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

WILL LIGHTBOURNE
DIRECTOR

GAVIN NEWSOM
GOVERNOR

October 5, 2020

Important notice about your Medi-Cal

Dear Medi-Cal Beneficiary,

Your Medi-Cal health coverage is now active again.

During the COVID-19 public health emergency, Medi-Cal must stay active for most people. You will keep your Medi-Cal coverage until the public health emergency ends. After it ends, the county will see if you still qualify for Medi-Cal. Your Medi-Cal will stay active even longer if you still qualify.

Your Medi-Cal benefits were restored to what you had in March 2020. If you had free Medi-Cal in March but got a share of cost later due to our mistake, then your free Medi-Cal is active again. We fixed these mistakes back to April 2020. You should have no gap in coverage.

If you had a share of cost or a premium in March 2020, it is the same.

You might not have to pay your Medi-Cal premiums during the public health emergency

To get your premium waived (stopped for now), please call us:

- For children and pregnant women programs, call 1-800-880-5305.
- For the 250 Percent Working Disabled Program, call 1-916-445-9891 or 1-916-650- 0490 for Spanish.

Keep your Medi-Cal Benefits Identification Card (BIC)

You should keep using your BIC. If you never got or no longer have a BIC, or need a temporary BIC, contact your eligibility worker. Ask to have one mailed to you. The BIC has the information your provider needs to check your Medi-Cal eligibility. Take your BIC with you to providers when you get care.

You have the right to appeal

If you think we made a mistake, you can appeal. To learn more about your rights and how to appeal, read “Your Hearing Rights” included with this letter. During the public health emergency, you have **210** days to ask for a hearing. The 210 days starts the day after the date on this notice.

Medi-Cal may pay for your medical, dental, and other health care bills

If you paid medical, dental, or other health care bills since March 2020, Medi-Cal may pay you back for those costs. You can file a refund claim to ask Medi-Cal to pay you back.

To learn more or to file a refund claim, you must **call** or **write** to Medi-Cal:

- For Medical, Mental Health, Drug and Alcohol, and In-Home Supportive Services Claims:
  California Department of Health Care Services Beneficiary Services
  P.O. Box 138008
  Sacramento, CA 95813-8008

  Phone: 1-916-403-2007 (TDD: 1-916-635-6491)

- For Dental Claims:
  Medi-Cal Dental Beneficiary Services
  P.O. Box 526026
  Sacramento, CA 95852-6026

  Phone: 1-916-403-2007 (TDD: 1-916-635-6491)

If you get In-Home Supportive Services (IHSS)

If Medi-Cal gave you a share of cost starting any time from April 1 to now, you may no longer have a share of cost. If your share of cost was subtracted from your IHSS provider’s check, please contact your county IHSS office. Tell them you no longer have a share of cost. You can ask them to pay your provider for the share of cost that was removed from their check.

What to do now

Since we have fixed your Medi-Cal benefits, you have been re-enrolled into the managed care plan in your county. If you have questions about your health care plan or about covered services, or you need a new member card, call you plan’s member

services phone number. Your health care plan will send you a new member card for free. This card is different from your BIC.

Questions?

If you have questions or need help, please contact your local county office. If you need help in a language other than English, see the attached list of numbers to call for language assistance services. Services include an interpreter to help you understand this letter.

Some county offices are temporarily closed to the public for in-person services. You can still contact your county by phone, mail, or email. You can find your local county office information on the county listing that came with this letter.

Thank you,
Department of Health Care Services

SHARE-OF-COST MEDI-CAL PROVIDER LETTER

(COUNTY STAMP)

Provider name and address

Notice date: _____

Case name: _____

Case number: _____

EW name: _____

EW number: _____

EW address: _____

_____

EW telephone number: _____

_____ , _____ , was determined eligible for Medi-Cal with a share of
Beneficiary's name Beneficiary's Social Security number

cost that has been changed for the following months:

Month/Year						
Original SOC						
Revised SOC						
Month/Year						
Original SOC						
Revised SOC						

The California Code of Regulations, Title 22, Section 51471.1, requires providers to cooperate with the Department of Health Care Services in making reimbursements to the beneficiaries for Medi-Cal program underpayments. The Welfare and Institutions Code, Section 14019.3 and the regulations further require that the provider accept an underpayment adjustment from the Medi-Cal program for such beneficiaries and reimburse such beneficiaries the full amount of that adjustment, up to the actual amount received in payment from the beneficiary for medical services in question.

