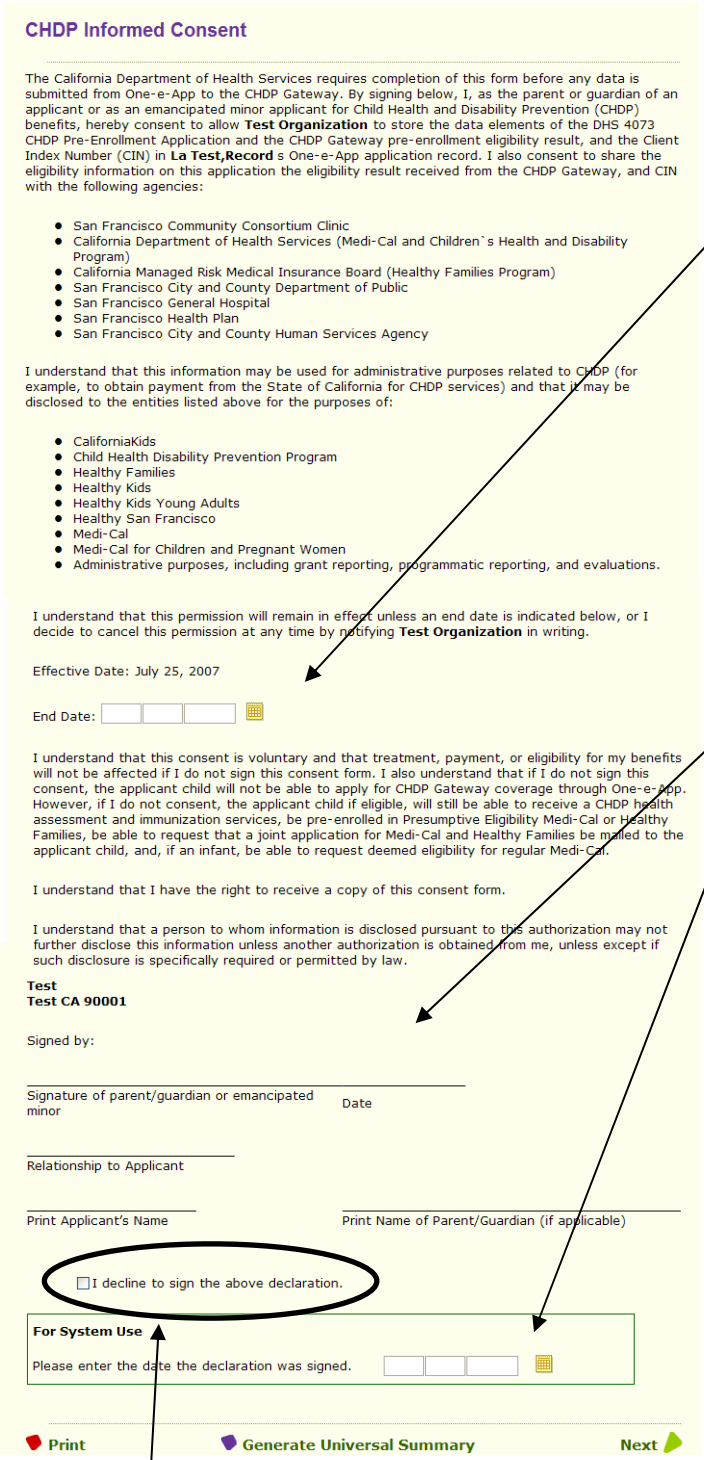
This is the CHDP Certification page. Follow the steps below.

Follow These Steps



1. Print a copy for signing.
2. Have the applicant sign and date. Then enter the date it was signed in One-e-App.
3. Make a copy for the applicant.
4. Fax with other required verification documents into One-e-App.

STEP 7: Program Information



CHDP Informed Consent

The California Department of Health Services requires completion of this form before any data is submitted from One-e-App to the CHDP Gateway. By signing below, I, as the parent or guardian of an applicant or as an emancipated minor applicant for Child Health and Disability Prevention (CHDP) benefits, hereby consent to allow **Test Organization** to store the data elements of the DHS 4073 CHDP Pre-Enrollment Application and the CHDP Gateway pre-enrollment eligibility result, and the Client Index Number (CIN) in **La Test,Record** s One-e-App application record. I also consent to share the eligibility information on this application the eligibility result received from the CHDP Gateway, and CIN with the following agencies:

