Children's Medical Services Network (CMS Net)

Eligibility Program

Revised 6/26/2026

AMENDMENTS

Amendment	Description	Date
1.0	Brenda: Created for Release 093	2022-01-05
1.1	Molly: Medical Section updated for Release 093.	2022-03-22
1.2	La Dosha: Residential Section updated for Release 093	2022-03-25
1.3	Galyna: Program Section updated for Release 093.	2022-03-29
1.4	Galyna: Program Service Agreement Section updated for Release 093.	2022-03-30
1.5	Brenda: Revisions, entire document.	2022-04-04
1.6	Molly: Updated screenshot of Modules for Client from Release 098 (Referral)	2023-02-16
1.7	Suyash: Attachments section updated for Release 099.	2023-09-25
1.8	Yolonda: Updated Medical Section 13.1 Release 100	2023-12-08
1.9	Suyash: Program Section updated for Release 101 Family Participation added	2024-05-22
2.0	Molly: Updated manual per Release 101 STRY0114501: Add [Case Note Description] and [Other Description] fields to all modules on CMS2020.	2024-05-23
2.1	Suyash: Updated manual per Release 107A: STRY0116059 [ISCD] Family Participation Field.	2025-06-23
2.2	Molly: Updated manual per Emergency Release: STRY0121201 [ISCD] Family Participation: Field required if end date is not blank and edited on Annual Medical Renewal period.	2025-07-08
2.3	Brenda: Updated Correspondence section for R108.	2025-10-22
3.0	Molly: Reviewed and updated all screenshots to reflect R109 California State Template Conversion (STRY0117155)	2026-04-06
3.1	Suyash: Updated manual per Release 110: STRY0122427 Financial Section: Mark Financial as Ineligible without Requiring Income Details	2026-06-19
3.2	LaVorra: Updated manual per Release 110 per story STRY0121702. Updated section: 6.8.4 Additional Information Related to Diagnosis Code	2026-06-25

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LIST OF FIGURES

1 DEFINITIONS, ABBREVIATIONS, & ACRONYMS

The following terms, abbreviations, and acronyms may be used in this document:

Acronym	Definition
A.K.A.	Also Known As (Alias)
CCS	California Children's Services
CIN	Client Identification Number
CMS	Children's Medical Services
CMS Net	CMS Case Management System
CMS Net Web	CMS Case Management System: Web Application
DHCS	Department of Health Care Services
DOB	Date of Birth
DX	Diagnosis
eSAR	Electronic Service Authorization Request
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
GHPP	Genetically Handicapped Persons Program
HCP or HP	Health Care Plan
ICD	Int'l Classification of Diseases (Diagnosis/Procedure Code)
ISCD	Integrated Systems of Care Division
IE	Internet Explorer (Microsoft web browser)
JPG	Joint Photographic Experts Group
MCP	Managed Care Plan
Medical Home	Client's designated primary care physician and/or the physician who provides a medical home.
MEDS	Medi-Cal Eligibility Data System
MOPI	MEDS Online POS Inquiry
MTP	Medical Therapy Program
MTU	Medical Therapy Unit
NICU	Neonatal Intensive Care Unit
PMF	Provider Master File (Medi-Cal Provider list)
PSA	Program Services Agreement
NPI	National Provider Identifier
PDF	Portable Document Format
PSSN	Pseudo Social Security Number
Requestor	Any referral source other than a provider listed in the PMF (Non–PMF provider)
SAR	Service Authorization Request
SCC	Special Care Center
SSN	Social Security Number
TIF, TIFF	Tagged Image File Format
TP	Trading Partner
TX	Treatment
WCM	Whole Child Model

2 OVERVIEW

This manual will help you successfully navigate the Eligibility Program module in CMS Net/CMS2020.

This module allows users to:

- Program: Establish program periods, generate interview correspondence, and set up follow-up ticklers.
- Program Services Agreement: Update PSA status and generate PSA correspondence.
- Residential: Determine residential eligibility and create follow-up ticklers.
- Financial: Determine financial eligibility, create correspondence, and create follow-up ticklers.
- Fees: Calculate enrollment and assessment fees, set up payment plans, record payments, and generate payment due correspondence.
- Medical: Determine medical eligibility, add Medical Home or Special Care Center, document medically eligible diagnoses, and create follow-up ticklers.
- Correspondence: View a list of correspondence letters generated by this module.
- Attachments: Upload, view, and remove electronic documentation to support the eligibility determinations within this module.
- Case Notes: Create case notes for the sections within this module.

3 RULES

3.1 Overall Rules

- Pending or Current Program Period Access
    - Users can view and edit Eligibility Program module if Registration Status is Pending, Reopen Pending, or Active.
- Past Period Eligibility Program Access
    - Incomplete, Unregistered, Duplicate, Bad Record:
        - Past periods hyperlink will be disabled
    - All other case statuses:
        - Past period hyperlink is enabled if there is a fee balance due > 0.
        - All sections collapsed except for fees and case notes.
        - Only users with edit role for the same county of eligibility that the program period resides in and State users can edit fees and case notes.
        - Past program periods: Filter case note type to only Fee Note (Elig-FeeUpdt).
        - No fee letters will be updated or created.
- There is one Save button on the screen.
- Keyboard shortcut to save the screen: Alt + S
- Clicking on a quick link will auto expand the corresponding accordion if it is collapsed.
- System will validate all fields in a section once a user enters data or changes the value of a field in that section. For example, changing the Residential Status to “Eligible” will validate all required fields in the Residential section upon Save.

4 NAVIGATING TO ELIGIBILITY PROGRAM

Select a client to navigate to the Modules for Client page.

Once on the Modules for Client page, click on Eligibility – Program link from the "Modules for Client" section to display the "Eligibility – Program Search Results".

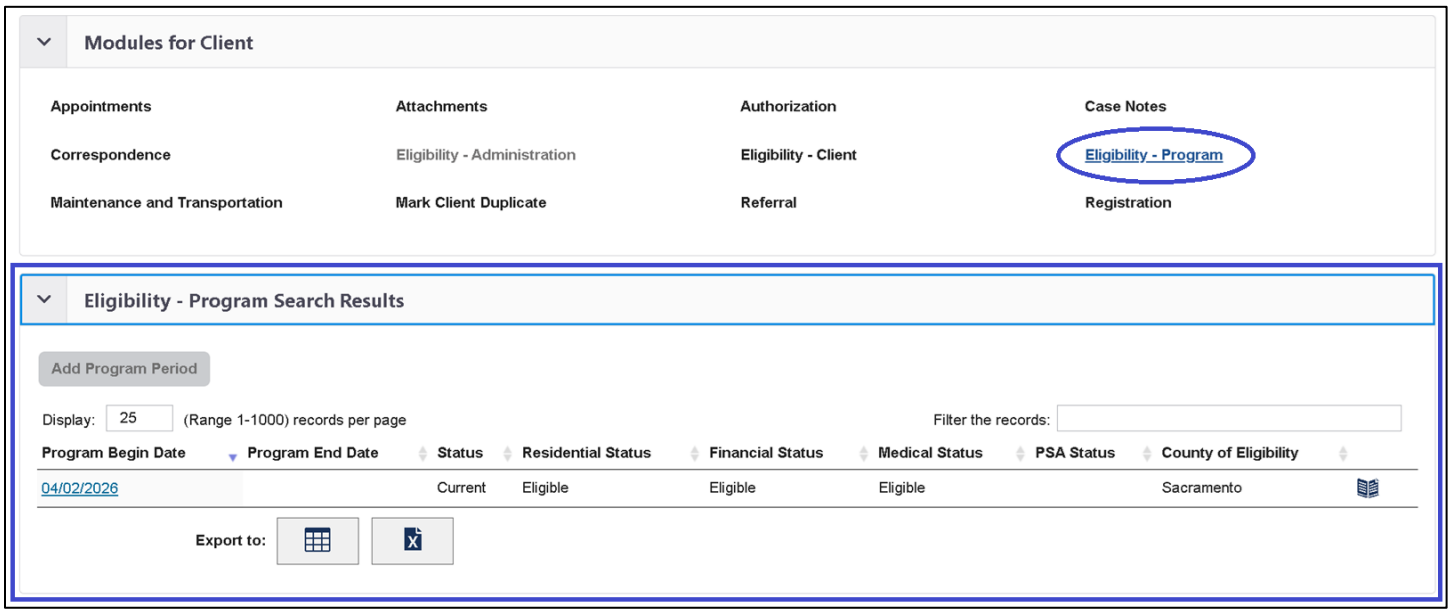

Figure 4-1 Eligibility – Program Search Results

The "Eligibility - Program Search Results" displays the selected client's program period information. The program period columns are sorted in reverse chronological order by Program End Date (latest period at the top).

Users may only enter the Program Eligibility module if registration status is Pending, Reopen Pending, or Active. Program Eligibility module is view only when the user does not have privileges or Registration status is Closed, Denied, Incomplete, Unregistered, Duplicate, Bad Record or Not Open unless recording payment of fees for past periods.

- Add Program Period button
  - Enable the "Add Program" button when no program period has been established or the program period end date is within 90 days or less of the current date.
  - Clicking this button navigates the user to the Program maintenance page to create a new program period.
- Program Begin Date
  - Begin date of eligibility

  - Hyperlink is enabled for program period row if the user has privileges to edit otherwise the Program Begin Date field is display only.
  - Hyperlink to Eligibility Program for that program period (see 3.1, Overall Rules for when this hyperlink is enabled/disabled)
- Program End Date
  - End date of eligibility
- Status
  - Status of the program period
  - Value: Pending, Current, Past
- Residential Status
  - Residential status determination
  - Value: Eligible, Ineligible, Pending Determination, Blank
- Financial Status
  - Financial status determination
  - Value: Eligible, Ineligible, Pending Determination, Blank
- Medical Status
  - Medical status determination
  - Value: Eligible, Ineligible, Pending Determination, Blank
- PSA Status
  - PSA status determination
  - Value: Not Required, Not Signed, Signature Pending, Signed, or Blank
- County of Eligibility
  - Client’s county of eligibility
- Eligibility Log Icon
  - Link to Eligibility History Log

5 PROGRAM DETAILS

5.1 Assessing Eligibility - Program Module

Select a client to navigate to the Modules for Client page.

Upon clicking the Eligibility - Program link, the “Eligibility – Program Search Results” accordion is expanded and displays program period results for the selected client.

Figure 5-1 Selected Client Modules

5.2 Eligibility - Program Search Results

The “Eligibility - Program Search Results” displays the selected client’s program period information. The program period columns are sorted in reverse chronological order by Program End Date (latest period at the top).

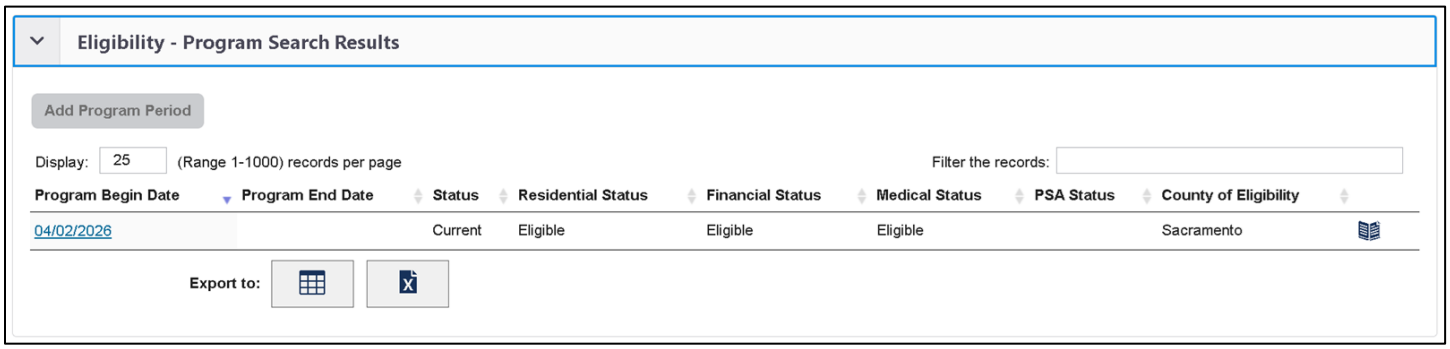

Figure 5-2 Eligibility Program Search Results

- Add Program Period button
  - Enable the “Add Program” button when no program period has been established or the program period end date is within 90 days or less of the current date.
  - Clicking this button navigates the user to the Program maintenance page to create a new program period.

Eligibility Program

- Program Begin Date
    - Begin date of eligibility
    - Hyperlink is enabled for program period row if the user has privileges to edit otherwise the Program Begin Date field is display only.
    - Hyperlink to Eligibility Program for that program period (see 3.1, Overall Rules for when this hyperlink is enabled/disabled)
- Program End Date
    - End date of eligibility
- Status
    - Status of the program period
    - Value: Pending, Current, Past
- Residential Status
    - Residential status determination
    - Value: Eligible, Ineligible, Pending Determination, Blank
- Financial Status
    - Financial status determination
    - Value: Eligible, Ineligible, Pending Determination, Blank
- Medical Status
    - Medical status determination
    - Value: Eligible, Ineligible, Pending Determination, Blank
- PSA Status
    - PSA status determination
    - Value: Not Required, Not Signed, Signature Pending, Signed, or Blank
- County of Eligibility
    - Client’s county of eligibility
- Eligibility Log Icon
    - Link to Eligibility History Log. Opens the client’s Eligibility History Log as a pdf.

5.2.1 Add Program Period

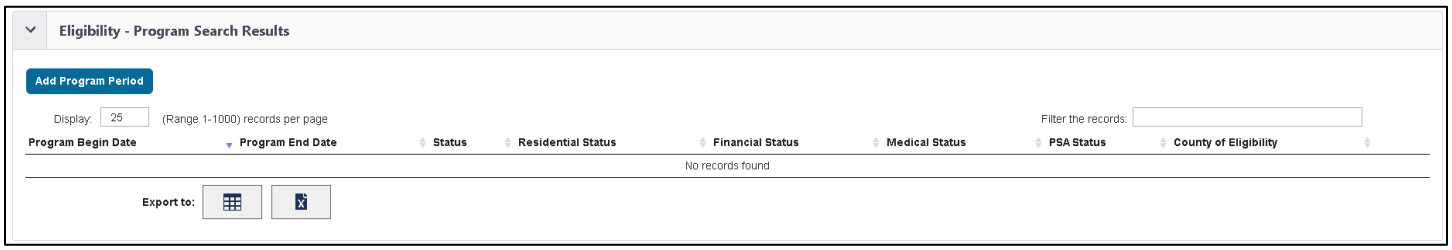

Figure 5-3 Eligibility Program Search Results – Add Program Period

Users may create a new program period using the [Add Program Period] button.

The Add Program Period button is only enabled when there is no program period or 90 days or less before the current period expires.

5.2.2 View Eligibility Log Icon

Upon clicking view log icon the system opens pdf in a new browser tab or downloads the pdf depending on the logged user's preferences.

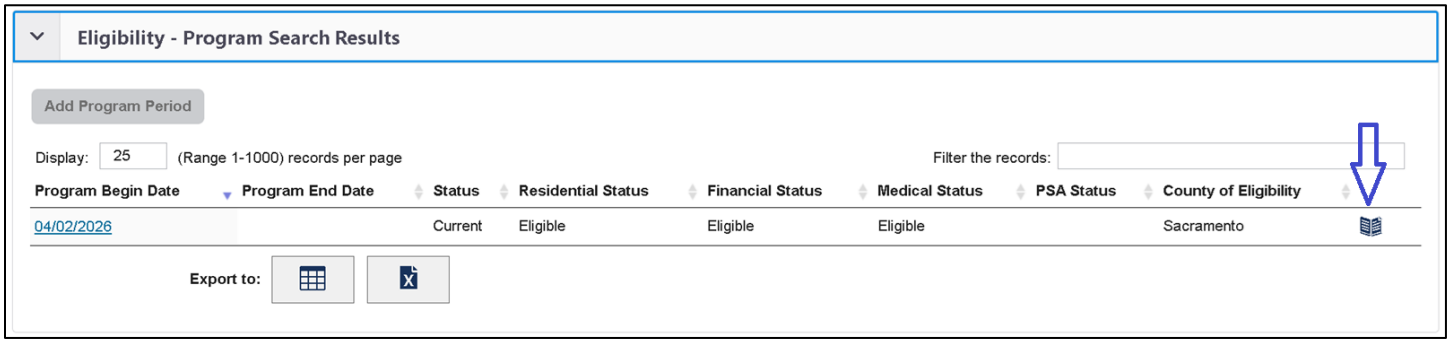

Figure 5-4 View Eligibility Log Icon

The PDF will display the program eligibility periods and the screens associated with the program eligibility periods.

