

HEALTH CARE CONNECTIONS:

A Guide for Families of Children with Special Health Care Needs

Produced by
Bay Area Family Health Links

Center for Access to
Resources & Education (CARE)

Family Resource Network
Of Alameda County

Matrix Parent Network
and Resource Center

Support for Families of Children
With Disabilities

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FORWARD

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While we have had this guide reviewed for accuracy by many people, the information contained herein is subject to change at any time. You should always ask anyone with whom you are working for copies of their current regulations, policies and guidelines should there be questions.

TABLE OF CONTENTS

ACKNOWLEDGMENTS

A. CORE VALUES FOR PROVIDING HEALTH CARE

B. DESCRIPTION OF SERVICES

- A description of managed care plans, private health care and public programs for which families of children with special health care needs may be eligible
- Federal poverty chart

C. CHOOSING A MANAGED CARE PLAN AND PROVIDER

- Tips on choosing the right plan and health care provider for your child
 - Worksheet: Choosing a Primary Care Provider

D. WORKING IN PARTNERSHIP WITH YOUR PROVIDER

- Tips on communicating and working together with your child’s care providers
 - Worksheet: Questions and Concerns
- Keeping Track of Records
 - Worksheet: Telephone Log
 - Worksheet: Key People Chart
 - Form: Authorization for Release of Medical Records

E. MAKING CHANGES: ADVOCACY

Tips on advocating for your child

- What to do When Things Go Wrong:
 - Who to Contact, Grievance Procedures, Flow Chart of Services
- Helpful Hints for Writing Letters
 - Sample Letter 1
 - Sample Letter 2
- Monitoring agencies

F. RESOURCES

- National Organizations
- State Resources
- Local Resources

G. GLOSSARY

Definitions of Health Care Terms

H. REFERENCES

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CORE VALUES FOR PROVIDING HEALTH CARE

The American Academy of Pediatrics has endorsed the core values defined below. The Academy believes that medical care should be “accessible, continuous, comprehensive, family-centered, coordinated and compassionate,” and delivered or directed by well-trained physicians who are “able to manage or facilitate essentially all aspects” of care. The Academy believes that the physician should “be known to the child and family and should be able to develop a relationship of mutual responsibility and trust with them.” (American Academy of Pediatrics, 1992)

These values should form the basis for the development and evaluation of health care systems for families of children with special needs.*

Family-Centered Care. The system of care recognizes the importance of the family and reflects this in the way services are planned and delivered. It facilitates parent/professional collaboration, responds to family needs and the priorities that the family has set for itself, recognizes and builds on individual and family strengths, and respects the diversity of families.

Informed Consumer Choice. The system of care provides families with complete and unbiased information about the health care financing options available to them. The structure, benefits, services and points of access are clearly explained in the primary language of the family. Consumer choice is achieved when family preference is supported in determining primary and specialty care providers, as well as health care facilities.

Collaborative Care. The role of families as primary decision-makers and caregivers is acknowledged and supported when the health financing system pays for services that support this role. Family participation in the allocation of health resources is achieved when the parent is recognized as the primary decision-maker in the development of individualized plans of care.

Information Sharing. The system of care should assure that information concerning diagnosis, treatment, prognosis and resources be shared with all members of the health care team, which includes the family.

Community-Based. The system of care responds to the needs identified by the community and draws from the community to address needs. Services are provided in or near the home community to the extent possible.

Culturally Competent. The system of care honors and respects the languages, culturally related beliefs, values, interpersonal styles, attitudes, and behaviors of families. Respect for those values is incorporated at all levels of policy, administration and practice.

* The Subcommittee on the Managed Care Initiative of Children’s Special Health Care Services Advisory Committee wishes to acknowledge that it drew upon documents provided by the Maternal and Child Health Bureau, New England SERVE, Family Voices, and others in developing this list of values and definitions.

Adapted from *Managed Care for Children with Special Health Care Needs: Physician Care Management Model* by Subcommittee on Managed Care Initiative of Children’s Special Health Care Services Advisory Committee.

DESCRIPTION OF SERVICES

CONTENTS

Health care services in California are delivered to children with special health care needs through many different programs and/or agencies. This section describes:

- Things you need to know
- Private health insurance
 - Fee-for-service
 - Managed care plans
 - Health Maintenance Organizations (HMOs)
 - Point of Service Plans (POS)
 - Preferred Provider Organizations (PPOs)
- Public Health Care Program Comparison Chart
 - Medi-Cal
 - Child Health and Disability Prevention (CHDP)
 - Healthy Families
 - CaliforniaKids
 - Kaiser Permanente Cares for Kids Child Health Plan
 - Early Start Under Individuals with Disabilities Education Act (IDEA)
 - In-Home Supportive Services (IHSS)
 - California Children Services (CCS)
 - Genetically Handicapped Persons Program (GHPP)
 - Women, Infants, Children Program (WIC)
 - Regional Center
 - Community Mental Health
- Federal Poverty Chart

HOW TO USE THIS SECTION

- If you have private health insurance, review this section and compare it to your present coverage. Also take a look at Section C (Choosing a Managed Care Plan and Provider) to see if the health coverage you have answers your needs.
- If your child is currently served through any of the public programs you can review the narrative here and compare it with the services your child is receiving.
- If you think your child may be eligible for services through any of the public programs described, review the eligibility rules and call the state and/or local numbers listed in this section or in Section F (Resources).

Obtaining appropriate health care services for children can be an enormous challenge. Educating ourselves about the options available is a first step. Below is a description of the various kinds of private health insurance generally available.

PRIVATE HEALTH INSURANCE PROGRAMS

Private health insurance can be purchased either individually or through an employer as part of a group plan.

Traditional Indemnity Plans (Fee-for-Service)

These used to be the most familiar type of insurance plans. The insurance company covers some percent of the cost of the services with the remaining costs the responsibility of the family. The family's part is called a co-payment. Plans often have annual deductibles, an amount you pay before the plan pays, as well as co-payments. While traditional indemnity plans allow you the widest choice of providers, your out-of-pocket costs may be higher than some other plans require. Indemnity insurance covers large and/or unexpected health care expenses, but often not routine or preventive care like regular check-ups and well-child visits.

Managed Care Plans

Managed care systems control costs by monitoring services and focusing on preventive health measures.

Under managed care, health plans, also called managed care organizations, get a fixed monthly payment for each person enrolled in their plan. For that money, they must agree to "manage" the person's health services and provide health care. People who enroll in health plans must choose one personal doctor (or sometimes a nurse) [Primary Care Provider] to coordinate their health services. When enrollees need to see a specialist or need other services that their primary care provider cannot give them, they must first get a referral from their primary care provider. Managed care plans require payment of a monthly premium from the purchaser. Unlike indemnity insurance, you may have to make small co-payments for office visits, prescriptions and selected other services.

Health Maintenance Organizations (HMOs)

An example of a managed care organized health plan that offers health care coverage to its members primarily through selected networks of doctors, hospitals and other health care professionals. They operate under many different models:

Staff Model HMOs typically own and operate their own health centers or clinics, where the doctors and other medical professionals are salaried employees. Many services under one roof allow for coordination of services. These types of HMOs can also closely monitor quality and costs of their physicians and services.

Group Model HMOs are typically made up of one or more physician group practices that are not owned by the HMO. The HMO contracts with the group practice to provide or arrange covered services for each HMO member who is a patient of the group.

Adapted from "Paying the Bills: Tips for Families on Financing Health Care for Children with Special Needs" from New England Serve and "PASSPORT: For Children with Special Health Care Needs" from University Affiliated Program, Child Development and Rehabilitation Center, Oregon Health Science University.

Independent Practice Associations (IPA)

IPAs are now the fastest growing form of HMO in the United States. IPAs include individual private practice physicians who are paid a fee or a fixed amount per patient to take care of the IPA's members. One of the advantages of this type of HMO is that you will have the largest number of physicians to choose from.

Point of Service (POS)

Plans are somewhere between standard HMOs and traditional fee-for-service (or indemnity) insurance. A member of a POS plan can receive care from doctors and hospitals inside the HMO network or outside the network, with costs covered either way. This is a more expensive option and is not offered by all HMOs or employer. It can mean a higher co-pay or out-of-pocket expense for out-of-plan services. You may also have to fill out claim forms for outside visits.

Preferred Provider Organizations (PPO)

Networks of doctors and hospitals created by insurance companies or employers to provide care at a lower cost than traditional insurance. Because PPO is "less managed" than HMO care, the premiums are usually higher. They can also impose restrictions such as pre-existing conditions, exclusions and waiting periods.

HEALTH CARE PROGRAM COMPARISON CHART CHILDREN'S HEALTH ACCESS AND MEDI-CAL PROGRAM (CHAMP)

QUESTIONS	MEDI-CAL	CHILD HEALTH AND DISABILITY PREVENTION (CHDP)	HEALTHY FAMILIES
Where can I/we apply?	<ul style="list-style-type: none"> • Applications for children and pregnant women who qualify for free Medi-Cal may be mailed in when complete: call (888) 747-1222 (free) • At Medi-Cal offices and other community sites such as clinics, hospitals and schools (see list). 	<ul style="list-style-type: none"> • At your doctor or clinic that is "CHDP-approved" (allowed to provide CHDP). • At local CHDP offices and other community sites (clinics and schools). • Call 800-993-CHDP (free) to learn more. 	<ul style="list-style-type: none"> • Call 800-880-5305 (free) to have an application & handbook mailed to you. • Applications may be mailed in when complete. • You may also apply at Medi-Cal offices, clinics, hospitals, schools and on-line.
How long does it take to get?	<ul style="list-style-type: none"> • Up to 45 days-usually it takes much less time • Another program, Presumptive Eligibility, helps women get prenatal care while their Medi-Cal application is being processed. 	<ul style="list-style-type: none"> • You can immediately get services if you qualify for CHDP. 	<ul style="list-style-type: none"> • Your child's application must be processed within 10 days of when it is received. • You should get an answer back in the mail within 20 days.
What benefits can I/my child get?	<ul style="list-style-type: none"> • Medi-Cal covers: medical office visits, hospitalizations, dental and vision care, prescription medicines, mental health, substance abuse services and needed medical tests. Children should also get any other help needed to correct a health problem. • Restricted Medi-Cal covers: pregnancy-related and emergency services. • Minor Consent, or "Sensitive Services" provides treatment for sexually transmitted diseases, drug and alcohol abuse, family planning, sexual assault, pregnancy and pregnancy-related services. 	<ul style="list-style-type: none"> • Medical office visits, vision and hearing tests, dental screenings, doctor and dentist referral. • CHDP covers preventive care services based on an age schedule. • Behavioral screening. • Hospitalizations are not covered. • Medicines are given by prescription. 	<ul style="list-style-type: none"> • Medical office visits, dental and vision care, hospitalizations, needed medical tests, prescription medicines, some substance abuse services and mental health services.
How and where do I/my child get services?	<ul style="list-style-type: none"> • One of two ways: Managed Care (health plans) or Regular Medi-Cal. • Most children will be in a health plan except children in foster care, adoption assistance, those with Share-of-Cost Medi-Cal, and those with restricted Medi-Cal. • Disabled people who do not have to join health plans. • There are exceptions to health plans if you have certain medical conditions. • People not in health plans may use "fee-for-service" (regular) Medi-Cal any place that takes Medi-Cal. • If in a health plan, you can only go to your primary care doctor unless you get a referral. • Dental, mental health, and substance abuse services are separate from health plans. • Health plans must provide the same benefits as "regular" Medi-Cal. • Health plan information comes in the mail after you sign up for Medi-Cal or when you sign up at the welfare office. 	<ul style="list-style-type: none"> • If you would like to find or verify that a doctor in your community is CHDP-approved, call 800-993-CHDP (free). • Your child's doctor may already be CHDP-approved, which means that he/she can provide CHDP check-ups for your child. • CHDP health exams are provided by: • CHDP-approved doctors, county health centers, certain school districts, and Medi-Cal managed care doctors (if child is enrolled in Medi-Cal managed care). 	<ul style="list-style-type: none"> • Services will be provided through health plans. • You choose a health plan when you apply. • Dental and vision services are separate. • The health plan sends you information about their doctors, clinics and hospitals. • You must then choose a doctor for each of your children in Healthy Families.
What if I/we have health insurance?	<ul style="list-style-type: none"> • Ask an Eligibility Worker or call the Health Insurance Premium Payment Program (HIPPP), (800) 952-5294 (free). • Medi-Cal might pay what the health insurance does not. 	<ul style="list-style-type: none"> • You may still be able to get CHDP with health insurance - ask your CHDP doctor. 	<ul style="list-style-type: none"> • In the future but not now, Healthy Families may be able to pay for your child's health insurance, if your job offers health insurance.

HEALTH CARE PROGRAM COMPARISON CHART CHILDREN'S HEALTH ACCESS AND MEDI-CAL PROGRAM (CHAMP)

QUESTIONS	MEDI-CAL	CHILD HEALTH AND DISABILITY PREVENTION (CHDP)	HEALTHY FAMILIES
Who is eligible?	<ul style="list-style-type: none"> • Children birth up to age 21 • Some parents/adults • Pregnant women • People who get CalWORKS (AFDC) or Supplemental Security Income (SSI) get Medi-Cal automatically. • Minors under 21 may apply for some confidential services on their own, called "Minor Consent" or "Sensitive Services" • Blind or disabled people • People 65 and over • People in nursing homes 	<ul style="list-style-type: none"> • Children birth up to 19 or • Children birth up to 21 if you have Medi-Cal 	<ul style="list-style-type: none"> • Uninsured children age one up to 19 with certain income limits. • 18 year olds can apply on their own.
What are the income limits?	<p>For no-cost (free) Medi-Cal:</p> <ul style="list-style-type: none"> • Children birth up to 1: up to 200% FPL • Children 1 up to 6: up to 133% FPL • Children 6 up to 19: up to 100 % FPL* • Children 19 up to 21: varies around 100% FPL 	<ul style="list-style-type: none"> • Children birth up to 19: up to 200% FPL • Children birth up to 21: on Medi-Cal 	<ul style="list-style-type: none"> • Children 1 up to 6: 133 to 250% FIG • Children 6 up to 19: 100 to 250% FIG
What does it cost?	<ul style="list-style-type: none"> • Medi-Cal is FREE for kids. • For adults, there may be a small fee for prescription medicines and emergency room if not an emergency. • Share-of-Cost Medi-Cal costs may change every month depending on monthly income. 	<ul style="list-style-type: none"> • If your child is eligible for CHDP, all CHDP services are provided at no cost. • If your child has Medi-Cal and is found to need treatment during the CHDP screening exam, Medi-Cal will be billed for those treatment services. 	<ul style="list-style-type: none"> • Medical office visits, dental and vision care, hospitalizations, needed medical tests, prescription medicines, some substance abuse services and mental health services.
What are the resource limits? (What if I have a car/house?)	<ul style="list-style-type: none"> • Resources (the things you own) do not count for pregnancy-related services and for children who are eligible for free Medi-Cal. • Adults must have under \$2,000 for one person, or \$3,000 for two people, \$3,150 for three people, and \$3,300 for four people • One car and one house is OK; if you have more, they count toward the resource limit you are allowed. 	<ul style="list-style-type: none"> • Resources (the things you own) do not count in this program. 	<ul style="list-style-type: none"> • Resources (the things you own) do not count in this program.
Do I have to be a legal resident?	<ul style="list-style-type: none"> • Citizens, Legal Permanent Residents and certain other immigrants may receive full-scope Medi-Cal. • Undocumented and certain other immigrants at this point can still get "restricted" Medi-Cal for emergency conditions and pregnancy-related services. 	<ul style="list-style-type: none"> • All children within the income limits for this program are eligible to receive CHDP services. 	<ul style="list-style-type: none"> • U.S. citizens and certain immigrants may qualify. • The parent does not have to be a citizen. • The application must state that your child is a California resident.
What papers do I need?	<ul style="list-style-type: none"> • Proof of income, identification, and California residency. • Immigration status and Social Security number (SSI) or proof of application if applying for full-scope Medi-Cal. • No SSN proof needed if applying for restricted Medi-Cal or if filing an application for someone else (i.e., child) • Car registration or other document showing state residency. • Proof of pregnancy if pregnant. • Other resources information: for adults only, not required for children who are eligible for free Medi-Cal or for pregnant women for their pregnancy-related services. 	<ul style="list-style-type: none"> • Self-stated monthly income — state your income when you apply at your doctor's or clinic. 	<ul style="list-style-type: none"> • Proof of income • Proof of immigration status or citizenship for child

HEALTH CARE PROGRAM COMPARISON CHART CHILDREN'S HEALTH ACCESS AND MEDI-CAL PROGRAM (CHAMP)

QUESTIONS	CALIFORNIAKIDS	KAISER PERMANENTE CARES FOR KIDS CHILD HEALTH PLAN
Who is eligible?	<ul style="list-style-type: none"> Children 2 up to 19 who are not eligible for full-scope, no cost Medi-Cal or other State assistance programs for health care, such as Healthy Families. Children may be enrolled in California Children's Services for specialty care and be eligible for CaliforniaKids for basic outpatient services. 	<ul style="list-style-type: none"> Uninsured children birth up to 19 who are not eligible for other public/private programs, such as Medi-Cal or Health Families. Children who are enrolled in participating public schools and their siblings and/or children. To find out if your child's school is participating, call 800-255-5053 (free).
What are the income limits?	<ul style="list-style-type: none"> All children 2 up to 19: 200%–300% FPL Children 2 up to 19 not eligible for Healthy Families or full-scope Medi-Cal: up to 200% FPL Foster children 18–19: up to 300% FPL 	<ul style="list-style-type: none"> Children birth up to 19 above 200% FPL and not more than 275% FPL
What does it cost?	<ul style="list-style-type: none"> All children 2 up to 19: 200%–300% — Cost Children 2 up to 19 not eligible for Healthy Families or full-scope Medi-Cal: up to 200% FPL — No Cost Foster children 18–19: up to 200% FPL — No Cost If you qualify to receive care at no cost, you will pay no monthly fee. You must still pay the copayments of about \$5–15. If you have a Monthly Cost, it will be about \$20–35/month, in addition to any copayments you are charged for the services. 	<ul style="list-style-type: none"> There are two costs with this program: Premiums paid every month are \$25–35 per child, depending on your family income. Copayments of \$5–10 are paid for some services. The most you will ever have to pay is for three children per month.
What are the resource limits?	<ul style="list-style-type: none"> Resources (the things you own) do not count in this program. 	<ul style="list-style-type: none"> Resources (the things you own) do not count in this program.
Do I have to be a legal resident?	<ul style="list-style-type: none"> No. All children within the income limits for this program are eligible to receive CaliforniaKids services. 	<ul style="list-style-type: none"> The child(ren)'s Social Security Number is requested on the application.
What papers do I need?	<ul style="list-style-type: none"> Proof of income (paycheck stubs, copy of 1040 Federal tax form) 	<ul style="list-style-type: none"> Proof of income (last filed income tax return and pay stubs, disability check stubs)
Where can I/we apply?	<ul style="list-style-type: none"> Call 818-461-1400 (free) to have an application mailed to you. Applications must be mailed in when complete. You may also apply at places around your community such as child care centers, clinics, schools, boys/girls clubs, group homes, and other organizations that see children in your area. 	<ul style="list-style-type: none"> Call 800-255-5053 (free) to have an application mailed to you. Applications must be mailed in when complete. Applications will be available in some participating schools.
How long does it take to get?	<ul style="list-style-type: none"> 2–4 weeks after CaliforniaKids receives your application. 	<ul style="list-style-type: none"> Expect about 30 days for processing. Coverage will begin September 1, 2001.
What benefits can I/my child get?	<ul style="list-style-type: none"> Comprehensive preventive and primary care coverage: medical office visits, dental and vision care, prescription drugs, mental health services, substance abuse services, and needed lab tests. Hospitalizations and major surgery are not covered. 	<ul style="list-style-type: none"> Comprehensive preventive, primary, and specialty health care coverage: medical office visits, vision care, prescription drugs, mental health services, substance abuse services, health education, hospital services, and needed lab tests.
How and where do I/my child get services?	<ul style="list-style-type: none"> Through the provider network of CaliforniaKids, including: community clinics, independent offices, and medical groups. Call 818-461-1400 (free) for a list of providers in your area. 	<ul style="list-style-type: none"> Through Kaiser Permanente medical offices and hospitals.
What if I/we have health insurance?	<ul style="list-style-type: none"> If child is eligible or enrolled in full-scope, no cost Medi-Cal or Healthy Families, he/she is not eligible for CaliforniaKids. Your child may be enrolled in California Children's Services and still be eligible for CaliforniaKids. Your child may have other private insurance with a high deductible (at least \$2,000 or more) and still be eligible for CaliforniaKids. 	<ul style="list-style-type: none"> Your child cannot have other health insurance, such as employer coverage or health coverage through Medi-Cal or Healthy Families, with this program.

