Resources & Health Care Program Alternatives

oneeapp
One Stop Access to Health Care

What can I do for a child, teen or family member that does not qualify for Full Scope Medi-Cal or Healthy Families?

- Is the child under 5 years of age? Enrollment is still open in the Healthy Kids program for children who are 5 1/2 and younger. You can call **(888) 452-5437** for more information.
- Does the child's family have an open, active case with Kaiser Child Health Plan for another sibling? If so, you can add a child that is not currently enrolled. You can call **(800) 464-4000** for more information.
- Does the child or family member have an urgent need for health care? Refer to LA County Department of Health Services or a Public Private Partnership program, depending on need. For urgent or ongoing care, LAC/DHS and PPPs should have free, a sliding scale or low-cost (for some PPP's) health care. If the family is under 133 1/3 % of poverty, the child or family member may be eligible for free coverage under ORSA – (Outpatient Reduced-Cost and Simplified Application) or the PPP's free services if under 133 1/3% of poverty. You can call **(800) 427-8700** to locate a LA County location or a PPP provider.
- Is the child within the Child Health and Disability Prevention Program (CHDP) schedule of visits or is a problem suspected or a visit needed outside the schedule for sports physical or foster care exam? See **http://www.dhs.ca.gov/pcfh/cms/chdp/**. If so, the child can get up to two months full Medi-Cal if s/he does not already have Restricted (sometimes called Emergency) Medi-Cal. During that time, it is possible to receive care for even longer by applying for ongoing coverage. To find a CHDP provider you can call toll-free (800) 993-CHDP.

CHDP Periodicity (schedule of visits):

Less than 1 month of age	9 months of age	2 years of age	9-12 years of age
2 months of age	12 months of age	3 years of age	13-16 years of age
4 months of age	15 months of age	4-5 years of age	17-20 years of age
6 months of age	18 months of age	6-8 years of age	

- For citizen/Qualified Immigrant children, has the parent's income been correctly determined? (deductions, countable/noncountable income, sibling income, stepparent issues) You want to be sure the child is not actually under 250% of poverty and thus eligible for Healthy Families.

- Is it possible the family member is "PRUCOL" (a Medi-Cal category) and thus eligible for full-scope Medi-Cal? The most likely reason is that his/her immigration status is being adjusted; the family has applied for Legal Permanent Residency (LPR or "green card") or in some other way is adjusting the child's status. For more information on PRUCOL you can call The Health Consumer Center of Los Angeles at **(800) 896-3203**.

- Does the child or family member have an urgent need that may be considered an emergency? If so, s/he may be able to use Restricted or Emergency Medi-Cal, regardless of immigration status. Children who have Restricted Medi-Cal will not be able to get full-scope Medi-Cal from the CHDP Gateway, but are still eligible for a CHDP exam and immunizations.

- Is the child or teen in need of confidential services for family planning, pregnancy, rape treatment, exam or treatment for a possible Sexually Transmitted Infection, outpatient mental health care, or alcohol or drug abuse services? S/he may be eligible for Minor Consent Medi-Cal if living in the parents' home; the parents' income will not count, immigration status does not matter, and parental consent is not required. Call the Department of Public Social Service Central Help Line at (877) 481-1044 to locate an office to apply.

- Is the teen or family in need of confidential health education, reproductive health services such as family planning, emergency contraception, or a gynecological exam, HIV and other STI screening, available from the Family PACT program? Call (800) 942-1054 or see **www.dhs.ca.gov/pcfh/ofp/Programs/FamPACT/default.htm** to locate a provider.

- Does the child have a serious or chronic medical condition? Immigrants ineligible for regular Medi-Cal and Healthy Families are still eligible for health care for serious and/or chronic medical conditions from California Children's Services (CCS), services from Regional Centers, mental health care, etc., in addition to Medi-Cal emergency services, Minor Consent Medi-Cal, and FamPACT. See the Health Consumer Center's brochure at **http://www.healthconsumer.org/publications.htm.** To make a referral to CCS, or for more information on the program, call **(800) 288-4584**.