5.2.3 Entering Eligibility Program maintenance page

Click on the Program Begin Date hyperlink to enter Eligibility Program maintenance page.

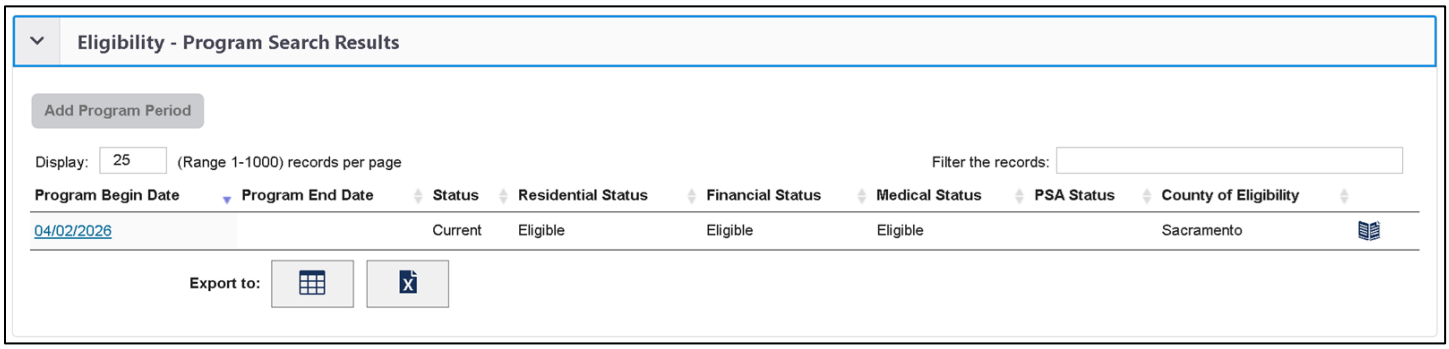

Figure 5-5 Eligibility Program Search Results

Hyperlink is enabled for program period row if the user has privileges to edit otherwise the Program Begin Date field is display only and meets the below criteria.

- Users may only enter the Program Eligibility maintenance page if registration status is Pending, Reopen Pending, or Active.
- Program Eligibility module is view only when the user does not have privileges or Registration status is Closed, Denied, Incomplete, Unregistered, Duplicate, Bad Record or Not Open unless recording payment of fees for past periods.

6 ELIGIBILITY PROGRAM (MAINTENANCE PAGE)

When the user clicks the **Add Program Period** button—or selects an existing **Program Begin Date** hyperlink—they are navigated to the **Eligibility Program Maintenance** page.

This section explains all the accordion/sections available on the Eligibility Program Maintenance page which are listed below:

- Eligibility Program Quick links
- Client Information
- Program
- Program Service Agreement
- Residential
- Financial
- Fees
- Medical
- Correspondence
- Attachments
- Other Information
- Case Note
- Case Note History

6.1 Eligibility Program Quick links

Eligibility Program Quick Links appear at the top of the Eligibility Program maintenance page. Links that are greyed out indicate sections that are disabled. Selecting any enabled link expands that section and automatically navigates the user to it.

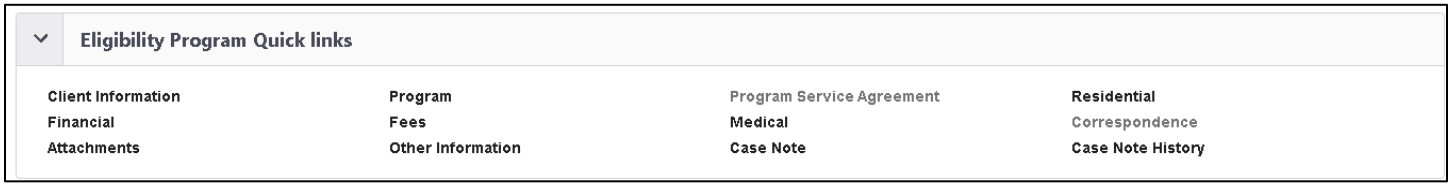

Figure 6-1 Quick Links

6.2 Client Information

Client Information header for the selected client.

Case Alerts are also in this section. View the Case Alerts Manual for information on how to use Case Alerts.

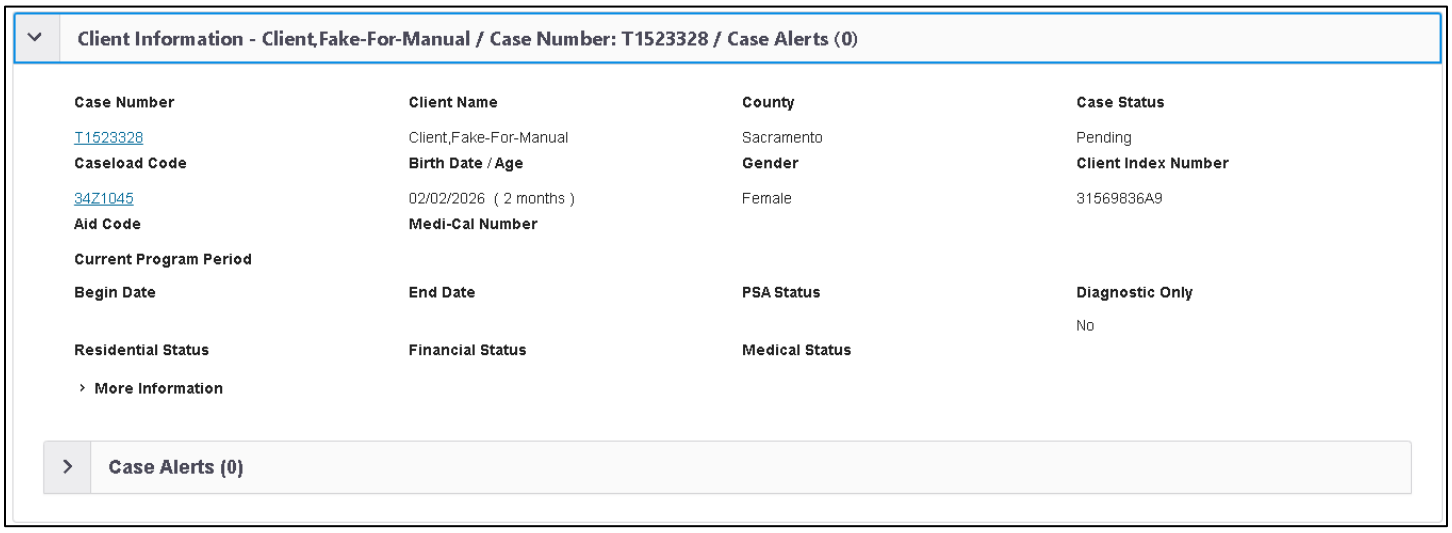

Figure 6-2 Client Information

The Case Number hyperlink downloads the client's facesheet.

The Caseload Code hyperlink opens an overlay displaying the caseload information for the client and which user is assigned to the caseload.

6.3 Program

Program section is used to establish current and future program periods; generate interview letters; and set up ticklers.

Figure 6-3 Program Section

Program section contains following fields: Begin Date, End Date, Eligibility Type, Coverage Type and Family Participation.

Program section contains following sub-sections: Interview Details and Pending Medi-Cal Information.

- Begin Date:
  - Required date field.
  - Enter begin date.
  - Creating initial program period: initially the Begin Date is populated from the completed Referral Date from Registration page.
  - When prior period exist: the Begin Date field defaults to the prior Program End date + 1.
  - No gaps in program dates are allowed unless case is being reopened.
  - FYI: Calendar short cut key for “Current Date”: Ctrl + T
- End Date:
  - Conditionally required date field
  - Enter end date.
  - End Date may not overlap with other periods
  - The end date must be after the begin date
  - For CCS: Required if Program Service Agreement section (PSA Status) is entered.
    - PSA Status as Signed, Signature Pending
      - System auto populates the program end date to be program begin date + 364 days (excluding leap years) or 1 day prior to client’s 21st birthday, whichever comes first with ability to edit
    - PSA Status as “Not Required” with “Reason Not Required” as DX only

- System auto populates the program end date to be program begin date + 90 days or 1 day prior to client's 21st birthday, whichever comes first with ability to edit

  - FYI: Calendar short cut key for "Current Date": Ctrl + T

- Eligibility Type:
  - Eligibility Type is a required dropdown field.
  - Eligibility Type drop down values are:
    - Eligibility Period Only
    - Interview Pending
      - When "Interview Pending" is selected, system enable and auto expands the "Interview Details" sub-section.
    - Medi-Cal Pending
      - When "Medi-Cal Pending" is selected, system enable and auto expands the "Pending Medi-Cal Information" sub-section.
- Coverage Type:
  - Conditionally required.
    - Disabled when Eligibility Type is: Medi-Cal Pending
    - Enabled when Eligibility Type is: Eligibility Period Only or Interview Pending
  - CCS: Coverage Type drop down values are:
    - Both Medi-Cal (Full-Scope/No SOC) and OTLICP
    - Medi-Cal (Full-Scope/No SOC)
    - Neither Medi-Cal (Full-Scope/No SOC) nor OTLIPC
    - OTLICP
  - GHPP: Coverage Type drop down values are:
    - Medi-Cal (Full-Scope/No SOC)
    - Neither Medi-Cal (Full-Scope/No SOC) nor OTLICP
    - User may update Eligibility Type and Coverage Type.

  - Coverage type triggers system to auto fill in Residential and Financial section based on the selection.
    - Selecting [Neither Medi-Cal (Full-Scope/No SOC) nor OTLICP], system leaves all fields in Residential and Financial sections empty for user to manually complete.
    - Selecting [Both Medi-Cal (Full-Scope/No SOC) and OTLICP] **or** [Medi-Cal (Full-Scope/No SOC], system auto completes Residential and Financial with the following information:

      Residential

      - Proof of Residence 1* = Medi-Cal Full Scope No SOC
      - Residential Status* = Eligible
      - Determined By = Logged in user
      - Determined Date = Today's date
      - Document Received Date = Today's date

Financial

- Financial Determination = Not Required
- Reason Not Required = Medi-Cal Full Scope No SOC
- Financial Status = Eligible
- Determined Date = Today's date
- Document Received Date = Today's date

- Selecting [OTLICP], system auto complete the Residential and Financial with the following information:

Residential

- Proof of Residence 1* = OTLICP Subscribers
- Residential Status* = Eligible
- Determined By = Logged in user
- Determined Date = Today's date
- Document Received Date = Today's date

Financial

- Financial Determination = Not Required
- Reason Not Required = OTLICP
- Financial Status = Eligible
- Determined Date = Today's date
- Document Received Date = Today's date

- Family Participation
  - GHPP:
    - Field is disabled
  - CCS:
    - Initial program period
      - Note: When there is a break in Eligibility (case reopening with gap), the 1st program period is considered an initial period.
      - Field optional.
    - Annual Eligibility Redetermination program period
      - Field required when:
      - Case Status: Active
      - Program End Date added or changed.
      - Program periods are continuous and not the initial period.
      - Note: when updating existing program period and end date is not added or changed, system will not require the family participation value (example: adding case note, attachment(s), updating diagnosis, etc.)
  - Family Participation dropdown values are:
    - Offered opportunity for feedback on CCS services received through surveys, group discussions, or individual consultations.

- Participate on advisory committees or task forces.
- Participate in SCC team meetings and/or transition planning.
- Family advocates are contracted, or consultants to the CCS program.

Field Dropdown Values	Family Participation
Offered opportunity for feedback on CCS services received through surveys, group discussions, or individual consultations.	Family members are offered an opportunity to provide feedback regarding their satisfaction with the services received through the CCS program by participation in such areas as surveys, group discussions, or individual consultation
Participate on advisory committees or task forces.	Family members participate on advisory committees or task forces and are offered training, mentoring, and reimbursement when appropriate
Participate in SCC team meetings and/or transition planning.	Family members are participants of the CCS Special Care Center (SCC) services provided to their child through family participation in SCC team meeting and/or transition planning
Family advocates are contracted, or consultants to the CCS program.	Family advocates, either as private individuals or as part of an agency advocating family centered care, which have experience with children with special health care needs, are contracted or consultants to the CCS program for their expertise

Figure 6-4 Family Participation

- Per Number Letter 09-1123: 20240314-CCS-Program-Reporting-and-Survey-NL

6.3.1 Interview Details (Sub-section)

The Interview Details sub-section is enabled and auto expanded when “Eligibility Type” is “Interview Pending”.

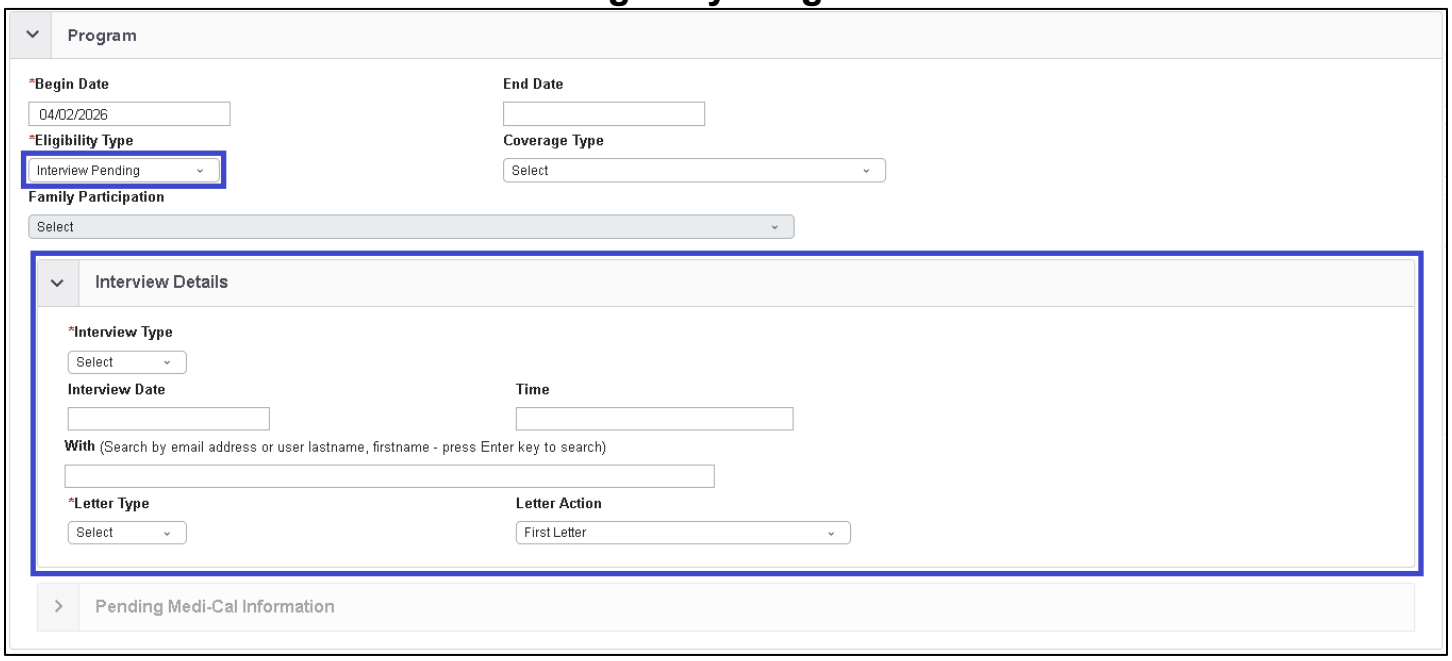

Figure 6-5 Interview Details Sub-Section

Interview Details section has the following fields: Interview Type, Interview Date, Time, With, Letter Type, Letter Action.