PUBLIC HEALTH CARE PROGRAM COMPARISON CHART

QUESTIONS	EARLY START UNDER I.D.E.A.	IN-HOME SUPPORTIVE SERVICES (IHSS)
Who is eligible?	Children birth through 2 years 9 months of age who: <ul style="list-style-type: none"> • Experience developmental delays • Have a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay or • Are at high risk for developmental disabilities 	<ul style="list-style-type: none"> • Individuals who are eligible for SSI/SSP, or similar types of assistance, and • If IHSS is needed for the individual to live safely in his/her home without assistance.
What are the income limits?	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • Same as SSI income limits
What does it cost?	<ul style="list-style-type: none"> • Nothing 	<ul style="list-style-type: none"> • Nothing
What are the resource limits? (Are other assets like a car or a house included?)	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • Same as SSI resource limits
Do I have to be a legal resident?	<ul style="list-style-type: none"> • No 	<ul style="list-style-type: none"> • California resident—yes. • Immigrants permanently living legally in the U.S. may be eligible for IHSS.
What papers do I need?	<ul style="list-style-type: none"> • Medical records • Results of specific diagnostic tests indicating disability 	<ul style="list-style-type: none"> • The county worker will fill out forms known as “SOC 293” and “SOC 293a,” which will set out how much time per week you have been allowed for service. Your county worker must give you copies of these forms if you ask for them.
Where can I/we apply?	<ul style="list-style-type: none"> • At the Regional Center or the local Special Education Plan Area (SELPA) 	<ul style="list-style-type: none"> • Apply at the Department of Social Services, also known as the welfare office. You may be able to initiate the process by phone. To find your local IHSS office call 915-654-1956 or look in the “Resources” section of this manual. • Once the application is filed, a home visit will be scheduled.
How long does it take to get?	Within 45 days of the child’s referral to the agency: <ul style="list-style-type: none"> • An assessment must be completed • An Individual Family Service Plan must be developed to decide upon the services for the family and child. 	<ul style="list-style-type: none"> • The application must be processed within 30 days. This includes eligibility determination, the needs assessment and the notice of action. An exception to the 30-day requirement may be made when a disability determination has not been received within that time period. Benefits may be approved back to the date of the initial application regardless of when the assessment is done.

PUBLIC HEALTH CARE PROGRAM COMPARISON CHART

QUESTIONS	EARLY START UNDER I.D.E.A.	IN-HOME SUPPORTIVE SERVICES (IHSS)
What benefits can I/my child get?	<ul style="list-style-type: none"> • Assistive technology devices/services • Audiology services • Family training, counseling, and home visits • Some health services • Medical services for diagnostic or evaluation purposes only • Nursing • Nutrition counseling • Occupational therapy • Physical therapy • Psychological services • Respite • Service coordination (case management) • Social work services • Special instruction • Speech and language services • Transportation services • Vision services • Others as needed 	<ul style="list-style-type: none"> • Domestic and related services (cooking, cleaning, laundry, shopping) • Personal care services (toileting, dressing, helping the person eat) • Essential transportation (e.g., to doctor's appointments) • Protective supervision (e.g., watching and intervening if someone would walk into the street, etc.) • Paramedical services, including giving injections. Under the condition that the person will become more self-sufficient, some teaching and demonstration can be included.
How and where do I/my child get services?	<ul style="list-style-type: none"> • This varies from county to county. Children with low-incidence disabilities may receive services from the Special Education Local Plan Area or the County Office of Education. Children with other disabilities receive services from programs funded by the Regional Center. 	<ul style="list-style-type: none"> • The IHSS recipient hires his/her own care provider. Services are provided in the recipient's home. The care provider must complete timesheets in order to be paid.
What if I/we have health insurance?	<ul style="list-style-type: none"> • Other insurance does not affect the services you are eligible for. Regional Center may ask that your primary insurance be billed first for some services that are also provided by Regional Center. If those services are denied, Regional Center will then pay for them. 	<ul style="list-style-type: none"> • Other insurance does not affect IHSS.

PUBLIC HEALTH CARE PROGRAM COMPARISON CHART

QUESTIONS	WIC	REGIONAL CENTER	COMMUNITY MENTAL HEALTH
Who is eligible?	<ul style="list-style-type: none"> • Low-income pregnant, breastfeeding or postpartum mothers • Children under 5 • Regular medical check-ups are required 	<ul style="list-style-type: none"> • Under 18 with certain disabilities including retardation and related diseases, cerebral palsy, epilepsy, autism, developmental disabilities 	<ul style="list-style-type: none"> • Children and adolescents with full service Medi-Cal • Special ed. referrals from schools
What are the income limits?	<ul style="list-style-type: none"> • Gross income below 200% FPL 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • None
What does it cost?	<ul style="list-style-type: none"> • Nothing 	<ul style="list-style-type: none"> • Nothing 	<ul style="list-style-type: none"> • Nothing except for psych. Emergency services if not covered by Medi-Cal or other health insurance.
What are the resource limits? (Are other assets like a car or a house included?)	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • None
Do I have to be a legal resident?	<ul style="list-style-type: none"> • No 	<ul style="list-style-type: none"> • No 	<ul style="list-style-type: none"> • No
What papers do I need?	<ul style="list-style-type: none"> • Medical form to be filled out by doctor • Proof of address • Proof of income • Child's food records 	<ul style="list-style-type: none"> • Medical records 	<ul style="list-style-type: none"> • None
Where can I/we apply?	<ul style="list-style-type: none"> • Contact WIC Office (888-WIC-WORKS) to find where to pick up an application. 	<ul style="list-style-type: none"> • Call your local Regional Center or the Dept. of Developmental Services, 916-654-1897 	<ul style="list-style-type: none"> • Call your local Community Mental Health Service or ask your school for a referral
How long does it take to get?	<ul style="list-style-type: none"> • Immediate benefits after completing application and providing papers 	<ul style="list-style-type: none"> • 60 days for an assessment 	<ul style="list-style-type: none"> • Immediate
What benefits can I/my child get?	<ul style="list-style-type: none"> • Food vouchers • Nutritional counseling • Breastfeeding support • Referrals for health care and other services 	<ul style="list-style-type: none"> • Assessment, rehabilitation and training, treatment, therapy, prevention, special living arrangements, community integration, family support, crisis intervention, special equipment, transportation, interpreter/translator, advocacy, vouchers 	<ul style="list-style-type: none"> • Outpatient assessment or psych. Evaluation and referral to community practitioners. • All services required of an IEP including day and residential treatment as necessary. • Psych. Emergency service (for a fee if not covered by insurance).
How and where do I/my child get services?	<ul style="list-style-type: none"> • At WIC clinics • Health services can be obtained from the doctor of your choice 	<ul style="list-style-type: none"> • Local Regional Center will refer 	<ul style="list-style-type: none"> • After assessment has been done, referrals will be given to community practitioners or treatment centers
What if I/we have health insurance?	<ul style="list-style-type: none"> • Does not affect WIC benefits 	<ul style="list-style-type: none"> • Does not affect benefits 	<ul style="list-style-type: none"> • Does not affect benefits, but will bill Medi-Cal or private insurance with permission.

PUBLIC HEALTH CARE PROGRAM COMPARISON CHART

QUESTIONS	CALIFORNIA CHILDREN SERVICES (CCS)	GENETICALLY HANDICAPPED PERSONS PROGRAM (GHPP)
Who is eligible?	<ul style="list-style-type: none"> • Children and young adults 21 and under with certain medical conditions whose parents pay for some or all services 	<ul style="list-style-type: none"> • Adults over 21 with certain inherited diseases such as Cystic Fibrosis, PKU, Hemophilia, Sick Cell Anemia
What are the income limits?	<ul style="list-style-type: none"> • Less than \$40,000 • If family income is greater than \$40,000, medical expenses must be greater than 20% of family income • Diagnostic services and PT and OT have no requirement • You may have to also apply for Medi-Cal 	<ul style="list-style-type: none"> • None
What does it cost?	<ul style="list-style-type: none"> • There is an income adjusted enrollment fee for treatment services except for people below 200% FPL 	<ul style="list-style-type: none"> • An income adjusted enrollment fee
What are the resource limits? (Are other assets like a car or a house included?)	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • None
Do I have to be a legal resident?	<ul style="list-style-type: none"> • No, but proof of county residence necessary 	<ul style="list-style-type: none"> • Yes
What papers to I need?	<ul style="list-style-type: none"> • Federal Income Tax form or other proof of income • Medical records 	<ul style="list-style-type: none"> • Federal Income Tax form or other proof of income • Medical records
Where can I/we apply?	<ul style="list-style-type: none"> • Referrals from doctors or social workers are preferred • Call 916-654-0499 	<ul style="list-style-type: none"> • Call 800-639-0597
How long does it take to get?	<ul style="list-style-type: none"> • Up to 120 days after application and medical records received 	<ul style="list-style-type: none"> • About 2 weeks after medical report received
What benefits can I/my child get?	<ul style="list-style-type: none"> • Free diagnostic services • All services which apply to condition: doctors, hospital, surgery, PT, OT, lab tests, x-rays, orthopedic and medical equipment, case management including transportation 	<ul style="list-style-type: none"> • All services must be pre-approved by case manager: medical care in and out of hospital, dental care, home health care, prescriptions and nutritional supplements, respite care, medical and orthopedic equipment, transportation
How and where do I/my child get services?	<ul style="list-style-type: none"> • CCS approved doctors and hospitals 	<ul style="list-style-type: none"> • GHPP approved centers, private physicians working with these centers, local hospitals
What if I/we have health insurance?	<ul style="list-style-type: none"> • CCS will cover only those services which have been denied by other insurers 	<ul style="list-style-type: none"> • Other insurance is allowed. GHPP will cover unpaid expenses and provide services if outside insurance is lost.

**US DEPT. OF HEALTH AND HUMAN SERVICES
POVERTY GUIDELINES 2005**

PERCENT OF FEDERAL POVERTY LEVEL	NUMBER OF FAMILY MEMBERS							
	1	2	3	4	5	6	7	8
100	\$9,570	\$12,830	\$16,090	\$19,350	\$22,610	\$25,870	\$29,130	\$32,390
125	\$11,963	\$16,038	\$20,113	\$24,188	\$28,263	\$32,338	\$36,413	\$40,488
150	\$14,355	\$19,245	\$24,135	\$29,025	\$33,915	\$38,805	\$43,695	\$48,585
200	\$19,140	\$25,660	\$32,180	\$38,700	\$45,220	\$51,740	\$58,260	\$64,780
235	\$22,490	\$30,151	\$37,812	\$45,473	\$53,134	\$60,795	\$68,456	\$76,117
300	\$28,710	\$38,490	\$48,270	\$58,050	\$67,830	\$77,610	\$87,390	\$97,170

Source: The Federal Register, Vol. 66 No. 33, February 18, 2005 pp. 8373-7375.
<http://aspe.os.dhhs.gov/poverty/05poverty.htm>

CHOOSING A MANAGED CARE PLAN AND PROVIDER

CONTENTS

- Choosing a Managed Care Plan
- Choosing a Primary Care Provider (PCP)
- Worksheet for Choosing a Provider

HOW TO USE THIS SECTION

- Read the material on choosing a plan.
- Answer the questions by checking the plan handbook or interviewing their Ombudsperson, preferably their Disabilities Coordinator.
- Review questions to ask the Pediatrician or Primary Care Provider.
- Use the worksheet to assess provider's appropriateness for your child's unique needs.
- Find a plan and provider that suits your child's and family's needs.

CHOOSING A MANAGED CARE PLAN

One of the first steps in your journey is to select the health care plan that best suits your needs. Choosing a plan, of course, depends on options available in your area, from your employer, or within your financial means. Take time to consider what factors are most important to you and your family. It is very important for you to have each plan's description of benefits and list of primary care providers. These are available from your employer, personnel office, plan ombudsperson, or state human resources department. If you need a particular specialist or primary care provider, you should begin your selection process with this in mind.

Most descriptions of benefits may seem like a foreign language: difficult to read and impossible to interpret. They may not describe all the available services or list all of the exclusions. Spend some time with your employer or a managed care plan membership service representative to help direct you through the maze. Be sure that the information received from your employer is consistent with the information given by the health plan and provides you with the detail you need.

Below is a list of health care services. When choosing a plan check to see that the services you really care about are included:*

Therapies/Home Care/Planning Services

- Speech and language therapy
- Physical therapy
- Occupational therapy
- Nutrition counseling services
- Home nursing services
- Personal care attendant
- Home health aide
- Counseling/mental health services
- Genetic services
- Hospice
- Case management
- Diagnostic testing
- Vision services
- Transportation

Medications and Supplies

- Tracheostomy tubes
- Gastrostomy tubes
- Feeding bags
- Specialize dietary products
- Dressings
- Prescription drugs
- Hearing aids

Adaptive Equipment

- Prone standers
- Corner tables
- Specialized car seats
- Bath aids
- Van adaptations
- Ramps
- Corrective shoes
- Eyeglasses
- Specialized orthodontics
- Prosthetic devices
- Communication equipment

Durable Medical Equipment

- Ventilator
- Suctioning equipment
- IV stands and equipment
- Air compressors
- Feeding pumps
- Monitor
- Wheelchair
- Braces
- Casts
- Prosthetic devices

* List is adapted from "PASSPORT: For Children with Special Health Care Needs" from University Affiliated Program, Child Development & Rehabilitation Center, Oregon Health Science University.

Specific questions you may want to ask include:

- Are you required to enroll your Medi-Cal eligible child in a managed care plan?
 - Is your child on Medi-Cal with no share of cost? (Probably required to join a plan)
 - Is your child on SSI or in foster care? (probably not required to join a plan)
- Which providers contract with this plan?
 - Does the plan include your current Primary Care Provider?
 - Do you want to stay with your Primary Care Provider?
 - Are you comfortable having one assigned?
- Are the specialists your child now uses available through this plan?
 - Can your child get direct access to specialists for some services?
- Where are the hospitals and clinics located?
 - Are they physically accessible?
 - Does your Primary Care Provider have privileges at nearby hospitals and clinics?
- Are funds available for transportation (or covered by the managed care organization)?
- Are the therapists and specialists trained in pediatric care?
- What is the procedure for authorizing urgent or emergency care when you are away from home or traveling out of state?
- Are translation services available at the clinics and by phone?
- What coverage is offered for equipment and medical supplies? Where will I get equipment and supplies? Who is responsible for repairs and replacements? Who has to approve my requests for equipment and supplies?
- How are prescription drugs covered and where can they be obtained? Are there any restrictions on the drugs that can be prescribed and paid for (formulary)?
- Is there a clinic in the plan that specializes in your child’s diagnosis/disability? Are there classes or informational materials that address parenting and health care issues for your child’s diagnosis/disability?
- If you have a complaint or disagreement, what process or alternatives are available?
- If you are dissatisfied, how easy is it to change out of the plan?
- Can you be disenrolled from the plan? On what basis? Is there an appeal process?
- Would you prefer that all your family members be enrolled in the same plan?
 - How do the plans “work” for all your family members? Do any of them have special needs as well?

CHOOSING A PEDIATRICIAN OR PRIMARY CARE PROVIDER

Your child may be seen by several doctors, clinics and hospitals. Ultimately you are the expert on your child and the case manager of your child's services. Your case manager duties are likely to include choosing a pediatrician, developing a relationship with him/her, evaluating the situation, and maintaining any records that will result from your visits. In developing a relationship, you are looking for someone who will value you as an expert on your child and acknowledge you as a competent partner on the health care team. You are also seeking someone who will accept that your child's health care needs are only a part of your family's priorities and that sometimes the family's needs and concerns may take precedence.

While the primary care provider or clinic will maintain files for their records, you should maintain your own home files. Detailed records keeping is a vital part of your responsibilities. Remember, you have a right to obtain copies of your child's medical reports and records. Your home files could be as simple as a box full of medical records or as sophisticated as you choose to have it (see following section: "Working in Partnership with Your Provider"). Most importantly, good communication and rapport among your child's team (you, your child if appropriate, primary health care provider, early intervention team, school personnel) should lead to quality care for your child.

From a family-centered perspective, you want your Primary Care Provider to:

- Help you find and continually update information you need to understand your child's condition, since it is not temporary and you will be learning about it for a lifetime.
- Not withhold or omit any information concerning the severity or extent of your child's condition. Also, not to hesitate to use medical terms when necessary.
- Agree to routinely provide you with copies of any medical records and reports.
- Help you to understand the range of possibilities and tell you the worst and best possible prognosis.
- Acknowledge your sense of urgency by responding quickly to requests for medical information, referrals, etc., so that appropriate services can begin or continue.
- Remind you of your child's strengths from time to time.
- Collaborate with other professionals providing care for your child.
- Take time to talk with you about your concerns.

WORKSHEET: CHOOSING A PRIMARY CARE PROVIDER

QUESTIONS TO ASK	Name: Address: Phone:	Name: Address: Phone:	Name: Address: Phone:
Do you see children with special needs in your practice?			
Do you have experience with children who have (describe your child's disability)?			
Would you be comfortable working in a medical team situation with other doctors who will be seeing my child?			
Can you schedule extra long appointments?			
Who sees your patients when you are not available?			
Which hospital do you use for patients who require hospitalization or hospital tests?			
What are the facilities of this hospital for children and families like mine? If my child were hospitalized, would I be allowed to stay with him/her?			
How do you handle a child's fear, discomfort, or pain when preparing him/her for invasive procedures?			
After you've examined my child, can you arrange for one of your staff to watch him/her for a few minutes so we can talk alone?			
Would there be any additional charges for any of these arrangements?			

