



**County of Sacramento**  
**Department of Human Assistance**  
**Program Fact Sheet**



***Medi-Cal***

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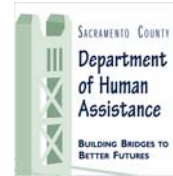
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**Overview of the Medi-Cal Program**

The Medi-Cal Program provides comprehensive medical benefits to all public assistance recipients, and to certain other eligible persons, who are seeking assistance with the cost of their medical care. The two main groups of beneficiaries are those persons receiving Public Assistance (PA) and those who are eligible for Medical Assistance Only (MAO). Adults between the ages of 21 and 65 who are not blind or disabled, pregnant, in a skilled nursing facility, and are not members of families who meet federal CalWORKs deprivation requirements are referred to as Medically Indigent Adults (MIA) and are not eligible for Medi-Cal. MIAs may receive their medical care through the County Medically Indigent Services Program (CMISP) from County public health facilities.

***Public Assistance (PA) Recipients***

Public Assistance (PA) Recipients include all aged, blind and disabled persons receiving Supplemental Security Income/State Supplemental Payment (SSI/SSP) or In-Home Supportive Services (IHSS), as well as most families with dependent children who are receiving cash assistance and children in Foster Care. These persons are automatically eligible for Medi-Cal coverage.

***Medical Assistance Only Beneficiaries (MAO)***

Medical Assistance Only Beneficiaries (MAO) are aged, blind, and disabled persons, as well as pregnant women, persons in a skilled nursing facility or long term care, and cash aid-linked families who do not receive cash assistance but who need help with medical expenses. A child who is deprived of parental care due to unemployment, incapacitation, absence or death may establish cash aid linkage. In families with such linkage, the parent(s) and children may be aided. In families where the cash aid linkage requirement is not established, only the children under age 21 are entitled to Medi-Cal benefits. As a condition of Medi-Cal eligibility, applicants with children under age 18, who are in certain aid code categories, must be referred to the District Attorney to provide medical support/paternity information, unless they are exempt or establish that good cause for not participating exists.

**Basic Requirements**

The following basic requirements must be met for Medi-Cal eligibility:

***Residency:***

The applicant must be a California resident, however, there is no durational requirement.

***Citizenship/Immigration Status***

To receive full-scope Medi-Cal benefits, an eligible applicant must be a U.S. citizen/national or a non-citizen with satisfactory immigration status and be able to provide acceptable proof. Individuals who are citizens/nationals and will not verify



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their status or are without satisfactory immigration status may receive coverage restricted to emergency and pregnancy related care.

***Private Health Insurance***

All eligible persons are required to use any other health insurance benefits to the maximum.

***Resources***

An applicant’s non-excluded resources must not exceed the limits, based on family size, as shown below:

1 person	\$ 2,000*	5 persons	\$ 3,450	9 persons	\$ 4,050
2 persons	3,000	6 persons	3,600	10 or more persons	4,200
3 persons	3,150	7 persons	3,750		
4 persons	3,300	8 persons	3,900		

**\*Property limit for one person for the 1931(b) Program is \$3,000**

***Real Property***

The applicant’s principal residence is not considered in determining resources and eligibility. The applicant may also exempt real property, other than his/her own home if it is utilized and the net market value (assessed value less encumbrances), does not exceed \$6,000.00. The value of other real property that exceeds \$6,000.00 is applied to the family’s total resources.

***Personal Property***

Other personal property, such as cash, bank accounts, and nonexempt vehicles are also included in the total resource valuation.

***Vehicles***

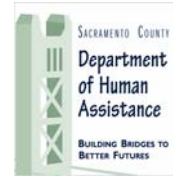
- For 1931(b), a vehicle may be exempt if it is used for self-employment, transportation of a disabled person living in the home, transportation of the primary supply of fuel or water for the home, or used as a home.
- For MAO, the family may chose one vehicle for exemption, regardless of its use. A vehicle used as a home is also exempt for this program. Applicants with resources valued in excess of the limit for their household size are not eligible. For some qualifying children and pregnant women, resources are not counted (see details in [Special Programs](#)).