- Interview Type
  - Conditionally required drop down field
  - Values: Initial, Annual. If the Interview Type is “Initial”, future dates are not allowed for begin date.
  - When selecting Interview Pending – Interview Type will be enabled/expanded
  - When selecting Eligibility Period Only or Medi-Cal Pending – Interview Type will be disabled
- Interview Date
  - Optional date field
  - Only current or future dates may be entered in this field
- Time
  - Conditionally required text field
  - Free text entry is required when the interview date is populated
- With
  - Conditionally required text field
  - Type user’s partial name or last name and hit enter
  - This field is enabled and required only when interview date is populated
- Letter Type
  - Required dropdown field
  - Values: Medi-Cal, CCS

- When selecting Interview Pending – Letter Type will be enabled/expanded.
- When selecting Eligibility Period Only or Medi-Cal Pending – Letter Type will be disabled

- Letter Action
  - Required dropdown field
  - Values: First Letter, Second Letter, Third Letter, Restart new series, Restart new series and Cancel existing series
    - When First Interview letter exists and it is not in [Incomplete] or [Ready to send] status, the following values are visible on the drop down value: Restart new series and Cancel existing series
  - When selecting Interview Pending – Letter Action enabled
  - When selecting Eligibility Period Only or Medi-Cal Pending – Letter Action disabled

Upon saving the page successfully, system displays the success message: “Eligibility Program details updated successfully. Correspondence(s) have been created successfully.”

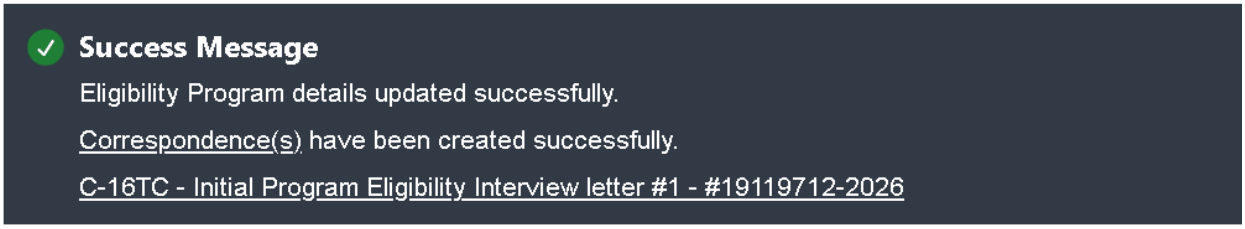

Figure 6-6 Success Message

To complete the letter, user can:

- Click on the letter description hyperlink from the message. Once clicked, system navigate to Correspondence maintenance page for the letter.

Or

- Click on “Correspondence(s)” hyperlink from the message to navigate to Correspondence section on page. Then under Correspondence section, click on letter link to navigate to Correspondence maintenance page for the letter.

Important Note about Interview Letter:

- **Batch Correspondence FYI:** In addition, for letters to display in “Batch Correspondence” for counties that participate in auto batch printing (Los Angeles & Orange County, for example), letter(s) will not be placed in the batch unless user changes the letter status to “ready to send” or “sent.”

6.3.2 Pending Medi-Cal (Sub-section)

The Pending Medi-Cal Information sub-section is enabled and auto expanded when “Eligibility Type” is “Medi-Cal Pending”.

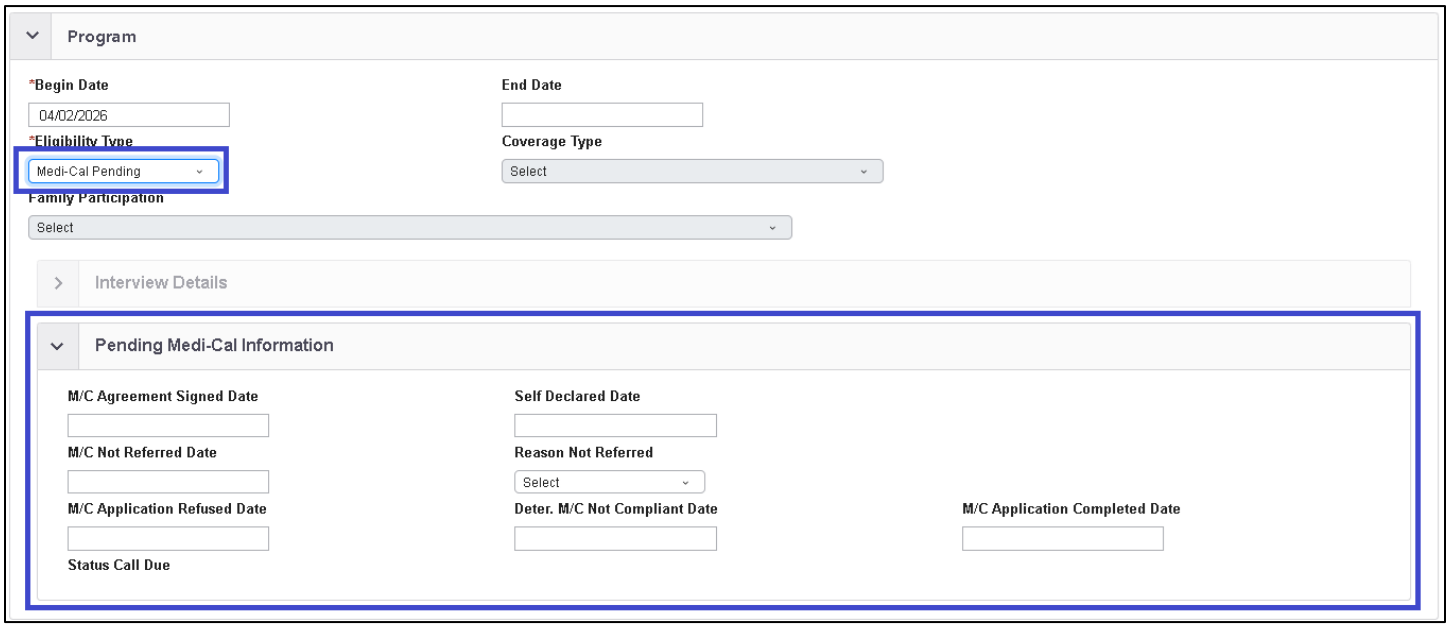

Figure 6-7 Pending Medi-Cal Information Sub-Section

The Pending Medi-Cal Information sub-section displays the following fields: M/C Agreement Signed Date, Self Declared Date, M/C Not Referred Date, Reason Not Referred, M/C Application Refused Date, Deter. M/C Not Compliant Date, M/C Application Completed Date and Status Call Due.

- M/C Agreement Signed Date
  - Conditionally required date field
  - M/C Agreement Signed Date is required when Self Declared Date field is not entered
  - If a date is entered, system sets up a 60-day Pending Medi-Cal (PMCAL) Tickler. Date displays in the Status Call Due field as display only when case is Pending or Reopen Pending status. Tickler is not set for case in active status.
  - Only current or past dates may be entered in this field. Future dates are not allowed.
  - Date the client/parent/legal guardian signs the Medi-Cal Agreement
- Self Declared Date
  - Conditionally required date field
  - Self Declared Date is required when M/C Agreement Signed Date field is not entered
  - Only current or past dates may be entered in this field. Future dates are not allowed.
  - Date that the client/parent/legal guardian tells the county that they did apply for Medi-Cal

- If a date is entered, system sets up a 60-day Pending Medi-Cal (PMCAL) Tickler. Date displays in the Status Call Due field when case is Pending or Reopen Pending status. Tickler is not set for an Active case.

- M/C Not Referred Date
  - Optional date field
  - Only current or past dates may be entered in this field. Future dates are not allowed
- Reason Not Referred
  - Conditionally required dropdown field
  - Reason Not Referred is required if the M/C Not Referred Date is entered
    a. Medi-Cal
    b. MTP Only
    c. Other
    d. OTLICP
    e. Recently Denied by M/C
- M/C Application Refused Date
  - Optional date field
  - Only current or past dates may be entered in this field. Future dates are not allowed.
  - Date the client/parent/legal guardian refused to sign the Medi-Cal Agreement.
  - If date is entered in M/C Application Refused Date field, user should review the case for denial or closure.
- Deter. M/C Not Compliant Date
  - Optional date field
  - Only current or past dates may be entered in this field. Future dates are not allowed.
  - The date the county discovered the client was not compliant in going through the Medi-Cal application process with the local social services agency.
    Note: If date is entered in Deter. M/C Not Compliant Date field, user should review the case for denial or closure.
- M/C Application Completed Date
  - Optional date field
  - Only current or past dates may be entered in this field. Future dates are not allowed.
  - The date the county discovers that the client did complete the Medi-Cal application process with the local social services agency.
- Status Call Due
  - Display only
  - Displays Pending Medi-Cal Tickler date (60 days) from the M/C Agreement Signed Date was signed or from the date the client was Self Declared from the Self Declared Date field.

6.4 Program Services Agreement

This Program Service Agreement section allows the user update the PSA letter and set PSA Due tickler.

Figure 6-8 Program Service Agreement Section

6.4.1 Program Services Agreement Business Rules

The Program Service Agreement is only enabled for a CCS client.

Program Service Agreement Section Accordion:

- Program Service Agreement Section is enabled/expanded for Active cases by default.

- Program Service Agreement Section is disabled/collapsed for Pending and Reopen Pending cases be default.

  Once the Residential and Financial statuses are set to ‘Eligible’, the section is enabled and expanded.

When PSA Status is entered, system auto populates the program end date based on the PSA Status selected:

- When user selects PSA Status as Signed, Signature Pending
  - System auto populates the program end date to be program begin date + 364 days (excluding leap years) or 1 day prior to client’s 21st birthday, whichever comes first with ability to edit
- When user selects PSA Status as “Not Required” with “Reason Not Required” as either Medi-Cal full scope no SOC, MTP Only, or OTLICP
  - System auto populates the program end date to be program begin date + 364 days (excluding leap years) or 1 day prior to client’s 21st birthday, whichever comes first with ability to edit
- When user selects PSA Status as “Not Required” with “Reason Not Required” as DX only:
  - System auto populates the program end date to program begin date + 90 days or 1 day prior to client’s 21st birthday, whichever comes first with ability to edit

6.4.2 Program Service Agreement Section

The “Program Service Agreement” section displays the following fields: PSA Status, Reason Not Required, PSA Signed Date, Signed PSA Received Date, PSA Signed By and PSA Due Date.

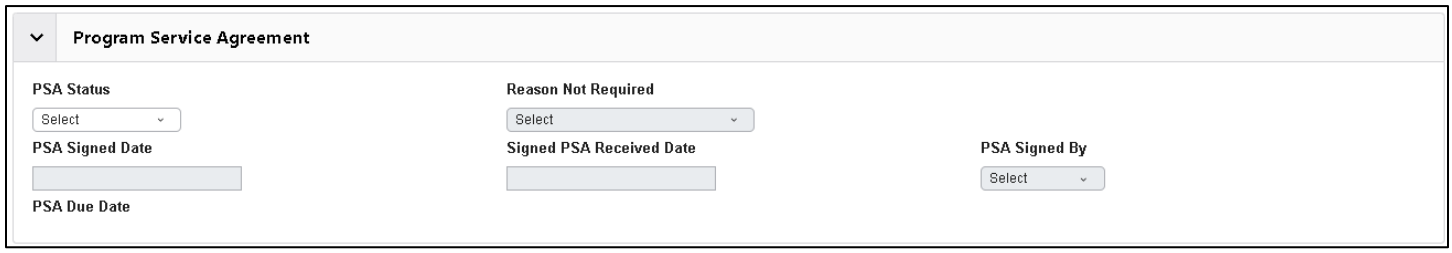

Figure 6-9 Program Service Agreement Section and Fields

1. PSA Status
    a. Conditionally required dropdown
    b. Dropdown list values: Not Required, Not Signed, Signature Pending, Signed
    c. When PSA Status is set to “**Not Required**”, “**Not Signed**” or “**Signature Pending**”, the following fields are disabled: PSA Signed Date, PSA Signed By, Signed PSA Received Date.
    d. When PSA Status is “**Signed**”, the following fields are enabled: PSA Signed Date, PSA Signed By, Signed PSA Received Date.
    e. When PSA Status is “**Signature Pending**”, upon successfully saving the page, system generates the PSA letter.
        - System creates the correspondence letter and displays the information under the Correspondence section. However, the **UNSENT** letter is placed in CMS Net Legacy.
        - **User must go to CMS Net Legacy to complete the letter.**
        - Reminder: Letters in the following statuses must be printed from Legacy: Incomplete and Ready to Send.

2. Reason Not Required
    a. Optional dropdown field
    b. When PSA Status ‘Not Required’ – Reason Not Required is enabled
    c. Reason Not Required values:
        - Dx Only
        - Medi-Cal Full Scope No SOC
        - MTP Only
        - OTLICP

3. PSA Signed Date
    a. Conditionally required date field
    b. Enabled when PSA Status is Signed

c. Enter the date PSA was signed
d. Date cannot be in the future
e. Date can equal Signed PSA Received Date
f. Date cannot be after Signed PSA Received Date

4. Signed PSA Received Date
    a. Conditionally required date field
    b. Enabled when PSA Status is Signed
    c. Enter date PSA was received
    d. Date can be on or after date PSA signed date
    e. Date cannot be in the future

5. PSA Signed By
    a. Conditionally required dropdown
    b. Enabled when PSA Status is Signed
    c. PSA Signed By values:
        - Legal Guardian(s)
        - Parents
        - Self
    d. Select who signed PSA from the dropdown list

6. PSA Due Date
    a. Display only date
    b. System sets date to be 30 days from “current/today’s date”.

6.5 Residential Section

Residential section within the Eligibility-Program module allows users to determine Residential eligibility for CCS and GHPP clients.

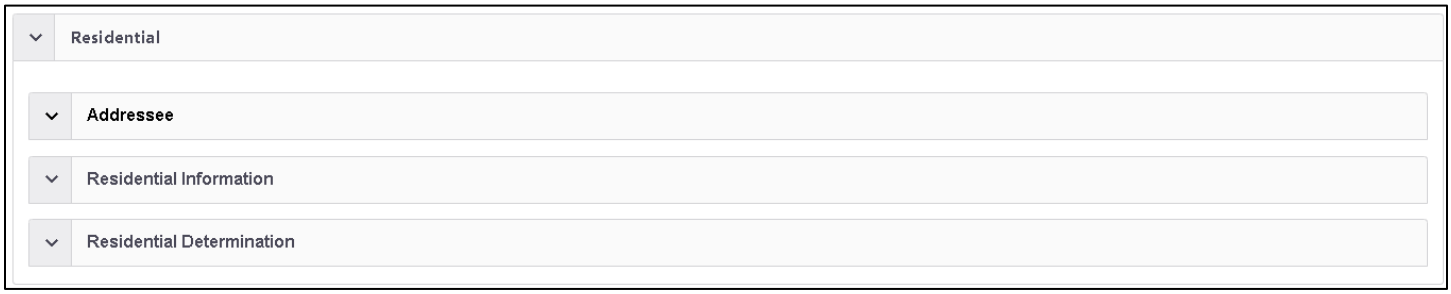

Figure 6-10 Residential Section Collapsed

The Residential section can be accessed within current and pending Program periods.

Upon selecting Coverage type field within the Program section, the system will auto-complete Residential status using the below rules:

- Selecting Neither Medi-Cal (Full-Scope/No SOC) nor OTLICP will not auto complete the Residential status.
- Selecting Medi-Cal (Full-Scope/No SOC), OTLICP, or Both Medi-Cal (Full-Scope/No SOC) and OTLICP will auto complete the Residential status.
- Pending Case, Coverage Type change from (Medi-Cal, OTLICP, or Both) to Neither:
    - Clear fields in Residential
    - Set Residential Status = "Pending Determination"
    - Set Residential Reason Pending Determination = "Awaiting Review" (Note: This is a new status)
    - Set Residential Follow up Date = 30 days from today's date
    - Active case, Coverage Type change: No fields are automatically changed on the screen when this field changes.

6.5.1 Addressee (Residential Sub-section)

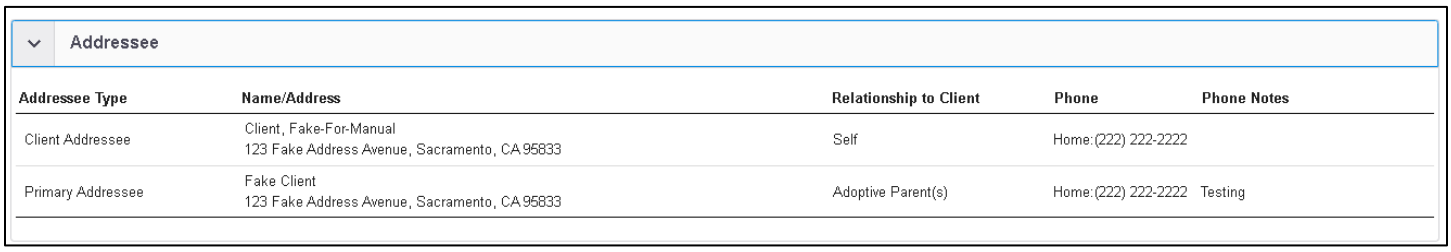

Figure 6-11 Addressee Section

The address fields are retrieved from Registration and are view only.