WORKING IN PARTNERSHIP WITH YOUR CARE PROVIDER

CONTENTS

- Working In Partnership With Your Provider
- Communicating With Your Provider
- Form: Questions or Concerns
- Keeping Track: How to Build Your Child's Information Binder
- Form: Telephone Log
- Form: Key People Chart
- Authorization for Release of Medical Records

HOW TO USE THIS SECTION

- Read over the material on communication and keeping records.
- Use this information to start building your child's notebook.
- Decide which forms will work best for your situation and copy to use.
- Remember to keep original forms in this manual.

WORKING IN PARTNERSHIP WITH YOUR PROVIDER

A key to getting the best care for your child is to work in partnership with the people who are part of her medical care. Partners are two or more persons working together on a common goal (in this case, caring for your child). Partners bring their strengths together to accomplish something that neither one could easily do alone.

Your doctors are the experts in diagnosing medical conditions and outlining options for your child's treatment. Your role as a parent is equally important. For some parents, this may be difficult to accept. You may just be getting to know your child. You may not be in the position to see her daily. Still, as a parent, you have the love and long-term commitment of her welfare. You have ideas that may work in your child's specific situation. You help prepare her for a doctor's appointment so it's not so scary; you comfort her if it is. While you may not have all the technical knowledge, you **are** qualified to make final decisions about what will work best for you and your family.

Sometimes getting the best care for your child depends on your ability to work in partnership with professionals who are diagnosing or treating her. Here is a checklist of characteristics of successful partnerships:

- Be clear. Tell providers how important their support or cooperation is to your child's care. Let people know what you need or want—and specifically how they can help.
- Put yourself in the doctor's shoes. Think about what you can do to make the doctor's life easier.
- Seek out professionals who are willing to work with you. If you don't think you are working well with a professional, let her know. If things do not work out, find another provider. With Medi-Cal, some health care plans, medical groups, or hospitals, there may be a medical service coordinator who can help you get answers to your questions.
- Share the whole picture. If your child has complex medical issues, it may be useful to call a meeting of all the professionals involved in her care so that you can discuss your child's complete medical picture.
- Be honest about your strengths and limitations. Exchange complete information and admit it if you do not have the answers. Trust and respect each other's judgment.
- Commit to team efforts and goals. Find creative solutions to problems. Support each other in getting things done.
- Problems can arise. If so, remember that solutions may not come easily. Often these are not under the control of you or your doctor. For example, getting approval for occupational therapy requires the doctor to submit a request for authorization, then wait for approval. If the approval is denied, then an appeal process may be used. This takes time and patience. For further information, see the Section E of this manual, "Making Changes: Advocacy."

Adapted from *Taking Charge: A Parent's Guide to Health Care for Children with Special Needs*, The Parent Educational Advocacy Training Center and The ARC of Northern Virginia.

COMMUNICATING WITH YOUR PROVIDER

In our daily lives, it is sometimes hard to share our ideas, questions, concerns or feelings. In the rush of a doctor's visit, with your child (or children) there, a waiting room full of patients or other distractions, it can be difficult to ask questions or express your thoughts and concerns. It may seem much easier to wait until the next visit.

Parents have suggested a variety of strategies that have helped them communicate more effectively with their doctors (or nurses, therapists, or other medical providers). By using some of the ideas below, you may be able to help your care provider understand a concern that you have about your child.

- Bring reinforcements. If possible, bring your spouse or a friend to the visit. If necessary, the friend can take your child out of the room so that you can talk to the doctor privately and without distractions. Another adult can help you remember what the doctor said.
- Prepare questions or concerns before the visit. Do this preferably in the form of a written list. Go over the list with the doctor, or ask the most important questions first and ask the doctor to respond to the others later.
- Prepare the doctor. Since doctors often have busy schedules, it may be useful to call before the visit and let them know that you have a number of questions and need an extended visit. In some cases, you might want to share these questions before the scheduled appointment.
- Recognize the positive. Let doctors know what you like or appreciate about their attention to you and your child's medical care. Celebrate successes. Share pictures of your child and her accomplishments. Keep the doctor informed of new skills your child achieves.
- Share your view of the situation. If you have personal, cultural or religious beliefs that will affect how you carry out the doctor's suggestions for your child's medical care, let the doctor know.
- Take notes. Review them with the doctor to make sure that you both understand.
- If you also see specialists, make certain that your child's primary care provider is sent copies of all reports in order to stay aware of all new developments. Use the "Authorization for Release of Medical Records" in this section to assist you in this process.
- During the appointment, ask for copies of your child's reports so that you can update your home files.

Adapted from *Taking Charge: A Parent's Guide to Health Care for Children with Special Needs*, The Parent Educational Advocacy Training Center and The ARC of Northern Virginia.

QUESTIONS AND CONCERNS

Date:
Provider's Name:
Telephone:

Questions or Concerns	Reponses
1)	
2)	
3)	
4)	

Instructions

Follow-Up	Who?	When?

Adapted from *Taking Charge: A Parent's Guide to Health Care for Children with Special Needs*, The Parent Educational Advocacy Training Center and The ARC of Northern Virginia.

KEEPING TRACK

Managing the unique, complex and multiple needs of your child is sometimes a daunting task. Even though you may have case managers or others who coordinate specific aspects of your child's care, you are the primary coordinator of all your child's services. Having a method and a specific notebook to organize information about your child and keeping careful records will help you as well as all of your child's providers.

Having information and keeping it current is time consuming. Having it available will give a complete and accurate picture of your child that you can provide to teachers, physicians, and others. It is well worth the effort. Here are some tips for getting organized:

- Keep all originals in a safe place in your home file and place only copies in your notebook.
- Fasten all records securely in a three-ring notebook. This will keep the pages from getting separated and out of order should the notebook fall.
- If the notebook becomes too cumbersome, transfer items not needed into your home record. Clean out the home files as needed.
- Keep a log or summary of the records contained in the notebook.
- If you have many records, separate them in a way that makes sense to you. Consider filing them in sections based on type of records or filing them in chronological order.
- Put tabs, with the doctor's name on them, on reports you know you'll refer to again (such as operation reports and discharge summaries). It makes finding them easier the next time around.
- Write any personal notes on a copy of the record or a blank sheet of paper. For example, if your child vomits when you give her a certain medication, note this so that your doctor can prescribe an alternative next time.
- If your child is on various medications, keep a list of medications including dosage changes, start date, and discontinue date. Be sure to note any adverse reactions. Do not rely on memory.

From *Passport Managed Care Guide*, "Families as Participants: Working Within a Managed Care System," and *Taking Charge: A Parent's Guide to Health Care for Children with Special Needs*, "The Parent Educational Advocacy Training Center and The ARC of Northern Virginia.

TELEPHONE LOG

Insurance	Public Program
Name	Name
Address	Address
Policy #	Phone #
Policy Holder	Child's ID#
Group Name	Contact Person
Group #	
Contact Person	
Phone	

Date/Time	Person Contacted	Phone Number	Topic Discussed	Decision Made

KEY PEOPLE CHART

	Name	Address	Phone
Primary Care Doctor			
Specialist			
Specialist			
Hospital			
Advice Nurse			
Health Plan			
Pharmacy			
Family Support			
Other Agency			
Other Agency			

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Date: _____

To: _____
(names of doctors, etc.)

_____ (phone)

_____ (fax)

RE: Medical records and communications re: _____
(name of your child)

From: _____
(your name)

_____ (address)

_____ (phone number)

Please send complete medical records of:

_____ (name of child)

_____ (date of birth)

To: _____
(contact person)

_____ (agency name)

_____ (address)

And to my home:

_____ (your name)

_____ (address)

_____ (phone)

➡ **I would like all future reports or communications to be sent to my home as well. This will make it easier for me to coordinate information and make decisions about my child's care.**

Thank you for your cooperation,

_____ (your signature)

MAKING CHANGES: ADVOCACY

CONTENTS

- Descriptions of appeal processes for specific services
- A “map” (or diagram) of each of the different service systems which illustrates
 - how referrals are made,
 - how services are delivered, and
 - where to go for help if your child has been denied services
- Helpful Hints for Writing Letters
- Sample Letters
- Monitoring Agencies

HOW TO USE THIS SECTION

- Read the written information so you will understand how to advocate within that system for your child.
- Use the “maps” to determine the next step to take on behalf of your child.
- Use the sample letters as a guide in writing your own letter.
- Keep a record of any phone calls you make.

HOW TO GET YOUR CHILD THE SERVICES HE/SHE NEEDS UNDER: PRIVATE INSURANCE MANAGED CARE PLANS (HMOs, PPOs)

If your child requires care, treatment or therapy from someone other than the Primary Care Provider (PCP):

- The PCP must approve your request and make a referral; and
- The managed care organization's (MCO) referral committee will approve or deny the service.

(Managed care frequently limits the use of specialists, treatment and therapy; therefore, it is not unusual to be denied.)

If you and your PCP disagree about your child's service needs:

- Remember, the first "no" is never the final answer.
- Repeat your request *in writing* and include documentation and/or additional reasons that support the need for the referral.
- Call your case manager to discuss your perspectives as to what services are needed. See if s/he can help to advocate for your child (i.e., advise you as to what information you could include that might be meaningful to the PCP and support an approval).
- Require that the reasons for the denial be put in *writing*.
- You might need to change your child's PCP. This should only be done after careful consideration. Weigh this one incident with past support this provider has shown.

If your PCP approves your request, but the managed care organization says no:

- Remember, the first "no" is never the final answer. Call again another day.
- Request a letter from your child's PCP to accompany the second request.
- Make sure to point out how services are medically related, how they will benefit your child, and how providing this service will avoid future expenses.
- Contact your case manager and ask her to help you advocate for your child's special needs (i.e., advise you as to what information you should communicate that might be meaningful to the managed care organization's committee and support an approval).
- Require the denial rationale be put in *writing*.
- Contact the medical director of the managed care plan in writing and let him know:
 - The importance of the service;
 - The efforts made to obtain the service;
 - The specifics of the denial of coverage.

State that the grounds of denial are unacceptable and that you are appealing the decision. Give them a deadline for their response to you.

- File a formal grievance with your managed care organization. Review the evidence of coverage and complain through their channels. Keep a record of everyone you talk to, including the date, phone number and a summary of the conversation. It is best to confirm everything in writing, and you may wish to send letters by certified mail. Request all responses in writing.
- If you cannot resolve your grievance through the MCO’s regular channels, call the Department of Managed Health Care HMO Help Center at 888-466-2219 or TDD 877-688-9891. “Subscribers and enrollees who would like to file a complaint against their health plan may call the consumer hotline to register urgent complaints immediately or to obtain a Consumer Complaint Form (“CCF”) when their health plan has not resolved their filed grievance within 30 days or has concluded its consideration of the grievance without resolving it to their satisfaction.” The Department of Managed Health Care will review your situation and confirm that you have tried to settle the issue with your managed care organization. They will send you a complaint form to complete and try to work with you and the MCO to resolve the problem.

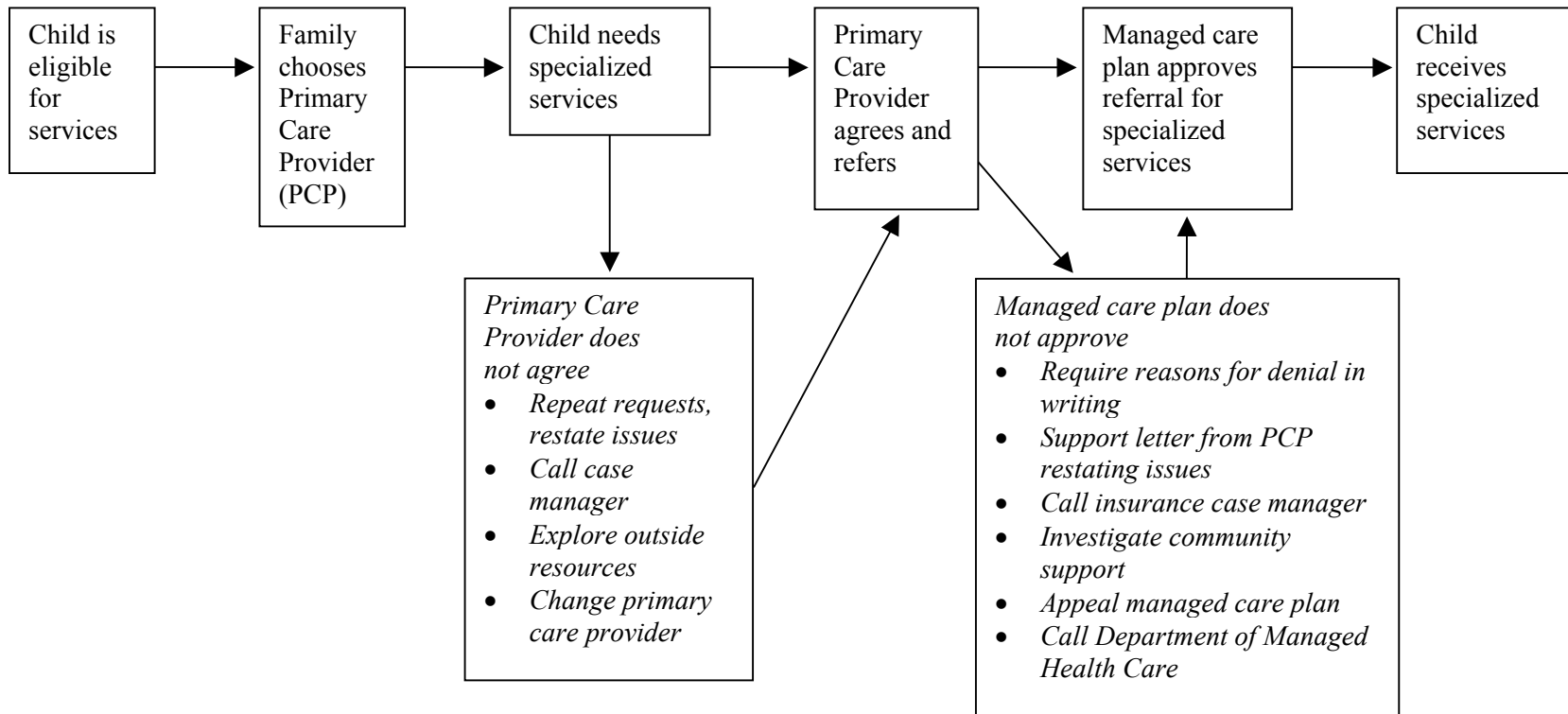
** Please note: Section 1368(b)(1)(A) of the Knox-Keene Act states the following regarding emergency care: “...*In any case determined by the Department to be a case involving an imminent and serious threat to the health of the patient, including, but not limited to, the potential loss of life, limb or major bodily function, or in any other case where the Department determines that an earlier review is warranted, a subscriber or enrollee shall not be required to complete the grievance process or participate in the process for at least 60 days.*” If you think the refusal of a service by the MCO poses a serious threat to the health of your child, file an urgent complaint with the Department of Managed Health Care.

THESE ARE GUIDELINES ONLY. FOR FULL INFORMATION ABOUT THE GRIEVANCE PROCEDURE, CONTACT YOUR HEALTH PLAN CUSTOMER SERVICE OFFICE AND THE DEPARTMENT OF MANAGED HEALTH CARE.

<p>HOW TO PROCEED WHEN REQUESTING SERVICES UNDER MANAGED CARE</p> <ul style="list-style-type: none"> ✓ Your primary care provider (PCP) ✓ Case manager in your MCO ✓ Medical director of MCO ✓ MCO grievance procedure ✓ Department of Managed Health Care

<p>THINGS TO REMEMBER</p> <ul style="list-style-type: none"> ✓ Review your Evidence of Coverage – know your plan ✓ Review the Knox Keene Act (see above)– know your rights ✓ Establish a relationship with one person within the MCO who seems responsive ✓ Document everything and keep copies ✓ Request all responses in writing. If they don’t write, <i>you</i> write and confirm your conversation ✓ Consider sending all correspondence by certified mail

PRIVATE INSURANCE (MANAGED CARE) FLOW CHART



HOW TO GET YOUR CHILD THE SERVICES HE/SHE NEEDS UNDER: PRIVATE INSURANCE FEE-FOR-SERVICE

When working with your private insurance health plan, it is imperative that you become familiar with your handbook, which will outline the evidence of coverage. Because each plan varies and their terms are so intricate, it is difficult to be specific. The following is a guideline only.

If you and your physician disagree about your child's service needs:

- Remember, the first “no” is never the final answer.
- Repeat your request in *writing* and include documentation and/or additional reasons that support the need for the referral.
- Call your case manager to discuss your perspectives as to what services are needed. See if s/he can help to advocate for your child (i.e., advise you as to what information you could include that might be meaningful to the physician and support an approval).
- Require the denial rationale be put in *writing*.
- You might need to change your child's physician. This should only be done after careful consideration. Weigh this one incident with past support this doctor has shown.

If your physician approves your request, but the insurance company says no:

- Remember the first “no” is never the final answer.
- Request a letter from your child's physician to accompany the second request.
- Make sure to point out how services will benefit your child and will avoid future expenses.
- Contact your case manager and ask him to help you advocate for your child's special needs (i.e., advise you as to what information you should communicate that might be meaningful to the managed care organization's committee and support an approval).
- Require the denial rationale be put in *writing*.
- Contact the medical director of the insurance plan in *writing* and let her know:
 - The importance of the service;
 - The efforts made to obtain the services;
 - The specifics of the denial of coverage.

State that the grounds of denial are unacceptable and that you are appealing the decision. Give them a deadline for their response to you.

- Use the insurance company's formal appeal process. Keep a record of everyone you talk to, including the date, phone number and a summary of the conversation. It is best to confirm everything in writing, and you may wish to send letters by certified mail. Request all responses in writing.

- If you cannot resolve your grievance through the insurance company’s regular channels or your agent/broker, call the California Department of Insurance’s (CDI) Consumer Services Division at (800) 927-HELP. Individuals who would like to file a complaint against their health plan may call the consumer hotline to register urgent complaints or to obtain a “Request for Assistance” (RFA).

Your RFA should contain your name, complete address and day phone number, the full name of the insurance company; the name and address of the agent or broker if appropriate; and a short description of your problem. This information is necessary for CDI’s review and is within the powers and duties expressed in the California Insurance Code, Section 12921.3. It is not mandatory that you furnish the requested information. However, failure to do so may delay or even prevent CDI to be of assistance.

Please include documents (preferable copies) related to your problem such as the declaration page of your policy or certificate, canceled checks, letters or correspondence. If you cannot get copies of documents made, and you need to send the original documents, it is suggested that you send them certified mail. The more complete the information sent to CDI, the quicker they can identify the issues and begin the review. You may inspect the information you submit at any time as long as the department’s file is maintained. All original documents will be returned to you upon completion of CDI’s handling.