- San Francisco Community Consortium Clinic
- California Department of Health Services (Medi-Cal and Children`s Health and Disability Program)
- California Managed Risk Medical Insurance Board (Healthy Families Program)
- San Francisco City and County Department of Public
- San Francisco General Hospital
- San Francisco Health Plan
- San Francisco City and County Human Services Agency

I understand that this information may be used for administrative purposes related to CHDP (for example, to obtain payment from the State of California for CHDP services) and that it may be disclosed to the entities listed above for the purposes of:

- CaliforniaKids
- Child Health Disability Prevention Program
- Healthy Families
- Healthy Kids
- Healthy Kids Young Adults
- Healthy San Francisco
- Medi-Cal
- Medi-Cal for Children and Pregnant Women
- Administrative purposes, including grant reporting, programmatic reporting, and evaluations.

I understand that this permission will remain in effect unless an end date is indicated below, or I decide to cancel this permission at any time by notifying **Test Organization** in writing.

Effective Date: July 25, 2007

End Date:

I understand that this consent is voluntary and that treatment, payment, or eligibility for my benefits will not be affected if I do not sign this consent form. I also understand that if I do not sign this consent, the applicant child will not be able to apply for CHDP Gateway coverage through One-e-App. However, if I do not consent, the applicant child if eligible, will still be able to receive a CHDP health assessment and immunization services, be pre-enrolled in Presumptive Eligibility Medi-Cal or Healthy Families, be able to request that a joint application for Medi-Cal and Healthy Families be mailed to the applicant child, and, if an infant, be able to request deemed eligibility for regular Medi-Cal.

I understand that I have the right to receive a copy of this consent form.

I understand that a person to whom information is disclosed pursuant to this authorization may not further disclose this information unless another authorization is obtained from me, unless except if such disclosure is specifically required or permitted by law.

Test
Test CA 90001

Signed by:

Signature of parent/guardian or emancipated minor

Date

Relationship to Applicant

Print Applicant's Name

Print Name of Parent/Guardian (if applicable)

I decline to sign the above declaration.

For System Use

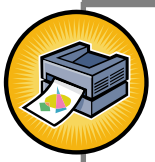
Please enter the date the declaration was signed.

Print | Generate Universal Summary | Next

Child Health and Disability Prevention Program (cont.)

This is the CHDP Informed Consent page. Review with the applicant. If they choose to they can put an end date as to when they approve the sharing of the data. Then follow the steps below.

Follow These Steps



1. Print a copy for signing.

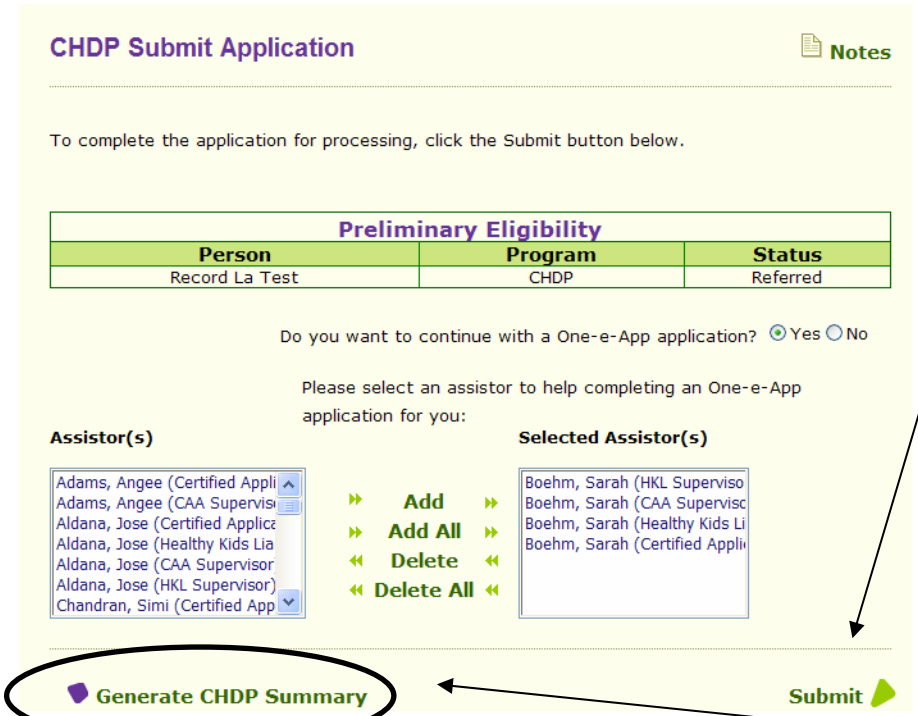
2. Have the applicant sign and date. Then enter the date it was signed in One-e-App.

