

DEPARTMENT OF SOCIAL SERVICES

144 P Street, Sacramento, CA 95814
(916) 322-5330



April 24, 1981

CHDP PROGRAM LETTER NO. 81-5
ALL-COUNTY LETTER NO. 81-43

TO: ALL-COUNTY WELFARE DIRECTORS
CHDP DIRECTORS AND DEPUTY DIRECTORS

SUBJECT: NEW CHDP DOCUMENTATION AND REFERRAL PROCEDURE FOR AFDC APPLICANTS
AND RECIPIENTS

REFERENCE:

This letter supersedes All-County Letters 79-68 and 79-69 and CHDP Program Letter 79-19.

This letter transmits a new CHDP referral form (Attachment I), instructions for its use (Attachment II) and revised informing, referral and documentation procedures which will be effective July 1, 1981.

The new form (PM 357) was developed jointly by the Department of Social Services and the Department of Health Services in consultation with the AFDC County Forms Advisory Committee, County Welfare Directors Association and the California Conference of Local Health Officers. The form is for use in all cases where a referral is being made for CHDP services or more information. Use of the form will ensure that all federally required information on referred cases will be available in the local CHDP Unit/EPSTDT Program. The PM 357 is mandatory, although modifications to the form or process may be made subject to the prior written approval of the DSS and DHS-CHDP Program. Submit modification requests to the DHS CHDP Branch.

The Department of Health Services plans to use this same form (PM 357) for Medi-Cal only applicants and beneficiaries and will issue similar instructions shortly. Current CHDP documentation and referral procedures for Medi-Cal only applicants and beneficiaries should remain in place until written notice is received from the Department of Health Services.

AFDC-FG & U

AFDC-FG and U informing, referral and documentation procedures are found in EAS 40.107.6, 40-131.3 and 40-181.2. Procedures are described below:

No Services Requested

For applicants and recipients who do not want CHDP services or more information the current procedures remain unchanged, as follows:

1. Give out the CHDP brochure and provide verbal explanation to all applicants or recipients.
2. Ensure the applicant or recipient has completed the Social Services question on the CA 2 regarding CHDP services or question 13 on the CA 20.
3. Check the box in the county use section of the CA 2 or CA 20 to indicate that the brochure and explanation were given.

Services Requested

For applicants and recipients who want services or more information the procedures above must be followed. In addition, after completing steps 1-3:

4. Complete Part A of the new CHDP Form PM 357. It is no longer necessary to document the response to the offer of transportation and scheduling on the CA 2 or CA 20.
5. Send two copies to the local ESDT Unit/CHDP Program for further processing, and retain the third copy in the case file.

AFDC-Foster Care (FC, formerly AFDC-BHI)

The CHDP Form PM 357 must be completed on all AFDC Foster Care cases, whether services are requested or not. A copy is to be retained in the services case record to ensure that the documentation requirements to be specified in MPP 30-209.66 are met. When services are requested, two copies of the form are forwarded to the local EPSDT Unit/CHDP Program, as in AFDC-FG & U.

Self-Referral

When a recipient requests services directly from the local EPSDT Unit/CHDP Program, complete steps 4 and 5 and retain the Form PM 357. The third copy is not needed.

Supplies of the new Form PM 357 will be produced in NCR carbonless paper and are expected to be available in one month. To order the forms, county welfare departments should use the GEN 727B process.

County health departments should order with the HAS 1390 forms request (Information Notice #80-J) with two shipping labels for each 1,000 forms. Send to:

Forms Clerk
CHDP Branch, DHS
714 P Street, Room 1792
Sacramento, CA 95814

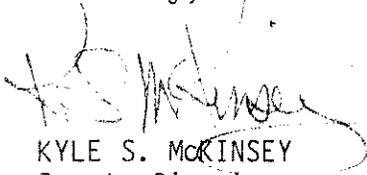
Counties may reproduce the attached form until supplies are available.

County welfare departments should direct their AFDC questions relating to Part A of the form to their AFDC Management Consultant at (916) 445-4458.

For all other questions and self-referral cases, county welfare departments should contact their Regional EPSDT Consultants.

Health departments with any questions about the form should contact their CHDP Regional Consultants.