***Long-Term Care***

For married persons who need Medi-Cal because one spouse receives long-term, inpatient care, the law allows the spouse at home to retain a portion of the combined community and separate property. The 2009 Community Spouse Resource Allowance is \$109,560.00. This amount is adjusted annually based on the Consumer Price Index.



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**What is the Cost of Medi-Cal Care?**

The amount that a family or an individual has to pay for Medi-Cal benefits is determined by the amount of available income that remains after appropriate exclusions and deductions are allowed. While there are no income limits for Medi-Cal eligibility, the amount of income that remains after all state-allowed deductions are applied must be paid or obligated toward the individual or family monthly medical expense before Medi-Cal coverage is utilized.

***Share of Cost***

This amount that must be paid or obligated is called a Share of Cost (SOC). Unlike a monthly medical premium, the SOC must only be met (paid) if Medi-Cal coverage is needed during the month. Each time a beneficiary obtains medical services, the service provider will swipe (use) the Benefits Identification Card (BIC) to determine how much, if any, is obligated to be paid.

***Third Party Liability***

In certain cases where a third party may be responsible for an individual's injuries or illness, the California Department of Health Services (CDHS) will try to recover the cost of Medi-Cal treatment from the responsible party.

**Which Services are Covered?**

***Full-Scope Benefits***

Persons who are certified to receive full-scope Medi-Cal benefits are entitled to a comprehensive range of health care services, dental care and prescription drugs (both in and out of a hospital or nursing home) from health care providers who participate in the program. Pregnant women may be entitled to benefits that include 60 days coverage after the end of a pregnancy, or pregnancy-related and postpartum services at no share of cost. In most instances, their newborns may continue to be covered, at the same share of cost as their mothers, until their first birthday.

***Optional Benefits***

Effective July 1, 2009, reductions in state programs, including the elimination of nine adult Medi-Cal optional benefits, will be made.

**Eliminated optional benefits include:**

- acupuncture services
- adult dental services
- chiropractic services,
- incontinence creams and washes
- optician/optical laboratory services
- optometry services
- podiatry services
- psychology services and
- speech and audiology services.



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Questions about these optional benefits? Call the Medi-Cal Beneficiary Services Line at **1-888-284-0623**.

***Limited Benefits***

Medi-Cal benefits for pregnancy related services and for emergency medical services only, which include labor and delivery of an infant, are available to non-citizens who do not have satisfactory immigration status, if otherwise eligible.

***Benefit Identification Card (BIC)***

The Department of Health Care Services (DHCS) establishes authorized services. Before providing and billing for certain benefits, providers of Medi-Cal services may need to obtain authorization from the Medi-Cal Consultant at the DHCS. Prior authorization is required for such things as dental services, prescription drugs not on the State-approved list, hearing aids, some sickroom equipment, prosthetic and orthodontic appliances, non-emergency hospitalization, nursing home services and intermediate facility care. A plastic Benefit Identification Card (BIC) is provided to each beneficiary and should be retained even if benefits are subsequently discontinued. In the event that benefits are restored at a later date or upon reapplication, the BIC is reactivated for use by the beneficiary. The BIC must be shown to the medical provider each time medical services are provided. The provider will use the BIC to determine the individual's Medi-Cal eligibility status and share of cost obligation.

***Managed Care Plans***

Certain persons entitled to zero SOC Medi-Cal are now required to enroll in a managed care plan. These are private health and dental organizations, which are required under contract with the State, to provide comprehensive health or dental services to Medi-Cal enrollees. Once enrolled in a managed care plan, the recipient must obtain his/her medical care through the plan except for any medical services not covered.

***Retroactive Coverage***

An applicant may be eligible for Medi-Cal coverage in any of the three months immediately preceding the month of application or re-application if all requirements are met for those past months. A beneficiary who is eligible for benefits on the first day of the month is entitled to services for the entire month.