You must do one of the following if the beneficiary paid or obligated to pay an original share of cost (SOC) amount to you.

If you...	And the share of cost...	Then you...
billed Medi-Cal for the balance of the charges,	has been reduced or is now zero,	may bill the program for the difference between the original share of cost and the adjusted share of cost. Submit a Claims Inquiry Form (CIF) with this MC 1054 attached. ***Note: Do not submit a new claim. It will be considered a duplicate claim and payment will be denied.***
did not bill Medi-Cal because the charges equaled or were less than the original SOC,	has been reduced,	may bill the program if the services you rendered now exceed the adjusted SOC. Submit a claim with the adjusted SOC amount in the "Patient's Share of Cost" field, and attach this MC 1054.
	is now zero,	may bill the program for the services you rendered. Submit a claim with a zero (0) in the "Patient's Share of Cost" field, and attach this MC 1054 form.

Once the CIF is approved and payment is received, you are required to reimburse the beneficiary any share of cost paid for the services, or eliminate/adjust the outstanding share of cost obligated for the services billed.

YOUR HEARING RIGHTS

You have the right to ask for a hearing if you disagree with any county action. You have only 90 days to ask for a hearing. The 90 days started the day after the county gave or mailed you this notice. If you have good cause as to why you were not able to file for a hearing within the 90 days, you may still file for a hearing. If you provide good cause, a hearing may still be scheduled.

If you ask for a hearing <u>before</u> an action on Cash Aid, Medi-Cal, CalFresh, or Child Care takes place:

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

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

Yes, lower or stop: ☐ Cash Aid ☐ CalFresh
☐ Child Care

While You Wait for a Hearing Decision for:

<u>Welfare to Work</u>:

You do not have to take part in the activities.

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

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

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

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

<u>Cal-Learn</u>:

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

OTHER INFORMATION

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

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

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

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

TO ASK FOR A HEARING:

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

  California Department of Social Services
  State Hearings Division, ACAB
  744 P Street, MS 9-17-97
  Sacramento, CA 95814
  OR Fax to: 1-916-651-2789
- **Call toll free: 1-855-795-0634 or** for hearing or speech impaired who use TDD, **1-800-952-8349.**

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

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

HEARING REQUEST

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

☐ Cash Aid ☐ CalFresh ☐ Medi-Cal

☐ Other (list)_____

Here's Why: _____

_____

_____

_____

_____

_____

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

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

My language or dialect is: _____

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

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

NAME	PHONE NUMBER	
STREET ADDRESS		
CITY	STATE	ZIP CODE

State of California
Health and Human Services Agency

County Social Services Agencies

If the information on this list has changed, you may verify the information in the phone directory under the county government listings.

A - L Counties

Alameda County (01)
(510) 383-8523
(888) 999-4772

Alpine County (02)
(530) 694-2235 Ext. 231

Amador County (03)
(209) 223-6550

Butte County (04)
(530) 538-7711
(877) 410-8803

Calaveras County (05)
(209) 754-6448

Colusa County (06)
(530) 458-0250

Contra Costa County (07)
Currently Enrolled
(866) 663-3225
New Application
(800) 709-8348

Del Norte County (08)
(707) 464-3191

El Dorado County (09)
(530) 642-7300

Fresno County (10)
Automated Assistance
(559) 600-1377
Call Center
(855) 832-8082

Glenn County (11)
(530) 934-6514

Humboldt County (12)
(877) 410-8809

Imperial County (13)
(760) 337-6800

Inyo County (14)
(760) 872-1394

Kern County (15)
Currently Enrolled
(877) 410-8812
New Application
(661) 631-6807

Kings County (16)
(877) 410-8813

Lake County (17)
(707) 995-4200

Lassen County (18)
(530) 251-8152

Los Angeles County (19)
Customer Service Center
(866) 613-3777
(877) 597-4777

M - O Counties

Madera County (20)
(559) 675-2300

Marin County (21)
(415) 473-3400

Mariposa County (22)
(209) 966-2000
(800) 549-6741

Mendocino County (23)
Fort Bragg Office
(707) 962-1000
Toll-Free in Mendocino
(877) 327-1677

Mendocino County (23)
(continued)
Ukiah Office
(707) 463-7700
Toll-Free in Mendocino
(877) 327-1711