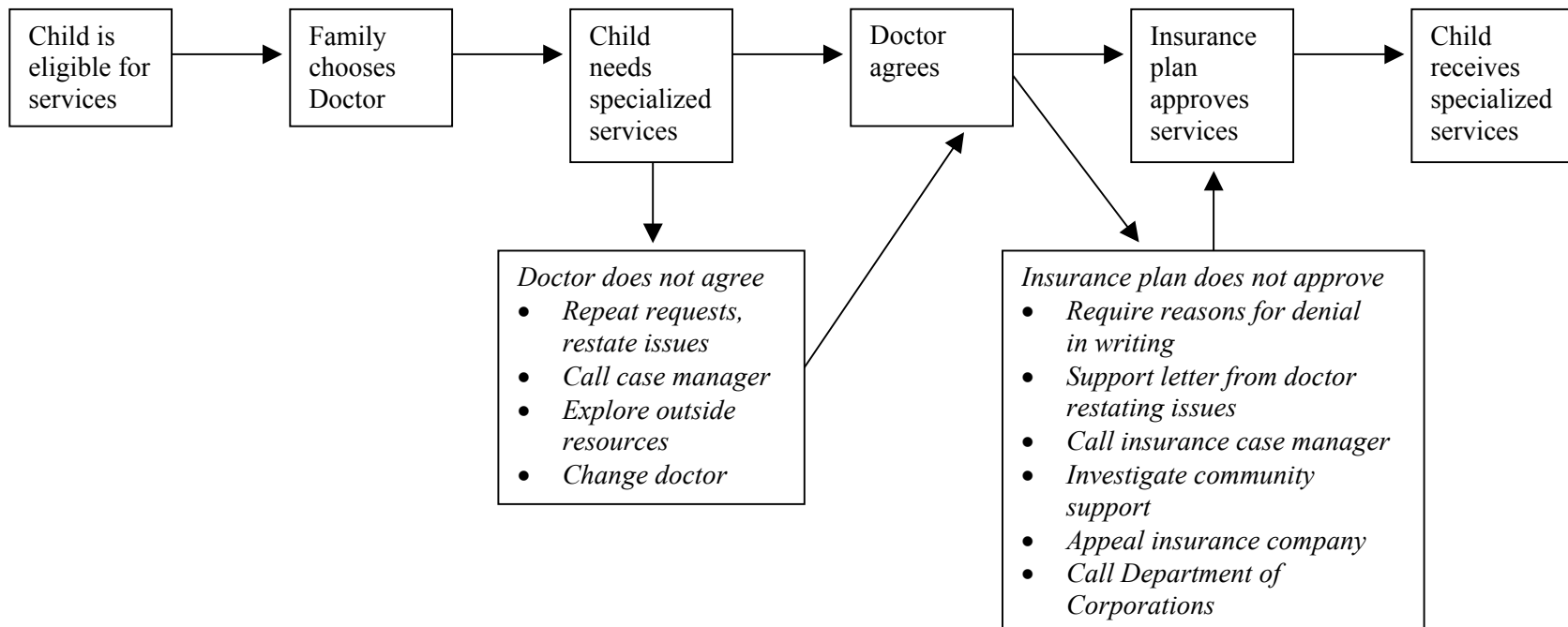
The time it takes to handle a request for assistance can vary greatly, depending on how complex the matter is. However, your request will be handled as quickly as possible.

THESE ARE GUIDELINES ONLY. FOR FULL INFORMATION ABOUT THE GRIEVANCE PROCEDURE CONTACT YOUR HEALTH PLAN CUSTOMER SERVICE OFFICE AND THE DEPARTMENT OF INSURANCE.

<p>HOW TO PROCEED WHEN REQUESTING SERVICES UNDER FEE-FOR-SERVICE PRIVATE INSURANCE</p> <ul style="list-style-type: none"> ✓ Your physician ✓ Case manager ✓ Medical director ✓ Insurance company grievance procedure ✓ Department of Insurance

<p>THINGS TO REMEMBER</p> <ul style="list-style-type: none"> ✓ Review your Summary of Coverage – know your plan ✓ Establish a relationship with one person within the insurance company who seems responsive ✓ Document everything and keep copies ✓ Request all responses in writing. If they don’t write, <i>you</i> write and confirm your conversation ✓ Consider sending all correspondence by certified mail

PRIVATE INSURANCE (FEE-FOR-SERVICE) FLOW CHART



HOW TO GET YOUR CHILD THE SERVICES HE/SHE NEEDS UNDER: MEDI-CAL MANAGED CARE PLANS

Please note: Federal law exempts children with complex medical conditions from mandatory enrollment in Medi-Cal Managed Care if he/she is receiving treatment from a doctor who is not part of the local initiative or commercial plan. **Exemption is not automatic and must be requested by you.**

- Request a “Medi-Cal Managed Care Medical Exemption” by calling 1-800-430-4263.
- Complete the form and have your current provider sign it.
- If your child meets the criteria and you are having trouble with this process, contact the Ombudsman office at 1-888-452-8609. You can also call the Health Consumer Alliance at 1-888-HMO-2219 for help.

If your child requires care, treatment or therapy from someone other than the Primary Care Provider (PCP):

- The PCP must approve your request and make a referral; and
- The managed care organization’s referral committee will approve or deny the service.

(Managed care frequently limits the use of specialists, treatment and therapy; therefore, it is not unusual to be denied. However, you can challenge these denials.)

If you and your PCP disagree about your child’s service needs:

- Remember, the first “no” is never the final answer.
- Repeat your request in *writing* and include documentation and/or additional reasons that support the need for the referral. Ask that your written request be made part of your medical record.
- Call your case manager to discuss your perspectives as to what services are needed. See if s/he can help to advocate for your child (i.e., advise you as to what information you could include that might be meaningful to the PCP and support an approval).
- Require the denial rationale be put in *writing*.
- You might need to change your child’s PCP. This should only be done after careful consideration. Weigh this one incident with past support this doctor has shown.

If your PCP approves your request, but the managed care organization says no:

- Remember the first “no” is never the final answer.
- Request a letter from your child’s PCP to accompany the second request.
- Make sure to point out how services will benefit your child and will avoid future expenses.

- Contact your case manager and ask her to help you advocate for your child's special needs (i.e., advise you as to what information you should communicate that might be meaningful to the managed care organization's committee and support an approval).
- Require the denial rationale be put in *writing*. This is a *federal* law.
- You can request a State Fair Hearing by calling the Department of Social Services at (800) 952-5253 within 90 days. This can be done even if you have filed a formal grievance with your managed care organization. Medical services should be continued until a fair hearing decision is reached if you request a hearing within 10 days of the denial.
- You can also file a formal grievance with your managed care organization. Review the summary of coverage and complain through their channels. Keep a record of everyone you talk to, including the date, phone number and a summary of the conversation. It is best to confirm everything in writing, and you may wish to send letters by certified mail. Remember, services will not continue by filing a grievance alone. You must also file a fair hearing.
- You may call the Ombudsman office at 1-888-452-8609 for assistance or clarification.
- If you cannot resolve your grievance through the MCO's regular channels, call the Department of Managed Health Care at 1-888-466-2219, 1-800-400-0815 or TDD 1-877-688-9891.

PLEASE NOTE: Depending on the Medi-Cal managed care plan you are enrolled in, the final road of appeal may be either through a State Fair Hearing or through the Department of Managed Health Care. Both options are included here for information purposes. Consult your MCO for clarification.

THESE ARE GUIDELINES ONLY. FOR FULL INFORMATION ABOUT THE GRIEVANCE PROCEDURE, CONTACT YOUR MEDI-CAL MANAGED CARE HEALTH PLAN CUSTOMER SERVICE OFFICE, THE DEPARTMENT OF MANAGED HEALTH CARE AND/OR THE DEPARTMENT OF SOCIAL SERVICES.

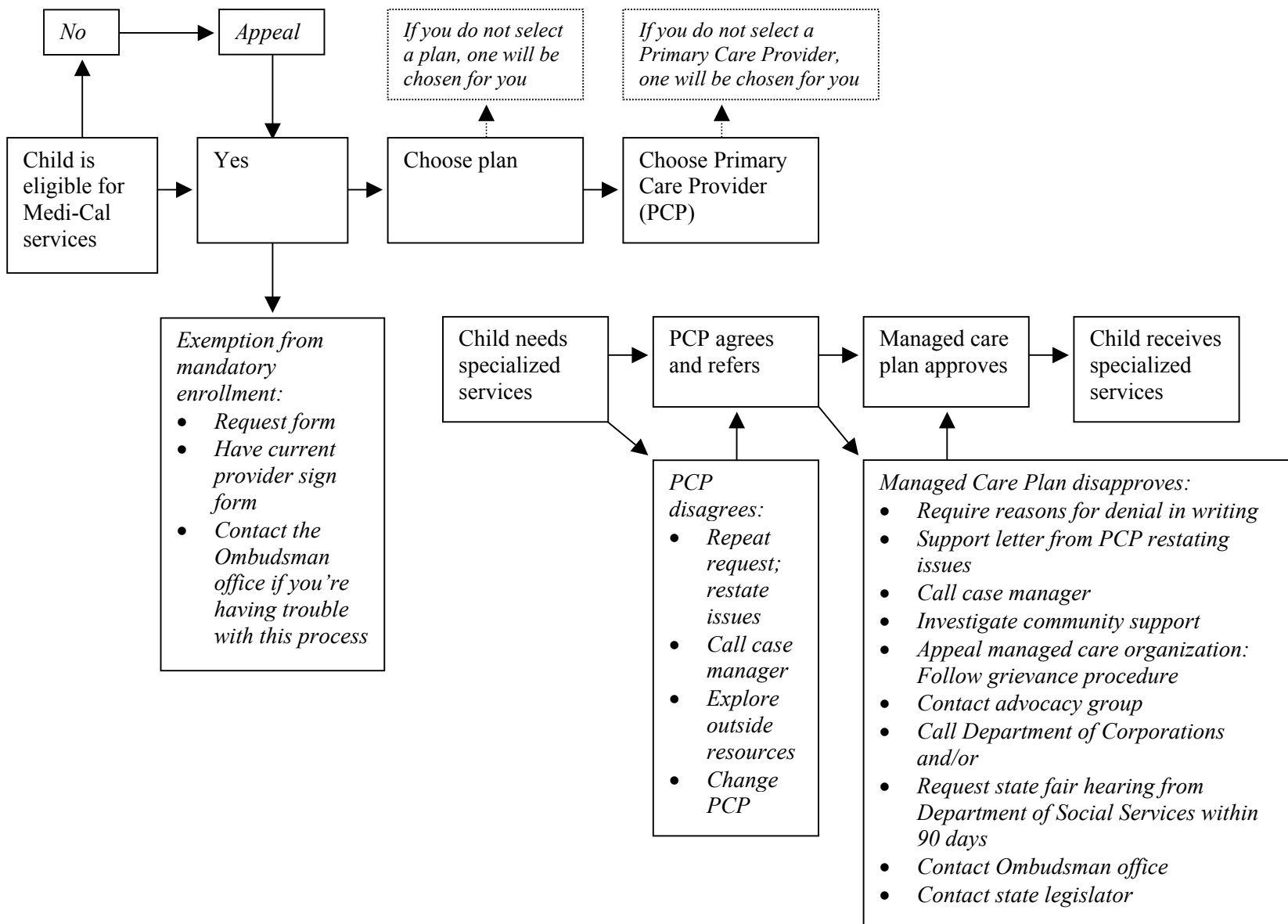
HOW TO PROCEED WHEN REQUESTING SERVICES UNDER MANAGED CARE

- √ Your primary care provider (PCP)
- √ Case manager in your MCO
- √ MCO grievance procedure
- √ Department of Corporations
- √ State Fair Hearing
- √ Department of Managed Health Care

THINGS TO REMEMBER

- √ Review your Summary of Coverage – know your plan
- √ Establish a relationship with one person within the MCO who seems responsive
- √ Document everything and keep copies
- √ Request all responses in writing. If they don't write, **you** write and confirm your conversation
- √ Consider sending all correspondence by certified mail
- √ Medi-Cal is a complicated program; avail yourself of the expertise offered by advocacy organizations, such as Protection and Advocacy and Health Consumer Alliance
- √ Medi-Cal managed care is relatively new; final road to appeal may be either through California Department of Health and Social Services or through the California Department of Managed Health Care

MEDI-CAL MANAGED CARE FLOW CHART



HOW TO GET YOUR CHILD THE SERVICES HE/SHE NEEDS UNDER: MEDI-CAL (FEE-FOR-SERVICE)

(We thank Protection and Advocacy Inc. and their manual “Medi-Cal: Service Rights and Entitlement Program Affecting Californians with Disabilities” for outlining the Medi-Cal grievance process. It is a valuable resource. You can call PAI at 800-776-5746 and request a copy. There is no charge, but there is a suggested donation amount.)

Federal law prohibits mandatory enrollment of children with special health care needs in Medi-Cal Managed Care.

If your child needs specialized care, treatment or therapy:

- The physician must approve your request and submit a treatment authorization request (TAR);
- Medi-Cal will return the TAR form with approval/denial and the reason for the denial.

If Medi-Cal denies your treatment authorization request:

- Medi-Cal must send you a notice of action when the TAR is denied with (1) explanation of the denial; (2) the regulation on which the denial is based, and (3) information about your rights to appeal.
- Remember, the first “no” is never the final answer.
- If you are currently receiving services, Medi-Cal must provide ten days’ advance notice before discontinuing or reducing services.
- Request a fair hearing/appeal during the ten-day period, and Medi-Cal must continue services until your fair hearing. You can appeal by filling out the back of the Notice of Action (NOA) or by writing directly to:

Office of the Chief Administrative Law Judge
Administrative Adjudications Division
Department of Social Services
744 P Street
Sacramento, CA 95814

- You have 90 days to file an appeal. However, if you did not receive the notice or the NOA does not explain the reason for denial, including a citation of the applicable regulation, the 90-day limit does not apply. The timeline starts when you receive the form with the appropriate citation.

Fair Hearing Process:

- As soon as you receive acknowledgement of your appeal request, write to the Medi-Cal office that denied the TAR.
- In this letter you can ask for the specific regulations that relate to the denied service/equipment and any Field Instruction Notices (FIN) and Policy Statements which address whether the type of request is covered under Medi-Cal and what medical necessity justification/documentation is required for the

TAR. If the Medi-Cal office does not supply you with the information, you can call the 800 number on the hearing request acknowledgement and ask them what you need to do to get the information.

- Ask your doctor to review the material and help provide an explanation in layman’s language.
- You can seek the services of an advocate to assist you in gathering the appropriate documentation and preparing for the fair hearing. See the “Resources” section for suggestions.

THESE ARE GUIDELINES ONLY. FOR FULL INFORMATION ABOUT THE GRIEVANCE PROCEDURE, CONTACT THE DEPARTMENT OF SOCIAL SERVICES.

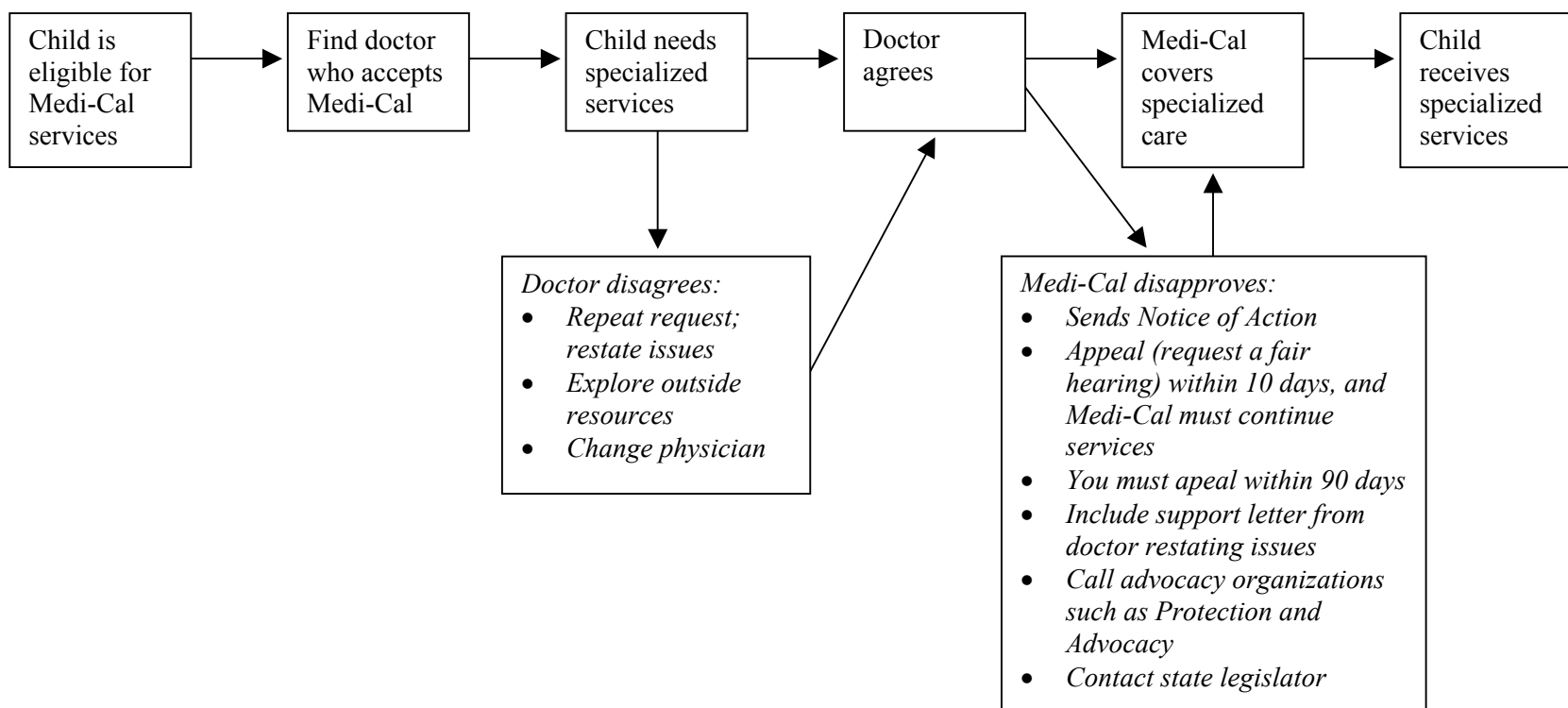
HOW TO PROCEED WHEN REQUESTING SERVICES UNDER MANAGED CARE

- ✓ Physician
- ✓ Medi-Cal Field Office
- ✓ Appeal
- ✓ Fair hearing

THINGS TO REMEMBER

- ✓ Medi-Cal is an extremely complicated program; Protection and Advocacy publishes guides and manuals to help
- ✓ Document everything and keep copies
- ✓ Request all responses in writing. If they don’t write, **you** write and confirm your conversation
- ✓ Consider sending all correspondence by certified mail
- ✓ Be sure to pay attention to appeal filing deadline dates
- ✓ Take advantage of the expertise of advocacy organizations

MEDI-CAL FEE-FOR-SERVICE FLOW CHART



HOW TO GET YOUR CHILD THE SERVICES HE/SHE NEEDS UNDER: CALIFORNIA CHILDREN SERVICES (CCS)

Eligibility/Provision of Services

Whether you have applied for CCS services or are already a client, you will be notified in writing if your eligibility/provision of service has been denied, reduced or stopped. This decision is called a “Notice of Action” (NOA). A NOA must be sent when:

- Medical or financial eligibility is denied
- Request for new service or benefit is denied
- Medical or financial eligibility is discontinued
- Services currently being provided are terminated or modified (except when the change is recommended by the doctor providing medical supervision or when the termination or modification is within the time limits of the authorization for services)

Note: A NOA is not sent if the service or benefit is a Medi-Cal benefit. If you feel that Medi-Cal wrongly denied a benefit, refer to the Medi-Cal section in this manual for assistance with their appeal process.