- Addressee Type

- Name/Address
- Relationship to Client
- Phone
- Phone Notes

6.5.2 Residential Information (Sub-section)

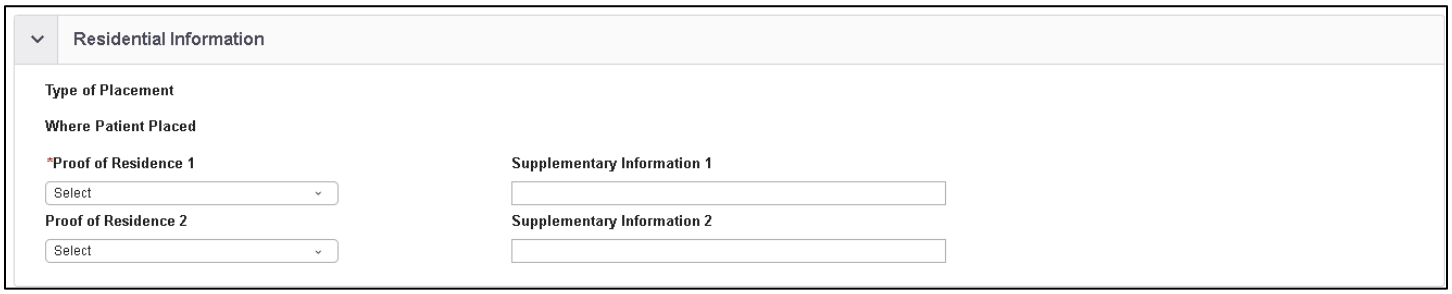

Figure 6-12 Residential Information Section

The Residential Information section displays the following fields.

- Type of Placement
  - Display Only
  - Displays from Primary Addresses
- Where Patient Placed
  - Display Only
  - Displays from Primary Addresses
- Proof of Residence
  - Required
  - When Coverage type Medi-Cal (Full-Scope/No SOC), OTLICP, or Both Medi-Cal (Full-Scope/No SOC) and OTLICP will auto complete Proof of Residence 1.
    - Note: For OTLICP and Medi-Cal Full Scope No SOC, only one proof of residence is required.
  - List of all proof of residences select values:
    - Aid to Families with Dependent Children (AFDC)
    - CA Driver License, ID, or DMV Reg
    - CalWORKS
    - CA Rent or Mortgage Receipt
    - Child Support
    - Cash Grant Award Ltr
    - Disability Income
    - Employment Document

- Evidence of CA public assistance
- Food Stamps
- Medi-Cal Full Scope No SOC
- Not Provided
- Others
- OTLICP subscribers
- Paystubs
- Registered employment agency
- Registered Voter
- State Tax Form
- Social Security Income
- Unemployment
- Utility Bill
- W-2 Forms

- Supplementary Information
  - Maximum length: 60 characters
  - Text box

6.5.3 Residential Determination (Sub-section)

Figure 6-13 Residential Determination Section

The Residential Determination section is where a CMSNet user will make a determination on residential eligibility when a case status is Pending or Reopen Pending.

- Residential Status
  - Required
  - Values

        - Eligible
        - Ineligible
        - Pending determination
- Reason Ineligible
    - Required when Residential Status set to Ineligible
    - Values
        - No Response at Last Known Address
        - No Document Provided
        - Others
        - Residence in another County
        - Residence in another Country
        - Residence in another State
- Reason Pending Determination
    - Required when Residential Status set to Pending Determination
    - Values
        - Awaiting PSA
        - Awaiting Review
        - Proof of residence
- Determined By
    - Required when Residential Status set to eligible and ineligible
    - Search by login identifier or email address or user last name, first name - press Enter key to search
- Date Determined
    - Required when Residential Status set to eligible or ineligible
- Date Document Received
    - Required when Residential Status set to eligible or ineligible
- Follow up Date
    - Required when Residential Status set to Pending Determination
    - Defaults 30 days from today's date
    - Tickler is set when “Pending Determination” is selected in the Residential Status Field and a date is entered in the Residential Follow-up Date Field.
    - Ticklers

- To run the follow up date tickler for your county, log into legacy CMSNet Web. Reports- Miscellaneous – Correspondence and Ticklers -Follow-up tickler Report- Enter the Begin and end date of Next review date- Select County and in “Type” select “Pending Financial Determination Follow up”.

6.6 Financial

Financial section allows users to determine Financial Eligibility for CCS and GHPP clients.

Figure 6-14 Financial Section

The Financial Determination and Reason Not Required fields are auto populated from the Program Eligibility Screen if the selected Coverage Type is one of the following:

- Both Medi-Cal (Full-Scope/No SOC) and OTLICP
- Medi-Cal (Full-Scope/No SOC),
- OTLICP

- Financial Determination
    - Required Field
    - Drop Down Value
        - Required
        - Not Required
- Reason Not Required
    - If the User selects “Not Required” user must also select a value from the Reason Not Required drop down list:
        - Adoption
        - Dx Only
        - HRIF Follow-up

- Medi-Cal Full Scope No SOC
- MTU Services Only
- No Income
- OTLICP

- Drop Down values for GHPP Clients:
  - Dx Only
  - Medi-Cal Full Scope No-SOC
  - No Income
- If the Financial Determination is “Not Required”, the Income Details is collapsed and the fields are disabled.
- If the Financial Determination is Required, the Income Details is expanded and the fields are enabled.

6.6.1 Income Details (Sub-section)

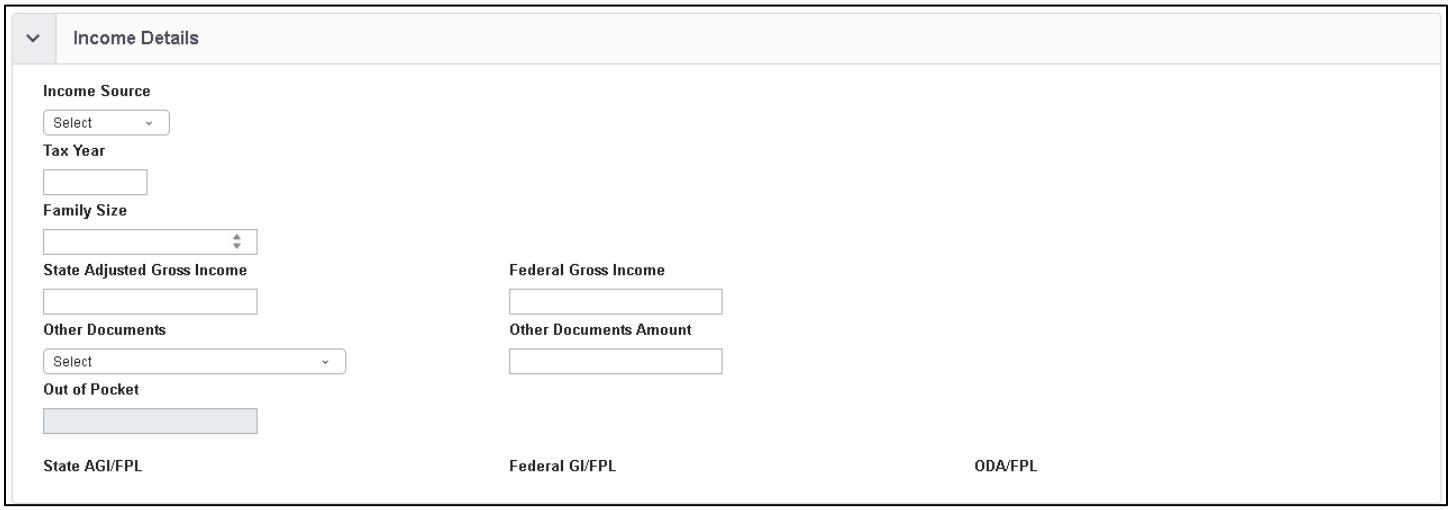

Figure 6-15 Income Details Sub-section

Income Details is required except in cases where the case status is Pending or Reopen Pending, and specifically when the Eligibility Determination section has the Financial Status dropdown value set as "Ineligible" and the Reason Ineligible dropdown value set as "No Document Provided".

In all other circumstances, Income Details should continue to be a required field per below:

- Income Source
  - Required field if “Financial Determination” is “Required”.
  - Select from the Drop down values:

- Father
- Joint
- Mother
- Other
- Self

- Tax Year
  - Required field if “Financial Determination” is “Required”.
  - User may enter four digit year (No Future Years Allowed)

- Family Size
  - Required Field. If “Financial Determination” is “Required”.
  - User may input a Number (1 to 99)

- State Adj. Gross Income
  - Required Field for CCS or GHPP Clients if Financial Determination is "Required” and no Income is entered in “Federal Gross Income” or “Other Documents” and “Other Docs Amount” fields.
  - User may enter dollar amount (00 – 999999999)
  - No commas, periods, or $ signs allowed.
  - Amount is used in the FPL calculation to determine if Enrollment and Assessment Fee is required for CCS Clients or if an Enrollment Fee is required for GHPP clients
- Other Documents
  - Required Field for CCS or GHPP Clients if no “State Adjusted Gross Income” or “Federal Gross Income”.
  - Select value from drop down list:
    - Adult Services Declaration
    - Aid to Families with Dependent Children (AFDC)
    - CA Driver License, ID or DMV Reg
    - CalWORKS
    - CA Rent or Mortgage Receipt
    - Cash Grant Award Ltr
    - Child Support
    - Clinic Visit Notes
    - Court Papers
    - Disability Income
    - Discharge Summary
    - Employee Confirmation Ltr
    - Employment Document
    - Evidence of CA Public Assistance

        - Food Stamps
        - H & P
        - Medi-Cal Full Scope No SOC
        - Notice of Admission
        - Not Provided
        - Other
        - Others
        - OTLICP Subscribers
        - Pay Stubs
        - Progress Notes
        - Registered Employment Agency
        - Registered Voter
        - Social Security Income
        - State Tax Form
        - Unemployment
        - Utility Bill
        - W-2 Forms
    - Field should be disabled if State Adjusted Gross or Federal Gross Income field(s) have an amount.
- Other Docs Amount
    - Required if “Other Documents” field is populated
    - No commas, periods, or $ signs allowed.
    - User may enter dollar amount (00 – 999999999)
- Out-of-Pocket
    - Optional for CCS or GHPP Clients
    - No commas, periods, or $ signs allowed.
    - User may enter dollar amount (00 – 999999999)
    - Field is disabled if Federal Gross Income less than $40,000
    - Field is enabled if Federal Gross Income is greater than $40,000
- State AGI/FPL, Federal GI/FPL, and ODA/FPL fields
    - Display Only.
    - The system calculates the percentage using the State Adjusted Gross Income (AGI) Federal Poverty Level (FPL), and Other Documents Amount (ODA).

6.6.2 Eligibility Determination (Sub-section)

Figure 6-16 Financial Eligibility Determination

- Financial Status
    - Required field
    - Select value from the drop down list:
        - Eligible
            - Users must enter the Determined Date and Document Received Date.
        - Pending Determination
            - If the user select “Pending Determination” they must also select a reason from the “Reason Pending Determination” drop down list.
- Reason Pending Determination
    - Required field if Financial Status is “Pending Determination.
    - User must select a reason from the drop down list:
        - Awaiting Insurance Information
        - Awaiting Review
        - Awaiting Program Services Agreement (PSA)
        - Verification of Income
- Follow-Up Date
    - Required if Financial Status is “Pending Determination”
    - User may enter date, no past date is allowed.
    - Tickler is set if “Pending Determination” is selected in the Financial Status Field and a date is entered in the Financial Follow-Up Date Field.
    - Ticklers are generated if the Financial Status is “Pending Determination”, there is a Reason pending determination with a Follow-Up date for pending Cases.

- Default Tickler date to current plus 30 days.

- Determined Date
  - Required if Financial Status is “Eligible” and “Ineligible”.
  - Not required if Financial Status is “Pending Determination”.
  - User may enter date, no past date is allowed.
- Document Received Date
  - Required if Financial Status is “Eligible” and “Ineligible”.
  - Not Required if Reason Ineligible is “No Document Provided”.
  - Not required if Financial Status is “Pending Determination”.
  - User may enter date, no past date is allowed.
- Legal Action Pending
  - Optional
  - Select value from drop down list:
    - Yes
    - No
- Known Funding
  - Optional (Multi Selection)
  - Value is checked when user clicks in the box from the list.
    - CCS
    - Healthy Families
    - Insurance
    - Medi-Cal
    - Medicare
    - OTLICP
  - Disabled when Financial Status is “Pending Determination”

Users must click the save button at the bottom of the screen to update the financial record.

6.7 Fees

Fees section allows users to mark fees as due, set up a payment plan, mark fees as received, and generate fee letters.

Users may view the fees for clients with any registration status except duplicate or incomplete. Users may view the fees for any program period as long as the Financial Status is Eligible for that period.

Fees are based on the Family Size and Annual Income Level Chart and the Annual Enrollment Fee Schedule. Users can change the calculated fields.

The system automatically calculates enrollment and assessment fees based on the Program and Financial Sections. Any changes to these two sections will automatically change the Fees.

6.7.1 Assessment Fee (Sub-section)

Figure 6-17 Assessment Fee

- Assessment Fee
  - Required field
  - Indicator whether an assessment fee is required. Expands to view and/or edit Assessment Fee.
  - Enable for CCS clients.
  - Disable for GHPP clients.
  - Select value from the drop down list:
    - Required
    - Not Required
  - System defaults field to “Not Required” if Program Eligibility Coverage Type is Medi-Cal, OTLICP, or Both Medi-Cal and OTLICP.
  - System defaults field to “Not Required” if Financial Screen Reason Not Required is:
    - Adoption
    - HRIF Follow-up
    - No Income
  - CCS Client – System uses Financial Section State AGI amount to determine if an assessment fee is required. If State AGI is blank, system uses Federal GI. If Federal GI blank, system uses Other Documents Amount.
  - GHPP Client - System defaults Assessment Fee to “Not Required”.

- Reason Fee Not Required
    - Required if Assessment Fee “Not Required”
        - Adoption
        - DX Only
        - Healthy Families
        - HRIF Follow-up
        - Income <200% FPL
        - Medi-Cal Full Scope No SOC
        - MTU Services Only
        - OTLICP
        - Sibling on Program
        - Waiver Induced
- Fee Amount ($)
    - System Calculated.
    - If Assessment Fee is “Required” system will enter fee amount of $20.00

6.7.2 Enrollment Fee (Sub-section)

Figure 6-18 Enrollment Fee

- Enrollment Fee
    - Required field
    - Indicates whether or not an enrollment fee is required.

- Select value from the drop down list:
  - Required
  - Not Required
- System defaults field to “Not Required” if Program Eligibility Coverage Type is Medi-Cal, OTLICP, or Both Medi-Cal and OTLICP.
- System defaults field to “Not Required” if Financial Determination “Reason Not Required” is:
  - Adoption
  - DX Only
  - Healthy Families
  - HRIF Follow-up
  - Medi-Cal Full Scope No SOC
  - MTU Services Only
  - No Income
  - OTLICP
- CCS Client – System uses Financial section Federal GI amount to determine if an enrollment fee is required. If Federal GI is blank, system uses State AGI. If State AGI blank, system uses Other Documents Amount.
- GHPP Client – System defaults field to “Required” if client’s Program Eligibility Coverage Type is not Medi-Cal.
- GHPP Client – If “Required”, G-42 letter will be cancelled.

