



Maternal and Child Health Access Monthly Meeting Thursday, February 21, 2013

Agenda

1. Introductions
2. Mailing sent, Meeting Materials, Additions to Agenda
3. Updates –
 - a. Healthy Families to Medi-Cal – State training - what else? - Liz Ramirez, MCHA

Webinar slideshow and toolkit items posted:

<http://www.dhcs.ca.gov/services/hf/Pages/HFPSHMFebruary.aspx>

- b. Children's dental health month – updates - Monica Ochoa, MCHA Oral Health Advocacy Coordinator
 - c. Maintaining continuity of care for pregnant women – Lynn Kersey, MCHA
4. Guest Speaker: Blanca Vargas, PHFE WIC
WIC in the transition from Healthy Families to Medi-Cal
5. Roundtable of issues and announcements

Next MCHA Monthly Meeting: Thursday, March 21, 2012, 10 AM – 12 Noon



don't guess

WWW.CALPOISON.ORG

be sure

Announcing the first-ever bilingual text messaging service for tips, facts and news about poisoning prevention!

Text **TIPS** or **PUNTOS** for Spanish to **69866**

You will receive one tip each day during National Poison Prevention Week and then once a week! The service is free, though standard rates may apply from your carrier.

Can you tell the difference between medicines and candy?

Play Pills vs. Candy at www.pillsvscandy.org

On **Facebook**? Become a fan of California Poison Control and test your knowledge of common poison-related questions, myths, folklore and incidents in popular culture with "**Gee, that tastes funny!**" and "**Stop it, you're killing me!**"

You can also share a poison prevention message with a friend by customizing and sending an **e-card** at www.calpoisonecards.org

For fast, free and expert help or information 24/7 in case someone has touched, tasted or breathed in something harmful, **call 1-800-222-1222**



POISON CONTROL 2013



We are ready to come out and tell you about Poison Prevention now~! There are internet games, an app for your smart phones to get weekly texts with poison control tips and a lot more!

If you are interested in a presentation on Poison Control for your staff, parent groups, community meetings, how to safely store poisonous products and medicines, common house plants and flowers that are poisonous and where to get more information, please call or email me:

Debra Winski, Health Education Coordinator

debraw@mchaccess.org

213-749-4261 x302



U.S. Department of Health and Human Services

NIH News

National Institutes of Health

[National Institute of Diabetes and Digestive and Kidney Diseases \(NIDDK\)](#)

[Eunice Kennedy Shriver National Institute of Child Health & Human Development \(NICHD\)](#)

For Immediate Release

Wednesday, February 20, 2013

Contact:

[Leslie Curtis](#)

301-496-3583

NIH launches study of long-term effects of blood glucose during pregnancy

Researchers to explore effects on body fat in children and development of diabetes in moms after giving birth

Researchers funded by the National Institutes of Health plan to determine whether elevated blood sugar during pregnancy, a less-severe condition than gestational diabetes, influences later levels of body fat in children and development of diabetes in mothers after giving birth.

The original study, the Hyperglycemia and Adverse Pregnancy Outcomes (HAPO), looked at 23,316 mother-child pairs and found that a mother's blood sugar levels, even short of diabetes, were associated with her newborn's birth weight and body fat.

The HAPO-Follow-up Study (HAPO-FUS) seeks to recruit 7,000 of the original HAPO mother-child pairs for a single visit to one of 10 of the original HAPO clinical centers. Mothers and children (now ages 8 to 12 years), will have their height, weight, blood pressure, body fat, blood sugar, insulin, and blood fats measured.

"The goal of this study is to determine the levels of blood sugar during pregnancy that are linked to increased body fat in the child, and to a mother's chances of developing diabetes 8 to 12 years after her pregnancy," said Mary Horlick, M.D., project scientist and director of the Pediatric Clinical Obesity Program at the NIH's National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK). NIDDK and NIH's Eunice Kennedy Shriver National Institute of Child Health and Human Development are jointly sponsoring HAPO-FUS.