There are two avenues to appeal a NOA decision:

1. Formal appeal process (Section 1 below)
2. Expert evaluation in lieu of formal appeal for physical and/or occupational therapy services (Section 2 below)

Section 1 [Formal Appeal Process] — If you disagree with the decision in a CCS NOA:

- Remember, the first “no” is never the final answer.
- The NOA will contain instructions for the appeal process. Call the CCS number listed on the NOA. Perhaps the problem can be resolved with a phone call. Make sure to keep of a log of any phone conversation and request confirmation of the conversation in writing if the resolution is different from that on the NOA.
- If you cannot resolve the problem, request an appeal within 30 days of the date of the NOA. Be sure to clearly state why you disagree with the CCS action and what action you want CCS to take. If CCS is already providing services to your child, ask that these services continue while your appeal is being decided.
- The first level appeal is reviewed at the county CCS level and must be completed within 21 days of receipt of your appeal.
- If your first appeal is denied, you have the right to request a fair hearing within 14 days of the date of CCS’s written decision. Be sure to include a copy of the first level appeal decision in your fair hearing request. If you need an interpreter, one will be provided for you at no cost – you must ask for the interpreter when you make your fair hearing request.

Section 2 [Expert Evaluation in Lieu of Formal Appeal] — Applicable to physical/occupational therapy services provided through the CCS Medical Therapy Program (MTP):

- Remember, the first “no” is never the final answer.
- Request a second opinion. You will be able to choose the doctor from a list of three experts that CCS will provide.
- The second opinion is considered final. There is no recourse to further appeal.

There are time lines for all actions. The “Resolutions of Complaints and Appeals by CCS Clients or Applicants” (California Code of Regulations, Title 22, Chapter 13, Sections 42700-42720) describes the formal due process system. You can get that by calling your local CCS office.

THESE ARE GUIDELINES ONLY. FOR FULL INFORMATION ABOUT CCS GRIEVANCE PROCEDURE, CALL YOUR CCS OFFICE.

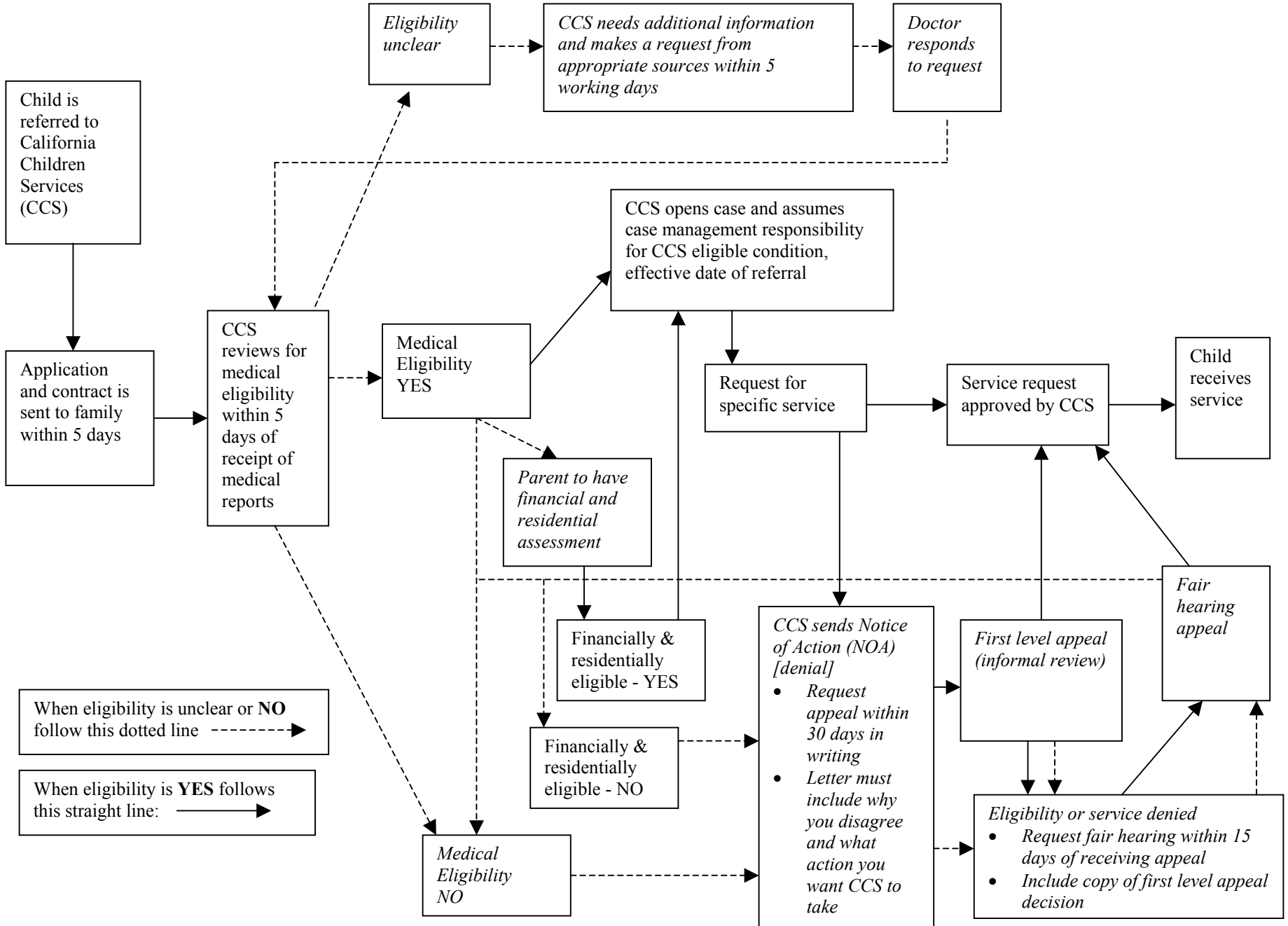
HOW TO PROCEED WHEN REQUESTING SERVICES UNDER CCS

- ✓ Your CCS physician
- ✓ Case manager
- ✓ Second opinion by a CCS expert
- ✓ First level appeal
- ✓ Fair hearing request

THINGS TO REMEMBER

- ✓ Review all CCS information – know the plan and your rights
- ✓ Establish a relationship with your CCS case manager
- ✓ Document everything and keep copies
- ✓ Request all responses in writing. If they don’t write, ***you*** write and confirm your conversation
- ✓ Consider sending all correspondence by certified mail
- ✓ Be sure to pay attention to appeal filing deadline dates
- ✓ Take advantage of the expertise of advocacy organizations

CALIFORNIA CHILDREN SERVICES FLOW CHART



HOW TO GET YOUR CHILD THE SERVICES HE/SHE NEEDS UNDER: REGIONAL CENTER (DEPARTMENT OF DEVELOPMENTAL SERVICES – DDS)

Under the Lanterman Act the regional centers are mandated to assist families in obtaining medical care and services when it is part of the Individual Program Plan (IPP):

4685C1 SUPPORT SERVICES

THE DEPARTMENT AND REGIONAL CENTERS SHALL GIVE VERY HIGH PRIORITY TO THE DEVELOPMENT AND EXPANSION OF SERVICES AND SUPPORTS DESIGNED TO ASSIST FAMILIES THAT ARE CARING FOR THEIR CHILDREN AT HOME, WHEN THAT IS THE PREFERRED OBJECTIVE IN THE INDIVIDUAL PROGRAM PLAN. THIS ASSISTANCE MAY INCLUDE, BUT IS NOT LIMITED TO, SPECIALIZED MEDICAL AND DENTAL CARE, SPECIAL TRAINING FOR PARENTS, INFANT STIMULATION PROGRAMS, RESPITE FOR PARENTS, HOMEMAKER SERVICES, CAMPING, DAY CARE, SHORT TERM OUT-OF-HOME CARE, CHILD CARE, COUNSELING, MENTAL HEALTH SERVICES, BEHAVIOR MODIFICATION PROGRAMS, SPECIAL ADAPTIVE EQUIPMENT SUCH AS WHEELCHAIRS, HOSPITAL BEDS, COMMUNICATION DEVICES, AND OTHER NECESSARY APPLIANCES AND SUPPLIES, AND ADVOCACY TO ASSIST PERSONS IN SECURING INCOME MAINTENANCE, EDUCATIONAL SERVICES AND OTHER BENEFITS TO WHICH THEY ARE ENTITLED.

If your child needs specialized care, treatment or therapy and you think it is a service you should receive from the Regional Center:

- Make a written request to your Case Manager, clarifying exactly what is needed. This is preferable to a phone call as it will expedite the process. Ask for an Individual Program Plan (IPP) meeting.
- Put requests for those items or services which are related to your child's developmental disability in your Individual Program Plan (IPP).
- The Regional Center is payer of last resort. Included in your request should be letters of denial from other payers (such as your insurance company) as well as prescriptions from doctors for equipment. Always keep copies.
- If you request that your child's IPP be reviewed, it should happen within 30 days of your request.

If your case manager cannot approve your request at the IPP meeting:

- Request a second IPP meeting within 15 days of the original meeting. Ask for a regional center "decision-maker" to be in attendance.
- There can be more meetings regarding your request IF you agree to them.

If your request is denied:

- The regional center must send you a written denial within 5 days of the second IPP meeting which contains the reasons for the denial, the legal basis, and notice of your right to appeal.
- Request a written denial of your request and an application for appeal.

- File your fair hearing request.
- You can call your Area Board or Protection and Advocacy for assistance in the process.

Fair hearing process (this process may change due to a proposed bill which would add a mediation process):

- An informal hearing must be held within 10 days of the date the Regional Center receives your request. The notice should include your rights to be present at all proceedings, to present oral and written evidence, to confront and cross-examine witnesses, to appear in person with counsel or other representatives of your choosing; your rights to records and to an interpreter; available advocacy assistance; proposed date and time.
- If you are dissatisfied with the results of the informal hearing, you have a right to a fair hearing. File a written request.
- You should receive notice within 20 days. The notice should include your rights to be present at all proceedings, to present oral and written evidence, to confront and cross-examine witnesses, to appear in person with counsel or other representatives of your choosing; your rights to records and to an interpreter; available advocacy assistance; proposed date and time. The fair hearing will be held at a reasonably convenient time and place for you and your authorized representative.
- Within 10 days of the concluding day of the hearing, the hearing officer shall render a decision, which is final.
- You can appeal any final administrative decision to a court of competent jurisdiction within 90 days.

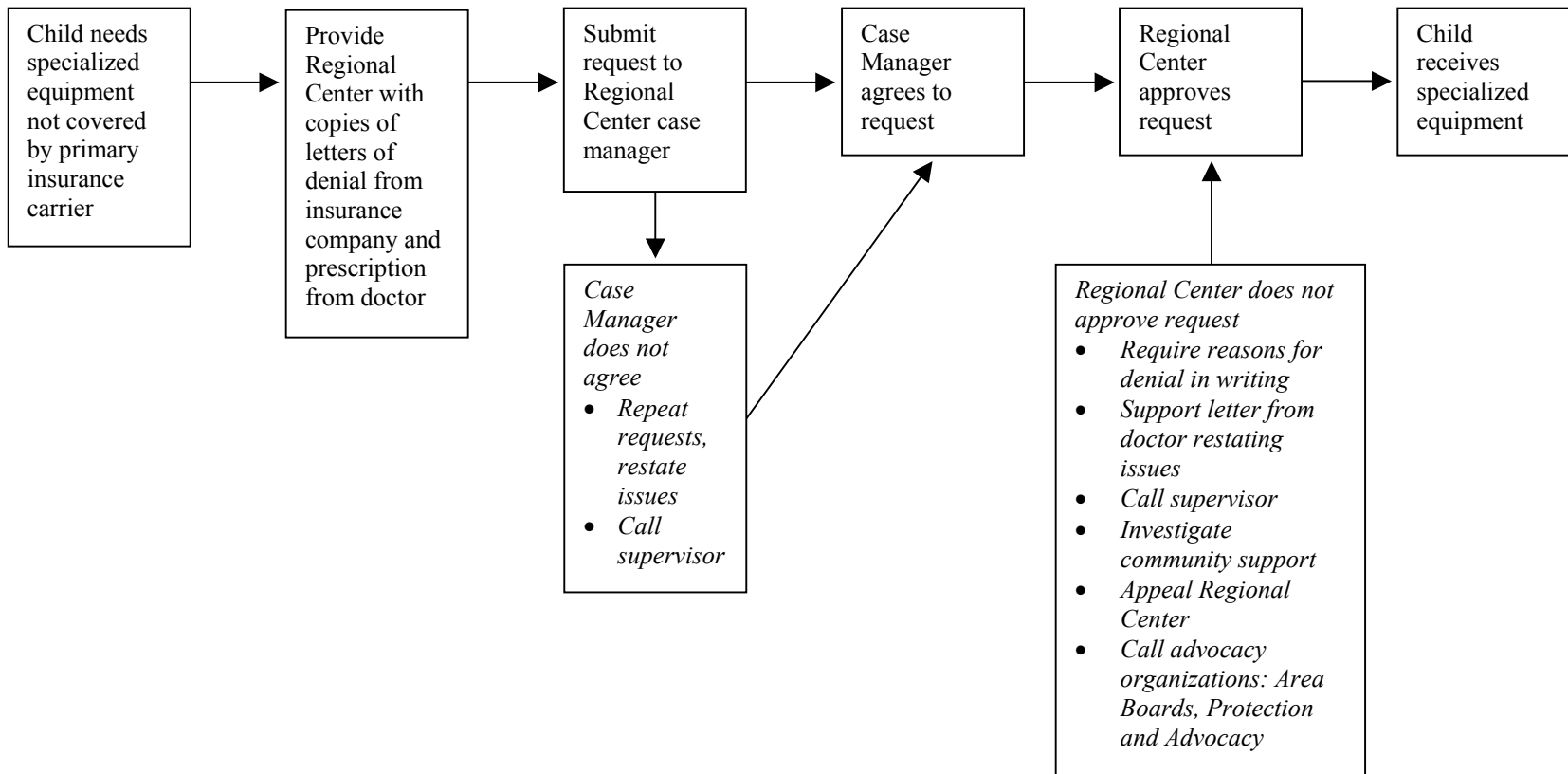
**HOW TO PROCEED WHEN
REQUESTING SERVICES
FROM THE
REGIONAL CENTER**

- ✓ Case manager
- ✓ Decision maker
- ✓ Informal hearing
- ✓ Fair hearing
- ✓ Court

THINGS TO REMEMBER

- ✓ Review the Lanterman Act — know your rights
- ✓ Establish a relationship with your case manager
- ✓ Document everything and keep copies
- ✓ Request all responses in writing; if they don't write, **you** write and confirm your conversation.
- ✓ Consider sending all correspondence by certified mail
- ✓ Be sure to pay attention to appeal filing deadline dates
- ✓ You can request assistance from an advocate; take advantage of their expertise

REGIONAL CENTER FLOW CHART FOR SPECIALIZED EQUIPMENT



HELPFUL HINTS FOR WRITING LETTERS

What to include:

1. It is best to address your letter to a specific person instead of a general department or to the managed care plan itself, for example:

Dr. John Smith
Medical Director
ABC Health Plan

2. Be sure to show your child's name and chart or account number within the plan, your address and phone number.
3. Begin your letter with a brief statement of who you are and why you are writing.
4. If you are requesting a written explanation of the reasons for denial, state that you have reviewed your contract and can't find a valid reason for the denial in your policy. Ask for specifics, not just a response that states "not a covered benefit" or "not medically necessary."
5. If you are appealing a denial, state your understanding of the denial and explain why you feel the services are necessary and/or should not be denied. Use any articles, research and other supporting professional opinions.
6. Include dates and names of those with those whom you have already spoken.
7. Ask for a response (a letter, meeting or phone call) within a reasonable deadline. Your coverage may have specific time frames that apply to appeals; be aware of appropriate processes.
8. Have someone proofread your letters.
9. Keep a copy for your personal records.
10. Send copies to as many persons as you can, for example:
 - Your child's Primary Care Provider or case manager
 - Your employer's human resources department (if your coverage is provided through your employer)
 - Membership services representative of your health plan
 - Any advocacy groups that have supported you
 - Your state or local politicians, if the first responses are not satisfactory

SAMPLE LETTER I

Your Name
Your Address
City, State, Zip
Telephone Number

Date

Full Name of Person to whom you're writing
Title
Name of Hospital/Medical Group/Agency
Street Address
City, State, Zip Code

Dear (name of person, use title and last name),

Opening paragraph. In this paragraph explain who you are, give the full name of your child, and date of birth, then *very briefly*, explain the reason you are writing.

Paragraph Two. In this paragraph explain what you would like to have happen or what you would like to see changed. You may *briefly* say what you would not like, but *spend most of this paragraph saying what you want*.

Paragraph Three. Say what type of response you want. For instance, do you need to meet with anyone, do you want a return letter, or a phone call?

Closing Paragraph. Finally, give your daytime telephone number and let the person you are writing know that you expect to hear from him/her soon (or give a date, i.e., "by the 15th").

Sincerely yours,

(Sign your full name)

SAMPLE LETTER II

January 5, 2001

Patient: Judy Jones
I.D. #:555-44-3333
Employee: Jasper Jones
Group: Acme Associates
Claim Number: 026439782

XYZ Insurance Company
555 Insurance Company Plaza
Anytown, USA Zip Code

Dear Insurance Company Representative:

Thank you for reviewing our appeal of the denial for a Touch Talker for our daughter, Judy Jones. We were dismayed, however, to receive a letter upholding the previous denial dated December 10, 1999 (see the enclosed copy), and would like to ask that you reconsider this decision. We understand that the denial of this request is based on the premise that the Touch Talker is not considered a prosthesis under this plan and it does not meet the Plan's definition of durable medical equipment. Since electronic communication devices are new in the medical field, some insurance companies have not yet been made aware of the medical nature of the devices or of the function they serve.

Judy is a nine year-old girl with cerebral palsy. Her larynx is non-functional for speech due to cerebral palsy, and this condition cannot be surgically corrected. The Touch Talker would serve to replace this nonfunctional organ, the larynx. Page 32 of the policy book states as covered items "...a prosthetic appliance replaces a limb or organ ..." The Touch Talker seems to clearly meet your requirements for a prosthesis.

Page 22 of the policy book describes "durable medical equipment" as equipment that:

- 1) "... can stand repeated use."

The Touch Talker can withstand repeated use. Because many people who use the Touch Talker do not have total voluntary control of their muscles, the Touch Talker is built of a highly durable material called Kydex, which is intended to withstand rough treatment.

- 2) "...is primarily and customarily used to serve a medical purpose."

As stated above, the Touch Talker serves to replace the function of the larynx, which is non-functional. It is primarily and customarily used for this purpose. This is documented in the enclosed letter from Judy's pediatrician.

- 3) "...is not useful in the absence of illness or injury."

The Touch Talker provides a voice to people who cannot speak. It does not have functions that would benefit a person who has functional use of his or her speech mechanisms.

XYZ Insurance Company
January 5, 2001
Page 2

4) "... can be used in the home."

The Touch Talker may be used in any setting, including the home.

It is clear that the Touch Talker satisfies the above conditions for coverage of durable medical equipment. Furthermore, I understood from my conversation with Mr. William Wilson of your company, that our request was denied because the Touch Talker was considered to be a computer. The Touch Talker is definitely a medical appliance, which replaces a malfunctioning body part.