- Reason Fee Not Required
  - Required if Enrollment Fee is “Not Required”
  - Drop down list. Select one of the following:
    - Adoption
    - Dx Only
    - HRIF Follow-up
    - Income < 200% FPL
    - Medi-Cal Full Scope No SOC
    - MTU Services Only

        - OTLICP
        - Sibling on Program
        - Waiver Induced
    - System sets appropriate “Reason Fee Not Required” if Program Eligibility Coverage Type is Medi-Cal, OTLICP, or Both Medi-Cal and OTLICP.
    - System sets appropriate “Reason Fee Not Required” if Financial Determination “Reason Not Required” is
        - Adoption
        - DX Only
        - Healthy Families
        - HRIF Follow-up
        - Medi-Cal Full Scope No SOC
        - MTU Services Only
        - No Income
        - OTLICP
- Fee Amount ($)
    - System calculated and can be edited by the user. Calculated from the Income Details.
    - CCS Client – System uses Financial Federal GI amount to determine if an enrollment fee is required. If Federal GI is blank, system uses State AGI. If State AGI blank, system uses Other Documents Amount.
    - GHPP Client – System uses the highest income from the Financial (State AGI, Federal GI, or Other Documents Amount) to calculate the enrollment fee amount.
- Reduced Amount ($)
    - Editable – Optional.
    - The user may reduce the total fee amount by entering a value. Enter amount fees are reduced by.
- Reduced Fee Reason
    - Required if Reduced Amount greater than zero.
    - Drop down list. Select one of the following:
        - Appeal
        - Financial Hardship

        - Other
    - Field is disabled if Reduced Amount Field value is zero.
- Total Amount ($)
    - System calculated and is Display only.
    - This total amount is the combination of Assessment Fee Amount and Enrollment Fee minus Reduced Amount.
- Balance Due ($)
    - System calculated and is Display only.
    - Total Amount minus the sum Payment Balance of all payment plans.
    - If the “Balance Due” is less than or equal to 0, the system removes the C-40 or G-40 series ticklers.
    - If the “Balance Due” is less than or equal to 0 and the user changes the payments so there is a positive (greater than 0) “Balance Due” on save, the system will restore the future C-40 or G-40 series ticklers.

6.7.3 Payment Plan (Sub-section)

Add Payment Plan to schedule when client fees are due. User can add unlimited payment plans by clicking on the “Add Payment Plan” button.

Payment plans can only be modified or deleted if the client’s case status is “Active” or “Pending” and the program eligibility period is the current or pending period.

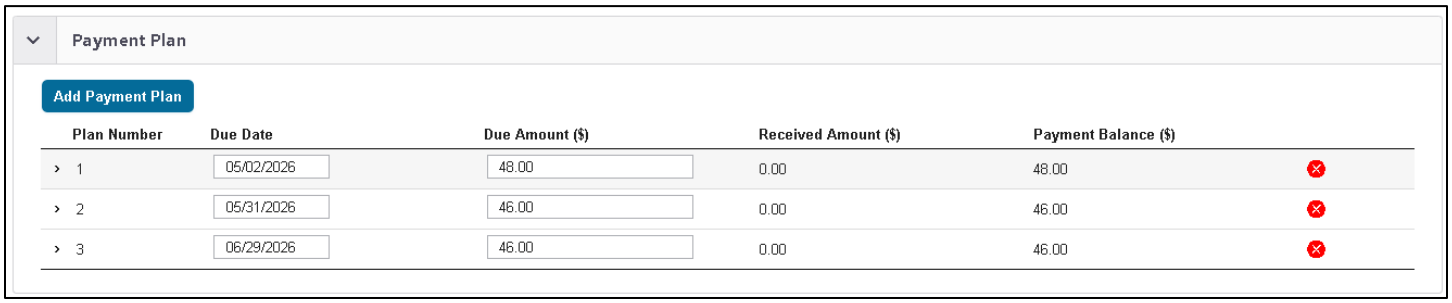

Figure 6-19 Payment Plan

- Add Payment Plan Button
    - Button
    - Click to Add a Payment Plan
- Caret “>”

- Click to Add a Payment received and display the Record of Payments received.

- Plan Number
  - Display only
  - System Calculated
- Due Date
  - Required
  - System calculated. First Plan number is set 30 days from current date. All other Due Dates are set 30 days from the prior payment plan date.
  - Editable by users.
  - Due Date cannot be before today's date or on or before the prior payment plan Due Date.
  - The Due Date of plan number 1 initiates the initial fee letter cycle.
- Due Amount ($)
  - Required
  - System calculated. Total Amount divided by number of payment plans. Any excess is added to payment plan number 1.
  - Editable by users
  - System recalculates this field when payment plans are added or deleted.
- Received Amount ($)
  - Display Only
  - System calculated
  - Display only
  - Sum of all payments received on the payment plan.
  - Can be a negative number
- Payment Balance ($)
  - Display Only
  - System calculated
  - Display only
  - Due Amount minus Received Amount
  - Can be a negative number

- (x) Button
    - Clicking on the (x) removes payment plan and any payments received for the payment plan.

6.7.4 Record Payments Received (Sub-section)

This section allows users to enter payments received in any program period if a Payment Plan has been established. Users can add unlimited payments received as long as the balance due for the payment plan is greater than zero. Received payments can be added to or deleted from a payment plan at any time as long as the user has access to the fees screen.

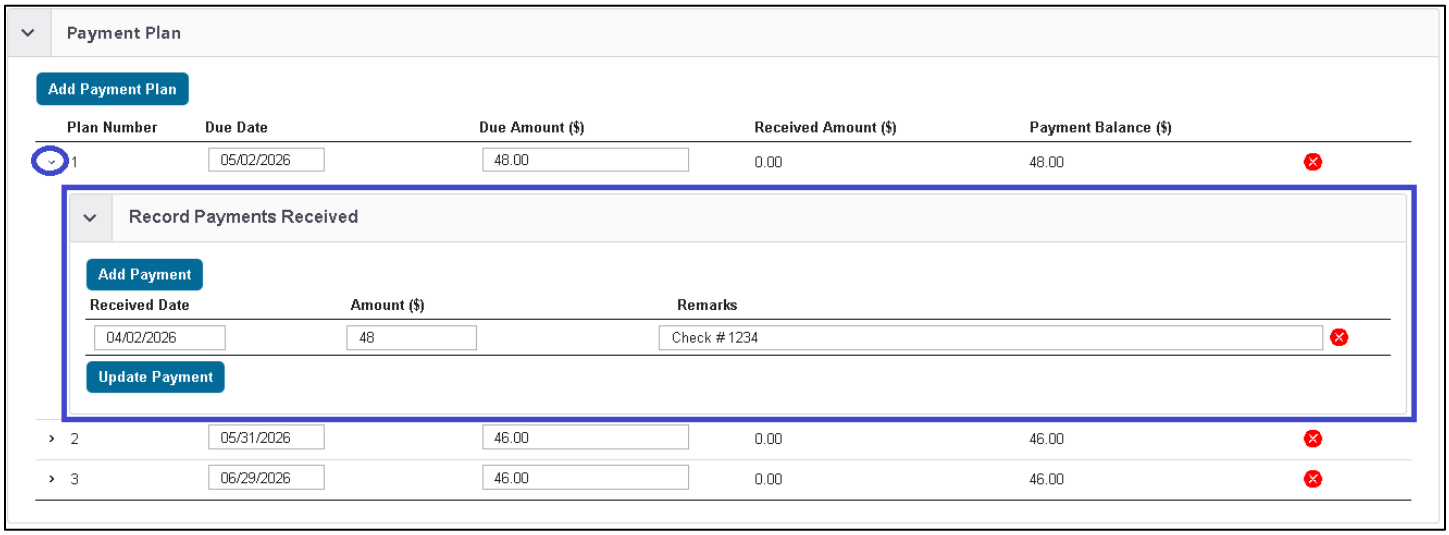

Figure 6-20 Record Payments Received

- Caret “>”
    - Click the Caret “>” next to the plan number to Add a Payment received.
- Add Payment Button
    - Click to add a payment. Adds a payment received row.
- Received Date
    - Required
    - Editable Field – Date payment was received.
    - Cannot be date in future.
- Amount ($)
    - Required
    - Editable Field – Amount paid.

- User enters

- Remarks
  - Optional

  - Editable Field –Remarks about the payment received: check number, etc.
  - User enters
- (x) Button
  - Clicking on the (x) removes the payment.
- Update Payment Button
  - Click to record the payment received.

Users must click the save button at the bottom of the screen to update the financial record and create letters (if applicable).

6.7.5 Fee Letters and Ticklers

There are three fee letters- a first letter, a second letter, and a third letter.

The first fee letter is created when the fees screen is saved with one or more payments and there is a balance due. Fee letters are considered history and changes on the fees screen will not update letters already created. The fee letters include details on what is owed, what has been paid, and an invoice for every payment still due. If a family pays more on one payment, the letter will apply the overpayment to the next payment.

When the Fees section is saved and a letter is generated the user must go to the Correspondence module to complete the letter. Users must go to Correspondence if they want to resend the letter.

Financial Letters for CCS Client – The following Letter Types are generated for CCS clients if they are associated with Fees.

- C-40 – Fee Letter
- C-40A – Fee letter #2
- C-40B – Fee Letter #3

Financial Letters for GHPP client - The following Letter Types are generated for GHPP clients if they are associated with Fees.

- G-40: GHPP Enrollment fee letter
- G-40A:GHPP Enrollment fee letter #2
- G-40B:GHPP Enrollment fee letter #3 (Final)
- G-41: GHPP Approval, fee due #1

- G-41 A: GHPP approval, fee due#2 (final notice)
- G-42: GHPP approval, No fee due

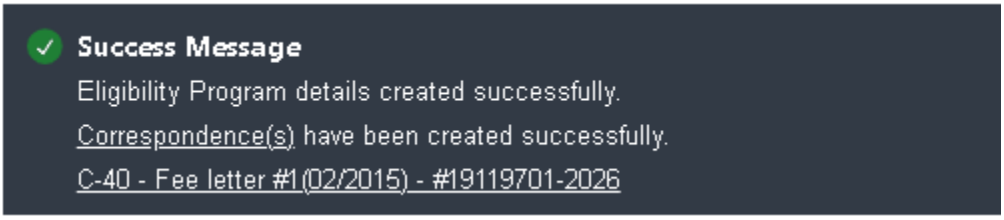

Figure 6-21 Success Message - Fee Letter

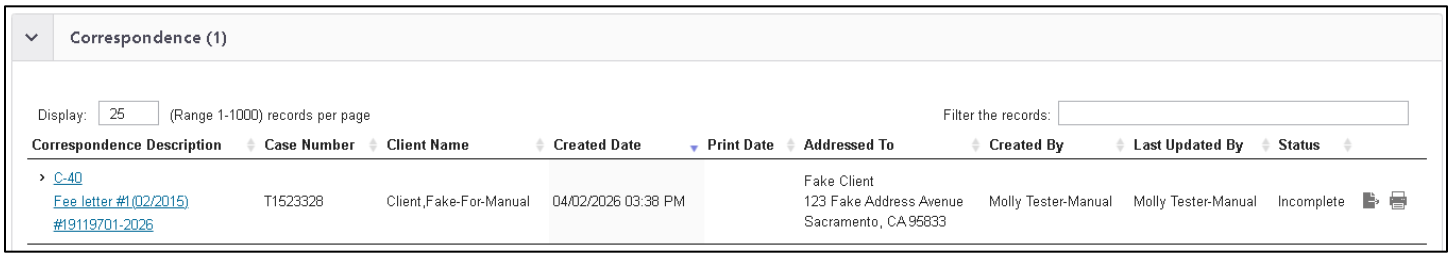

Figure 6-22 Correspondence Section - Incomplete Letter

Tickler: CMS Net will create a letter tickler for the second letter 30 days from the date the first letter is sent. The tickler for the third letter will be set 30 days from the date the second letter is sent.

Removing Tickler: letter ticklers will be removed from the system if the fees are paid in full, the Financial screen is changed to not require a fee.

Restoring Letter and Tickler: when fees paid in full is removed (balance is made greater than zero), system creates a new letter and letter tickler.

- When original tickler date is still in the future, system will restore the “future date” tickler. Letter will be generated to “ready to send” status when that “future date” becomes a current date.
- When original tickler date is past, the “Next Letter Due” tickler date will default to the “current date” (today’s date). Letter will be generated to “ready to send” status the next business day.

Reissue Letter: the tickler will be updated with a new date if the letter is resent.

Fee letter history for the selected program period is shown in the Correspondence Section.

6.8 Medical

Medical section is used to determine medical eligibility for the client. Users may update the client’s medical status, add/update/delete medical home/Special Care Center, and add/update/delete diagnosis.

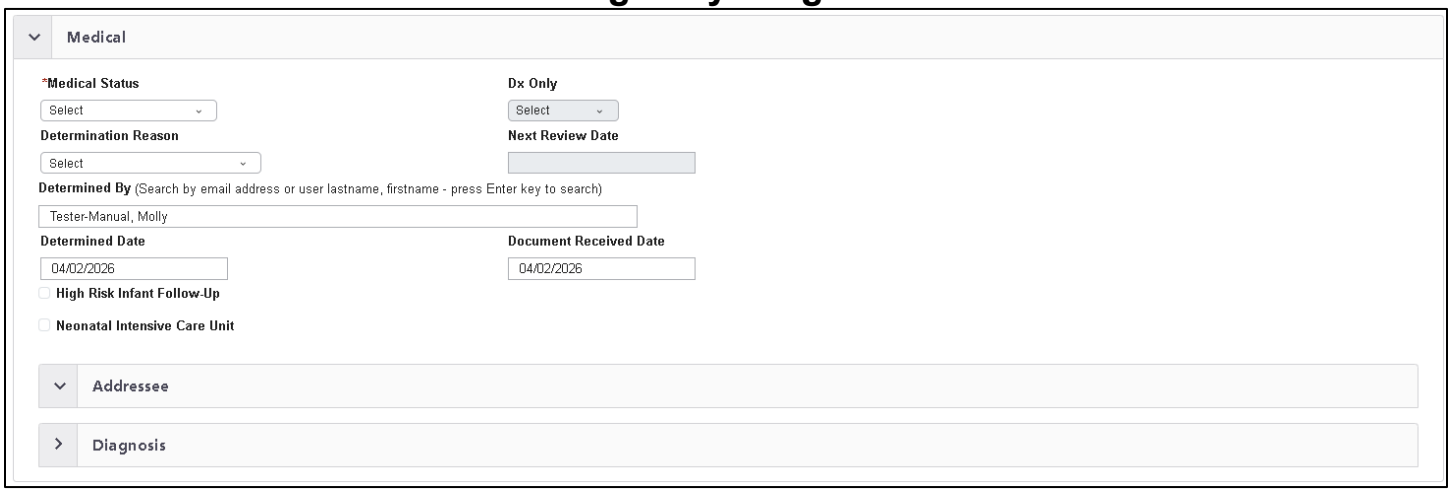

Figure 6-23 Medical Section

Pending and Reopen Pending Case:

- When creating new program period, medical section is available for the user to update.
- Creating new program period after case is reopened, medical related field data is never copied over from prior program period.

Active Case (Annual Renewal):

- When a new program period is created (annual renewal for on-going case), system copies **ALL** medical eligibility information from prior program period over to new program period.
- However, if the case was recently activated and prior program period belongs to another county (due to “negotiated transfer” related).
    - When new county does annual renewal, the medical information from prior program period (belonging to the prior county) does NOT copy over to new program period created by new county.
    - User has to complete medical determination for the first program period created for the new county.