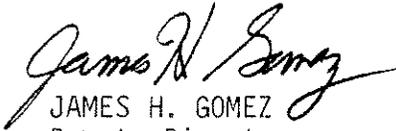
Sincerely,



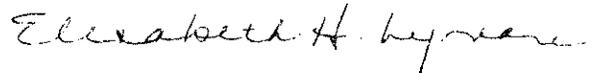
KYLE S. MCKINSEY
Deputy Director
Welfare Program Operations Division
Department of Social Services



SIEGRID A. CENTERWALL, M.D.
Chief, CHDP Branch
Department of Health Services



JAMES H. GOMEZ
Deputy Director
Adult and Family Services Division
Department of Social Services



ELISABETH H. LYMAN
Deputy Director
Health Care Policy and
Standards Division
Department of Health Services

Attachments

cc: CWDA
CCLHO

CHDP REFERRAL FORM

ATTACHMENT 1

All Medi-Cal Eligible Persons Under 21 Years of Age Can Receive a Health and Dental Check-Up.

Client: Fill In Unshaded Area Only

PART A: COMPLETE FOR ALL CASES REQUESTING SERVICES OR ADDITIONAL INFORMATION

1. Case Name (Last, First, Middle)	2. Co. Code	3. AIG Code	4. Case Number
------------------------------------	-------------	-------------	----------------

5. Requested Additional Information, But No Services

REQUESTED MEDICAL SERVICES (Health Assessment)

6. Services <input type="checkbox"/> Yes <input type="checkbox"/> No	7. Transportation <input type="checkbox"/> Yes <input type="checkbox"/> No	8. Scheduling <input type="checkbox"/> Yes <input type="checkbox"/> No
--	--	--

REQUESTED DENTAL SERVICES

9. Services <input type="checkbox"/> Yes <input type="checkbox"/> No	10. Transportation <input type="checkbox"/> Yes <input type="checkbox"/> No	11. Scheduling <input type="checkbox"/> Yes <input type="checkbox"/> No
--	---	---

12. <input type="checkbox"/> New Application	13. <input type="checkbox"/> Redetermination	14. <input type="checkbox"/> Self-Referral
15. <input type="checkbox"/> AFDC	16. <input type="checkbox"/> AFDC Foster Care	17. <input type="checkbox"/> Medi-Cal Only
		18. <input type="checkbox"/> Share of Cost

19. Primary Language, if Other Than English _____

20. Other Circumstances _____

Person No.	Client(s) Name (Last, First, Middle)	Birthdate			Age	
		Month	Day	Year		
21	Parent or Caretaker Name					If PHP, Give Name of Plan
22	Other Parent in Home					If PHP, Give Name of Plan
23	Child's Name					If PHP, Give Name of Plan
24	Child's Name					If PHP, Give Name of Plan
25	Child's Name					If PHP, Give Name of Plan
26	Child's Name					If PHP, Give Name of Plan
27	Child's Name					If PHP, Give Name of Plan
28	Other Person in Home					If PHP, Give Name of Plan
29	Residence Address	Zip Code			30. Home Phone	
		CA				
31	Mailing Address	Zip Code			32. Message Phone	
		CA				
33	Family or Children's Doctor (Optional)	34. Family or Children's Dentist (Optional)				

This information is requested to meet Federal reporting requirements (Federal Register CFR 42, Part 441) and to inform you of services available. The county is required by law to keep this information confidential except as provided in state or federal law or regulation. Further information is available at your local welfare or CHDP offices.

COMMENTS:

35. Worker Signature	36. Worker Number	37. Worker Phone	38. Date Eligibility Determined
----------------------	-------------------	------------------	---------------------------------

Copy 1—County CHDP; Copy 2—County CHDP; Copy 3—Client Case Record (Welfare Department)
CHDP REFERRAL AND CASE MANAGEMENT FORM

PART B: Follow-Up to Health Assessment and/or Dental Services

Contact Attempt With Responsible Person:

Type of Contact	Date	Result	Who Contacted	Date	Result	Who Contacted
<input type="checkbox"/> Face-to-Face						
<input type="checkbox"/> Telephone						
<input type="checkbox"/> Mail						

FINAL RESULT:
 Contact Made
 No Contact Made

COMMENTS:

Client Name	Type		Assistance Given	Date	Provider Name and Phone Number	Appt. Date	Appt. Kept		Further Dx Rx Needed		Source of Info.	Date PM 160 Received
	T	S					Yes	No	Yes	No		
	M											
	D											
	M											
	D											
	M											
	D											
	M											
	D											

(If More Space Is Needed, Attach Additional Sheets)

COMMENTS:

WORKER SIGNATURE:

Date:

PART C: Follow-up to Diagnosis and Treatment

Contact Attempt With Responsible Person:

Type of Contact	Date	Result	Who Contacted	Date	Result	Who Contacted
<input type="checkbox"/> Face-to-Face						
<input type="checkbox"/> Telephone						
<input type="checkbox"/> Mail						

Final Result:
 Contact Made
 No Contact Made

Client Name	Type Of Condition	Response To Offer		Assistance Given	Date	Provider Name and Phone Number	Appt. Date	Appt. Kept		Source Of Info.
		Trans.	Sched.					Yes	No	

COMMENTS:

HEALTH PROFESSIONAL SIGNATURE:

INSTRUCTIONS FOR COMPLETING PART A

Items 1—4. Self-explanatory.

Item 5. Check the box if no services are requested but the client wants additional information about the program.

Item 6. Check yes or no as appropriate.

Items 7 and 8. If Item 6 is checked no, skip these items. If Item 6 is checked yes, check the boxes in both 7 and 8 indicating the response to the offer of transportation and scheduling assistance.

Item 9. Check yes or no as appropriate.

Items 10 and 11. If Item 9 is checked no, skip these items. If Item 9 is checked yes, check the boxes in both 10 and 11 indicating the response to the offer of transportation and scheduling assistance.

Items 12, 13, and 14. When the referral is being made by an AFDC, Medi-Cal or placement worker, check Item 12 if a new application or restoration or Item 13 if it is the annual redetermination. When services have been requested directly from the local EPSDT Unit or CHDP Program, check Item 14.

Item 15—17. Check the one applicable box.

Item 18. Check the box when a Medi-Cal only beneficiary has to pay a share of the costs.

Items 19 and 20. Complete if applicable.

Items 21—28. Fill in the state person number. (Example: 01-father, 02-mother, 11-child, etc.), and the name of the PHP if applicable. A person number need not be entered on self-referrals. The unshaded portion must be completed in full by the county welfare department, local EPSDT Unit or CHDP program for self-referrals, or by the client.

Items 29—32. Record the caretaker's address and phone number.

Items 33—34. Optional — Not Required. Enter the name of the doctor or dentist who currently provides care to eligible children.

Comments: Use this section to record any comments which will help recipients receive requested services, such as the best time for them to be contacted.

Items 35—37. Self-explanatory.

Item 38. "Date Eligibility Determined" — This is the date that the application is approved, *not* the date the application was made. For redetermination, the date eligibility is determined is the date that the county verifies and certifies that eligibility continues. For "self-referrals" the date of request for services should be entered.

Item 38, "Date Eligibility Determined" - This is the date that the application is approved, not the date the application was made. For redetermination, the date eligibility is determined is the date that the county verifies and certifies that eligibility continues. For "self-referrals" the date of request for services should be entered.

Part B

It is mandatory that EPSDT, CHDP, or placement workers complete this part for every individual requesting transportation and/or scheduling assistance for medical and/or dental services ("penalty liable" individuals). This part should also be used for documenting follow-up of other (non penalty liable) individuals requesting CHDP services when such follow-up is done.

From Part A of the Form, record the names of each individual for whom services are requested in the spaces under the heading "Client Name". Circle the CHDP services - Medical (M), Dental (D), or both, and mark with an (X) the support services that were requested - Transportation Assistance (T), and Scheduling Assistance (S).

Contact the family and, at the top of Part B, mark with an (X) the type of contact made - face-to-face, telephone, or mail. Record the date of the contact, the result of the contact (e.g., "at home", "not found", etc.), and the person contacted (e.g., "mother"). When contact is by mail, the family's response or failure to respond within 30 days should be noted.

Space is provided for recording the same type of contact a second time.

Under "Final Result", mark with an (X) whether contact was finally made or not made with the family or recipient.

The "Comments" Section provides space for explanatory notes and for responses from families when contacted, such as "family now desires scheduling as well as transportation assistance".

When contact is established, complete the second part of Part B. Record the kind of assistance given, (e.g., appointment made); the date the assistance was given, the provider(s) name and phone number(s); and the appointment date(s).

After the appointment date(s), contact the family or provider and document if the appointment was kept, if further diagnosis and treatment is needed, and the source of the information (e.g., "doctor" or "mother"). Record the date the PM 160 is received from the provider.