Merced County (24)
(209) 385-3000

Modoc County (25)
(530) 233-6501

Mono County (26)
North County Office
(760) 932-5600
South County Office
(760) 924-1770

Monterey County (27)
(866) 323-1953

Napa County (28)
(800) 464-4214
(707) 253-4511

Nevada County (29)
(888) 809-1340
(530) 265-1340

Orange County (30)
Automated Assistance
(949) 389-8456
(714) 541-4895
Currently Enrolled
(800) 281-9799
New Application
(855) 478-5386

P - R Counties

Placer County Human Services (31)
(888) 385-5160
From outside of the County
(916) 784-6000

Plumas County (32)
(530) 283-6350

Riverside County (33)
Call Center – Customer Service
(800) 274-2050

S Counties

Sacramento County (34)
(916) 874-3100
(209) 744-0499

San Benito County (35)
(831) 636-4180

San Bernardino County (36)
(877) 410-8829

San Diego County (37)
(866) 262-9881

San Francisco City and County (38)
(415) 558-4700
(855) 355-5757

San Joaquin County (39)
(209) 468-1000

San Luis Obispo County (40)
(805) 781-1600

San Mateo County (41)
(800) 223-8383

Santa Barbara County (42)
Access Cal Win:
(866) 404-4007

Santa Clara County (43)
Benefits Assistance Center
(408) 758-3800
(408) 758-4600
Automated Assistance
(877) 962-3633

Santa Cruz County (44)
Benefit Call Center
(888) 421-8080

Shasta County (45)
(877) 652-0731

Sierra County (46)
Loyalton
(530) 993-6721
Downieville
(530) 289-3711

Siskiyou County (47)
(530) 841-2700

Solano County (48)
Benefit Action Center
(800) 400-6001
Fairfield
(707) 784-8050
Vacaville
(707) 469-4500
Vallejo
(707) 553-5000

Sonoma County (49)
(877) 699-6868

Stanislaus County (50)
(877) 652-0734

Sutter County (51)
(877) 652-0735

T - Y Counties

Tehama County (52)
(530) 527-1911

Trinity County (53)
(800) 851-5658
(530) 623-1265

Tulare County (54)
(800) 540-6880

Tuolumne County (55)
(209) 533-5711
For Mailed Application
(209) 533-5725

Ventura County (56)
(888) 472-4463
(805) 477-5100

Yolo County (57)
(855) 278-1594

Yuba County (58)
(877) 652-0739

STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

NOTICE OF LANGUAGE SERVICES

English: Your eligibility for public benefits could be affected by information contained in this letter. Your response may be required by a certain date. If you need additional help with this information, you can call your county worker. You have the right to ask for help in your own language. There is no cost for this help.

Spanish: Su elegibilidad para recibir beneficios públicos podría ser afectada por la información contenida en esta carta. Su respuesta podría ser requerida antes de cierta fecha. Si necesita ayuda adicional con esta información, llame a su trabajador del condado. Tiene el derecho a pedir ayuda en su propio idioma. No hay ningún costo para esta ayuda.

Arabic: قد تتأثر أهليتك للحصول على المزايا العامة بالمعلومات الواردة في هذه الرسالة. قد يكون ردك مطلوبًا بحلول تاريخ معين. إذا احتجت إلى مساعدة إضافية لفهم هذه المعلومات، فيمكنك الاتصال بمسؤول الملف في مقاطعتك. لديك الحق في طلب المساعدة بلغتك. لا توجد تكلفة مقابل هذه المساعدة.

Armenian: Այս նամակում պարունակվող տեղեկությունները կարող են ազդել պետական նպաստներ ստանալու Ձեր իրավասության վրա: Ձեր պատասխանը կարող է պահանջվել մինչև որոշակի ամսաթիվը: Եթե Ձեզ այս տեղեկությունների հետ կապված լրացուցիչ օգնություն է հարկավոր, կարող եք դիմել Ձեր վարչաշրջանի աշխատակցին: Դուք իրավունք ունեք Ձեր մայրենի լեզվով օգնություն ստանալու: Այդ ծառայությունն անվճար է:

Cambodian: សិទ្ធិទទួលបានអត្ថប្រយោជន៍សាធារណៈរបស់អ្នក អាចត្រូវប៉ះពាល់ដោយសារព័ត៌មានដែលមាននៅក្នុងលិខិតនេះ។ ការឆ្លើយតបរបស់អ្នកចាំបាច់ត្រូវឱ្យបានតាមកាលកំណត់។ ប្រសិនបើអ្នកត្រូវការជំនួយបន្ថែមទាក់ទងនឹងព័ត៌មាននេះ អ្នកអាចទូរសព្ទទៅកាន់បុគ្គលិកធ្វើការនៅក្នុងខោនធីរបស់អ្នក។ អ្នកមានសិទ្ធិស្នើសុំជំនួយជាភាសាកំណើតរបស់អ្នក។ ការផ្តល់ជំនួយនេះពុំមានគិតថ្លៃនោះទេ។

Chinese: 您的公共福利资格可能会受到本信中所含信息的影响。您可能需要在特定日期内作出回应。如果您需要有關此信息的其他帮助，您可以致电所在区县的工作人员。您有权使用母语请求帮助，并無費获取该类帮助。

Farsi: صلاحیت شما برای برخورداری از مزایای عمومی ممکن است با اطلاعات مندرج در این نامه تحت تأثیر قرار بگیرد. ممکن است تا تاریخ معینی ملزم به دادن پاسخ باشید. اگر به کمک بیشتری نیاز دارید، می توانید با مددکار کانتی تان تماس بگیرید. شما حق دارید درخواست کنید که کمک به زبان خودتان ارائه شود. ارائه این کمک هزینه ای برای شما در بر ندارد.

Hindi: इस पत्र में दीये हुये जानकारी के कारण आपकी सार्वजनिक लाभों की योग्यता प्रभावित हो सकती है। एक निश्चित तिथि तक आपके उत्तर की आवश्यकता हो सकती है। यदि आपको इस जानकारी के सन्दर्भ में अतिरिक्त सहायता चाहिए तो अपने काउंटी कार्यकर्ता से संपर्क करें। आपको अपनी भाषा में सहायता की माँग करने का अधिकार है। इस सहायता के लिए कोई शुल्क नहीं लगता।

Hmong: Koj txoj kev pab los ntawm pej xeem cov kev pab cuam yuav cuam tshuam txog qhov muaj cai tau txais kev pab. Tej zaum koj yuav tsum teb rov qab mus raw li hnub hais tseg. Yog koj tsis nkag siab cov ntaub ntawv no hu rau tus neeg pab lis hauj lwm hauv koj lub zos. Koj muaj txoj cai thov kev pab ua yog hais koj hom lus. Yuav tsis tau them nqi dab tsi rau qhov kev pab no.

Japanese: あなたの公的給付金の受領資格は、本文書に含まれる情報にによって影響を及ぼされる可能性があります。回答を期限までに要請される可能性があります。本情報に関してさらに援助が必要な場合は、郡の職員にお電話にてお問い合わせください。言語支援サービスがご利用できます。このサービスは無料です。

Korean: 공공 혜택에 관한 귀하의 자격이 이 편지에 포함된 내용에 의해 영향을 받을 수 있습니다. 귀하께서는 정해진 날짜까지 이에 응답할 필요가 있을 수도 있습니다. 본 내용과 관련하여 도움이 필요하시면 카운티 담당 직원에게 연락하십시오. 귀하의 사용 언어로 도움을 요청하실 수 있는 권리가 있으십니다. 도움 비용은 무료입니다.

Lao: ຜົນປະໂຫຍດການຊ່ວຍເຫຼືອຂອງທ່ານ ອາດໄດ້ຮັບຜົນກະທົບຈາກຂໍ້ມູນໃນຈົດໝາຍສະບັບນີ້. ທ່ານອາດຈຳຕ້ອງ ຕອບກັບຄືນພາຍໃນວັນທີທີ່ໄດ້ກຳນົດໄວ້. ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອກັບຂໍ້ມູນນີ້, ທ່ານສາມາດໂທຕິດຕໍ່ ພະນັກງານປະຈຳຄຸ້ມເຂດຂອງທ່ານໄດ້. ທ່ານມີສິດທີ່ຈະຂໍຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານ. ໂດຍບໍ່ເສຍຄ່າໃນການຂໍ ຄວາມຊ່ວຍເຫຼືອນີ້.