- **Access for Infants and Mothers (AIM): 1-800-433-2611**
  http://www.aim.ca.gov/english/AIMHome.asp

  AIM provides health coverage for pregnant women who are less than 30 weeks pregnant at the time their application is accepted. The mother's immigration status does not matter. **This program is for pregnant women who do not qualify for free Medi-Cal for pregnancy.**

Medi-Cal and Deemed Eligibility for Newborns

A Medi-Cal application usually requires completing an application form and providing verification such as proof of income. But for babies whose mothers had Medi-Cal at the time of delivery, there's a "shortcut" for enrollment for the first year of life *without* any of the usual paperwork.

Infants born to teens or women who were receiving Medi-Cal at the time of the birth and who live with their mothers during the birth month. These infants are "**deemed eligible**" for "full-scope" Medi-Cal for the first year of life.

Minor Consent Medi-Cal moms are treated just like infants of moms with other kinds of Medi-Cal: they are "deemed eligible" for full-scope Medi-Cal until the first birthday if they live with the mom in the birth month.

Reminder: Newborns are automatically covered for full-scope Medi-Cal under the mother's Medi-Cal card and number during the birth month and the month after. This gives families a little breathing room to inform the County that the baby has been born so that the County can issue a separate Medi-Cal card and number for the newborn.

What is the process for enrolling a "deemed eligible" infant into Medi-Cal using the shortcut?

The most direct way is to contact the mother's Eligibility Worker, preferably by phone. If the client does not know who his/her Eligibility Worker is they can call (877) 481-1044 to find out.

You also have the option of faxing or mailing a MC 330, Newborn Referral Form (attached in Spanish and English) to the County. You can use the attached copy to fax or download form at:
http://www.dhcs.ca.gov/formsandpubs/forms/Pages/MCEBbyNumber.aspx

FAX TO: (213) 763-8666

State of California—Health and Human Services Agency

Department of Health Services

NEWBORN REFERRAL
(NOT AN APPLICATION FOR MEDI-CAL)

(PLEASE USE INK AND PRESS FIRMLY.)

The Newborn Referral Form is used to assist a Medi-Cal eligible mom to report the birth of her child(ren) to Medi-Cal. By completing the information on this form, you help the county confirm the eligibility of the newborn. Mail or fax this form to the county. County information is located on the back of this form. Any changes to the household must be reported to the county, so, turn in this information quickly. The mother may also report the birth by phone to her eligibility worker. If you are acting on behalf of the mother and are not a spouse, relative, or guardian, then your signature and identifying information is required in Section C. If entering through Gateway Program enter the BIC number assigned to the infant ***(optional).***

SECTION A *The mother's Medi-Cal card can be used during the birth month and the month following for services and billing for the newborn.*

Mother's name (first, MI, last)		Mother's date of birth	BIC or Medi-Cal ID number or SSN
Mailing address (number and street) or location			County
City	State	ZIP code	Telephone number ( )

SECTION B **Reminder:** *A child born to a mother with restricted benefits is eligible for full-scope benefits.*

Newborn name (first, MI, last)	Date of birth (month/day/year)	Gender ☐ Male ☐ Female	*Optional*—Gateway ID number
Newborn **2** name (first, MI, last)	Date of birth (month/day/year)	Gender ☐ Male ☐ Female	*Optional*—Gateway ID number
Newborn **3** name (first, MI, last)	Date of birth (month/day/year)	Gender ☐ Male ☐ Female	*Optional*—Gateway ID number

Where born (hospital name, clinic name, etc.)

Address (number and street, if available)	City	State	ZIP code

Will baby and mother live in the same household? ☐ Yes ☐ No

If no, has the mother given up rights to the newborn child? ☐ Yes ☐ No

If yes, date child(ren) given up: _____/_____/_____

This form does not start Medi-Cal, CalWORKs, or Food Stamp benefits. If you currently get these benefits, you must contact your eligibility worker to continue getting these benefits.

I hereby authorize release of this information to the County Department of Social Services/county welfare department.

Date of request	Parent/Relative/Guardian (of the infant) signature ⊠

SECTION C *(Fill in this section if form was completed by person other than parent, relative, or guardian.)*

Completed by **(PLEASE PRINT)**	Title
Medi-Cal ID number (If Medi-Cal provider/hospital/clinic/group, etc.)	Telephone number ( )

I certify to the best of my knowledge that the information above is verified and accurate.