A PM 160 must be on file to verify that a health assessment was received if the recipient is "penalty liable". If a PM 160 is not received, verbal or written confirmation of services must be obtained from the provider. This is to assure that needed health assessment services were given and to ascertain if further diagnostic and treatment services are needed.

The "Comments" Section provides extra space for explanatory notes.

Instructions for Completing the CHDP Form PM 357

Part A

Items 1-4. Self explanatory.

Item 5. Check the box if no services are requested but the client wants additional information about the program.

Item 6. Check yes or no as appropriate.

Items 7 and 8. If Item 6 is checked no, skip these items. If Item 6 is checked yes, check the boxes in both 7 and 8 indicating the response to the offer of transportation and scheduling assistance.

Item 9. Check yes or no as appropriate.

Items 10 and 11. If Item 9 is checked no, skip these items. If Item 9 is checked yes, check the boxes in both 10 and 11 indicating the response to the offer of transportation and scheduling assistance.

Items 12, 13 and 14. When the referral is being made by an AFDC, or placement worker, check Item 12 if a new application or restoration or Item 13 if it is the annual redetermination. When services have been requested directly from the local EPSDT Unit or CHDP Program, check Item 14.

Item 15-17. Check the one applicable box.

Item 18. Check the box when a Medi-Cal Only beneficiary has a share of cost.

Items 19 and 20. Complete if applicable.

Items 21-28. Fill in the state person number. (Example: 01-father, 02-mother, 11-child, etc.); and the name of the PHP if applicable. A person number need not be entered on self-referrals. The unshaded portion must be completed in full by the county welfare department, local EPSDT Unit or CHDP program for self-referrals, or by the client.

Items 29-32. Record the caretaker's address and phone number.

Items 33-34. Optional - Not Required. Enter the name of the doctor or dentist who currently provides care to eligible children.

Comments. Use this section to record any comments which will help recipients receive requested services, such as the best time for them to be contacted.

Items 35-37. Self-explanatory.

Part B should be signed and dated by the worker when completed. If more than one worker has provided services, a signature should accompany each entry.

Part C

Health department CHDP staff must complete Part C for all "penalty liable" recipients found to need further diagnosis and treatment as a result of the health assessment, (Codes 4 or 5 on the PM 160).

A separate Part C may be completed for each recipient if more space is needed because multiple health problems are identified. Be sure that identifying information is on the form.

Record the client's name and the type of condition from the PM 160. Use a separate line for each condition.

As in Part B contact the family and mark with an (X) the type of contact made, face-to-face, telephone, or mail. Record the date of the contact, the result of the contact (e.g., "at home", or "not found") and the person contacted (e.g., "mother"). When contact is by mail, the family's response or failure to respond within 30 days of the contact should be noted. Under "Final Result", mark with an (X) whether contact was finally made or not made with the family or recipient.

When the family or recipient is contacted, reoffer Transportation (T) and Scheduling (S) assistance and record the response ("Yes" or "No") to the offer for each individual and for each condition.

Record the kind of assistance given (e.g., "appointment made"), the date the assistance was given, the provider(s) name and phone number(s), and the appointment date(s) for each condition for each individual.

After the appointment date, contact the family or the provider and record whether the appointment was kept or not kept and the source of information.

Confirmation that medical care was received must be obtained from the doctor by phone or in writing. Confirmation that dental care was received can be obtained from the client or the dentist.

Space is provided in the "Comments" Section for explanatory notes.

The health professional should sign and date Part C. If several persons have provided services, a signature should accompany each entry.

Use of Part C for Non-Penalty Liable Individuals

Part C alone may be completed when PM 160s are received indicating diagnostic and treatment services are needed on individuals who did not request support services to receive health assessments. Scheduling and Transportation Assistance does not have to be reoffered. Local programs, however, should offer assistance to ensure that children with potentially disabling conditions receive needed care.

Retention of Form

The first copy of the form must be retained by the local CHDP Program or EPSDT Unit for federal penalty audit purposes. The second copy of the form, must be kept by the local CHDP Program or EPSDT Unit to compile the monthly list of AFDC recipients requesting services and the statistics needed for the quarterly Child Health Status Report. (See CHDP Program Letters 80-5 and 80-14). For self-referrals, the third copy is not needed.