3. Make a copy for the applicant.

4. Fax with other required verification documents.

Applicant can choose to decline to sign the form. This will end the application process.

STEP 7: Program Information



Child Health and Disability Prevention Program (cont.)

Submit to CHDP

You have reached the CHDP Submit Application page. Click “Submit” to begin the process of transferring data to the CHDP Gateway.

You can choose to refer the application to one or more CAAs to complete a full screen across all programs. It will go into the workload of the CAAs listed until one CAA picks it up from their workload to complete it.

You can also generate a CHDP Application summary from this page.

STEP 7: Program Information

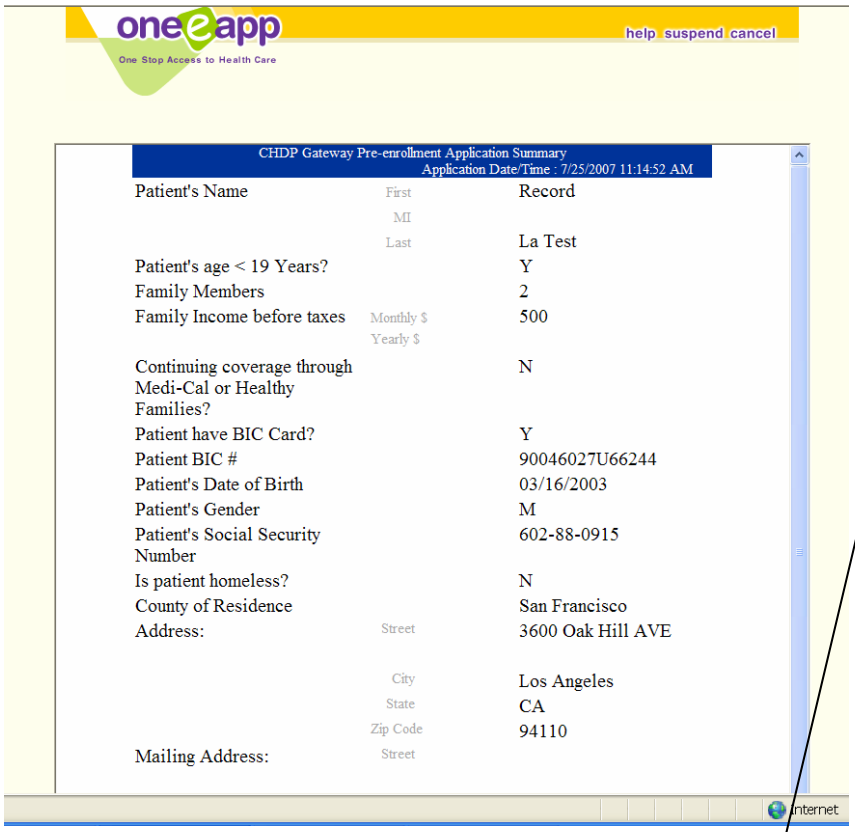
Child Health and Disability Prevention Program (cont.)