In the general information section of our policy, on page 42, "medical necessity" is defined as: "A medical condition requiring medical services and treatment. Such services and treatment must be in keeping with generally accepted medical practices for the diagnosis and condition of the patient."

Enclosed is a prescriptive letter from Judy's attending physician, Dr. Penelope Perkins, certifying the medical necessity of this equipment for Judy. Judy has significant speech apraxia that can be specifically habilitated with an oral communicator. Without this device, should Judy find herself in an emergency situation, she has no other means of conveying her needs. Without a means of communicating a medical problem, it could go undetected until it became more serious, requiring more extensive treatment, and ultimately greater expense to the insurance company.

Thank you for your attention to this appeal. I trust that with this clarification of the Touch Talker communication device, you will see that it should definitely be a covered expense under our plan.

Enclosed please find copies of all correspondence to date related to this request. Please contact us if you have any further questions.

Sincerely,

Jane Jones

Jasper Jones

Enclosures

RESOURCES

MONITORING AGENCIES

To complain about indemnity or fee-for-service insurance policies, call or write:

California Department of Insurance
Consumer Services Division
300 South Spring Street
Los Angeles, CA 90013
1-800-927-HELP
(1-800-927-4357)

Questions or complaints regarding most HMOs should be addressed to:

Department of Managed Health Care
HMO Help Center, IMR Unit
980 Ninth Street, Suite 500
Sacramento, CA 95814-2725
888-HMO-2219
TDD: 877-688-9891
www.hmohelp.ca.gov

For information about the federal Employees Retirement Security Act (ERISA) or employer self-insured plans contact:

U.S. Department of Labor
Pension & Welfare Benefits Administration
200 Constitution Avenue, N.W.
Room N-5658
Washington, DC 20210
415-744-6700 Northern California

LOCAL CONTACTS

Program:	California Children Services	Program:	Medi-Cal
Contact:		Contact:	
Address:		Address:	
Phone #:		Phone #:	
State Phone #:	916-654-0499	State Phone #:	888-747-1222
Program:	Child Health & Disability Prevention (CDHP)	Program:	Regional Center
Contact:		Contact:	
Address:		Address:	
Phone #:		Phone #:	
State Phone #:	916-654-0499	State Phone #:	916-654-1897
Program:	Family Resource Center	Program:	Supplemental Security Income (SSI)
Contact:		Contact:	
Address:		Address:	
Phone #:		Phone #:	
State Phone #:	800-515-BABY	State Phone #:	800-772-1213
Program:	Genetically Handicapped Persons Program (GHPP)	Program:	Temporary Assistance for Needy Families (TANF / CalWorks)
Contact:		Contact:	
Address:		Address:	
Phone #:		Phone #:	
State Phone #:	800-639-0597	State Phone #:	800-952-5253
Program:	Health Plan	Program:	Women, Infants & Children (WIC)
Contact:		Contact:	
Address:		Address:	
Phone #:		Phone #:	
State Phone #:		State Phone #:	888-942-9675
Program:	Healthy Families	Program:	Advocacy Organization
Contact:		Contact:	
Address:		Address:	
Phone #:		Phone #:	
State Phone #:	888-747-1222	State Phone #:	

PUBLIC AGENCY RESOURCES

Here are numbers of the various public health-related agencies mentioned throughout this manual. Some of the state agencies will be able to refer you to local resources.

PUBLIC AGENCY	STATE / 800 NUMBER	LOCAL NUMBER
<p>Access for Infants and Mothers (AIM) AIM provides health coverage for pregnant women and their children, and also provides health insurance for the baby for two years. Eligibility rules apply.</p>	<p>800-433-2611 Fax: 888-889-9238 www.aim.ca.gov</p>	<p>Same</p>
<p>California Children Services (CCS) CCS is California’s Title V program for children with special health care needs. CCS arranges, directs and pays for medical care, equipment and rehabilitation for CCS eligible conditions. Eligibility rules apply. See Description of Services, Section B of this manual.</p>	<p>916- 327-1400 www.dhs.ca.gov/pcfh/cms/ccs/ This number is for the Department of Health Services, Children’s Medical Services Branch, which oversees CCS regional/local offices.</p>	<p>San Francisco County CCS: 415-575-5700 Fax: 415-575-5790</p>
<p>CaliforniaKids CaliforniaKids provides outpatient, dental, eye care, prescription, mental health services for uninsured children ages 2–18. Eligibility rules apply. See Description of Services, Section B of this manual</p>	<p>818-755-9443 www.californiakids.org</p>	<p>Same</p>
<p>CalWorks CalWorks is the name of California’s federal welfare program Temporary Assistance for Needy Families (TANF), which offers cash assistance to families. Eligibility rules apply. See Description of Services, Section B of this manual.</p>	<p>(916) 445-6951 www.dss.cahwnet.gov/cdssweb/california_169.htm This number is for the California Department of Social Services, which oversees the CalWorks program.</p>	<p>(415) 557-5723</p>
<p>Child Health and Disability Prevention Program (CHDP) CHDP is a preventive health program that provides early no-cost health care and information to children and youth. Eligibility rules apply. See Description of Services, Section B of this manual</p>	<p>916-327-1400 www.dhs.ca.gov/pcfh/cms/chdp/ TDD (916) 440-7399 This number is for the CA Department of Health Services, Children’s Medical Services Branch, which oversees CHDP regional/local offices.</p>	<p>415-575-5712 Fax: 415-558-5905</p>

PUBLIC AGENCY RESOURCES, CONTINUED

PUBLIC AGENCY	STATE / 800 NUMBER	LOCAL NUMBER
<p>Department of Developmental Services (DDS)</p> <p>DDS provides services and supports to persons with developmental disabilities through 21 Regional Centers throughout California. See Description of Services, Section B of this manual</p>	<p>(916) 654-1690 www.dds.cahwnet.gov</p>	<p>Golden Gate Regional Center: 415-546-9222 Fax: 415-546-9203 www.ggrc.org</p>
<p>Department of Education, Special Education Division</p> <p>The Special Education Division provides leadership and assistance to all public and private agencies that offer educational services to individuals, birth through 21, with exceptional needs.</p>	<p>916-319-0800 www.cde.ca.gov/sp/se/</p>	<p>San Francisco Unified School District—Special Education Division: 415-355-7735 Fax: 355-7741</p>
<p>Department of Health Services</p> <p>The Department of Health Services oversees medical service programs in California, including California Children Services (CCS), Medi-Cal, CHDP and other programs</p>	<p>916-327-1400 www.dhs.ca.gov TDD 916-440-7399</p>	<p>San Francisco Department of Public Health: 415-554-2500</p>
<p>Department of Insurance</p> <p>The Consumer Services Division of the Department of Insurance can provide information and help investigate complaints regarding health insurance plans that are issued by <i>insurance companies</i>. Grievances against health plans <i>not</i> issued by insurance companies (such as managed care health plans) are handled through the Department of Corporations.</p>	<p>800-927-HELP (4357) TDD: 800-482-4833 This number is to the Consumers Communications Bureau which oversees the CA Dept. of Insurance. www.insurance.ca.gov</p>	<p>Same</p>
<p>Department of Managed Health Care</p> <p>The Department of Corporations is responsible for regulating health care services. The DOC can assist with grievances against private health care plans.</p>	<p>888-HMO-2219 or TDD 877-688-9891 www.dmhc.ca.gov</p>	<p>Same</p>
<p>Department of Social Services Fair Hearing Division (for Medi-Cal Grievances)</p> <p>For information about or to request a State Fair Hearing for a Medi-Cal grievance.</p>	<p>916-657-3550 FAX: 916-651-6258 www.dss.cahwnet.gov/shd/Mission_Vi_1544.htm</p>	<p>Bay Area Regional Office: 510-622-4000 Fax: 510-622-4004</p>

PUBLIC AGENCY RESOURCES, CONTINUED

PUBLIC AGENCY	STATE / 800 NUMBER	LOCAL NUMBER
<p>Genetically Handicapped Persons Program (GHPP) GHPP arranges and pays for medical care and rehabilitation for some adults and eligible children who have certain inherited conditions. Eligibility rules apply. See Description of Services, Section B of this manual.</p>	<p>916-327-0470 800-639-0597 Fax: 916-327-1112 www.dhs.ca.gov/pcfh/cms/ghpp</p>	<p>Same</p>
<p>Healthy Families Health Families is California’s State Child Health Insurance Plan to provide health insurance for low-income children in families with incomes too high to qualify for Medi-Cal. Eligibility rules apply. See Description of Services, Section B of this manual.</p>	<p>800-880-5305 <i>(if you do NOT have a child enrolled)</i> 866-848-916 <i>(if you DO have a child enrolled)</i> HealthyFamilies Maximus.com www.healthyfamilies.ca.gov/hf/hfhome.jsp</p>	<p>Same</p>
<p>Kaiser Permanente Cares for Kids Child Health Plan The Child Health Plan provides health coverage to uninsured children under 19 who are not eligible for other public/private programs. Eligibility rules apply. See Description of Services, Section B of this manual.</p>	<p>800-255-5053 www.kaiserpermanente.org</p>	<p>Same</p>
<p>Medi-Cal for Children Medi-Cal is California’s public program that pays for health and long-term care services for low-income Californians as well as others with very high medical expenses. Medi-Cal offers two types of coverages: Fee for Service and Managed Care. Eligibility rules apply. See Description of Services, Section B of this manual.</p>	<p>888-747-1222 www.medi-cal.ca.gov</p>	<p>San Francisco Department of Human Services: 415-863-9892</p>
<p>Medi-Cal Waivers Medi-Cal waivers allow some children with special needs whose parents are over income limits to qualify for Medi-Cal benefits. Waivers are administered by the Department of Developmental Services (DDS) or by the In-Home Operations division of Medi-Cal. Eligibility rules apply. See Description of Services, Section B of this manual.</p>	<p>“Home & Community-Based Services (HCBS) Waivers” 916-874-9377 or 916-324-5903 or DDS 916-654-1690</p>	<p>Golden Gate Regional Center: 415-546-9222 Fax: 415-546-9203 www.ggrc.org</p>

PUBLIC AGENCY RESOURCES, CONTINUED

PUBLIC AGENCY	STATE / 800 NUMBER	LOCAL NUMBER
<p>Supplemental Security Income (SSI)</p> <p>SSI is a federal program that provides monthly cash stipends and access to Medi-Cal for children with specific disabilities/chronic illnesses. Eligibility rules apply. See Description of Services, Section B of this manual.</p>	<p>800-772-1213 TTY: 800-325-0778 www.ssa.gov/notices/supplemental-security-income/</p>	<p>Same</p>
<p>Women, Infants and Children (WIC) Supplemental Nutrition Program</p> <p>WIC provides coupons for food, nutrition education and referral to other services for some women and children. Eligibility rules apply. See Description of Services, Section B of this manual.</p>	<p>888-942-9675 www.wicworks.ca.gov</p>	<p>415-575-5788</p>

ADVOCACY AND INFORMATION RESOURCES

Here are telephone numbers of various information and referral and/or advocacy organizations in California.

NAME OF ORGANIZATION	STATE / 800 NUMBER	LOCAL CONTACT
<p>Developmental Disabilities Area Boards Area Boards were established to monitor and review the service delivery system for persons with developmental disabilities in each region. There are 13 in California.</p> <p>Office of the California State Council on Developmental Disabilities 1507 21st Street, Suite 210 Sacramento, California 95814</p>	<p>916-227-2148 www.scdd.ca.gov You can also find out which Area Board serves your location by contacting your local Regional Center.</p>	<p>Area Board 5: 510-286-0439 510-286-4397 (County roster can be found at: www.scdd.ca.gov/area_board_roster.htm)</p>
<p>Family Resource Centers Most communities/counties have a family resource center that can help you with information and referrals for issues that relate to children with special health care needs. One of the Parent Training and Information Centers (PTIs) listed among these resources, your Regional Center, or your local school district can direct you.</p>	<p>www.familyresourcecenters.net</p>	<p>Support for Families of Children with Disabilities at Open Gate: 2601 Mission Street, 3rd Floor, San Francisco, CA 94110 415-920-5040</p>
<p>Family Voices 2340 Alamo SE, Ste. 102 Albuquerque, NM 87106</p> <p>Family Voices is a grassroots network of families and friends speaking on behalf of children with special health care needs.</p>	<p>505-872-4774 888-835-5669 Fax: 505-872-4780 www.familyvoices.org</p>	<p>CA Coordinator: Linda Vossler-Swan Support for Families 2601 Mission Street, 606 San Francisco, CA 94110 415-282-7494</p>
<p>Medi-Cal Community Assistance Project (MedCap) 924 Market Street, Suite 402 San Francisco, CA 94102</p> <p>MedCap is a statewide mobilization and advocacy effort working to ensure that the Medi-Cal program operates effectively and efficiently on behalf of the people who count on it.</p>	<p>415-395-7959</p>	<p>Same</p>

ADVOCACY AND INFORMATION RESOURCES, CONTINUED

Parent Training and Information Centers (PTIs)

The following are PTIs in California. You can call any of them for information about children with special health care needs (this list was provided by “Technical Assistance Alliance for Parent Centers” found at: www.taalliance.org/centers).

NAME OF ORGANIZATION	STATE / 800 NUMBER	LOCAL CONTACT
<p>Disability Rights Education & Defense Fund (DREDF) 2212 Sixth Street Berkeley, CA 94710 dredf@dredf.org www.dredf.org</p>	<p>510-644-2555 (TDD available) Fax: 510-841-8645 800-466-4232</p>	<p>Same</p>
<p>Exceptional Parents Unlimited 4440 N. First St. Fresno, CA 93726 bcoulbourne@exceptionalparents.org www.exceptionalparents.org</p>	<p>559-229-2000 Fax: 559-229-2956</p>	
<p>Fiesta Educativa (CPRC) 3839 Selig Place Los Angeles, CA 90031 fiestaed@aol.com www.fiestaeducativa.org</p>	<p>323-221-6696 Fax: 323-221-6699</p>	
<p>Matrix Parent Network & Resource Center 94 Galli Drive, Suite C Novato, CA 94949 matrix@matrixparents.org www.matrixparents.org</p>	<p>415-884-3535 415-884-3554 (TDD) 415-884-3555 (fax) 800-578-2592</p>	
<p>Parents Helping Parents of Santa Clara 3041 Olcott Street Santa Clara, CA 95054-3222 info@php.com www.php.com</p>	<p>408-727-5775 408-727-7655 (TDD) 408-727-0182 (fax)</p>	
<p>Protection and Advocacy, Inc. (PAI) 100 Howe Avenue, Suite 185-N Sacramento, CA 95825 www.pai-ca.org PAI is the agency appointed under federal law to protect the civil, legal and service rights of Californians with disabilities.</p>	<p>916-488-9950 800-719-5798 TTY 800-776-5746</p>	<p>Bay Area Office: 433 Hegenberger Rd, Suite 220 Oakland CA 94621 510-430-8033 TTY: 800-649-0154 800-776-5746</p>

ADVOCACY AND INFORMATION RESOURCES, CONTINUED

The following are PTIs in California. You can call any of them for information about children with special health care needs.

NAME OF ORGANIZATION	STATE / 800 NUMBER	LOCAL CONTACT
Rowell Family Empowerment of Northern CA 6319 A Skyway Paradise, CA 95969 sklowrance@aol.com www.sea-center.org	530-226-5129 530-226-5141 888-263-1311	
SSI for Children with Disabilities Project of the Volunteer Legal Services Program 1360 Mission Street Suite 201 San Francisco, CA 94103 www.sfbar.org/vlsp/children.html rmolloy@sfbar.org This project provides free legal assistance to parents who apply for SSI on behalf of their children.	415-865-9215 Fax: 415-575-3132	Same
Support for Families of Children with Disabilities at Open Gate 2601 Mission St., 3 rd Floor San Francisco, CA 94110-3111 info@supportforfamilies.org www.supportforfamilies.org	415-920-5040 Fax: 415-920-5099	
Team of Advocates for Special Kids (TASK)-Anaheim 100 West Cerritos Ave. Anaheim, CA 92805 taskca@yahoo.com www.taskca.org	714-533-8275 714-533-2533	Same
Team of Advocates for Special Kids (TASK)-San Diego 4550 Kearny Villa Road, Suite 102 San Diego, CA 92123 taskca@yahoo.com www.taskca.org	858-874-2386 Fax: 858-874-0123	

NATIONAL RESOURCES

<p>Bazelon Center For Mental Health Law 1101 – 15th Street NW, Suite 1212 Washington, D.C. 20005 202-467-5730 Fax: 202-223-0404 www.bazelon.org</p>	<p>The Bazelon Center is a non-profit legal advocacy organization for people with mental illness and mental retardation.</p>
<p>Exceptional Parent Library 800-535-1910 www.eplibrary.com</p>	<p>Exceptional Parent Library offers books for sale on a number of disability-related issues.</p>
<p>Family Voices 2340 Alamo SE, Ste. 102 Albuquerque, NM 87107 505-872-4774 or 888-835-5669 Fax: 505-872-4780 www.familyvoices.org kidshealth@familyvoices.org</p>	<p>Family Voices is a national, grassroots clearinghouse for information and education concerning the health care of children with special health needs.</p>
<p>Fathers Network, The Kindering Center 16120 NE 8th Street Bellevue, Washington 98008 425-747-4004 Fax: 425-747-1069 jmay@fathersnetwork.org www.fathersnetwork.org</p>	<p>The Fathers Network provides current information and resources to assist all families and care providers involved in the lives of children with special needs.</p>
<p>Institute for Child Health Policy University of Florida 1329 SW 16th St., Room 5130 Gainesville, FL 32608 352-265-7220 Fax: 352-265-7221 www.ichp.ufl.edu</p>	<p>The Institute for Child Health Policy focuses its attention on children in managed care with special emphasis on children with special health care needs.</p>
<p>Institute for Health and Disability 420 Delaware Street SE, Box 721 Minneapolis, Minnesota 55455 instihd@tc.umn.edu www.peds.umn.edu/Centers/ihd</p>	<p>The Institute for Health and Disability is a network of programs for children and youth and their families designed to improve the health and functioning of children and youth within the context of their families and communities.</p>
<p>Mothers United for Moral Support, Inc. (MUMS) National Parent to Parent Network 150 Custer Court Green Bay, Wisconsin 54301-1243 877-336-5333 Fax: 920-339-0995 mums@netnet.net www.netnet.net/mums</p>	<p>MUMS is a national parent-to-parent organization for families of children with any disability, disorder, chromosomal abnormality or health conditions which provides support in the form a networking system that matches parents with other parents whose children have the same or similar condition.</p>

NATIONAL RESOURCES, CONTINUED

<p>National Committee for Quality Assurance (NCQA) 2000 L Street NW, Suite 500 Washington, D.C. 20036 202-955-3500 www.ncqa.org</p>	<p>NCQA is a private, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans.</p>
<p>National Dissemination Center for Children and Youth With Disabilities (NICHCY) P.O. Box 1492 Washington, D.C. 20013-1492 800-695-0285 or 202-884-8200 TTY: 800-695-0285 Fax: 202-884-8441 nichcy@aed.org www.nichcy.org</p>	<p>NICHCY is the national information and referral center that provides information on disabilities and disability-related issues for families, educators and other professionals, with a special focus on children and youth (birth to age 22).</p>
<p>HRSA: Health Resources and Services Administration Information Center Parklawn Building 5600 Fishers Lane 888-275-4772 www.hrsa.gov</p>	<p>HRSA works to improve and extend life for people living with HIV/AIDS, provide primary health care to medically underserved people, serve women and children through state programs, and train a health workforce that is both diverse and motivated to work in underserved communities through publications, resources, and referrals on health care services for low-income, uninsured individuals and those with special health care needs.</p>
<p>National Organization for Rare Disorders (NORD) PO Box 1968 Danbury, Connecticut 06813 203-744-0100 TTY: 203-797-9590 Fax: 203-798-2291 orphan@rarediseases.org www.rarediseases.org</p>	<p>NORD is a federation of not-for-profit voluntary health organizations serving people with rare disorders and disabilities.</p>
<p>National Parent to Parent Support and Information System (NYPPSIS) P.O. Box 907 Blue Ridge, GA 30513 706-632-8822 800-651-1151 (Parents) Fax: 706-632-8830 Judd103w@wonder.em.cdc.gov</p>	<p>NPPSIS is a non-profit organization established to support, strengthen and empower families through one-to-one parent contacts.</p>

NATIONAL RESOURCES, CONTINUED

<p>National Rehabilitation Information Center for Independence (NARIC) 4200 Forbes Boulevard, Suite 202 Lanham, MD 20706 800-346-2742 or 301-459-5900 TTY: 301-459-5984 naricinfo@heitechservices.com www.naric.com</p>	<p>NARIC collects and disseminates information to anyone interested in disability and rehabilitation.</p>
<p>Technical Assistance Alliance for Parent Centers Parent Training & Information Centers (PTI's) & Community Parent Resource Centers PACER Center 8161 Normandale Blvd Minneapolis, MN 55437-1044 952-838-9000 888-248-0822 TTY: 952-838-0190 Fax: 952-838-0199 alliance@taalliance.org www.taalliance.org</p>	<p>The Technical Assistance Alliance for Parent Centers provides technical assistance for establishing, developing and coordination Parent Training and Information Projects under IDEA (Individuals with Disabilities Education Act).</p>

ADDITIONAL WEB SITES OF INTEREST

Alliance of Genetic Support Groups Directory

<http://www.medhelp.org/agsg/agsgup.htm>

An alphabetical listing of links to the web sites of support groups that focus on specific genetic disabilities/disorders.