DEPARTMENT OF SOCIAL SERVICES

P Street, Sacramento, CA 95814
(916) 322-0181



April 24, 1981

ALL-COUNTY LETTER NO. 81-44

TO: ALL COUNTY WELFARE DIRECTORS

SUBJECT: MASS MAILING OF FAMILY PLANNING SERVICES OFFER

REFERENCE: MPP 30-411.41

This is to remind you that the annual mass mailing of the family planning services offer to all AFDC families is due with the July warrants.

Section 402(a)(15) of the Social Security Act requires that States offer and provide promptly, directly or under arrangements with others, family planning services to all recipients of AFDC (including minors who can be considered to be sexually active) who desire such services. Section 403(f) of the Act imposes a fiscal penalty of one percent of total federal payments to the State under Title IV-A for failure to meet the requirement.

Beginning April 1974, a one-time mass mailing offer to the entire AFDC caseload was required and in subsequent years the counties have been asked to send the annual mass mailing with the July warrants to ensure statewide compliance within a prescribed time.

The information sent in the mass mailing should be in English, Spanish, or other language commonly spoken in the county. Attached for your convenience is a suggested notification in English, Spanish, Filipino (Tagalog), Vietnamese and Chinese.

If you have any questions, please contact your Program Management Consultant at (916) 445-8724.

Sincerely,


JAMES H. GOMEZ
Deputy Director

Attachment

ENGLISH

Family Planning Services (sometimes called "birth control") such as diagnosis, medical supplies and treatment are available through the use of your Medi-Cal card. Information about family planning and answers to your questions can be obtained from the social worker at the county welfare department. Your request for information will be confidential. If transportation to the clinic or child care is necessary or if you have further questions, ask the county social worker or family planning clinic for assistance.

SPANISH

Los Servicios de Planificación Familiar (a veces conocidos como "Control de Natalidad") tales como diagnosis, provisiones médicas, y tratamiento están disponibles por medio del uso de su tarjeta de Medi-Cal. El trabajador social del departamento de bienestar del condado puede darle información acerca de la planificación familiar y puede contestarle sus preguntas. Su petición para información será confidencial. Si necesita transportación para ir a la clínica o que le cuiden a sus niños o si tiene otras preguntas, pídale al trabajador social del condado o a la clínica de planificación familiar que le ayude.

TAGALOG

LINGKOD NA KATULAD NG PANTIYAK-KAALAMAN (DIAGNOSIS), GAMUT NA KAILANGAN AT PAGTINGIN NG MANGAGAMOT UKOL SA PAGBABALAK NG MAGANAK (FAMILY PLANNING SERVICES) O SA IBANG KASABIHAN "PAGPIGIL NG PAGDADALANG-TAO" (SOMETIMES CALLED "BIRTH CONTROL") AY MAKUKUHA SA PAGAMIT NG "MEDI-CAL CARD". MAGTANONG SA "SOCIAL WORKER" NG "COUNTY WELFARE DEPARTMENT" TUNGKOL SA IBA PANG BAGAY NA GUSTO NINYONG MALAMAN UKOL SA PAGBABALAK NG MAGANAK. ANG INYONG PAGUSISA AY TRATRATUHING SARILING LIHIM. MAGTANONG DIN KAYO SA "SOCIAL WORKER" KUNG KAILANGAN NINYONG MALAMAN KUNG SAAN HIIHINGI NG IBANG TULONG.

VIETNAMESE

"Dịch-Vụ Kế-Hoạch Gia-Đình (đôi khi gọi là 'hạn-chế sinh-sản') như khám nghiệm, vật dụng y-học, và chữa trị được cung-ứng cho quý vị qua thẻ Trợ Giúp Y-Tê của quý vị. Nhân viên xã-hội thuộc cơ quan xã-hội tại quận có thể giải đáp những thắc mắc và chuyển đến quý vị những tin tức về kế-hoạch gia-đình. Những câu hỏi hoặc lời yêu cầu của quý vị sẽ được giữ kín. Nếu cần đi chuyên đến dương-dương, hoặc cần người chăm sóc trẻ em, hay có thắc mắc nào, xin quý vị hỏi nhân viên xã-hội hoặc dương-dương kế-hoạch gia-đình để được giúp đỡ.

CHINESE

家庭計劃服務(避孕方法)可以用加省
醫藥証得到診斷,醫藥和治療的福利
關於家庭計劃的問題,也可以從地區
福利機關得到答覆,您們對福利處
所尋問的一切是絕對機密的.若有車送
托兒的需要及任何詳細的問題,請找
您們地區的社會服務人員,或者到家庭
計劃服務所找幫助.