Signature (person other than parent, relative, or guardian) ⊠	Date completed

For provider billing inquiries concerning or how to bill for infants, call the EDS Billing Hotline at 1-800-541-5555.

Distribution: *White—County* *Yellow—Hospital/Clinic/Nurse-Midwife/CAA/AR* ☐ *Pink—Parent/Relative/Guardian*

MC 330 (7/03)

State of California—Health and Human Services Agency

Envie Por Fax Al: (213) 763-8666

Department of Health Services

FORMULARIO DE INFORMACIÓN DE RECIÉN NACIDOS
(NO ES UNA SOLICITUD PARA RECIBIR MEDI-CAL)

(Por favor use una pluma e imprima firmemente)

Este Formulario De Información De Recién Nacidos es para asistirle a la madre elegible para Medi-Cal reportar el nacimiento de su bebé(s) a Medi-Cal. Completando la información en este formulario, usted ayuda al condado a confirmar la elegibilidad del recién nacido. Envíe por correo o fax este formulario al condado. La información del condado se encuentra al reverso de este formulario. Cualquier cambio en el hogar tiene que ser reportado al condado, por eso, envíe esta información lo más pronto posible. La madre también puede reportar el nacimiento por teléfono a su trabajador de elegibilidad. Si usted está actuando en representación de la madre y no es esposo, familiar o tutor, entonces su firma e información de identificación son requeridas en la Sección C. Si está entrando por medio del Programa Gateway escriba el número del BIC asignado al bebé. ***(Opcional)***

SECCIÓN A *La tarjeta de Medi-Cal de la madre se puede usar durante el mes de nacimiento del bebé y el mes siguiente para servicios y cobros del recién nacido.*

Nombre de la madre (nombre, inicial de en medio, apellido)		Fecha de nacimiento de la madre	BIC o Identificación de Medi-Cal o N. del Seguro Social
Dirección postal (número y calle) o ubicación			Condado
Ciudad	Estado	Código postal	Número de teléfono ( )

SECCIÓN B ***Recordatorio:*** *Un bebé nacido a una madre con beneficios limitados es elegible para beneficios completos.*

Nombre del recién nacido	Fecha de nacimiento (mes/día/año)	Sexo ☐ Niño ☐ Niña	*Opcional*—Número de Gateway
Nombre del recién nacido #2	Fecha de nacimiento (mes/día/año)	Sexo ☐ Niño ☐ Niña	*Opcional*—Número de Gateway
Nombre del recién nacido #3	Fecha de nacimiento (mes/día/año)	Sexo ☐ Niño ☐ Niña	*Opcional*—Número de Gateway

Lugar de nacimiento (nombre del hospital, nombre de la clínica, casa, etc.)

Dirección (número y calle, si es disponible)	Ciudad	Estado	Código postal

¿El bebé y la madre vivirán en el mismo hogar? ☐ Sí ☐ No

Si su respuesta es no, ¿Ha renunciado la madre a sus derechos sobre el recién nacido? ☐ Sí ☐ No

Si es así, de la fecha de renuncia: _____/_____/_____

Este formulario no inicia los beneficios de Medi-Cal, CalWORKs o Estampillas de Comida. Si usted ahora está recibiendo estos beneficios, tiene que llamar a su trabajador de elegibilidad para que continúe recibiendo estos beneficios.

Autorizo la entrega de esta información al Condado del Departamento de Servicios Sociales/condado del departamento de bienestar.

Fecha de petición	Firma del padre/madre/pariente/tutor del niño ⊠

SECTION C *(Fill in this section if form was completed by person other than parent, relative, or guardian.)*
SECCIÓN C *(Llene esta sección si este formulario fue completado por otra persona además de un padre, familiar o tutor.)*

Completed by **(Please print)** / *Completado por* ***(Por favor escriba en letra de molde)***	Title / *Título*
Medi-Cal number (if Medi-Cal provider/hospital/clinic/group, etc.) / *Número de Medi-Cal (sí es completado por el proveedor de Medi-Cal/hospital/clinica/grupo, etc)*	Telephone number / *Número de teléfono* ( )

I certify to the best of my knowledge that the information above is verified and accurate.
Certifico al mejor de me conocimiento que la información arriba es verificada y exacta.