Launched in 2000, the original HAPO study was funded by NIH and conducted at 15 clinical centers in nine countries. HAPO sought to determine whether high sugar levels, less severe than diabetes, were associated with adverse pregnancy and birth outcomes. The women underwent a 75-gram, 2-hour oral glucose tolerance test between the 24th and 32nd week of pregnancy.

In the first HAPO study, researchers also found that women with higher glucose levels also had an increased risk of needing a cesarean section. These results were found across the clinical centers and led an international panel of experts to recommend new diagnostic criteria for gestational diabetes, a form of diabetes that develops during pregnancy, in 2010. However, not all professional groups have adopted these proposed criteria.

"This research will help determine if these new lower blood sugar cutpoints effectively predict later type 2 diabetes in the mothers and overweight, obesity, and disorders of glucose metabolism in their offspring," said principal investigator, Boyd Metzger, M.D., Tom D. Spies Professor of Metabolism and Nutrition at the Northwestern University Feinberg School of Medicine, Chicago.

The HAPO-FUS clinical centers are:

- Northwestern University and Lurie Children's Hospital, Chicago
- Kaiser-Permanente Southern California Department of Research and Evaluation, Downey, Calif.
- Case Western Reserve University at Metro Health Medical Center, Cleveland
- The Hospital for Sick Children, Toronto
- Rajavithi Hospital, Bangkok
- The University of the West Indies, Bridgetown, Barbados
- Royal Victoria Hospital, Belfast, Northern Ireland
- The Chinese University of Hong Kong
- Royal Manchester Children's Hospital, Manchester, England
- Helen Schneider Hospital for Women, Petah Tikva, Israel

While research continues, the NIH's National Diabetes Education Program's (NDEP) campaign, It's Never Too Early... To Prevent Diabetes, encourages women who have had gestational diabetes to be tested for diabetes six to 12 weeks after their baby is born, eat smaller amounts of food to reach and stay at a healthy weight, and be active each day. Women with the following risk factors are more likely to develop gestational diabetes:

- Overweight or obese
- A strong family history of diabetes
- A previous diagnosis of gestational diabetes
- Being African-American, American Indian, Asian-American, Hispanic/Latino, or Pacific Islander

NDEP resources on gestational diabetes are available at <http://www.yourdiabetesinfo.org> or by calling toll-free 1-888-693-NDEP (1-888-693-6337).

The NIDDK, a component of the National Institutes of Health (NIH), conducts and supports research on diabetes and other endocrine and metabolic diseases; digestive diseases, nutrition and obesity; and kidney, urologic and hematologic diseases. Spanning the full spectrum of medicine and afflicting people of all ages and ethnic groups, these diseases encompass some of the most common, severe, and disabling conditions affecting Americans. For more information about the NIDDK and its programs, see <http://www.niddk.nih.gov>.



MATERNAL AND CHILD HEALTH ACCESS

1111 W. 6th St., Fourth Floor
Los Angeles, CA 90017-1800
Tel 213. 749.4261
Fax 213.745.1040
info@mchaccess.org

Please Post and Distribute

February 2013

Receptionist Bilingual - English/Spanish

Maternal and Child Health Access Project (MCHA) is seeking to fill an entry-level front office Receptionist position. MCHA is a non-profit community based organization with a mission of improving the health of low income women and families through advocacy, direct services, education and training. MCHA provides information, support and technical assistance to health and social service organizations, assists individual women to achieve healthy pregnancies and obtain quality health care for themselves and their families and educates policymakers and the general public to improve the health and social services systems for all low income women and families, and to benefit the entire community in which we live.