American Academy of Pediatricians

<http://www.aap.org>

The American Academy of Pediatricians web site.

American Speech-Language-Hearing Association

<http://www.asha.org>

Web site of the American Speech-Language-Hearing Association with information for parents, consumers, and professionals.

DrugInfonet

<http://www.druginfonet.com>

Provides information and links to areas on the web concerning health care and pharmaceutical-related topics.

Family Village

<http://www.familyvillage.wisc.edu>

A website that provides information, resources and communication opportunities for families of children with disabilities. Contains many links to other sites.

MMRL-Multi-Media Medical Reference Library

<http://www.med-library.com/medlibrary>

Through this web site you can search a multitude of medical journals/databases.

National Institute of Health—Health Info

<http://www.nih.gov/health>

Web site that contains some of the health information resources provided by the National Institutes of Health.

Office of Rare Diseases

<http://rarediseases.info.nih.gov/ord>

Web site of the Office of Rare Diseases (ORD). Includes information on more than 6000 rare diseases.

Pedbase

<http://www.icodata.com/health/pedbase/index.htm>

A pediatric database designed to provide information on various pediatric disorders.

PubMed

<http://www.ncbi.nlm.nih.gov/PubMed>

The National Library of Medicine's search service to access citations in MedLine and other related databases.

GLOSSARY

HEALTH CARE DEFINITIONS

These definitions have been adapted from the following sources:

- PASSPORT: Knowing the Language (produced by "Families as Participants: Working Within a Managed Care System", a project funded by the US Maternal and Child Health Bureau)
- "Alphabet Soup: Health Care Definitions for Children with Special Health Needs" and other information sheets by Family Voices
- "The ABCs of Managed Care", a report from the Egg Harbor Family Summit
- "Managed Care for Children with Special Health Care Needs: Physician Case Management Model" by Subcommittee on the Managed Care Initiative of Children's Special Health Care Services Advisory Committee.
- "Understanding Medi-Cal: The Basics", published by the Medi-Cal Policy Institute

ACCESS:

Ability to receive services from a health care system or provider.

ACCOUNTABLE:

There is a mechanism to provide information concerning the performance and utilization of the system of services.

ACUTE CARE:

Medical services provided after an accident or for a disease, usually for a short time.

ADVERSE SELECTION:

Occurs when those joining a health plan have higher medical costs than the general population; if too many enrollees have higher than average medical costs, the health plan experiences adverse selection.

ALLOWABLE EXPENSES:

The necessary, customary and reasonable expenses that an insurer will cover.

AMBULATORY CARE:

Medical care provided on an out-patient (non-hospital) basis.

ANNIVERSARY DATE:

The date on which a health plan or insurer contract with an employer or an individual subscriber is renewed each year. It is the date when premium costs and benefits are most likely to change. It may be preceded by an "open enrollment period," when employees have the option to switch health plans.

ANNUAL MAXIMUM LIMITS OR CAPS:

The limit an insurance plan sets on a given service. It may be a certain number of visits or a dollar amount. If a person needs more of a given service than is allowed by the limits in a plan, one will need to request an exception.

APPEAL:

To formally request a health plan to change a decision.

ASSISTIVE TECHNOLOGY DEVICE:

Under IDEA, any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of a child with a disability.

ASSISTIVE TECHNOLOGY SERVICE:

Under IDEA, any service that directly assists a child with a disability in the selection, acquisition, or use of an assistive technology device.

AVERAGE LENGTH OF STAY:

Measure used by hospitals to determine the average number of days patients spend in their facilities. A managed care firm will often assign a length of stay based on standards of care to patients when they enter a hospital and will monitor them to see that they don't exceed it.

BAD FAITH:

Unreasonable refusal by a health plan or insurer to pay a valid claim which can be remedied in a civil suit.

BALANCE BILLING:

The practice of billing a patient for any portion of health care charges that are not "covered" (paid for) by health insurance. The circumstances under which balance billing is allowed are usually spelled out in providers' contracts with plans.

BASIC BENEFITS:

A set of "basic health services" specified in your member handbook and those services required under applicable federal and state laws and regulations.

BEHAVIORAL HEALTH CARE FIRM:

Specialized managed care organizations, focusing on mental health and substance abuse benefits, which they term "behavioral health care." These firms offer employers and public agencies a managed mental health and substance abuse benefit. Almost none existed 10 years ago, but they are now a large industry.

BENEFICIARY:

The patient (your child) or family who receives the "benefits" or services from health insurance.

BENEFITS or BENEFIT PACKAGE:

The health care services covered by a health plan or health insurance company, under the terms of its member contract.

CAPACITY:

Ability of a (health) organization to provide necessary health services.

CAPITATION:

Method of payment for health services in which the insurer pays providers fixed amounts for each person served regardless of the type and number of services used. Some HMOs pay monthly capitation fees to doctors, often referred to as a per member per month amount.

CARE COORDINATION:

Process of having all care needs coordinated by one person with an emphasis on maximizing a family's capabilities to manage their child's needs and provide quality care without duplication or inappropriate usage.

CASE MANAGEMENT PROGRAM:

Special programs now offered by many insurance companies, particularly for individuals who require high-cost care or have a chronic condition. Under such a program, a case manager is assigned to oversee a given member's health needs. Case managers may arrange alternative benefits within or

outside the plan. Contact your plan to find out if you are eligible and how it works.

CATEGORICAL:

Designates persons eligible for assistance because they fall into certain welfare groups or categories (Aged, Blind, Disabled).

CERTIFICATE OF INSURANCE:

A description of health benefits included in a health plan, usually given to insured members by the employer or group.

CHILD WITH A DISABILITY:

Under IDEA, a child with mental retardation, hearing impairments (including deafness), speech or language impairments, visual impairments (including blindness), emotional disturbance, orthopedic impairments, autism, traumatic brain injury, other health impairments, or specific learning disabilities who needs special education and related services.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS:

Those children who have or at increased risk for chronic physical, developmental, behavioral or emotional conditions and who also require health and related services of a type or amount beyond what is required by children generally.

CLAIM:

The documentation of a medical service that was provided to a covered patient by a doctor, hospital, laboratory, diagnostic service or other medical professional. In managed care, claims are not necessary (See Capitation and Co-payment definitions.)

CLINICIAN:

A term that is often used to describe all types of medical professionals who care for patients--doctor, nurse, physicians' assistant, therapist, etc.

CLINICAL STANDARDS:

The care guide used by health plans and providers in making decisions about medical necessity.

CO-PAYMENT (or CO-INSURANCE):

The portion of charges paid by the patient for medical and hospital services, after any deductible has been paid. Indemnity plans typically require a co-payment to be a percent of the charge for the service (for example, 20%). The amount may vary based on the type of service, when the service is received (for example, within a certain number of days of an emergency), or where the service is received (out-

patient versus in-patient). In managed care plans, the co-payment is usually a small fixed amount regardless of the cost of the service.

COBRA (Consolidated Omnibus Budget Reconciliation Act) PL.99-272:

A federal law that provides the opportunity for individuals to continue the same insurance coverage for 18-36 months after they lose their jobs or for covered dependents to continue coverage after the death of the insured. The individual is responsible for paying the full insurance premium. There may also be language in the policy on provisions for continuing the same coverage. The Insurance Commissioner in your state [Chuck Quackenbush in California; Consumer Information and Assistance Line is 1-800-027-4357] or your employer may offer information on your rights for continuation.

COLLABORATIVE CARE:

The role of families as primary decision makers and caregivers is acknowledged and supported when the health financing system pays for services that support this role. Family participation in the allocation of health resources is achieved when the parent is recognized as primary decision maker in the development of individualized plans of care.

COMMUNITY-BASED:

The system of care responds to the needs identified by the community and draws from the community to address needs. Services are provided in or near the home community to the extent possible.

COMMUNITY RATING:

An insurance practice of pooling people within a geographic area and charging everyone a set premium for a set benefit package without considering their individual health status.

CONCURRENT REVIEW:

A managed care technique in which a representative of a managed care firm continuously reviews the charts of hospitalized patients to determine whether they are staying too long and if the course of treatment is appropriate.

CONTINUITY OF CARE:

The degree to which the care of a patient from the onset of illness until its completion is continuous; that is, without interruption.

CONTINUUM OF CARE:

A range of medical, nursing treatments, and social services in a variety of settings that provides services most appropriate to the level of care required. For

example, a hospital may offer services ranging from nursery to a hospice.

COORDINATION OF BENEFITS:

The process for how benefits will be applied if you have more than one health plan. Regulations on coordination of benefits may exist within your state or your insurance plan may describe how such coordination should happen. Usually one plan is designated to pay all claims first and the residual bills are the responsibility of the secondary carrier. These provisions are to prevent individuals from collecting more than once for the same medical charge.

CO-PAYMENT:

A cost-sharing arrangement in which the member pays, to the provider, a specified amount for a specific service.

COST SHIFTING:

A phenomenon occurring in the US health care system in which providers, hospitals or health care centers are less than adequately reimbursed for their costs and subsequently raise their prices to other payers in an effort to recover costs. Low reimbursement rates from government health care programs often cause providers to raise prices for medical care to private insurance carriers.

COST CONTAINMENT:

An attempt to reduce the high costs surrounding the allocation and consumption of health care. These costs may from inappropriately used services and from care that can be provided in less costly settings without harming the patient.

COVERAGE:

Agreed upon set of health services that a plan will pay for and/or provide.

CREDENTIALING:

The process of verifying a physician's (or other provider's) credentials to participate as a provider in a health care plan. Criteria for credentialing vary from plan to plan, but examples of typical credentialing requirements for physicians include state licensure and admitting privileges at plan hospitals, and may include other accreditation or certification requirements.

CROSSOVER:

Refers to a claim that has been processed and paid in part by Medicare and then processed by Medi-Cal for those with dual eligibility.

CURRENT PROCEDURAL TECHNOLOGY (CPT):

A set of codes developed by the American Medical Association that describes medical procedures for billing. Each item submitted by your provider to an insurance company for payment must be listed by code on the bill.

CUSTODIAL CARE:

Care provided primarily to assist a patient in meeting the activities of daily living, but not care requiring skilled nursing services.

CUSTOMARY AND REASONABLE:

Refers to a fee that falls within a common range of community fees.

DEDUCTIBLE:

The amount that you must pay out-of-pocket for covered medical care before the benefits of the coverage begin. Check what this amount is per family member. There may also be a total family limit. Deductible amounts vary a great deal from policy to policy. Deductibles are usually set as an annual amount.

DIAGNOSIS-RELATED GROUPS (DRGs):

Method of reimbursing providers based on the medical diagnosis for each patient. Hospitals receive a set amount determined in advance based on length of time patients with a given diagnosis are likely to stay in the hospital. Also called prospective payment system.

DOCUMENTATION:

Written records relating to your family's medical care and insurance. You may need detailed records to support your case if you disagree with your insurer.

DUAL-ELIGIBLES:

People who are eligible for both Medicaid (called Medi-Cal in California) and Medicare. In such cases, payments for any services covered by Medicare are made before any payments are made by the Medicaid program.

DURABLE MEDICAL EQUIPMENT (DME):

Necessary medical equipment that is not disposable; for example, wheelchairs, walkers, ventilators, commodes.

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT PROGRAM (EPSDT):

Mandatory Medicaid benefits and services for Medicaid-eligible children and adolescents under age

21; designed to ensure children's access to early and comprehensive preventive health care and treatment. State Medicaid programs must provide EPSDT benefits.

EFFECTIVE DATE:

The date on which coverage under a health plan or insurance contract begins.

EMERGENCY CARE:

The immediate care that is necessary when a child has a condition, illness, or injury that is life-threatening or would significantly impair his/her health.

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA):

A federal law that establishes uniform standards for employer-sponsored benefit plans. Because of court decision, the law effectively prohibits states from experimenting with alternative health-financing arrangements without waivers from Congress.

EMPLOYER CONTRIBUTION:

The amount of money an employer pays toward the health benefit plans of its employees usually through a payroll deduction. The employer may pay the same fixed number of dollars toward every plan it offers to its employees ("an equal-dollar contribution"); it may pay a fixed percentage of the premium for every plan offered ("equal-percentage"); or it may adjust its contribution in other ways.

ENROLLEE:

Person (consumer) who is covered under a health insurance plan, whether fee-for-service or managed care.

ENROLLMENT AREA:

The geographical area within which a health plan member must reside in order to be eligible for coverage. Most HMOs place a limit on the length of time members (except students) can live outside the enrollment area each year and still be covered.

ERISA (Employee Retirement Income Security Act of 1974):

Administered by the U.S. Department of Labor, ERISA regulates employer-sponsored pension and insurance plans for employees.

EVIDENCE OF COVERAGE:

The written document provided by a health plan to an enrollee that describes exactly what services are covered and under what conditions. Providing such a document is required by law, and the document

describes the obligations of the plan toward the member and the member's responsibilities as an enrollee.

EXCEPTION TO POLICY:

A plan (public or private) can choose a different method of treatment, usually after agreement among the patient, care coordinator, and/or primary provider.

EXPLANATION OF BENEFITS:

The statement from your insurance plan that itemizes the actions taken on claims that have been submitted.

EXCLUSION:

A treatment or service that is not covered by a policy.

EXPERIENCE RATING:

An insurance practice of setting premiums based on previous use of health services and health status. An employer whose employees have a high use of services will pay higher rates. This practice generally discriminates against people with disabilities or chronic illness.

EXPERIMENTAL TREATMENT:

Medical treatment not usually covered by insurance companies or public programs because its efficacy is considered unproven. Insurance companies or public programs may reject claims when they decide that the treatment is experimental. Insurers may rely on an internal medical review, consultation with outside experts, or a combination of these and other means. Articles in the current medical literature may influence decision. Individuals have won claims by proving that other insurance companies have paid for the treatment in question or that the treatment has been beneficial in other ways.

FAMILY CENTERED CARE:

Health care delivery and systems that are based on the concerns, priorities and resources of the family, recognizing that the family is the constant in the child's life and the child's best advocate. Parent-professional partnerships are facilitated in family centered practices.

FEDERALLY QUALIFIED:

An HMO that has met certain federal standards regarding financial soundness, quality assurance, member services, marketing and provider contracts can be federally qualified. HMOs that are not federally qualified are still subject to federal and state regulations and requirements intended to protect consumers and providers and ensure quality of care.

FEE-FOR-SERVICE:

Traditional health insurance, allowing consumer to choose providers and services, often with a deductible and co-payment. Also known as indemnity coverage.

FIRST-DOLLAR COVERAGE:

A health insurance policy with no required deductible.

FORMULARY:

A list of prescription drugs and their recommended doses that have been selected by a health plan, insurer or group of doctors as the best choices in terms of effectiveness and value, among the many possible options for a given condition. Formulary drugs may be recommended or required as a condition of HMO prescription drug coverage (unless individual circumstances make a different drug a more appropriate choice for the patient). Formularies are frequently changed based on cost and availability.

GATEKEEPER:

A term given to a primary care provider in a managed care organization network who controls patient access to medical specialists, services and equipment.

GENERIC MEDICINES:

Medications that do not carry a brand name, but contain the same ingredients. Usually less expensive.

GRACE PERIOD:

A specified period immediately following a premium due date, during which payment can be made to continue the policy in force without interruption. States may have laws requiring health insurance policies to allow a set number of days of "grace."

GRIEVANCE PROCEDURE:

Defined process in a health plan for consumers or providers to use when there is disagreement about a plan's services, billings or general procedures.

GROUP PRACTICE:

The provision of health care services by a group of physicians formally organized in a business entity that shares equipment, records and personnel in the provision of patient care and in business management.

GUARANTEE RENEWABLE:

An insurance contract that an insurer cannot terminate, providing the insured pays the required premiums in a timely manner. With these contracts, insurers have the right to raise premiums but only for an entire class of policyholders.

GUARANTEED ISSUE:

An insurance contract that is issued regardless of prior medical history. Small employers (between 3-50 employees) cannot be refused coverage because of the medical history of one or more employees. Some individual plans are available on a Guaranteed Issue basis, although premiums are higher.

HEALTH CARE FINANCING ADMINISTRATION (HCFA):

Federal agency that oversees all aspects of financing for Medicare and also oversees the Federal Office of Prepaid Health Care Operations and Oversight.

HEALTH INSURANCE PURCHASING COOPERATIVE (HIPC):

A group of employers and individuals functioning as an insurance broker to purchase health coverage, certify health plans, manage premiums and enrollment and provide consumers with buying information. The larger group may be able to negotiate for lower premiums and/or more comprehensive benefits than smaller companies or individuals. Also called health insurance purchasing group, health plan purchasing cooperative or health insurance purchasing corporation (See Managed Competition definition.)

HEALTH MAINTENANCE ORGANIZATION (HMO):

An organized health care system responsible for financing and delivering health care to an enrolled population.