Medical Status Field:

Medical Eligibility as Eligible sets the following fields to required:

- Medical Status
- Dx Only
- Next Review Date (If Dx only is Yes)
- Determined By
- Determined Date
- Document Received Date (If CCS Client)
- Diagnosis

Medical Eligibility as Ineligible sets the following fields to required:

- Medical Status
- Determined By
- Determined Date
- Document Received Date (If CCS Client)

Medical Eligibility as Pending Determination sets the following fields to required:

- Medical Status
- Determination Reason
- Next Review Date

6.8.1 Medical (Sub-section)

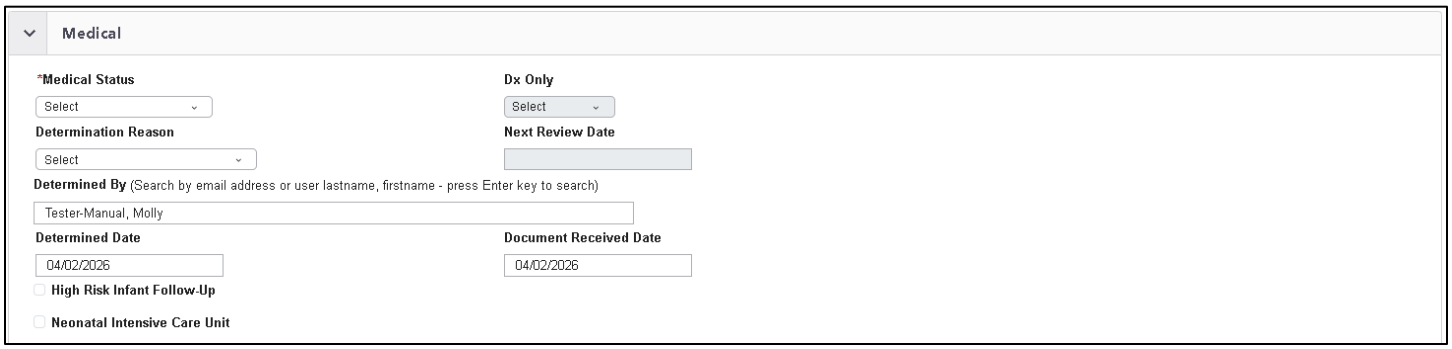

Figure 6-24 Medical Section

The “Medical” section has the following fields:

1. Medical Status*
    a. Required.
    b. Dropdown list values: Eligible, Ineligible, Pending Determination.
    c. Medical Status dropdown list value is filtered based on case status when updating current period or creating pending program period.
        a) Case status is Pending or Reopen Pending: Drop down value = Eligible, Ineligible, and Pending Determination.
        b) Case status is Active: Drop down value = Eligible, Pending Determination.
    d. When “Medical Status” is “Pending Determination”, system populates a date in the “Next Review Date” field.
2. Dx Only *
    a. Conditionally required
    b. Dx Only is required when Medical Status is set to Eligible.
    c. Drop down list values: Yes, No.
    d. When “Dx Only” is set to “Yes”, system populates a date in the “Next Review Date” field.

3. Determination Reason *
    a. Determination Reason is enabled and required when Medical Status is set to Pending Determination.
    b. Drop down list values: Awaiting Medical Report, Medical Appointment Pending, and Requested Medical Report.
4. Next Review Date *
    a. Date field.
    b. No past dates allowed.
    c. User may manually select a different Next Review Date but it should not exceed more than 365 days from the Program Begin Date when the Program End date is empty or may not exceed the Program End Date, when present.
    d. Conditionally required.
        a) Enabled and required when "**Dx Only**" is "**Yes**"
            - Defaults date to 90 days from current/today's date.
                - Users may edit date field by entering a date or using the calendar picker.
            - Sets DX Case Review Tickler.
                - Tickler is removed when DX is set to 'No'.
                - DX Tickler is removed when Medical Eligibility Status is changed to 'Ineligible' or 'Pending Determination'.
            - Tickler is removed when the Case Status is set to Closed, Denied or Not Open.
            - Ticklers are restored when the following are true:
                - When the Case Status is restored to 'Active', Pending' or 'Reopen Pending'.
                - When the Medical Eligibility Status is set to 'Eligible'.
                - When Dx only is set to 'Yes' and the ticker date is in the future.
            - When the Case Status is restored to 'Active', Pending' or 'Reopen Pending', system will not restore tickers that are in the past.
        b) Enabled and required, if "**Medical Status**" is "**Pending Determination**".
            - Defaults to 20 days from the current date.
                - Users may edit date field by entering a date or using the calendar picker.
            - Sets Pending Determination Tickler.
                - Tickers will be set to next review date when the Case Status is set to Pending.
                - Tickler is removed when:
                    - Medical Eligibility Status is changed to 'Ineligible' OR 'Eligible'.
                    - Registration Status is set to 'Closed', 'Denied' or 'Not Open'.
                - Ticklers is restored when:
                    - The Case status is set to 'Pending' or 'Reopen Pending'.
                    - The Medical Eligibility Status is set to 'Pending Determination'.
                    - The tickler date is in the future.

- When the Case Status is restored to ‘Active’, Pending’ or ‘Reopen Pending’, system will not restore tickers that are in the past.
- Pending Determination tickler is set by the Medical Eligibility follow up date. This tickler is removed when the case is set to Closed; Denied, or Not Open, Medical Eligibility changes to ‘Eligible’ or ‘Ineligible’, or the Program Eligibility Period is deleted.

5. Determined By:
    a. Required unless Medical Status is ‘Pending Determination’.
    b. Search by User ID or email address or user Last Name, First Name - press Enter key to search.
        - When search result has more than one result, an overlay displays with list of users. Click on the user’s last name hyperlink to select the user.
        - Name displays inside field when a 1:1 match is found.
6. Determined Date:
    a. Required unless Medical Status is ‘Pending Determination’.
    b. No future dates allowed.
    c. Users may edit date field by entering a date or using the calendar picker.
7. Document Received Date:
    a. Required Field for CCS clients when Medical Status is “Eligible” or “Ineligible”
    b. Optional for GHPP.
    c. No future dates allowed.
    d. Users may edit date field by entering a date or using the calendar picker.
8. High Risk Infant Follow-Up:
    a. Optional
    b. Check box
    c. Indicates client is a High Risk Infant Follow-up client.
9. Neonatal Intensive Care Unit
    a. Optional
    b. Check box
    c. Indicates client is in the Neonatal intensive Care Unit

6.8.2 Addressee (Sub-section)

The “Addressee” section is used to record Medical Home and Assigned Special Care Center (SCC). No other addressee types are allowed besides Medical Home and SCC.

- Medical Home: Only 1 Medical Home allowed.
- Special Care Center: Multiple SCC are allowed.

Addressee List:

- The Addressee section has an addressee list with these columns: Addressee Type, Name/Address, Relationship to Client, Phone, and Phone Notes.

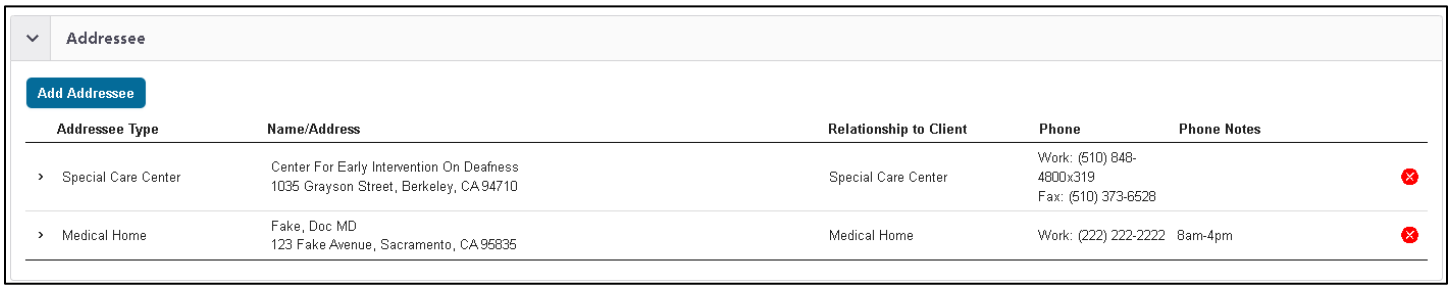

Figure 6-25 Addressee Section

Add Addressee button:

- Adding a new addressee:
- Click Add Addressee button
- Addressee field container expands. Enter data.
- Click on Add Addressee again to add addressee to table list.
- Validation message if user does not click “Add Addressee” to add the addressee to the table list: Addressee must be completed to continue saving.

Updating Addressee (Address/Contact):

- Click **>** to expand and view the addressee you wish to view details on.
  FYI Note:
  - Only Medical Home addressee may be updated.
  - SCC addressee is updated by Special Care Center team. It is not editable.
- Update information as necessary.
- When finish updating, click on Update button to add updated addressee to table list.
- Validation message if user does not click “Update” after making changes: Addressee must be completed to continue saving.

Updating Addressee (Name/Provider Type):

- Provider addresses are complex and are updated by the Medi-Cal Provider Master File. Some fields are not editable. System does not allow edits to the Addressee Type, Relationship to Client or name fields once addressee is added to addressee list.
- This also prevents a user from creating unnecessary provider records.
- If the user wants to update the provider itself (Provider’s Name), user needs to remove that addressee using the [X] icon and then re-enter/add the addressee to the Addressee List.

Below section will breakdown Addressee subsection and provide field information in more detail.

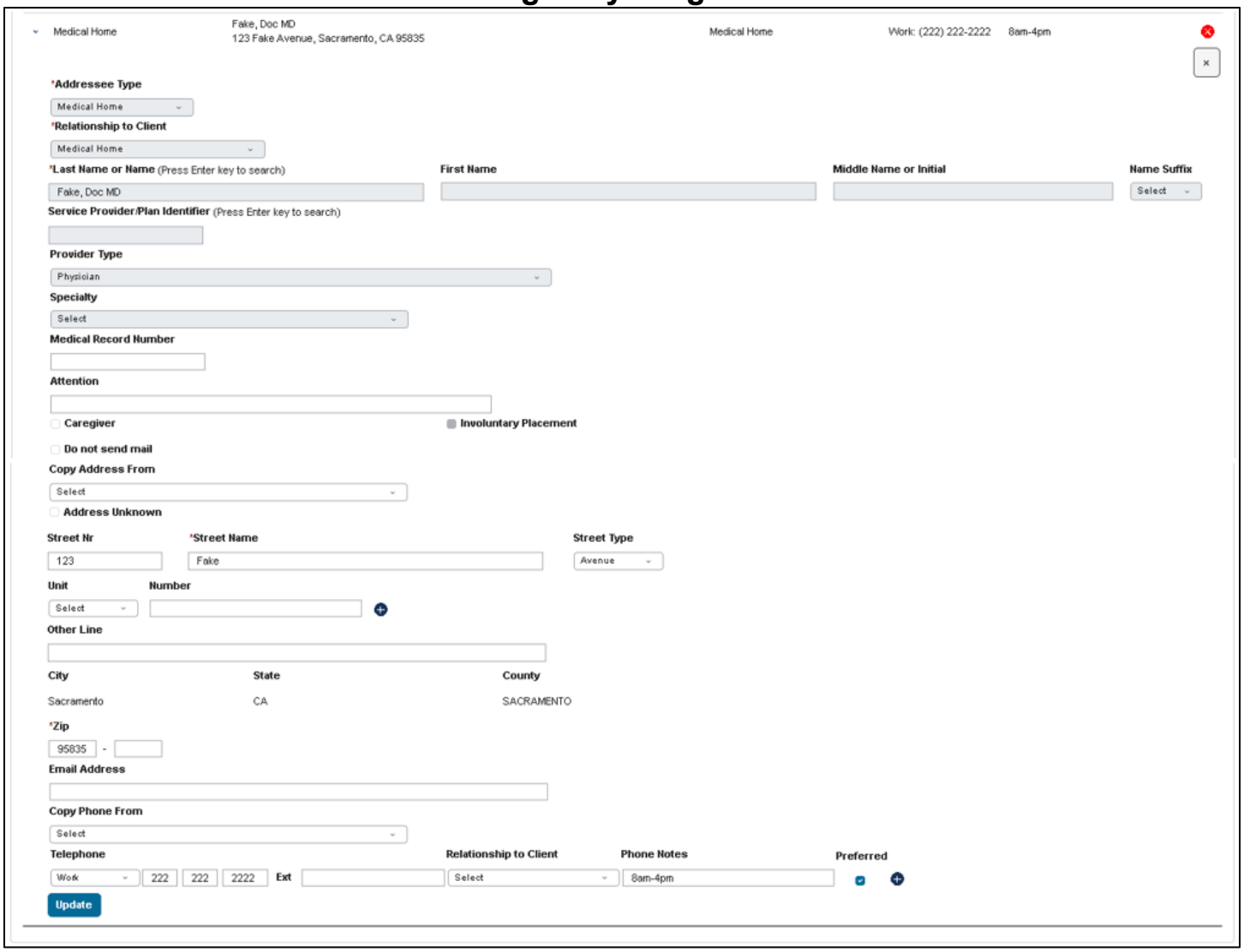

Figure 6-26 Add Addressee

- Addressee Type*:
  - This is a required drop down list.
  - The Addressee type indicates what type of contact is being added. Fields on may be enabled/disabled depending on selection.
- Relationship to Client*:
  - This is a required drop-down list.
  - Indicates the addressee's relationship to client.
  - The list is filtered based on the addressee type chosen.
- Last Name or Name (Press Enter key to search)*:
  - This is a required text field.
  - The maximum characters length is 50.

- Validation is performed on the characters that may be entered during entry and upon save.

- (Press Enter key to search) –Provider/Plan search only.
- When the client relationship type = Provider:
  - Upon pressing the enter key, the provider search method is activated.
  - When more than one record is found, the results are displayed in an overlay. When there is only one record, the provider related fields and the address are populated.
  - Only one Provider may be selected at a time to search for. The selected provider information is populated in the provider fields.

- First Name:
  - Disabled for provider/plan related.
- Middle Name or initial:
  - Disabled for provider/plan related.
- Name Suffix:
  - Disabled for provider/plan related.
- Service Provider/Plan Identifier (Press Enter key to search) *:
  - This is an optional text field.
  - The maximum characters length is 10.
  - Alpha-numeric values with period (punctuation) are allowed.
  - (Press Enter key to search) – Functional for Provider/Plan search only.
  - Field is enabled based on the relationship value (when it is of type provider), otherwise disabled.
  - Upon pressing the enter key, the provider search method is activated.
  - When more than one record is found, the results are displayed in an overlay. When there is only one record, the provider related fields and the address are populated.
  - Only one Provider may be selected at a time to search for. The selected provider information is populated in the provider fields.
- Provider Type
  - This is an optional dropdown field.
  - Field is enabled only when the relationship is of type Provider.
- Specialty
  - This is a conditionally required dropdown.
  - The field is enabled only for the Addressee Type is Specialist.
  - Allows user to indicate what medical field this specialist belongs to.
- Medical Record Number
  - This is an optional text field.
  - The field is enabled only for the relationship is of Provider, otherwise disabled.
  - The maximum characters length is 20.
  - A number issued by a client’s provider or plan that is unique to the individual or institution that issued it but may not be unique within CMS Net. Therefore, the same medical record number may potentially appear on more than one case.

- Attention
  - This is an optional text field.
  - Field is enabled only when the relationship is of type Provider, otherwise disabled.
  - The maximum characters length is 20.
  - Used to direct correspondence to a specific individual within an organization.
- Caregiver:
  - This is an optional checkbox.
  - Upon checking the checkbox, enable the Involuntary Placement checkbox.
  - When unchecked, Involuntary Placement checkbox is disabled.
  - Individual who attends to the needs of the client.
- Involuntary Placement:
  - This is an optional checkbox field.
  - Client is placed in care without their voluntary consent. Dependent upon Caregiver and is enabled only when Caregiver box is checked.
- Do not send mail
  - This is an optional checkbox field.
  - This field is disabled for Client and Primary Addressee address types.
  - For provider addresses, when the address is marked as bad, do not send mail flag is set to true and is marked when the provider is selected. Address will not appear on Correspondence.
- “Copy Address From” and “Copy Phone From”:
  - This is a dropdown checkbox.
  - This dropdown is populated with the available address types from the address list that are present.
- Address Unknown
  - This is an optional checkbox.
  - Upon checking this box, all the address fields are disabled.
- Address (Street Nr, Street Name, Street Type, Unit, Number, Other Line, City, State, County, and Zip):
  - These are the standard address fields.
  - Street address or PO Box number of addressee.
  - Apartment, suite, unit, building, floor, and/or room number of addressee.
  - City and State fields are automatically populated when the Zip code is selected and there is a 1 to 1 match. If multiple cities exist in this zip code, an overlay allows the user to select the city.
- Email Address:
  - This is an optional field.
  - Addressee’s email address for electronic communication purposes.
- Copy Phone From
  - This is a dropdown checkbox.
  - This dropdown is populated with the available address types from the address list that are present.
- Telephone

- This fields is conditionally required for certain address types such as Primary Addressee.

- Relationship to Client
  - Indicates the addressee's relationship to client.

- Phone Notes
  - Comments regarding corresponding phone number, such as 'No Calls after 5pm', or 'Available 7am-9pm'.
- **Update** Button
  - Upon clicking the button, the details are validated and updated in the addressee list.
  - Don't forget to click on the **Update** button. Validation message: Addressee must be completed to continue saving.