Qualifications:

- Bilingual (English-Spanish) required
- Two years clerical/receptionist experience
- Good “people skills” – ability to empathize with MCHA’s clients
- Knowledge of Windows-based computers and relevant software application; MS Office, Internet, and some graphics programs helpful
- Excellent verbal and written communication skills
- Detail-oriented, extremely responsible, organized and able to prioritize work assignments
- Interest in health care for women and children
- Own transportation - car and insurance – required

Responsibilities:

- Answer a multi-line phone console and direct calls to appropriate staff
- Take and relay accurate messages
- Interact with clients to provide information
- Be aware of staff movements in and out of the office daily
- Inventory, order and distribute agency office supplies
- Keep records, including filing, for various project systems
- Receive and sort mail and deliveries
- Assist with special events
- Other duties as arranged

| | |
|----------------------------------|--|
| Hours: | 40 hours weekly, must work 9 AM – 5 PM |
| Salary: | Competitive and includes health and dental benefits and parking. |
| Application deadline: | Until filled |
| Send cover letter and resume to: | Martin Garcia, Office Administrator/Information Technology Maternal and Child Health Access 1111 W. 6 th St., Suite 400 Los Angeles, CA. 90017-1800 FAX #: 213-745-1040 marting@mchaccess.org |

MCHA is an Equal Opportunity Employer.
Women and people of color are strongly encouraged to apply.



Infant Development Association of California
South Chapter

For Parents and Providers
**How To Make the Individual Program Plan (IFSP and IPP)
Work For You and Support Your Individual Program Plan**
Even if it hasn't until now . . .

This presentation explores some of the unique benefits of the Lanterman Act that impact the transition from your IFSP to your first IPP and IEP. We will walk through the rights and tools provided in the Act for your child. It is the intent of the Lanterman Act that your child's IPP includes the service and supports in your IEP and much more.

- Did you know that the IPP process delivers a full entitlement to each child based on the services and supports identified in their IPP?
- Did you know that if your child is under six years of age the Lanterman Act allows the regional center to authorize and pay for the services and supports they often imply are the responsibility of the school district or other generic agencies?
- Did you know that you have the right to make an audio recording of your child's IPP meetings?

We will explain how to use these and other tools in the law that are designed to support you and your child.

In recent years the legislation funding shortfalls and bureaucratic policies have chipped away at our precious legislation. Family members and advocates need to understand what is happening before we reach a "Tipping Point" – a point when all the power to make decisions through the IPP (and IFSP) process is in the hands of the state and regional centers.

Speakers:

Peter Bowers and Jim Stream, Volunteer Trainers and Keeping the Lanterman Promise Board Members

Where:

Braille Institute – 741 N. Vermont Avenue, Los Angeles, CA 90029
Free parking /resource materials /refreshments

When:

Thursday, February 28, 2013

Time:

8:30 am REGISTRATION and 9:00 am to Noon PRESENTATION

Registration Fee:

IDA Members - \$20.00 IDA Members and Non-IDA Members- \$25.00
Each Service Provider that registers themselves for the fees above can bring a Parent for FREE!

**Register by mail, fax or online at www.idaofcal.org
See attached form**



Pregnant women on Medi-Cal – maintaining their provider relationship

1. Assess current Fee-for-Service (regular) prenatal client for future managed care path.

Citizen or Legal Permanent Resident and:

- a. First baby OR
- b. Not first baby, but new applicant to Medi-Cal or WILL be family aid code either immediately or at six months of pregnancy
- c. Regardless of number of babies, on PE now – transition into 200% program or family aid code?

If you need help with this assessment, call MCHA.

2. Assess eligibility for Medical Exemption:

- a. Prenatal care provider does not take managed care
- b. MCHA maintains that even if provider takes managed care, if there is a need to stay in FFS for a specific hospital access, perinatologist specialty or other reason, we will file. Best to have the provider who DOES NOT take managed care file the MER.
- c. Remember ACWDL #11-39E: SUBJECT: MEDI-CAL MANAGED CARE ENROLLMENT – EXEMPTION FOR PREGNANT WOMEN TRANSITIONED FROM AID CODE 44 (RESTRICTED SERVICES) TO AID CODE 3N (FULL-SCOPE SERVICES) DURING THE LAST TRIMESTER OF PREGNANCY.

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c11-39E.pdf>

3. Prepare client – Medi-Cal Managed Care packet will arrive sometime around sixth month (ideally) of pregnancy. She MUST let you/your office know and work with her provider to file a Medical Exemption Request (MER) if provider:

- takes no managed care plans, OR
- does take managed care plans, but pregnant women needs to be in FFS situation for hospital, or other care contracting reason

4. When woman gets packet, file immediately for **Medical Exemption Request – HCO 7101 (12/00)**. For pregnancy, no ICD-9 codes are needed; box is shaded.