Signature (person other than parent, relative, or guardian) / *Firma (otra persona que no sea un padre, familiar o tutor)* ⊠	Date completed / *Fecha en que se completó este formulario*

For provider billing inquiries concerning or how to bill for infants, call the EDS Billing Hotline at 1-800-541-5555.

Distribution: *White—County* *Yellow—Hospital/Clinic/Nurse-Midwife/CAA/AR* ☐ *Pink—Parent/Relative/Guardian*

MC 330 (SP) (7/03)

According to our Department of Public Social Services, some 60% of the denied Medi-Cal applications for children that arrive in Los Angeles monthly either already have Medi-Cal or already have started the process to apply. Duplicate submissions waste resources that could be used to help more children with enrollment and finding health care.

Healthy Families

Healthy Families will only answer questions from the CAA who originally helped the client, until the application is accepted or denied, or that person him/herself (the parent or teen). If you are not the original assistor, it may be necessary to have the client on the phone, in person or with a three-way phone call, or have client sign a Authorized Representative form that can be faxed. You can download one at http://www.healthyfamilies.ca.gov/English/download.html

Call (800) 880-5305 to find out about the status of an application or an existing or previous case.

Healthy Kids

If the applicant thinks she or he might have an open Healthy Kids case, call LA Care at (888) 452-5437 for assistance.

Medi-Cal

The following pages contain resources to help you screen clients for any open Medi-Cal case.

Certified Application Assistor (CAA) Questionnaire
Medi-Cal Benefits Screening Tool

Ask your clients the following questions before filing out the MC 321, Joint Medi-Cal/Healthy Families application.

		Yes	No
1)	**Are you receiving cash (CalWORKs) benefits?** If yes, as a recipient of CalWORKs, the client is entitled to receive Medi-Cal. Ask the client for his/her BIC. If the client never received one, check eligibility.*	☐	☐
2)	**Are you receiving Supplemental Security Income (SSI)?** If yes, as a recipient of SSI, the client is entitled to receive Medi-Cal. Ask the client for his/her BIC. If the client never received one and/or needs a replacement BIC, he/she can request one from any Department of Public Social Services (DPSS) office by presenting his/her award letter to the SSI Liaison.	☐	☐
3)	**Do you have a Benefits Identification Card (BIC)?** If yes, then check eligibility on MEDS, AEVS, SAEVS or with the client's Eligibility Worker. If the client needs a replacement card, he/she can call his/her Eligibility Worker to request one. If the client does not know his/her Worker, he/she can call the Los Angeles County Health & Nutrition Hotline at 1(877)597-4777.	☐	☐
4)	**Are you enrolled in a health plan or HMO such as Health Net or Care First?** If yes, ask the client if he/she has a BIC and check eligibility.* Ask if the client has a health plan card and if yes, explain to them how managed care works. To use dental benefits, the client needs to show a BIC, not a health plan card.	☐	☐
5)	**Have you or your children received medical treatment or dental care anywhere recently?** If yes, how did the client pay for these services or is the client receiving bills? Did the client fill out any paperwork at a county or other facility? Ask the client to bring any paperwork he/she has. Help the client to address any bills and obtain retroactive Medi-Cal if needed and if eligible.	☐	☐
6)	**Have your children received free immunizations?** The child may have been put through the CHDP Gateway. Did the client receive a BIC? Check eligibility.* The child may need to fill out the joint Medi-Cal/Healthy Families application to finish the application process.	☐	☐

		Yes	No
7)	**Are there other children in the household already receiving aid?** If yes, the client and/or other children may be able to be added onto an existing case. Check eligibility. *	☐	☐

If the applicant answers "Yes" to any of the above mentioned questions, he/she may already be receiving Medi-Cal benefits. Additionally, if the application is for a newborn, determine if a Newborn Referral (MC 330) should be completed instead of the Joint Medi-Cal/Healthy Families Application (MC 321 HFP).