- **Add Addressee** button:
  - When adding a new addressee, you must click on Add Addressee to add the addressee to table list.
  - Validation message: Addressee must be completed to continue saving.

6.8.3 Diagnosis (Sub-section)

List of diagnosis codes currently assigned to the selected case. You may add and delete diagnoses or change the diagnosis priority as needed.

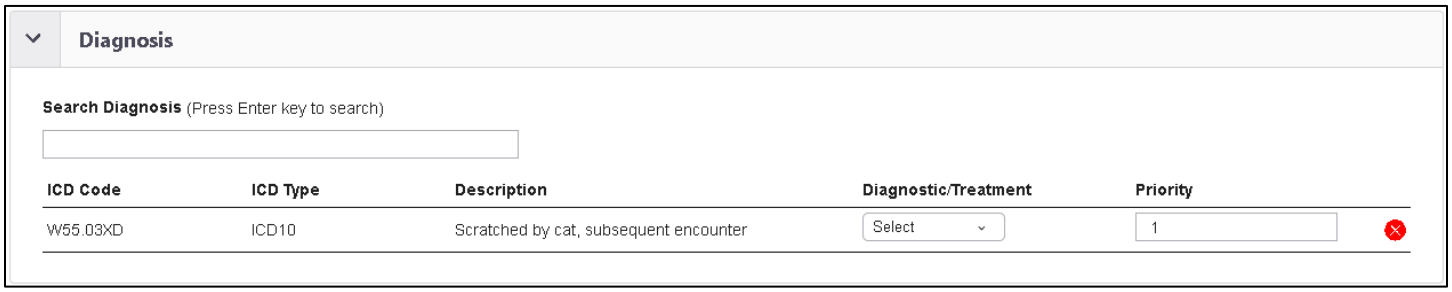

Figure 6-27 Diagnosis Section

The section contains a search field and a list for displaying the client diagnoses.

- Search Diagnosis field
  - This is a text field.
  - Upon entry and pressing the "Enter" key, a search is performed to retrieve the diagnosis information. When a direct match is found, the value is appended in the list with the resulting information. When there are multiple matches, an overlay is presented to display the diagnosis information and upon selection, the list is appended with the selected diagnosis entry.
  - Diagnosis may be searched by code or description.
  - Duplicate entries are not allowed and restricted while adding or selecting the codes.
  - Any new entry is added to the bottom of the table with the next priority in the list.

- Diagnosis List
    - The diagnosis list contains the following fields:
        - ICD Code
            - Diagnosis code that identifies client's condition.
        - ICD Type
        - Description
            - Description of diagnosis code that identifies client's condition.
        - Diagnostic/Treatment
            - This is an optional drop down using the select control.
            - The two dropdown values are hardcoded as "Diagnostic" and "Treatment".
            - Indicates if corresponding diagnosis code is approved for Diagnostic only or Treatment.
        - Priority
            - This is a required text field.
            - The maximum characters length is three.
            - Users may not enter the same priority twice. Value must be unique.
            - Only real numbers may be used.
            - When the priority value is changed, the list is resorted based on the priority value in ascending order. The values are reset to start from 1 (top to bottom).
        - Remove icon
            - Click the X icon to remove diagnosis from list.
            - When row is removed, the list is resorted based on the priority value in ascending order.

6.8.4 Additional Information Related to Diagnosis Code

- **Diagnosis code will display on Registration or Face Sheet for Closed or Denied case.**
    - When a case is closed or denied, diagnosis codes entered via the Medical Eligibility screen will continue to appear on both the Registration and the Face Sheet.
    - Diagnosis codes entered via Registration or Program Eligibility module will remain on case until the codes are removed.
- **Pending Program Eligibility Period:**
    - For cases with a pending program period, diagnosis added to the current period will be visible on the pending program period, Registration, and the Face Sheet.
    - Diagnosis added to the pending program period will also be displayed on the current program period, Registration, and Face Sheet.

6.9 Correspondence

Lists the correspondence tied to program eligibility.

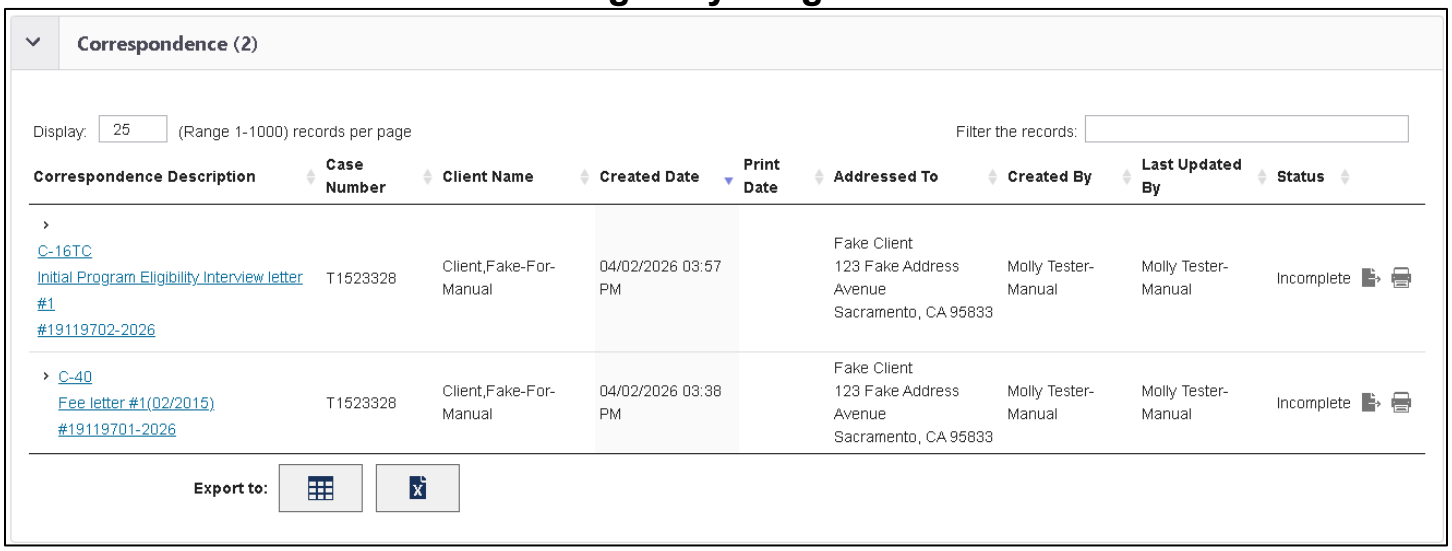

Figure 6-28 Correspondence Section

- Caret: Clicking on the caret icon will expand the Correspondence Details.
- Case Number: Case number of client.
- Created Date: Date letter was generated.
- Correspondence Description: Correspondence Template Number, Letter Name, and unique Letter ID. Clicking on the Hyperlink will navigate the user to the Correspondence Maintenance Page.
    - Hyperlink is Disabled if Correspondence status is Sent, Cancelled, Reissued, Deleted, Waiting for Approval, or if the user does not have the privilege to edit the Correspondence.
- Print Date: Date letter was printed/sent
- Addressed to: Primary addressee of letter
- Created By: User who generated the letter.
- Last Updated By: User who last updated the letter.
- Status: Status of letter (Incomplete, Ready to Send, Waiting for Approval, Sent, Cancelled, Deleted)
- Create First Level Appeal Letter for this NOA Icon: Clicking on the icon will navigate user to the Correspondence Maintenance page to create a first level appeal letter for the NOA.
- Print Icon: Disabled if Correspondence Status is Incomplete, Waiting For Approval or Deleted, else enabled. Clicking on the icon will download a PDF of the letter for the user to view.

The following letter types will be displayed for the client and selected program period:

- C-16 – CCS First Letter
- C-16A – CCS Second Letter
- C-16B – CCS NOA/Third Letter

- C-16M – Medi-Cal First Letter
- C-16MA – Medi-Cal Second Letter
- C-16MB – Medi-Cal NOA/Third Letter
- C-16HF – Healthy Families First Letter
- C-16HFA – Healthy Families Second Letter
- C-16HFB – Healthy Families NOA/Third Letter
- C-38 – CCS First Letter
- C-38A – CCS Second Letter
- C-38B – CCS NOA/Third Letter
- C-38M – Medi-Cal First Letter
- C-38MA – Medi-Cal Second Letter
- C-38MB – Medi-Cal NOA/Third Letter
- C-38HF – Healthy Families First Letter
- C-38HFA – Healthy Families Second Letter
- C-38HFB – Healthy Families NOA/Third Letter
- C-40 – CCS First Fee Letter
- C-40A – CCS Second Fee Letter
- C-40B – CCS Third Fee Letter
- G-40 – GHPP First Fee Letter
- G-40A – GHPP Second Fee Letter
- G-40B – GHPP Third Fee Letter
- G-41 – GHPP approval, Fee Due First Letter
- G-41A – GHPP Approval, Fee Due Second Letter
- G-42 – GHPP Approval, no Fee Due
- PSA – Program Services Agreement Letter

6.9.1 Printing Correspondence

If a letter is generated, the system displays the success message.

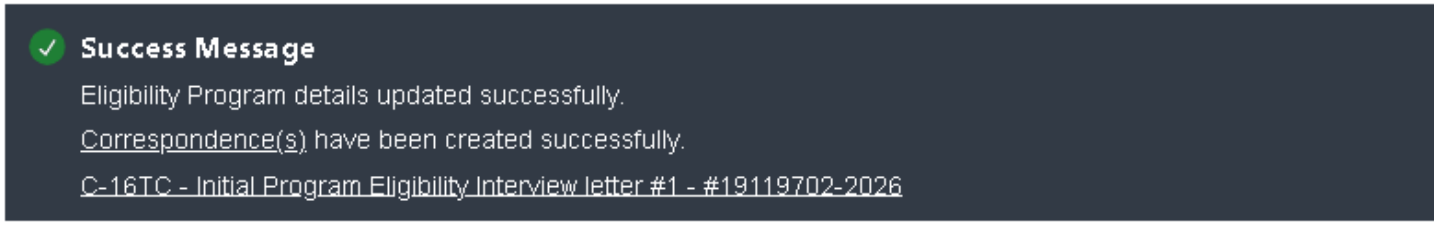

Figure 6-29 Success Message

- [Action Name] updated/created successfully.: [Action Name] will be replaced with whatever action on the screen was updated/created.
- Correspondence(s) have been created successfully.: Clicking on the Correspondence(s) link expands the Correspondence section of the current screen. Appears if correspondence has been created.
- Correspondence description link: Will either download letter or navigate user to maintenance page based on letter status. Appears if correspondence has been created.
    - If letter is in "Sent" status, clicking on the Correspondence description link downloads a PDF of the letter for the user to view.
    - If letter is "Incomplete" or "Ready to Send" status, clicking on the Correspondence description link navigates to Correspondence maintenance page.

Batch Correspondence FYI: In addition, for letters to display in “Batch Correspondence” for counties that participate in auto batch printing (Los Angeles & Orange County for example), letter(s) will not be placed in the batch unless user puts the letter to “ready to send” or “sent” status.

6.10 Attachments

The Attachments section allows you to attach Eligibility Program-related electronic documentation to a client’s record.

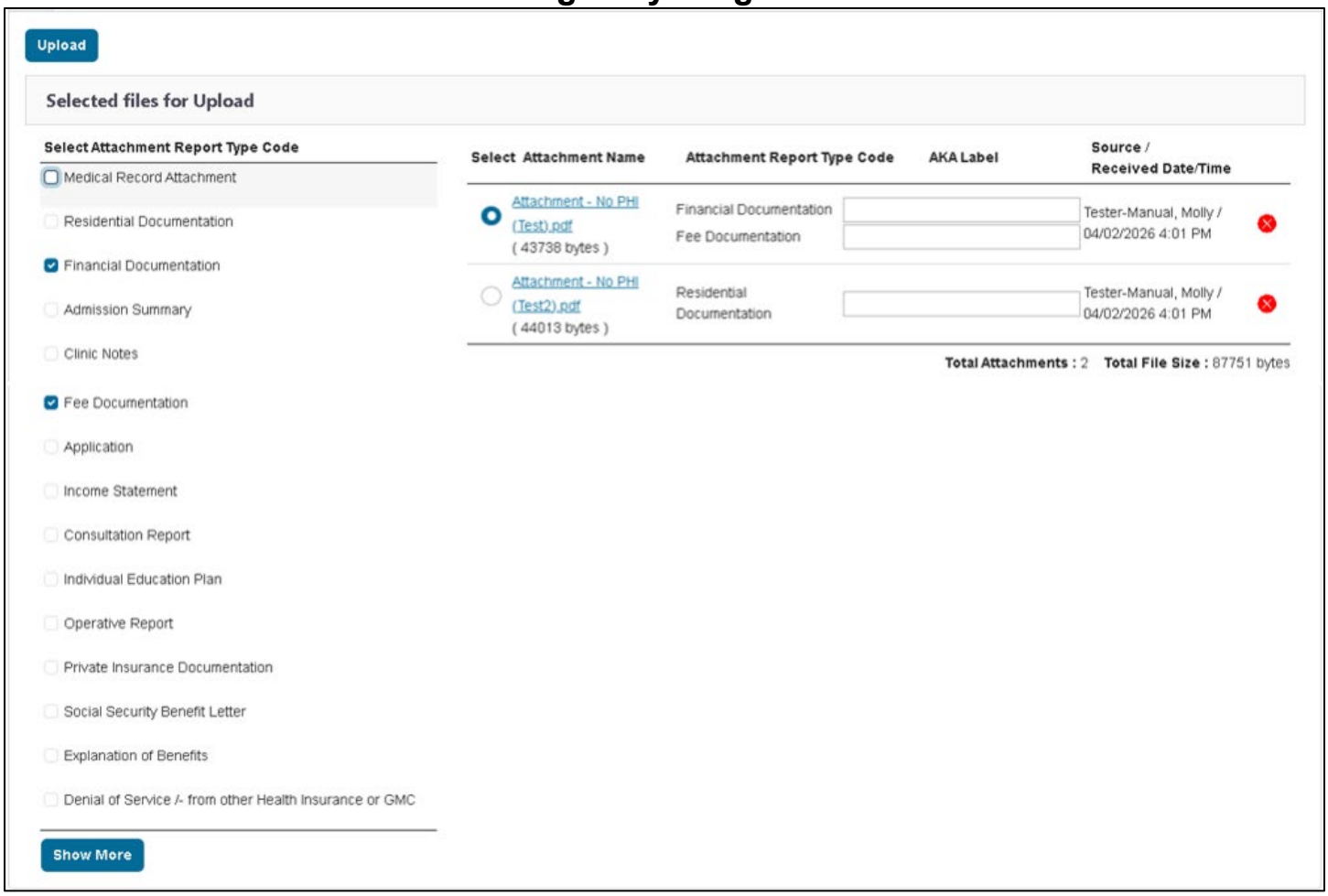

Figure 6-30 Attachments Section

Click the **Upload** button to upload an attachment.

Note: Only PDF, JPG, and TIF/TIFF files can be uploaded. Maximum file size per attachment: 5MB.