5. **Follow closely** so that women does not go beyond end of 2nd month after packet, into 1st of month default date
6. **Call HCO** (800-430-4263) if getting close to the default date and ask whether woman is showing remaining on FFS or not. She should remain on FFS until the MER is decided.
7. **If MER denied, file for a hearing BEFORE HER DEFAULT DATE if possible (phone call).** If she is defaulted and hasn't been told about her exemption request, this is basis for extending FFS. Again, she should not be defaulted pending this hearing date.
8. Hearings are by telephone. **Client should request an in-person hearing (number on hearing information letter sent when she gets her hearing date).** It is better to go with her and provide representation, or even if she goes by herself, in person than on the phone. Everyone has a right to an in-person hearing.
9. Via a HIPAA-compliant form, i.e. that you have the right to request with/for the woman, ask for information about her denial (see form example). This information is valuable in preparing for her eventual hearing, after you get the information.
10. If information is not sent, follow up with letter asking about it (MCHA has example to send you).
11. With information about her case, and a statement from provider about her need to stay with that provider, attend hearing with woman or have someone go with her for support. MCHA MAY be able to help.

LET MCHA KNOW YOUR EXPERIENCE/RESULTS: (213) 749-4261 – Celia, Liz, DD, Lynn

Info@mchaccess.org

February, 2013

REQUEST FOR MEDICAL EXEMPTION FROM PLAN ENROLLMENT

Each area of the Request For Exemption From Plan Enrollment form must be completed.

If not, the medical exemption will be denied – **Please Print or Type (Ink Only)**

To Be Completed and Signed By Beneficiary
Part I

| | | | | | |
|---|------------|--|---|--|---------------------------------|
| 1. Name: (Please Print) _____ | | | 2. Benefits Identification Card Number: _____ | | |
| Last Name | First Name | | M.I. | | |
| 3. Date of Birth: ____/____/____ Month Day Year | | | 4. Check One: <input type="checkbox"/> Female <input type="checkbox"/> Male | | 5. Medi-Cal ID Number: _____ |
| 6a. Are you a member of a health Plan? <input type="checkbox"/> Yes (go to box 6b) <input type="checkbox"/> No (go to box 7a) | | 6b. Plan Name: _____ | | 6c. Plan Membership Number: _____ | |
| 7a. Is someone other than the beneficiary completing this section? <input type="checkbox"/> Yes (go to box 7b) <input type="checkbox"/> No (go to box 8) | | 7b. If yes, please provide the following information: _____ Print Name Relationship Phone Number | | | |
| 8. I am requesting that Dr. _____ send in a request for a Medi-Cal Managed Care medical exemption for me. Name of Doctor | | | | | |
| 9. Beneficiary's Signature: _____ Signature of beneficiary or Parent of beneficiary if a minor child | | | | 10. Date Signed: ____/____/____ Month Day Year | |
| This information is requested by the Department of Health Care Services, Medi-Cal Managed Care Division, under Title 22, California Code of Regulations, Sections 53887 or 53923.5, in order to comply with requirements of continuing with Fee-for-Service medical care. Completion of this form is mandatory for an exemption. Not completing this form could result in enrollment in a Managed Care health plan. For help with this form, please call Health Care Options at (800) 430-4263. This call is free. | | | | | |

Physician's Certification For Medical Exemption
Part II

The beneficiary's rendering physician MUST fill out AND SIGN this section.