***Ways of checking eligibility:**

1. **Medi-Cal Eligibility Data System (MEDS)**
   This State system is used by Los Angeles County DPSS Eligibility Workers; at provider offices and hospitals; at county clinics and hospitals; and at the health departments in the cities of Long Beach and Pasadena.

2. **Automated Eligibility Verification Systems (AEVS)**
   Non-providers can apply to get a PIN number to check eligibility via the telephone. To obtain an application for AEVS call (916) 552-9492. AEVS will not work, however, unless the client has Medi-Cal. In addition, AEVS does not have information for "pending" Medi-Cal.

3. **Supplemental Automated Eligibility Verification System (SAEVS)**
   Non-providers can access a temporary PIN number which is good for 24 hours only. Non-providers can request a PIN every day if needed.
   - Call 1(800) 541-5555 Monday – Friday from 8:00 a.m. to 5:00 p.m.
   - Press option 11, 16, 16
   - Request a temporary PIN number for non-provider
   - EDS will ask for first name, first letter of last name and agency telephone number
   - You will be issued a five-digit number that is good for 24 hours only. However, depending, when you call it may be good for a few hours only until midnight
   - To check eligibility, call 1(800) 541-5555
   - Press option 11, 16, 15, 2
   - Verify PIN number
   - Press 1 for eligibility, enter the recipient ID # and press #
   - Press 2 for Share of Cost (SOC) clearance

4. **Calling DPSS Eligibility Workers**
   Have the client contact his/her Medi-Cal or CalWORKs worker if a new/replacement BIC card is needed. The client may also call the Los Angeles County Health & Nutrition Hotline at 1(877) 597-4777.

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY
PETE WILSON, Governor

DEPARTMENT OF HEALTH SERVICES
714-744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320
(916) 657-2941

SEP 5 1995

Dear Organization:

BENEFIT ASSISTANCE TO MEDI-CAL BENEFICIARIES

When the Department of Health Services (DHS) transferred from the old paper Medi-Cal card to the new Beneficiary Identification Card, or plastic card, the fact that many other government agencies and even community-based civilian organizations provided assistance and/or benefits to welfare recipients in general, and Medi-Cal recipients in particular were not recognized; therefore, many of those organizations are now having problems in verifying eligibility for their clients. These organizations used the paper Medi-Cal card as a quick means of verifying eligibility for various community benefits. DHS completed implementation to a one-time issue plastic card September 1, 1994.

Due to confidentiality laws and regulations, these organizations are legally barred from access to the Medi-Cal Eligibility Data System (MEDS) or any other present means to verify the client's current eligibility. Until now, the organizations had to rely on the client or call the county welfare office to verify eligibility.

With the assistance of Electronic Data Systems, DHS can now provide these organizations with a modified version of the Automated Eligibility Verification Systems (AEVS) which is a voice response system that will enable you to perform eligibility verification transactions for Medi-Cal and County Medical Services Program recipients using a touch-tone telephone. A copy of the Telephone AEVS User Guide is included with this letter as Enclosure No. 2. The AEVS service is provided at no cost to the user. The AEVS User Guide was developed for the use of Medi-Cal providers seeking billing information. Some information will not pertain to your organization. AEVS is available by using a touch-tone telephone between the hours of 2:00 A.M. and midnight, seven days a week.

With reference to page 100-54-2 of the enclosed User Guide for Telephone AEVS, the information you should have ready to enter using your touch-tone telephone when prompted by AEVS is your eight-digit PIN, the recipient's Medi-Cal ID number and the recipient's month and year of birth and the date the recipient's Medi-Cal card was issued. This information is required for each eligibility transaction.

The enrollment procedure to participate in AEVS consists of completion of the enclosed AEVS Enrollment Form which is included as Enclosure No. 1. You must provide all requested information. Once DHS receives the completed enrollment form, you will be issued a non-Medi-Cal provider number and a PIN number, which you must have to use AEVS.

If you have any questions, please contact ana.fellines@dhcs.ca.gov
Ana Fellines at (916)552-9507

Sincerely,

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Enclosures

Automated Eligibility Verification Systems (AEVS)
Enrollment Form

All non-providers intending to perform eligibility verification through AEVS must complete the Oath of Confidentiality and provide all other information as requested by this form.