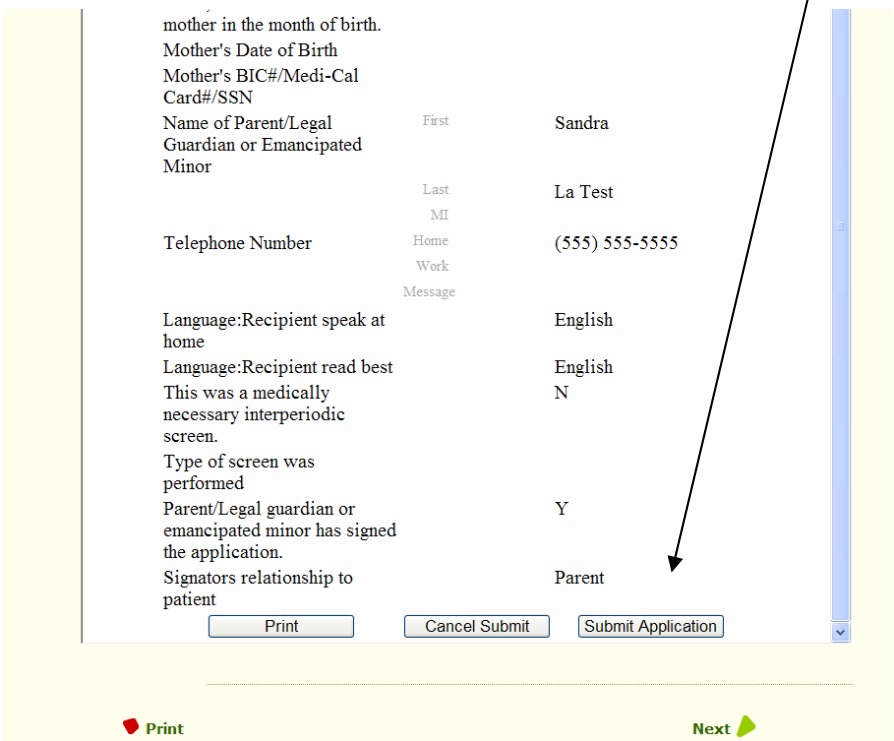
IMPORTANT: The CHDP Gateway website page will appear in One-e-App. At this point, you are in One-e-App viewing the live CHDP Gateway site. Do not leave One-e-App to go to the CHDP Gateway.

Click on the "Transaction Login" button to login.

Then enter your CHDP Gateway User ID and Password and click "Submit".

STEP 7: Program Information



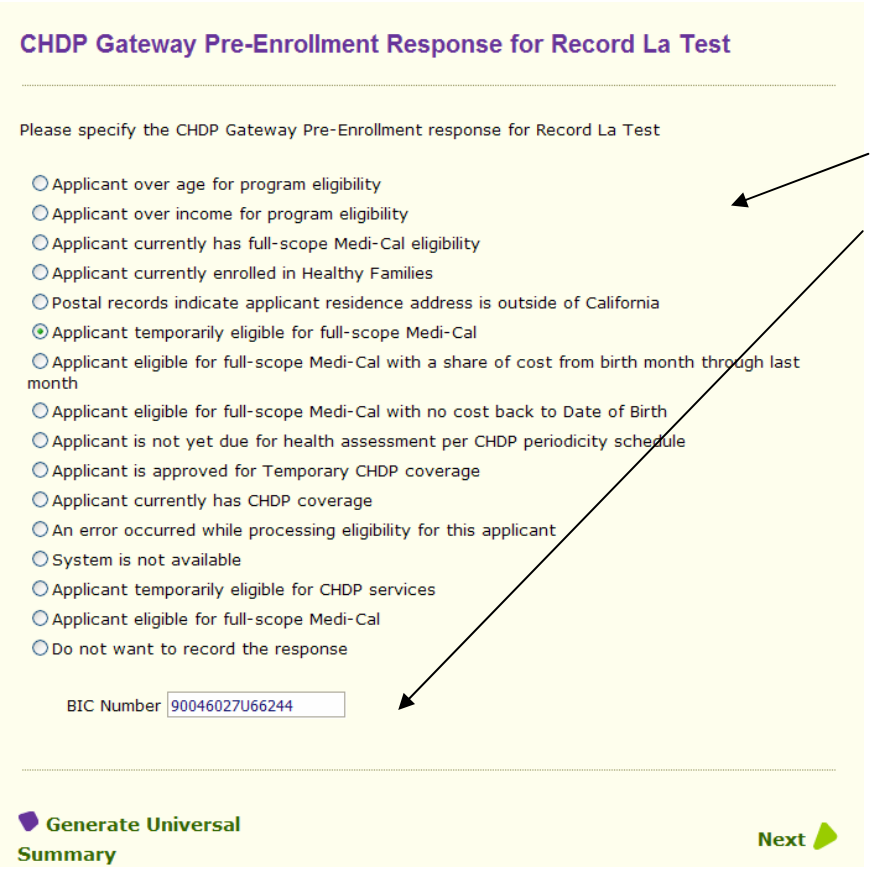


Child Health and Disability Prevention Program (cont.)

One-e-App will automatically populate the CHDP Gateway with the data you entered in One-e-App. Review the page and validate the information.

Scroll to the bottom and click on “Submit Application”

STEP 7: Program Information



Child Health and Disability Prevention Program (cont.)

Record the eligibility outcome from the CHDP Gateway on this screen.

You can also enter the BIC# from the Gateway. If a BIC# was previously provided by you in One-e-App, it will populate the number here.