For State Use Only:

Approved:
Denied: Initials: _____
Deferred: Date: _____

| | | | |
|---|---|---|-----------------|
| 11. Date you started treating beneficiary for one of the conditions listed below in box 13: ____/____/____ Month Day Year | | 12. Estimated date of completion of treatment or therapy for condition requiring exemption: ____/____/____ Month Day Year | |
| <i>For state use only:</i> | 13. Please check the following as appropriate (ICD-9-CM code must be included in column 14 at right, or the exemption will be considered incomplete and returned.) | | 14. ICD-9 Codes |
| P | <input type="checkbox"/> A. Pregnant and currently under your care for the pregnancy. Due Date _____ | | |
| F | <input type="checkbox"/> B. HIV+ or has been diagnosed with AIDS | | 1. 2. |
| D | <input type="checkbox"/> C. Receiving chronic renal dialysis treatment under your supervision | | 1. 2. |
| E | <input type="checkbox"/> D. Undergoing one of three transplant classifications (see item 13-D on page 4) Classification: _____ Medi-Cal designated transplant center: _____ | | 1. 2. |

PART II – To Be Completed and Signed By Beneficiary’s Rendering Physician

Dear Medi-Cal Physician: If you are **currently** providing medical services to the Medi-Cal beneficiary identified in Part I and who has one of the conditions or reasons for a medical exemption listed in Box 13 of this page AND you are NOT affiliated with any Medi-Cal Managed Care health plans in the county of residence of the beneficiary, you may be able to continue providing services to the individual. The beneficiary must request a medical exemption, and you and the beneficiary must fill out this form, sign it, and mail or fax it (Part I and Part II) to the Health Care Options office (see mailing address and fax number at the bottom of Part II). Please refer to Title 22, California Code of Regulations, Sections 53887 or 53923.5, for additional information concerning requirements for medical exemptions.

This exemption is valid until the date you indicate the individual will be stabilized enough to allow enrollment in a Medi-Cal Managed Care health plan or the condition is resolved. An exemption can be requested for a maximum of 12 months. An extension may be requested at the end of 12 months by submitting a new exemption form.

Instructions for completing Boxes 13-D through 13-I (and 14):

Item 13-D

Please list on the line provided which of the following transplant situations is relevant. Please specify the Medi-Cal designated transplant center involved in the evaluation, transplant procedure or current follow-up. Please specify ICD-9 code for organ transplanted/to be transplanted and any codes for complications in box 14. *(Please note: this exemption does not apply to beneficiaries who are medically stable on post-transplant therapy.)*

Transplant classifications:

- Beneficiary is under active evaluation for the need for an organ transplant
- Beneficiary has been approved for and is awaiting an organ transplant
- Beneficiary has received a transplant and is currently either immediately post-operative or exhibiting significant medical problems related to the transplant performed.

Item 13-E

The type of therapy must be described on the line provided, and both the start date and the expected duration of therapy must be listed in boxes 11 and 12. *Beneficiaries in long-term remission without signs of disease or who are classified as “cured” are not eligible for medical exemption.*

Cancer classifications:

- Beneficiary has been diagnosed with cancer and is currently receiving chemotherapy or radiation therapy or another course of accepted therapy for cancer
- Beneficiary has been approved for such therapy and is awaiting initiation of approved therapy

Item 13-F

Please check this item if beneficiary has been approved for and is awaiting a major surgical procedure, **including surgery for cancer.**

List both ICD-9 (in box 14) and appropriate CPT code(s) for pending procedure(s) on the line provided. If beneficiary is immediately post-operative, estimate duration of time necessary for recovery under your supervision in box 12.

Item 13-I (and all box 14 ICD codes)

The ICD-9 code must be listed in box 14, and the treatment must be stated on the line provided.

Please check this item if beneficiary has a complex and/or progressive disorder not covered above which requires ongoing medical supervision, such as:

- Cardiomyopathy
- Amyotrophic lateral sclerosis and/or has been approved for or is receiving ongoing complex medical treatment for the disorder, the administration of which cannot be interrupted