- -

OATH OF CONFIDENTIALITY

As a condition of obtaining access to the Automated Eligibility Verification System maintained by the California Department of Health Services, I/we agree to not divulge any information obtained in the course of my/our assigned duties to unauthorized persons, and I/we agree not to publish or otherwise make public any information regarding persons receiving Medi-Cal services such that the persons who received such services are identifiable.

Access to such data shall be limited to personnel who require the information in the performance of their duties, and to such others as may be authorized by Department of Health Services.

I/we recognize that unauthorized release of confidential information may make me/us subject to civil and criminal sanctions pursuant to the provisions of the Welfare and Institutions Code Section 14100.2.

_____
Organization Name

SIGNATURE(S): DATE:

_____ _____
_____ _____
_____ _____
_____ _____

- -

Organization: _____

Attention to: _____

Address: _____

City: _____

ZIP Code: _____

Contact Person: _____ Phone #: (___) ___-_____

The purpose of requesting this access is to: _____
_____

When complete, fax this form to: Ana Fellines (916)552-9478

AEVS Eligibility-Checking by Internet

You need to have either a Medi-Cal Provider Number or apply for an AEVS non-provider number (see page 115).

•Go to www.medi-cal.ca.gov/Eligibility/Login.asp

•Click on Transaction Log-in on the left hand side

•Enter your user ID (provider number) and password and click on Submit

•Click on Single Subscriber and enter the clients Subscriber ID (BIC number), birth date, the BIC issue date and the service date, and click on Submit

AEVS will give you the clients name, eligibility status, county code, aid code, scope of benefits and which health plans (if any) the client is enrolled in.

What do I do if I get a Health-e-App Data transfer error?

Once the system has completed the data transformation process it will start migrating the application data to the Health-e-App system. When the transfer fails due to System Error you will receive a pop-up message that your transmission has failed.

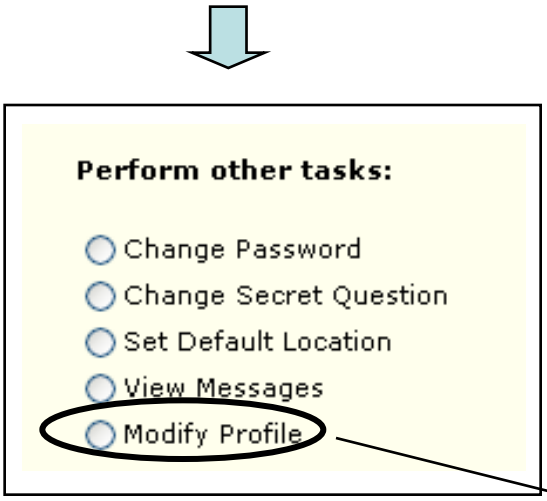
- Call the One-e-App Help Desk and notify them of the error received. Be prepared to give detailed information, including the application ID number and error number (the first line in the screen).

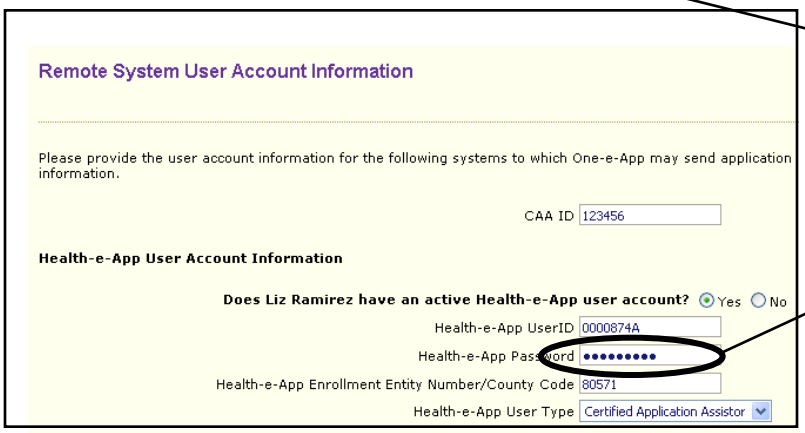
Take a screenshot of the error message and send in an e-mail to the One-e-App Help Desk. (see Bug Reporting in Chapter 5)