**Special Programs For Families, Women and Children**

The following programs provide Medi-Cal at zero share of cost to certain eligible women, families, and children:

***1931(b) Program***

Provides no share of cost Medi-Cal benefits to families receiving CalWORKs payments and those families who do not receive CalWORKs but who meet the eligibility requirements which were in force for the Aid to Families with Dependent Children (AFDC) Program prior to the passage of welfare reform legislation on July 16, 1996.



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Eligibility staff must first determine if eligibility can be granted under the 1931(b) Program, and if not, then determine eligibility under the appropriate Medi-Cal program.

***100% Program***

Provides Medi-Cal benefits with no share of cost to children age six to 19 if the family's net nonexempt income is at or below 100% of the Federal Poverty Level (FPL). Family resources are not counted for this program.

***133% Program***

Provides Medi-Cal benefits with no share of cost to children age one to six if the family's net nonexempt income is not more than 133% of the FPL. Family resources are not counted for this program.

***200% Program***

Provides Medi-Cal benefits with no share of cost is available to pregnant women and infants under age one, who do not meet the no share of cost criteria under other programs. The adjusted net income can be no more than 200% of the FPL. The benefits for women are limited to pregnancy-related and postpartum medical care. Infants receive full-scope Medi-Cal services. Family resources are not counted for the pregnant woman or infant.

***Continuous Eligibility for Children (CEC)***

Establishes eligibility, with no share of cost, for up to a 12-month period that ends the date of the next determination of eligibility or the child's 19<sup>th</sup> birthday, whichever occurs first. During the CEC guarantee period, any changes in the family's income or resources which would cause the child to have a share of cost or be totally ineligible are disregarded until the annual redetermination. CEC will protect the child from discontinuance, even if resource changes affect the other family members.

***Presumptive Eligibility (PE) for Pregnant Women***

Allows certain qualified health care providers to extend zero share of cost prenatal Medi-Cal coverage to eligible pregnant women with income up to 200% of the FPL at the first clinic/office visit. This coverage ends either at the end of the second month of PE or upon approval or denial of the regular Medi-Cal application filed by the pregnant woman. Family resources are not counted for the pregnant woman's eligibility.

***Transitional Medi-Cal (TMC) Program***

Provides up to 12 months of no share of cost benefits to families who have lost eligibility to CalWORKs or 1931(b) only Medi-Cal benefits due to employment or increased earnings. Certain eligibility requirements must be met.

***Four-Month Continuing Medi-Cal***

Allows families who have lost eligibility to CalWORKs or 1931(b) Medi-Cal due to receipt of, or an increase in child support or alimony, to receive no cost, full scope benefits, under certain conditions, for four additional months.



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**Former Foster Care Children (FFCC) Program**

Provides for *automatic*, continuing, no cost, full-scope Medi-Cal coverage for children who were in foster care on their 18<sup>th</sup> birthday and who were subsequently released from the foster care system due to age. There are no income or resource requirements for this program. Medi-Cal coverage continues until the FFCC's 21<sup>st</sup> birthday as long as he/she remains in the state.

**Breast and Cervical Cancer Treatment Program (BCCTP)**

BCCTP is administered by the State. It provides urgently needed cancer treatment coverage to individuals diagnosed with breast and/or cervical cancer, who require treatment and have met the Centers for Disease Control (CDC) screening criteria, or were screened by a CDC provider. An eligible applicant must be a resident of California with an income that does not exceed 200 percent of the Federal poverty level, based on family size. Eligible applicants must be screened by a State-funded Breast Cancer Early Detection Program (BCEDP), Federally-funded Breast and Cervical Cancer Control Program (BCCCP) or Family PACT screening provider and found to be in need of breast and/or cervical cancer treatment. Individuals may be eligible, even if they have other health coverage, as long as their premiums, co-payments and deductibles are expected to exceed \$750 annually. For more information, call 1-800-824-0088 between the hours of 8:00am and 5:00pm.