Part II Continued

| | | |
|---------------------------|--|-----------------|
| <i>For state use only</i> | | 14. ICD-9 Codes |
| C | <input type="checkbox"/> E. Undergoing one of two cancer classifications (see item 13-E on the reverse side). Classification: _____ Type of Therapy: _____ | 1. 2. |
| | | |
| G | <input type="checkbox"/> F. Has been approved for and is awaiting a major surgical procedure (see item 13-F on the reverse side). CPT code(s) for pending procedure(s): _____ | 1. 2. |
| | | |
| A | <input type="checkbox"/> G. Has a complex neurological disorder, such as multiple sclerosis | 1. 2. |
| | | |
| B | <input type="checkbox"/> H. Has a complex hematological disorder, such as hemophilia or sickle cell disease | 1. 2. |
| | | |
| M | <input type="checkbox"/> I. Has other complex and/or progressive disorder not covered above which requires ongoing medical supervision (See item 13-I on the reverse side). Describe treatment: _____ | 1. 2. |
| | | |

Please note that chronic disorders, such as asthma and diabetes, do not generally constitute grounds for approval as a medical exemption. Providers who believe that the severity of such a condition, or any other condition or combination of conditions, is/are sufficient to require a medical exemption should attach to this form additional medical documentation to establish the necessity for an exemption. Please include the beneficiary's Medi-Cal identification number and Benefits Identification Card Number on each page of medical documentation submitted.

| | |
|---|--|
| 15. Beneficiary's Benefits Identification Card Number _____ | 18. Medi-Cal Provider: Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ FAX: _____ |
| 16. Are you affiliated with any Medi-Cal Managed Care health plan(s) in the beneficiary's county of residence? <input type="checkbox"/> Yes _____ <small>Print the name of health plan</small> <input type="checkbox"/> No | 19. Medi-Cal Billing Information: (If different from box 18 above.) Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ FAX: _____ |
| 17. Physician National Provider Identification Number used to bill the Medi-Cal Program for this beneficiary: _____ | |

I have read this form and certify that the information I have provided on this form is correct. I also understand that the Department of Health Care Services may audit this form to determine if I am affiliated with a Medi-Cal Managed Care health plan(s) and/or to determine whether the Medi-Cal beneficiary's listed medical condition constitutes grounds for a medical exemption.

| | |
|---|--|
| 20. Rendering Physician's Medical License Number: _____ | 21. If you are NOT affiliated with any Medi-Cal Managed Care health plan(s) in the beneficiary's county of residence, you MUST complete this box. If you are affiliated with any Medi-Cal Managed Care health plan(s) in the beneficiary's county of residence, please make sure boxes 18 and 19 are complete. Rendering Physician's Phone number: _____ FAX: _____ |
|---|--|

| | |
|---|---|
| 22. Signature: _____ (No Stamp) <small>(Authorized Rendering Medical Physician)</small> | 23. Date Signed: _____ <small>Month / Day / Year</small> |
|---|---|

MAIL COMPLETED FORM to: **Health Care Options** or FAX this form to: **(916) 364-0287**
P.O. Box 989009
West Sacramento, CA 95798-9850

INSTRUCTIONS FOR COMPLETING REQUEST FOR MEDICAL EXEMPTION FROM PLAN ENROLLMENT

PART I – To Be Completed and Signed By Beneficiary

Dear Medi-Cal Beneficiary: You and/or your family is now or may soon be required to receive your health care through a Medi-Cal Managed Care health plan. You may be seeing a doctor who is not part of a health plan. If you want to keep seeing this doctor, you may qualify for what is called a **medical exemption**. To receive a **medical exemption**, you must be seeing your doctor for something serious, and your doctor must NOT be a part of a health plan in the county where you live.

If you want to ask for a **medical exemption**, you must fill out Part I of this form. Please sign it and give it to your doctor. Your doctor will fill out and sign Part II of this form. If your request for a **medical exemption** is approved, you will NOT have to join a Medi-Cal Managed Care health plan for the time being. You can remain on regular Medi-Cal (non-managed care) and keep seeing your current doctor for up to 12 months. (In some cases, the exemption will be for fewer months. Your doctor will decide this). If you need another medical exemption after your exemption period is over, you and your doctor must fill out and sign a new exemption form.

All information in this medical exemption form will be kept confidential. This information will only be used by the Medi-Cal program, its employees, and contractors.

If you have any questions regarding this form, please call Health Care Options at (800) 430-4263.