Health-e-App Data Transfer

Password Data Transfer Errors

- If the transfer failed after the Health-e-App password verification, some information may have been sent to the Health-e-App. You will need to log in to Health-e-App, look in your workload, find the application in question and continue from there.
- If the reason for the transfer error was your Health-e-App password being disabled, you will need to login in to Health-e-App, **www.healtheapp.net** and have your password reset or you can call the HeA Help Desk at **(866) 861-3443.**
- Once you have confirmed you new password you must now go to One-e-App and update it there.





UPDATING YOUR HEALTH-E-APP PASSWORD IN ONE-E-APP

To update your Health-e-App password in One-e-App, you will need to:

1. Log in to

   https://thecenter.oneeapp.org

1. Select *Modify profile* on the Menu page.
2. Keep clicking *Next* till you get to the **Remote System User Account Information** screen. You then can update your password.
3. Notify supervisor or anyone else of new password according to agency protocol.

PASSWORD TIPS

Passwords must be changed every 30 days in both One-e-App and Health-e-App. Seven days before your One-e-App password expires you will receive a tickler reminder that your password is about to expire, it will be displayed on the tickler banner on the top of the Menu screen until the user changes the password. Health-e-App does not remind about password changes, however, it is recommended that you update your Health-e-App password (on the Health-e-App website or by calling the Health-e-App help desk to reset) every time your One-e-App password is reset. That way you won't receive data transfer errors from the Health-e-App website from an expired password. **www.healtheapp.net** or (866) 861-3443.

You can use the One-e-App Password for Health-e-App (but not the reverse). When you get the reminder follow these steps:

1. Change your password in One-e-App
2. Modify your profile in One-e-App to change your Health-e-App Password (the same one you changed it to in One-e-App)
3. Go to Health-e-App and change your password to the new password.

Password Requirements

The following are requirements for the password you create each 30 days:

- It must be at least 8 characters in length
- It must contain at least one number
- It must be a combination of upper and lower case characters
- It must contain at least one special character, like, #, @, %
- It must be case sensitive (It matters if you type in capital or lower case letters)

Faxing Tip Sheet

To complete the application process, you must fax your verification documents (e.g., income, rights and declarations, proof of residency) after submitting an application in One-e-App. This one-pager contains tips on the faxing process.

IMPORTANT – Suspend until you are ready to fax: Please note that there are some time limits associated with faxing documents. We strongly recommend that if you are not ready to fax documents immediately after submitting the application, you should suspend the application **prior to submitting**. When the documents are ready for faxing, you can continue to submit the application and fax the documents immediately after.

Step 1: Print the Fax Cover Sheets

There are different fax cover sheets for documents for One-e-App and Health-e-App as described below:

- **One-e-App** has a one set of two fax cover sheets for documents *for each application* - one for permanent and one for temporary documents. These can be used for all four children's programs (Medi-Cal, Healthy Families, Healthy Kids, and CHDP). Fax cover sheets may be printed during the application process by clicking the "Generate Fax Cover" button at the bottom of the submit page OR by selecting the Menu option "Retrieve Fax Cover Sheets".

- **Health-e-App** has one fax cover sheet *for each Medi-Cal/Healthy Families application*. You will be navigated to the Health-e-App fax cover sheet during the data transfer process. If you forget to print out the Health-e-App fax cover sheet during the data transfer process, you can access it from the Menu by selecting the "Health-e-App Fax Cover".

Note: If you use the Menu option to print fax cover sheets, you will be asked to conduct an application search. From the search results, click on "Fax" in the "Retrieve Fax" column to retrieve the fax cover sheets.