Mien: Meih duqv zipv naaiv zeiv waa-fienx bun taux meih se wueic laaix benx zuqc ninh yaac haih maaih jau-louc mingh ging-dongx taux meih nyei ze'buonc pui-zipv tengxx fu'loqc nyaanh aengx caux oix zuqc heuc meih dau waac daaux nqaang bun nzuonx hingh gan hnoi-nyieqc ziangh hoc.. Se gorngv meih maiv bieqc hnyouv taux naaiv deix waa-fienx jau-louc nor korh waac mingh buangh taux meih nyei kaau div gong-gorn zangc zoux gong mienh. Meih corc maaih do-leiz ze'buonc tov heuc tengx faan benx meih nyei mienh fingz waac bun muangx maiv zuqc cuotv haaix diuc jaa-zinh.

Punjabi: ਜਨਤਕ ਲਾਭ ਲਈ ਤੁਹਾਡੀ ਯੋਗਤਾ ਪ੍ਰਭਾਵਿਤ ਹੋ ਸਕਦੀ ਹੈ, ਇਸ ਪੱਤਰ ਵਿਚ ਸ਼ਾਮਿਲ ਜਾਣਕਾਰੀ ਦੇ ਮੁਤਾਬਿਕ। ਇੱਕ ਖ਼ਾਸ ਤਾਰੀਖ਼ ਤੱਕ ਤੁਹਾਡੇ ਜਵਾਬ ਦੀ ਜ਼ਰੂਰਤ ਹੋ ਸਕਦੀ ਹੈ। ਜੇਕਰ ਤੁਹਾਨੂੰ ਇਸ ਜਾਣਕਾਰੀ ਦੇ ਨਾਲ ਹੋਰ ਵਾਧੂ ਮਦਦ ਦੀ ਜ਼ਰੂਰਤ ਹੈ, ਤਾਂ ਤੁਸੀਂ ਆਪਣੇ ਇਲਾਕੇ ਦੇ ਵਰਕਰ ਨੂੰ ਕਾਲ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਲੈਣ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਇਹ ਮਦਦ ਮੁਫ਼ਤ ਹੈ।

Russian: Информация, содержащаяся в этом письме, может повлиять на Ваше право получать государственные пособия. Возможно, Вам необходимо будет предоставить ответ до определенной даты. Если Вам нужна дополнительная помощь в связи с этой информацией, обратитесь к сотруднику администрации округа. У Вас есть право обратиться за помощью на Вашем род ном языке. Эта помощь оказывается бесплатно.

Thai: การมีคุณสมบัติที่จะได้รับเลือกผลประโยชน์ของภาครัฐของคุณมีผลกระทบจากข้อมูลในจดหมายฉบับนี้ การตอบรับของคุณจะต้องทำภายในเวลาที่กำหนด หากคุณต้องการความช่วยเหลือจากข้อมูลนี้ คุณสามารถติดต่อกับพนักงานในท้องที่ คุณมีสิทธิที่จะขอความช่วยเหลือโดยใช้ภาษาของคุณ ไม่มีค่าใช้จ่ายในการขอความช่วยเหลือครั้งนี้

Tagalog: Ang iyong pagiging karapat-dapat para sa mga pampublikong benepisyo ay maaaring makaapekto sa impormasyong nilalaman ng liham na ito. Ang iyong tugon ay maaaring kailanganin sa pagsapit ng partikular na petsa. Kung kailangan mo ng karagdagang tulong sa impormasyong ito, maaari mong tawagan ang iyong manggagawa sa county. May karapatan kang humingi ng tulong sa sarili mong wika. Walang gagastusin para sa tulong na ito.

Ukrainian: Інформація, яку надано цим листом, може вплинути на Ваші умови отримання допомоги по соціальному забезпеченню. Вона також може вимагати від вас відповіді не пізніше певної дати. Якщо Ви потребуєте додаткової допомоги відносно наданої інформації, зателефонуйте працівнику місцевої служби. Ви маєте право на отримання безкоштовних послуг перекладача.

Vietnamese: Tính đủ điều kiện nhận các phúc lợi công cộng của quý vị có thể bị ảnh hưởng bởi thông tin có trong thư này. Chúng tôi có thể yêu cầu quý vị hồi đáp trước một ngày cụ thể. Nếu quý vị cần thêm trợ giúp với thông tin này, quý vị có thể gọi đến nhân viên tại quận hạt của quý vị. Quý vị có quyền yêu cầu trợ giúp bằng ngôn ngữ của quý vị. Quý vị không mất chi phí khi nhận sự trợ giúp này.