INSTRUCCIONES PARA COMPLETAR LA CERTIFICACION DE EXENCION DE ATENCION MEDICA DE LOS PLANES ADMINISTRADOS DE MEDI-CAL

Primera Parte - Para Ser Completado y Firmado Por el Beneficiario.

Estimado Beneficiario de Medi-Cal : Usted o su familia estan ahora o pueden requerirse que pronto recivan su cuidado de salud a través de un plan de Medi-Cal por Managed Care. Usted puede estar viendo a un doctor que no es parte de un plan de salud. Si usted quiere seguir viendo a este doctor, usted puede calificar para lo que se llama una exención médica. Al recibir una exención médica, usted debe estar viendo a su doctor para algo serio, y su doctor no debe de participar en uno de los planes de Managed Care en el condado donde usted vive.

Si usted quiere pedir una exención médica, usted debe completar la primera parte de esta forma. Por favor fírmelo y dáselo a su doctor. Su doctor completara la segunda parte de esta forma. Si su peticion para una exención médica es aprovada, usted no tendrá que afiliarse en un plan de Medi-Cal Managed Care por el momento. Usted puede permanecer en Medi-Cal regular (sin plan de salud) y seguir viendo a su actual doctor hasta por 12 meses. (En algunos casos, la exención sera por menos meses. Su doctor decidirá esto.) Si usted necesita otra exención médica después de que su periodo de la exención haya terminado, usted y su doctor deben completar y firmar una nueva forma de exención.

Nos gustaria informarle que toda la información en esta forma de la exención médica se mantendra confidencial. Esta información sólo será usada por el programa de Medi-Cal, sus empleados, y contratistas.

Para mas informacion por favor llame a Health Care Options al (800) 430-3003 esta llamada es completamente gratis.

CONFIDENTIAL

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

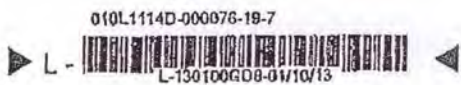


P.O. Box 989009

West Sacramento, CA 95798-9850

*** IMPORTANT INFORMATION ABOUT YOUR MEDI-CAL ENROLLMENT***

January 10, 2013



Example - denial of MER



RE:

130100GD8/480575

Dear

Your request for an exemption from enrollment in a Medi-Cal managed care health plan has been denied. The reason for this denial is listed below (Reference: California Code of Regulations, Title 22, Section 53887 or 53923.5)

- Your medical condition does not qualify for a medical exemption. This decision is based on the information sent to us by your doctor.

Note: This denial does not change your Medi-Cal eligibility. You can still get all Medi-Cal services that are medically needed.

You must enroll in a Medi-Cal managed care health plan because you do not qualify for an exemption. If you are already in a Medi-Cal managed care health plan, you do not need to do anything. If you are not in a Medi-Cal managed care plan, in about 30 days you will receive information telling you how to enroll. The packet will have the information you need to choose a Medi-Cal managed care health plan.

FOR HELP ENROLLING IN A MEDI-CAL PLAN: Call Health Care Options at 1-800-430-4263 from 8:00 AM to 5:00 PM Monday through Friday if you need help enrolling in a Medi-Cal managed care health plan.

SEE YOUR DOCTOR ABOUT YOUR MEDICAL CONDITION: Once you are in a Medi-Cal managed care health plan, please see your plan doctor about your medical condition. If you are already in a Medi-Cal managed care health plan, be sure your doctor knows about your medical condition.

FOR HELP WITH YOUR MEDI-CAL PLAN: If you need help getting care from your Medi-Cal managed care health plan, call the plan's member services department. You can also call the Office of the Ombudsman at 1-888-452-8609 from 8:00 AM to 5:00 PM Monday through Friday.

YOUR RIGHT TO A STATE HEARING: You have the right to ask for a State Hearing about this denial. (Welfare and Institutions Code Section 10950 and California Code of Regulations, Title 22, Section 50951).

You must ask for a State Hearing within 90 days from the date of this notice. You can ask for a State Hearing even if you have filed a grievance with your health plan.