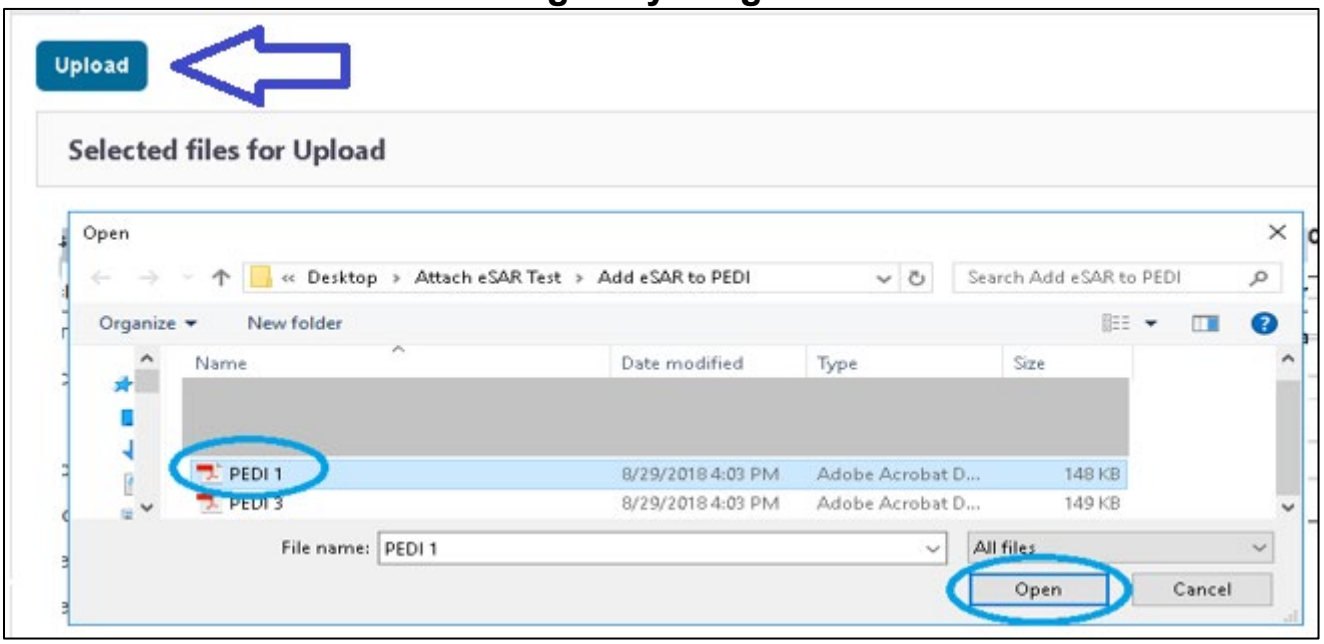

Figure 6-31 Upload Attachment

Once an attachment is selected, it appears on the right side of the Attachments section.

The latest attachment is auto selected upon appearing on the screen for you to add the attachment report type.

Select Attachment Report Type Code: Select the attachment report type(s) that apply to the attachment. Click **Show More** button to see all attachment report types.

The report type selected appears on the attachment. Uncheck the report type to remove it from the attachment.

Add an optional AKA label if the attachment needs an additional description.

Click the red X icon to remove the attachment.

Click the radio button next to the attachment to modify the attachment report type codes or AKA label.

Saving the screen will save the attachment changes to the client's record.

6.11 Other Information

Accordion is collapsed by default.

Figure 6-32 Other Information

Fields in this section:

- Last Updated By
    - Display Only
    - System name of user who was last working on the screen
- Last Updated Date
    - Display Only
    - System date of last save to the screen

6.12 Case Note

Users can select the case note they want to use when writing a case note for this screen. Case notes will be updated when the system text is changed and saved on the same day the note was entered. User text will be updated when the same user updates the note for the same day.

Figure 6-33 Case Note Section

Case Note Description field:

- Displays all case note descriptions.
- Default dropdown value is "select".

Other Description field:

- Free Text field and optional.

- When new text is entered into field, upon saving, the new text replaces the existing case note subject description text on case note modules (legacy) and for CMS2020 Case Notes History, it displays below the subject code in the subject column.
- Maximum characters allowed = 60 characters.

Case Note Text:

- This is a conditionally optional field. Required when “Case Note Description” is entered.
- The maximum characters length is 15,000.
- Case note is created when users enter case note comments in the Case Note textbox.

Available notes that can be chosen to enter user text from the Case Note Description drop down:

- All Program Eligibility
- Enrollment and Assessment Fee Update
- Financial Eligibility
- Medical Eligibility
- Program Eligibility
- Residential Eligibility

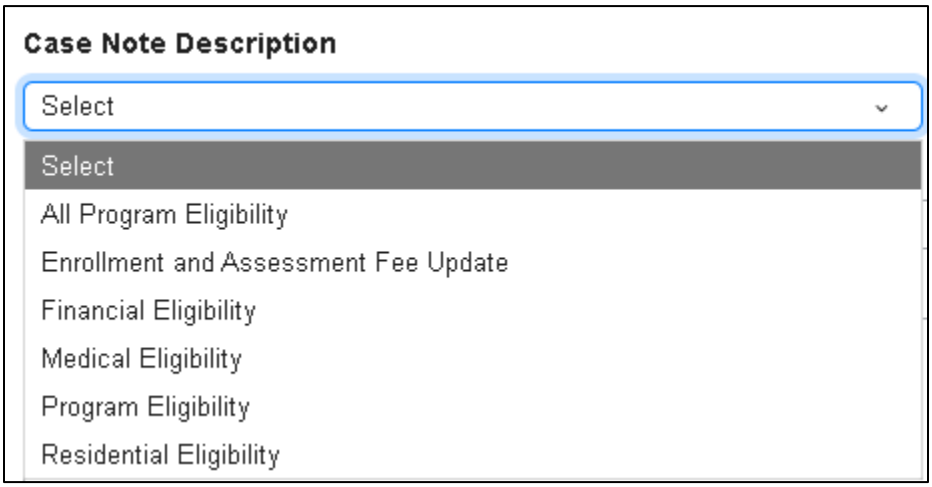

Figure 6-34 Case Note Description

6.12.1 All Program Eligibility

Generated when an All Program Eligibility case note is entered.

User Text

test note

System Text

Pending Program Eligibility
PGRM BEGIN DATE: 12/07/2021
PENDING ELIG TYPE: Eligibility Period Only

Residential Eligibility
RESIDENTIAL STATUS: Eligible

DATE DETERMINED: 01/06/2022
PROOFS OF RESIDENCE: Medi-Cal Full Scope No SOC

Financial Eligibility
FINANCIAL STATUS: Eligible
DATE DETERMINED: 01/06/2022
FINANCIAL DETERMINATION:
REASON NOT REQ'D: Medi-Cal Full Scope No SOC
STATE ADJ GROSS INCOME:
FEDERAL TAX GROSS INCOME:

Enrollment and Assessment Fee Update
Program Eligibility Begin Date: 12/07/2021
Program Eligibility End Date:
Total Amount: 0.00
Balance Due: 0.00

Medical Eligibility
MEDICAL STATUS:
Dx Only:
LIST OF DX:
G80.0 Spastic quadriplegic cerebral palsy

Figure 6-35 All Program Eligibility Note

6.12.2 Program Eligibility

Generated when a Pending Program Eligibility case note is entered. System text fields change based on user entries.

Eligibility Type: Eligibility Period Only, Interview Pending

User Text
test

System Text
PGRM BEGIN DATE: 01/01/2021 PGRM END DATE: 12/31/2021
PENDING ELIG TYPE: Eligibility Period Only

Figure 6-36 Eligibility Period Only, Interview Pending Note

Eligibility Type: Medi-Cal Pending (M/C Not Referred Date entered)

User Text
test

System Text
PGRM BEGIN DATE: 11/20/2018
PENDING ELIG TYPE: Medi-Cal Pending
DT M/C NOT REF: 05/12/2021 REASON: Medi-Cal

Figure 6-37 Medi-Cal Pending, Not Referred Note

Eligibility Type: Medi-Cal Pending (M/C Agreement Signed Date entered)

User Text
test

System Text
PGRM BEGIN DATE: 11/20/2018
PENDING ELIG TYPE: Medi-Cal Pending
DT M/C AGR SIGN: 05/13/2021
STATUS CALL DUE DT: 07/12/2021

Figure 6-38 Medi-Cal Pending, Agreement Signed Note

Eligibility Type: Medi-Cal Pending (M/C Application Refused Date entered)

User Text
test

System Text
PGRM BEGIN DATE: 11/20/2018
PENDING ELIG TYPE: Medi-Cal Pending
DT M/C APL REFUSE: 05/13/2021

Figure 6-39 Medi-Cal Pending, Application Refused Note

Eligibility Type: Medi-Cal Pending (Deter. M/C Not Compliant Date entered)

User Text
test

System Text
PGRM BEGIN DATE: 11/20/2018
PENDING ELIG TYPE: Medi-Cal Pending
DT M/C NOT COMP: 05/13/2021

Figure 6-40 Medi-Cal Pending, Not Compliant Note

Eligibility Type: Medi-Cal Pending (M/C Application Completed Date entered)

User Text
test

System Text
PGRM BEGIN DATE: 11/20/2018
PENDING ELIG TYPE: Medi-Cal Pending
DT M/C APL COMP: 05/13/2021

Figure 6-41 Medi-Cal Pending, Application Completed Note

Eligibility Type: Medi-Cal Pending (Self Declared Date entered)

User Text
test

System Text
PGRM BEGIN DATE: 11/20/2018
PENDING ELIG TYPE: Medi-Cal Pending
DT SELF DECLARE: 05/13/2021
STATUS CALL DUE DT: 07/12/2021

Figure 6-42 Medi-Cal Pending, Self Declared Note

6.12.3 Residential Eligibility

Generated with a Residential Eligibility case note is entered.

User Text

test

System Text

RESIDENTIAL STATUS: Eligible

DATE DETERMINED: 12/29/2021
PROOFS OF RESIDENCE: Medi-Cal Full Scope No SOC
Social Security Income

Figure 6-43 Residential Eligibility Note

6.12.4 Financial Eligibility

Generated when a Financial Eligibility case note is entered.

User Text
test

System Text
FINANCIAL STATUS: Eligible
DATE DETERMINED: 05/11/2021
FINANCIAL DETERMINATION: Required
INCOME SOURCE: Joint
TAX YEAR: 2020
FAMILY SIZE: 2
STATE ADJ GROSS INCOME: 55000
FEDERAL TAX GROSS INCOME:

Figure 6-44 Financial Eligibility Note

6.12.5 Enrollment and Assessment Fee Update

Generated when an Enrollment and Assessment Fee Update case note is entered or a field is entered/updated in the Fees section.

User Text
test

System Text
Program Eligibility Begin Date: 01/01/2021
Program Eligibility End Date: 12/31/2021
Total Amount: 520.00
Balance Due: 300.00

Payment Plan
Payment #1: Amount Due: 174.00 Due Date: 06/12/2021
Payment #2: Amount Due: 173.00 Due Date: 07/12/2021
Payment #3: Amount Due: 173.00 Due Date: 08/11/2021

Payments
Plan #1 Payment Received #1: Amount Received: 20.00 Date Received: 05/13/2021
Plan #2 Payment Received #1: Amount Received: 200.00 Date Received: 05/04/2021

Figure 6-45 Enrollment and Assessment Fee Update Note

6.12.6 Medical Eligibility

Generated when a Medical Eligibility case note is entered. System text fields change based on user entries.

Eligibility Status: Eligible or Ineligible

User Text

test

System Text

MEDICAL STATUS: Eligible
DATE DETERMINED: 01/06/2022
DETERMINED BY: Test, Viewonly
Dx Only: NO
LIST OF DX:
G80.0 Spastic quadriplegic cerebral palsy

Figure 6-46 Medical Eligibility Eligible or Ineligible Note

Eligibility Status: Pending Determination

User Text

test

System Text

MEDICAL STATUS: Pending Determination
Dx Only:
LIST OF DX:
G80.0 Spastic quadriplegic cerebral palsy
G80.1 Spastic diplegic cerebral palsy

Figure 6-47 Medical Eligibility Pending Determination Note

6.12.7 PSA-Not Required

Generated when PSA Status is changed to Not Required.

This is an auto generated case note when PSA section is completed.

System Text
Program Eligibility Begin Date: 01/01/2021
Program Eligibility End Date: 12/31/2021
PSA status: Not Required
Reason PSA not required: Medi-Cal Full Scope No SOC

Figure 6-48 PSA Not Required Note

6.12.8 PSA-Not Signed

Generated when PSA Status is changed to Not Signed.

This is an auto generated case note when PSA section is completed.

System Text
Program Eligibility Begin Date: 01/01/2021
Program Eligibility End Date: 12/31/2021
PSA status: Not Signed

Figure 6-49 PSA Not Signed Note

6.12.9 PSA-Signature Pending

Generated when PSA Status is changed to Signature Pending.

This is an auto generated case note when PSA section is completed.

System Text
Program Eligibility Begin Date: 01/01/2021
Program Eligibility End Date: 12/31/2021
PSA status: Signature Pending
Correspondence #: 15209277-2021

Figure 6-50 PSA Signature Pending Note

6.12.10 PSA-Signed

Generated when PSA Status is changed to Signed.

This is an auto generated case note when PSA section is completed.

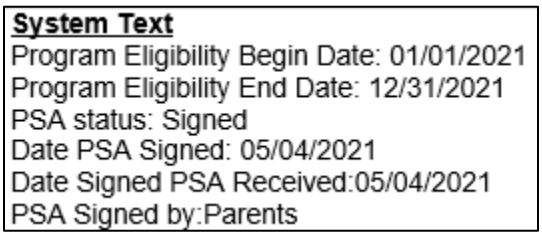

Figure 6-51 PSA Signed Note

6.13 Case Notes History

This Case Notes History section contains a list of historical case notes associated with Eligibility Program. Note will be modified if the same user changes the same note on the same day for the same client.

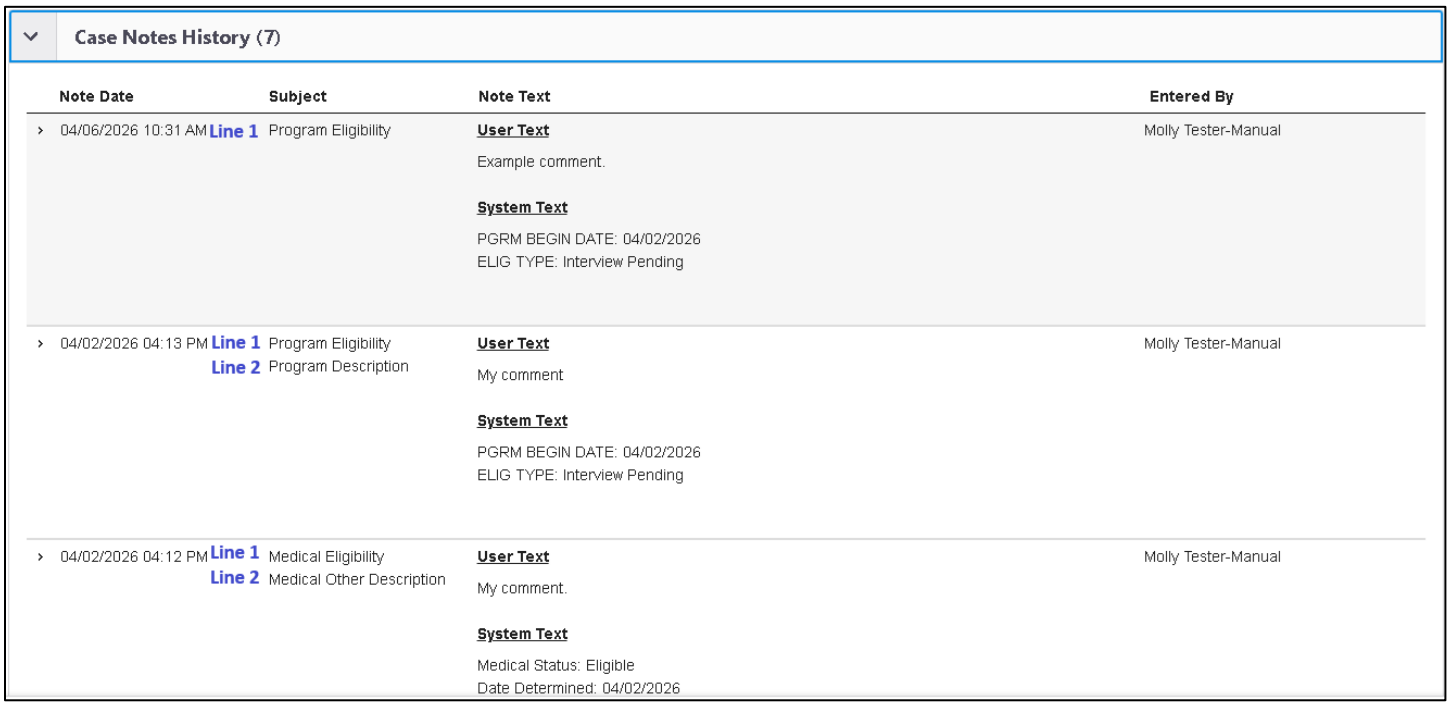

Figure 6-52 Case Notes History

This section is an accordion and by default is collapsed. You may expand to view.

The list has the following fields:

- Note Date
  - This is a timestamp with (MM/DD/YYYY HH:MM AM/PM) format.

- Subject
  - Line 1: Case note subject code
  - Line 2: Other Description (if entered from Case Note – Other Description field)
- Note Text
  - Displays user text and system text.
- Entered By
  - User’s name that entered case note.