**Special Programs For Adults**

The following programs provide Medi-Cal at zero share of cost to certain eligible adults:

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

Provides zero share of cost Medi-Cal to income-eligible aged and disabled persons. To be eligible to this program, the individual must be at, or over 65 years of age or be considered disabled by Social Security criteria, have resources below the medically needy limits (see [Resources](#), page 4, and have net countable income at or below 100% of the FPL.

**Federal Poverty Level for the Blind Program (FPLB)**

Provides zero share of cost Medi-Cal to income-eligible blind persons who have resources below the medically needy limits (see [Resources](#), page 4, and have net countable income at or below 100% of the FPL. To be evaluated a person must be:

1. Individuals who have not yet met, or who cannot meet, the Title II criteria for disability based upon blindness. Individuals, who meet the Title XVI criteria for blindness, shall be placed in this program.
2. Blind individuals who allege that they have blindness as a disability and who are waiting for disability evaluations, shall also be placed in this program until their disability evaluations are completed, as otherwise eligible.



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***Pickle Amendment Benefits***

Under the Pickle Amendment to the Social Security Act, Medi-Cal benefits at no share of cost, are available to persons who have lost their eligibility for SSI cash benefits due to cost-of-living adjustments in their regular Social Security disability or retirement benefits. To be eligible, an individual's countable income must be less than the current SSI payment level after all cost of living adjustments subsequent to SSI ineligibility due to increased SSA benefits have been disregarded.

**Other Special Programs**

The programs listed below provide financial or medical assistance to persons who may or may not otherwise be eligible for Medi-Cal benefits.

***Child Health and Disability Prevention Program***

The Child Health and Disability Prevention (CHDP) Program is a federal and state mandated program which provides preventive health care to Medi-Cal eligible children ages 0-20 years of age. Eligible children receive services that include periodic assessments and referrals for diagnosis and treatment of suspected health care problems. Non-Medi-Cal eligible children, ages 0-19, whose family income is equal to or less than 200% of the Federal Poverty Level (FPL), are also eligible for these services. The primary goal of the program is to keep children and teens healthy through regular check-ups and to find health problems before they become more serious and more expensive to treat. The CHDP Program is administered by the Department of Health and Human Services. For more information you can call 916-875-7151.

***Minor Consent Services***

This program provides confidential services to minors related to sexual assault, pregnancy and pregnancy-related services, family planning, sexually transmitted diseases, drug and alcohol abuse and outpatient mental health treatment and counseling.

***250% Working Disabled Program***

This program expands the Medi-Cal zero share of cost eligibility to include disabled working persons, subject to payment of a monthly premium. Applicants must meet SSI eligibility rules, although their countable net income can be as high as 250% of the FPL. The county determines eligibility and premiums are collected by the State. The monthly premium is set using a sliding scale, based on individual income.

***Dialysis and Related Services***

Limited Medi-Cal coverage is provided to property ineligible persons who need life-sustaining dialysis and related services. Eligible persons are obligated to pay a percentage of the treatment costs for services not covered by other health insurance or government programs.



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***Health Insurance Premium Payment (HIPP) Program***

Under the State's Health Insurance Premium Payment (HIPP) Program, the Department of Health Care Services (DHCS) will pay health insurance premiums on behalf of certain MAO beneficiaries who have high-cost medical conditions. County Eligibility staff refers potentially eligible clients to DHCS for possible participation in the program.

***Tuberculosis Program***

This is an optional program for persons infected with tuberculosis who do not qualify for federally mandated Medi-Cal programs. To be eligible, income and resource requirements are applied.

**Medicare Buy-In**

Medicare Buy-In is the payment of Medicare Part B Premiums by DHCS for certain eligible aged, blind or disabled Medi-Cal beneficiaries under the Medicare Buy-In agreement with the Social Security Administration.