To ask for a State Hearing, write:
California Department of Social Services
State Hearings Division
P.O. Box 944243; MS 19-37
Sacramento, CA 94244-2430

You also can ask for a State Hearing by calling 1-800-952-5253 from 8:00 AM to 5:00 PM Monday through Friday. This number can be very busy. You may get a message asking you to call back later. (If you have trouble hearing or speaking, call TDD 1-800-952-8349). This call is free.

If you ask for a State Hearing in writing, please include:

- Your name
- Person asking for a State Hearing
- Your Medi-Cal Benefits Identification Number
- Your address
- Your telephone number
- Reason you are asking for a State Hearing
- Language or dialect (in case you need an interpreter)
- Name, address, and telephone number of your authorized representative

If you ask for a State Hearing, the State Hearing Office will set up a file. You and/or your authorized representative have the right to see this file.

You can represent yourself at the State Hearing or have someone else represent you. For information about how to get free legal help, call the California Department of Social Services at 1-800-952-5253 from 8:00 AM to 5:00 PM Monday through Friday. You can also call your local County Bar Association for a list of organizations that give free legal help.

Sincerely,

California Health Care Options
1-800-430-4263

CONFIDENTIAL

IDENTIFYING INFORMATION

COPY OF IDENTIFICATION ATTACHED

TYPE _____ (CA DRIVER'S LICENSE, CA DMV
IDENTIFICATION CARD, BIRTH CERTIFICATE, BENEFITS IDENTIFICATION CARD,
MANAGED CARE CARD, STATE OR FEDERAL EMPLOYEE ID CARD)

NUMBER _____

**IF NO IDENTIFICATION IS ATTACHED, YOUR SIGNATURE MUST BE
NOTARIZED.**

NOTARIZED BY _____

ON _____ (DATE)

NOTARY PUBLIC NUMBER _____

NOT OFFICIAL UNLESS STAMPED BY NOTARY PUBLIC

PERSONAL REPRESENTATIVE INFORMATION

WHAT LEGAL AUTHORITY DO YOU HAVE TO MAKE MEDICAL DECISIONS FOR THE

- | | |
|--|---|
| <input type="checkbox"/> PARENT | <input type="checkbox"/> CONSERVATOR |
| <input type="checkbox"/> GUARDIAN | <input type="checkbox"/> EXECUTOR OF WILL |
| <input type="checkbox"/> MEDICAL POWER OF ATTORNEY | <input type="checkbox"/> OTHER |

NOTE: ATTACHING LEGAL DOCUMENTATION IS REQUIRED TO VERIFY THAT YOU
ARE THE PARENT, CONSERVATOR, GUARDIAN, EXECUTOR OF A DECEDENT'S WILL,
OR HAVE MEDICAL DECISION-MAKING AUTHORITY FOR THE INDIVIDUAL.



PHFE WIC Program
12781 Schabarum Avenue
Irwindale, CA 91706
(626) 856-6650

Dear Medical Provider,

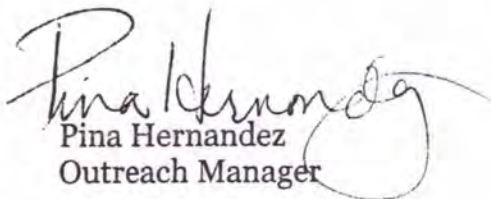
The PHFE-WIC has important information to share with you. In order to better serve our participants we are changing our hours of operation at our WIC centers. In March 2013, we will have new hours and PHFE WIC is in the process of delivering supplies to all our providers with the new hours of operation.

In addition, we would like to share that all Healthy Families will be converting to the Medi-Cal Program in the next months. **Many of the families will now be eligible for the WIC program and may not know they are eligible.** We are asking that you please:

- Inform your patients of the change in hours by having them call **888 942-2229**.
- Refer all Medi-Cal families to the WIC program

We thank you for supporting PHFE WIC by referring all Medi-Cal families to the WIC program. If your office does not have the new maps with our new hours, please have your families call us. For questions or concerns, please call me at 626 856-6618, ext. 260.

Regards,


Pina Hernandez
Outreach Manager

Mission Statement

To nourish, educate, support and empower our clients and ourselves.