Step 2: Fax Verification Documents

- **For Healthy Kids or CHDP, you are *required* to fax to One-e-App at 888-398-6328.**
  - Arrange documents behind the permanent and temporary cover sheets
  - Clearly mark an "X" on the cover sheet next to those items that are attached
  - Send the set of two fax cover sheets and documents in each fax transmission

- **For Medi-Cal or Healthy Families, you are *required* to fax to Health-e-App within 24 hours of submitting the application at 866-848-4976.**
  - Arrange documents behind the fax cover sheet
  - Clearly mark an "X" on the cover sheet next to those items that are attached
  - Send only one fax cover sheet and documents in each fax transmission

As a *best practice*, we strongly recommend to also fax Health-e-App documents into One-e-App for permanent storage. This provides easy access to documents if they need to be re-faxed to Health-e-App and stores permanent documents for renewals.

Step 3: Verify the fax was received

For faxes sent to One-e-App, you should verify that the fax was received and is showing up properly. To do this,

1. Select "View Faxes" from the Menu
2. Search for the application
3. In the search results, click on the Applicant's Name. This will take you to the Application Details page. To view the faxes, click on the column header labeled "Fax" under "Verification Documents".

oneeapp
One Stop Access to Health Insurance

Monday, January 14, 2008

Dave Cote
3600 Oak Hill Ave
Los Angeles, CA - 90032

Application ID:

Dear Dave Cote ,

On 01/20/2007 you began an application for health care coverage at (Los Angeles Unified School District,Lausd Main Office). It appears you have not finished the application process. Without a complete and signed application, we can not submit your application for the health care coverage. Your application is not complete for the reason(s) listed in the attached page.

We cannot finish processing your application, please call me so we can arrange a time for you to provide the missing information and complete the interview.

Your application will expire on 3/31/2007. You will need to complete a new application if we do not hear from you by the expiration date.

We know how important it is to obtain health coverage. Call me at 1-866-429-1979 to schedule your appointment or with questions.

Sincerely,

Mitchell Smith

One-e-App Sample 13 Day Letter

oneeapp
One Stop Access to Health Insurance

Monday, January 14, 2008

Dave Cote
3600 Oak Hill Ave
Los Angeles, CA - 90032

Application ID:

Dear Dave Cote

On 01/20/2007, you began an application for health care coverage at (Los Angeles Unified School District, Lausd Main Office). It appears you have not finished the application process. Without a complete and signed application, we were unable to submit your application for health care coverage.

At this time, your application has expired and we can not continue with your application. If your needs or circumstances change, we encourage you to reapply for health care coverage. When you decide to reapply please bring with you the information as indicated on the attached page.

Feel free to call me at 1-866-429-1979 with any questions.

Sincerely,

Mitchell Smith

Medi-Cal Authorized Representative Designation Form

TO: Los Angeles County Department of Public Social Services

I, _____ residing at _____,

_____,

have requested _____,
(NAME)

_____,
(ADDRESS)

to represent me in matters concerning my case.

I also authorize your department to release to the above authorized representative any non-privileged information requested about my _____ case. This authorization is valid until
(AID TYPE OR TYPES)

_____. I understand that this authorization will expire on the above date or in one year, whichever is earlier, unless I cancel it.
(DATE)

(SIGNATURE OF APPLICANT/RECIPIENT)		(DATE)
(BIRTHDATE)	(SOCIAL SECURITY NUMBER)	(STATE NUMBER, IF KNOWN)
(BIRTHPLACE) (TOWN OR CITY)	(COUNTY)	(STATE)

(SIGNATURE OR NAME OF SPOUSE: HE/SHE MUST SIGN IF IN THE HOME)	(DATE)
(BIRTHDATE OF SPOUSE)	(BIRTHPLACE OF SPOUSE)

LDA/Perm

76A7708 PA 2461 (7/81)

WE CAN HELP!

hcc

Health Consumer Center
of Los Angeles

- Learn About Health Care Programs
- Find Free or Affordable Health Care
- Choose the Right Health Care Plan
- Get Medical Treatment & Prescriptions
- Be Heard By Your HMO, Clinic or Doctor
- Use Grievance & Appeals Procedures

CALL 800-896-3203

9:00am - 11:45
Mondays, Tuesdays, Thursdays & Fridays

SERVICES ARE FREE IF YOU ARE A LIMITED-INCOME RESIDENT OF LOS ANGELES COUNTY

A project of Neighborhood Legal Services

Los Angeles County NEIGHBORHOOD Legal Services

Funded by The California Endowment