**Medicare Savings Programs**

The Medicare Catastrophic Coverage Act (MCCA) of 1988 requires that states pay the Medicare Part A and Part B cost-sharing expenses of low-income Medicare beneficiaries that include premiums, deductibles and coinsurance fees.

Under the Qualified Medicare Beneficiary Program (QMB) and the Specified Low-Income Medicare Beneficiary (SLMB) Program, Medi-Cal will help pay monthly Medicare premiums plus deductible and coinsurance fees for certain aged and disabled persons. For Part A Medicare premium coverage under the QMB Program, these persons may have income up to 100% of the FPL. Under the SLMB Program, these persons may have income above 100% but less than 120% of the FPL. Coverage under SLMB is limited to the payment of Medicare Part B premium, not payment of Medicare Part A premium or the Part B deductibles or coinsurance fees.

The QI-1 Program is limited to the payment of the Medicare Part B premium. It does not pay Medicare Part A premium or the Part B deductibles or coinsurance fees. To be eligible, a QI-1 person must have income at or above 120% of the FPL and up to but not including 135% of the FPL.

**Other Paths To Medi-Cal**

Several programs have been developed by the Department of Health Care Services (DHCS) to facilitate children's access to Medi-Cal benefits and expedite the application process. These programs offer either no-cost Medi-Cal benefits for certain apparently eligible children for a period of up to 60 days or until an eligibility determination has been completed OR use alternate application methods to expedite the eligibility determination. For the programs that offer temporary, pre-enrollment benefits, an application must be filed before the end of the temporary benefit period if the benefits



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are to continue. Applications are returned to the DHCS Single Point of Entry. The programs are:

***Accelerated Enrollment***

This program allows apparently eligible children under age 19 to receive no-cost, fee-for-service Medi-Cal benefits for a period of 60 days by mailing a Joint Medi-Cal/Healthy Families application (MC 321) to the Single Point of Entry. The application is then sent to the county of residence or Healthy Families for a determination of eligibility. Benefits continue until the eligibility determination is completed.

***CHDP Gateway***

Apparently eligible children, age 0 to 19 years, are enrolled into this temporary, no-cost Medi-Cal benefit through providers at the time of the CHDP periodic screening. An application must be submitted during the 60-day temporary enrollment period if benefits are to be continued. If an application is not returned, the temporary benefit ends at the end of the 60-day period.

***Deemed Eligibility***

An application is not required for newborns less than one year old enrolled through this program who were born to mothers who were eligible to, and receiving Medi-Cal in the birth month. These children establish deemed eligibility based on their mother's eligibility in the birth month, until age one.

**How To Apply**

There are a variety of methods in which an application can be made:

***General Application***

Persons interested in applying for Medi-Cal who will be treated by a private medical provider should apply by calling the automated application telephone number (916) 874-2215 or submitting an application at a Department of Human Assistance bureau. For the bureau closest to you, call (916) 874-2072.

***Care Received In Intermediate or Nursing Facility***

A Medi-Cal application for a person who is receiving care in an intermediate or skilled nursing facility may be made at:

Medical Assistance Bureau  
Adult Services Center  
4875 Broadway, Suite C  
874-9460 (long term care)

***Received Emergency Treatment or Hospitalization at UCD Medical Center***

Persons interested in applying for Medi-Cal who receive emergency treatment or hospitalization at the UCD Medical Center should apply at:

Medical Assistance Bureau



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UCD Medical Center  
2420 Stockton Boulevard – Davis II Building  
Screener for Hospitalization: **734-1600**  
Screener for Emergency Room: **734-1260**

***Emergency Medical Condition***

Persons who have an emergency medical condition should go to a hospital emergency room.

**Appeal Rights**

Medi-Cal or Medicare Savings Program (i.e. QMB) applicants or recipients have the right to appeal decisions, which they do not believe are right. The appeal process is explained at the time of application and on the back of notices of action.

**Contact**

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