HEALTH SCREENING:

A method used by some insurers and health plans to determine whether applicants are likely to create high medical costs, either because they are already sick or because they are likely to have a costly illness in the future. Health screening is used to detect pre-existing medical conditions and to determine whether the applicant is at risk for illness because of factors like excessive weight, smoking or a past history drug abuse.

HEALTHY FAMILIES:

California's State Children's Health Insurance Program to fund health coverage for uninsured children who are not eligible for Medi-Cal.

HEALTH PLAN EMPLOYER DATA AND INFORMATION SET (HEDIS):

System for determining the quality of a health plan's services and outcomes, based on certain data. HEDIS data, information and guidance about children are limited.

HIGH RISK INSURANCE POOLS:

State programs that enable people with health problems to join together to purchase health insurance; even with subsidies, premium rates are high because pool members are high risk.

HOME AND COMMUNITY-BASED WAIVERS:

Medicaid waiver that allows states to offer an alternative health care package for people who would otherwise require nursing home or hospital care.

HOSPICE SERVICES:

Services to provide care to the terminally ill and their families.

HOSPITAL DAY:

A term to describe any 24-hour period commencing at 12:00 am or 12:00 pm, whichever is used by a hospital to determine a hospital day, during which a patient receives hospital services at the hospital.

ICP-9:

A numerical system for medical conditions and procedures that is used for billing, research and statistical purposes. For example, a specific diagnosis like cleft lip and palate has a unique code.

INDEMNITY HEALTH INSURANCE:

Usually a fee-for-service health plan that reimburses physicians and other providers for health services furnished to plan enrollees.

INDIVIDUAL (or INDEPENDENT) PRACTICE ASSOCIATION (IPA):

Association of physicians and other providers, including hospitals, who contract with an HMO to provide services to enrollees, but usually still see non-HMO patients and patients from other HMOs.

INDIVIDUALIZED EDUCATION PROGRAM (IEP):

Under IDEA, a written education plan for a school-aged child that is the student's primary education document and is developed by a team including the child's parents.

INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP):

Under IDEA, the planning document used for children under three years of age, and their families.

INDIVIDUAL PROGRAM PLAN (IPP):

Under the Lanterman Act, the program plan developed by the responsible regional center, the developmentally disabled person, and the person's parents, legal guardian, or conservator.

INDIVIDUALS WITH DISABILITIES

EDUCATION ACT (IDEA):

The federal law pertaining to students with special needs within the education system.

INPATIENT CARE:

Medical care that requires the patient be admitted to and treated in a hospital. Most hospital care is inpatient care; a patient can also receive "outpatient" care in a hospital's emergency room or ambulatory care center.

INTERAGENCY COORDINATING COUNCIL (ICC):

A state council composed of families and professionals to set policy and monitor Part H/C, the federal early childhood special education law.

LANTERMAN ACT:

California state law guaranteeing certain rights to persons with developmental disabilities, including a right to treatment and habilitation services, humane care, prompt medical care and treatment, and to be free from harm and hazardous procedures.

LIFETIME MAXIMUM:

The total amount that an insurance policy will pay out for medical care during the lifetime of the insured person. In the case of a chronic condition, one should check into options for enrolling in another group plan during an open enrollment period well before approaching a lifetime maximum.

LIMITATIONS:

Conditions or circumstances for which benefits are not payable or are limited. It is important to read the limitations, exclusions and reductions clause in your policy or certificate or insurance to determine which expenses are not covered.

LOCK-IN:

The requirement that members of an HMO or other managed care plan must have all of their covered services provided, arranged or authorized by the plan or its doctors, except in life-threatening emergencies or when members are temporarily "out of area." This contrasts with a "point-of-service" plan, which allows patients to receive covered services without prior authorization but at a higher cost outside a plan's network.

LONG-TERM CARE:

A continuum of maintenance, custodial and health services for people with chronic illness, disability or mental retardation.

MANAGED CARE:

The integration of health care delivery and financing. It includes arrangements with providers to supply health care services to members, criteria for the selection of health care providers, significant incentives for members to use providers in the plan and formal programs to monitor the amount of care and quality of services.

MANAGED CARE ORGANIZATION (MCO):

Health organization, whether for-profit or not-for-profit, that finances and delivers health care using a specific provider network and specific services and products.

MANAGED COMPETITION:

A method for controlling health care costs by organizing employers, individuals and other buyers of health care into large cooperatives that will purchase coverage for their members. Insurance companies and managed care organizations will compete to supply coverage for the lowest cost. (See Health Insurance Purchasing Cooperative definition.)

MANDATED BENEFITS:

Specific benefits that insurers are required to offer by state law. Each state has its own legislation on mandated benefits.

MANDATORY ENROLLMENT:

Requirement that certain groups of people must enroll in a program. Medicaid managed care, for example.

MEDICAID:

Federal program (Title XIX of the Social Security Act) that pays for health services for certain categories of people who are poor, elderly, blind, disabled or who are enrolled in certain programs, including Medicaid Waivers. Includes children whose families received assistance. Is financed with federal and state funds, amount varying by state.

MEDICAL HOME:

A concept wherein health care is accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally competent. In a "medical home," physicians and parents share responsibility for ensuring that children and their families have access to all the medical and non-medical services needed to help them achieve their maximum potential.

MEDICAL NECESSITY:

Legal term used to determine eligibility for health benefits and services. It describes services that are

consistent with a diagnosis, meet standards of good medical practice and are not primarily for convenience of the patient.

MEDICALLY NECESSARY SERVICES:

A clause in a health insurance policy that states that the policy covers only services needed to maintain a certain level of health. The clause also defines--often in general terms--what those services are. One should find out exactly what an insurer means by this term in order to present a request in the most appropriate way. Interpretations of the term "medically necessary" vary widely.

MEDICARE:

Title XX of the Social Security Act, which pays for health care for the elderly, and adults who are disabled.

MEDICALLY UNNECESSARY DAYS:

A term used to describe that part of a stay in a facility, as determined by a case manager, as excessive to diagnose and treat a medical condition in accordance with the standards of good medical practice and the medical community. Excessive may be because stay was too long or was in a more costly or less efficient setting.

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (NAIC):

An organization of state insurance commissioners that writes model laws and regulations governing the insurance industry.

NATIONAL COMMITTEE ON QUALITY ASSURANCE (NCQA):

An independent, not-for-profit organization that reviews and accredits managed care plans, including HMOs. NCQA also developed a set of tools called Health Plan Employer Data and Information Set (HEDIS) which provides standardized performance measures for reporting on health plans they review.

OMBUDSMAN:

Person designated by a health plan or Medicaid to solve problems and answer questions from consumers in an objective way.

OPEN ENROLLMENT PERIOD:

A period when employees may sign up for a health plan without waiting periods or consideration for preexisting conditions. Many employers offer these periods yearly and when employment begins.

OPT-OUT:

An option available through some managed care plans, such as point-of-service HMOs and Preferred Provider Organizations, to choose or receive covered care from providers outside the plan's network at a higher cost.

OUT OF AREA:

Beyond or outside the geographical area served by an HMO or other managed network plan. When HMO members are inside their plan's service area, they must have their care provided, arranged or authorized by their HMO or HMO doctor in order to get full coverage; when they are temporarily out of area, different coverage rules apply.

OUT-OF-PLAN SERVICES:

Services furnished to patients by providers who are not members of a patient's managed care network.

OUT-OF-POCKET COSTS:

All the health expenses that you must pay, including deductibles, co-payments and charges not covered by any health plan.

OUTCOMES MEASURE:

A tool to assess the impact of health services in terms of improved quality and/or longevity of life and functioning.

OUTPATIENT BENEFITS OR COVERAGE:

Treatment or services received in a setting such as a clinic or doctor's office and not as an admitted patient in a hospital. In the case of a chronic condition, one should carefully check the out-patient benefits in any plan because most services will take place on an out-patient basis.

PARENT TRAINING AND INFORMATION CENTER (PTI):

Every state has a parent-run organization funded by the U.S. Department of Education to provide information and training to families around education issues for their children with special needs.

PART C:

Early Start - the early childhood component of IDEA which used to be called Part H. Regional Centers and Special Education departments are responsible for Early Start services for children birth to three years of age who are developmentally delayed or who are at risk of delay.

PARTICIPATING PROVIDERS:

A physician who signs a contract with a PPO or HMO plan and agrees to accept the plan's allowable charges.

PER DIEM COST:

Cost per day; hospital or other institutional cost for a day of care.

PHYSICIAN HOSPITAL ORGANIZATION (PHO):

Organization that includes hospitals and physicians contracting with one or more HMOs, insurance plans or directly with employers to provide medical services.

POINT-OF-SERVICE:

A term that applies to certain health maintenance organizations and preferred provider organizations. Members in a point-of-service HMO or PPO can go outside the network for care, but their reimbursement will be less than if they had remained inside.

PRACTICE GUIDELINES OR PROTOCOL:

Description of a course of treatment or established practice pattern. Managed care entities develop and distribute these to providers in their network to guide clinical treatment decisions. (See also Standard of Care definition.)

PRE-AUTHORIZATION:

Approval from an insurance plan or a designated primary care provider is obtained before specialty services are provided or the service will not be reimbursed.

PRE-EXISTING CONDITIONS:

A physical or mental health condition that has been treated or would normally have been treated before enrollment in an insurance plan. Policies may exclude coverage for such conditions for a specified period of time. In some cases, pre-existing conditions exclude a person completely from buying health insurance. An insurance company may decide to charge higher premiums or offer the insurance but refuse to cover any treatment relating to the specific condition. Some states have laws limiting exclusions for pre-existing conditions.

PREFERRED PROVIDER ORGANIZATION (PPO):

A form of managed care plan in which a group of providers contract with an insurer and agree to provide services at pre-negotiated fees. Members must have a primary care provider who is a member of the PPO. Members are given incentives to use

providers within the organization, but may use providers outside the plan for greater out-of-pocket costs.

PREMIUM:

The charge paid to the insurer for health coverage. This may be paid weekly, monthly, quarterly or annually.

PREPAID HEALTH CARE ACT:

A federal law passed in 1973 that sets standards for federally qualified health maintenance organizations. Among the standards are minimum benefits and formal grievance procedures.

PREPAID HEALTH PLAN (PHP):

Health organization that receives prepaid capitation payments for a select set of benefits; for example, physician services or lab tests.

PREPAID PLANS:

A health insurance plan where you pay a fixed premium to cover much of the care you receive. Prepaid plans include HMOs and PPOs.

PREVENTIVE CARE:

Medical services that try to reduce the chances of illness, injury or other conditions. This contrasts with acute care, which is given after the condition has occurred.

PRIMARY CARE:

Routine medical care, usually provided in a doctor's office.

PRIMARY CARE CASE MANAGEMENT:

System that pays primary care providers a monthly fee to coordinate medical services. Especially used by Medicaid.

PRIOR APPROVAL:

Permission needed from a Primary Care Provider or the health plan before a service can be delivered or paid for.

PROFESSIONAL REVIEW ORGANIZATION (PRO):

An organization that determines whether care and services provided are medically necessary and meet professional standards under Medicare and Medicaid.

PROLONGED ILLNESS CLAUSE or EXTENDED BENEFITS:

A possible option in insurance coverage for 100 percent reimbursement (instead of partial) for all

services relating to a condition. This option may also add to the lifetime maximum.

PROSPECTIVE REVIEW:

The process in which a plan reviews a planned hospital admission prior to the admission date in order to evaluate whether the admission is medically necessary. A component of utilization management.

PROVIDER:

A hospital, skilled nursing facility, outpatient surgical facility, physician, practitioner or other individual or organization which is licensed to provide medical or surgical services, therapy, treatment and accommodations.

QUALITY ASSURANCE:

A term that describes attempts by health care organizations to measure and monitor the quality of care delivered.

QUALITY MANAGEMENT:

A formal set of activities to assure the quality of services provided. Quality management includes quality assessment and corrective actions taken to remedy any deficiencies identified through the assessment process.

RATIONING:

The allocation of medical care by cost or availability of services.

REFERRAL:

A formal process by which a patient is authorized to receive care from a specialist, therapist or hospital. Most managed care organizations (MCO's) usually require a referral from the member's primary care provider in order for specialty care to be covered.

REFERRAL PHYSICIAN:

A physician who has a patient referred to him by another source for examination, surgery, or to have specific procedures performed on the patient, usually because the referring source is not prepared or qualified to provide the needed service.

REINSURANCE:

Insurance purchased by a health plan to protect against extremely high medical costs, either for specific groups or individuals.

RENEWAL:

The clause in an insurance plan that describes how one might renegotiate the contract after the term is finished. Guaranteed renewability of an insurance

policy protects from loss of coverage, although an insurer may still raise premiums.

REPORT CARD:

A published report for consumers on the premium costs for a plan and overall quality of a health plan or provider. Report card generally measure a plan's delivery of appropriate services, patient outcomes, patient satisfaction and cost structure.

RIDER:

A legal document added to an insurance plan that either restricts or adds to coverage. States may have regulations about riders.

RISK:

An insurance term related to financial responsibility for medical care. A "high-risk" individual is someone who has a high likelihood of having a serious illness, because of past medical history, family history or health-related behavior, such as smoking or alcohol abuse. "At risk" or "risk-bearing" means being responsible for the cost of care for a group of people. For instance, if an HMO pays a hospital a fixed amount of money per member to provide all of the care he or she needs, the hospital is "at risk" for that member. "Risk adjustment" is an extra payment made by a medical insurance company to a health provider or medical group if its members are, on average, sicker and more expensive to care for.

RISK POOLS:

Arrangements by states to provide health insurance to the unhealthy uninsured who have been rejected for coverage by insurance carriers.

RISK SHARING:

A situation in which a managed care entity or a provider assumes responsibility for services for a specific group but in which it is protected against unexpectedly high costs by a pre-arranged agreement. The Managed Care Organization (MCO) or provider may receive higher payment for those individuals who need significantly more costly services. Usually Medicaid and an MCO, agree through a formula to share any losses that result when medical costs exceed payments.

SCHIP:

The State Children's Health Insurance Program recently passed by Congress to fund health coverage for America's 10 million uninsured children. SCHIP sends millions of dollars to every state over the next 10 years for states to design and plan their own programs. Also known as Title XXI. [California's proposed SCHIP is called "Healthy Families."]

SECOND OPINION REVIEW:

A managed care technique in which a second physician is consulted regarding diagnosis or course of treatment.

SECONDARY CARE:

A level of medical care between primary care and tertiary care, usually provided by medical specialists and usually requiring a referral from an HMO member's primary care provider.

SELF-INSURED:

An arrangement in which an employer writes its own plan to cover health care costs for employees. Benefits and costs are determined by the employer. These plans may be administered by an insurance company or involve an insurance broker.

SELF-REFERRAL:

A patient's ability to refer himself or herself, under certain circumstances, for specialty care, without receiving a formal referral or prior authorization from the patient's MCO or primary care provider.

SERVICE AREA:

The geographical area within which an HMO or other managed care plan provides and arranges medical care for its members. This area is sometimes the same as the plan's enrollment area, but not always.

SERVICE LIMITS:

Certain number of times you may use a health service and a certain time period when you may use a service.

SINGLE-PAYER SYSTEM:

A health care financing arrangement in which money, usually from a variety of taxes, is funneled to a single government entity which then pays the medical bills for all covered members. Canada and England are single-payer health systems.

SINGLE POINT OF ENTRY:

An individual can gain access to services only through a primary care provider who decides what services are needed. (See Gatekeeper definition.)

SKILLED NURSING FACILITY (SNF):

An institution providing skilled nursing and related services to residents; a nursing home.

SOCIALIZED MEDICINE:

A health care financing and delivery system in which doctors work for the government and receive a salary for their services.

SOLE-SOURCE OPTION:

An employer chooses a single insurer or health plan to cover all of its employees. If the sole-source option is an HMO, it will usually offer both a standard lock-in plan and a point-of-service plan that allows members to choose to get care outside the HMO network at a higher cost.

SPEND-DOWN:

The process of using up all income and assets on medical care in order to qualify for Medicaid.

STAFF-MODEL HMO:

An HMO that directly employs on a salaried basis the doctors and other providers who furnish care.

STANDARD OF CARE:

Written practice guidelines based on medical diagnosis that physicians and managed care organizations may use to guide treatment and service choices. See also "Practice Guidelines or Protocol."

STATE INSURANCE REGULATIONS:

The laws and regulations that govern insurance companies operating within a given state. There is also a state process for filing complaints and appeals. A state Commission of Insurance and associated departments or division provide information and assistance. [In California, the Insurance Commissioner is Chuck Quackenbush. Consumer Information and Assistance Line is 1-800-027-4357]

STOP-LOSS:

A clause that limits liability to a specified amount on medical expenses covered by a policy. After expenses reach that amount, the insurance company pays all remaining covered medical expenses for the year including deductibles and co-payments.

SUPPLEMENTAL SECURITY INCOME (SSI):

Monthly cash assistance for people, including children, who have low incomes and who meet certain age or disability guidelines. In most states, SSI also includes access to Medicaid.

SUPPLEMENTARY AIDS AND SERVICES:

Under IDEA, the developmental, corrective, or supportive services required to assist a child with a disability to benefit from special education. Includes, transportation, speech-language pathology, audiology, psychological services, physical and occupational therapy, recreation, social work services, counseling, orientation and mobility, medical services for diagnostic and evaluation purposes.

TARGETED CASE MANAGEMENT:

A Medicaid term for case management services covered under Title XIX of the Social Security Act (as of November 1995). Federal law defines Targeted Case Management as services that will assist individuals eligible under the state Medicaid plan in gaining access to needed medical, social, educational and other services.

TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1988 (TEFRA):

Federal program allowing a child with extensive health needs to receive medical assistance, even if the family's income is higher than allowed under regular medical assistance guidelines.

TERTIARY CARE:

The upper level of medical care and services, usually provided in hospitals by highly trained "sub-specialists" using the most advanced medical technology.

THIRD PARTY PAYMENT:

The payment for health care by a party other than the beneficiary.

TITLE V/CSHCN:

The state agency that uses state and federal funds to provide services, programs and systems of care for Children with Special Health Care Needs (CSHCN). The federal version (Division for Children with Special Health Care Needs/DCSHCN) is located in the federal Maternal and Child Health Bureau (MCHB).

UNCOMPENSATED CARE:

The care provided by doctors and hospitals for which no reimbursement or payment is made; also known as charity care.

UNDERWRITING:

An insurance company practice of assessing risks of illness and costs and setting premiums based on the assessments. Similar to experience rating.

URGENT CARE:

Occurs when a patient has an illness that is not life-threatening but that requires immediate attention.

USUAL, CUSTOMARY AND REASONABLE (UCR):

A fee controlling system to determine the lowest value of physician reimbursement based on: (1) the

physician's usual charge for a given procedure; (2) the amount customarily charged for the service by other physicians in the area; and (3) the reasonable cost of services for a given patient after medical review of the case. If charges are higher than what the carrier considers normal. The carrier will not pay the full amount charged and the balance is your responsibility.

UTILIZATION:

The amount of medical services used by a given population, usually over a specific period of time or as an average related to the number of people in the population. For instance, an HMO's utilization rate for office visits might be five visits per member per year. Hospital utilization is often reported as the number of days in the hospital, on average, for each 1000 members of the group being measured (days/1000). In the interest of reducing costs, health plans and insurers try to reduce unnecessary or inappropriate utilization through "utilization management" or "utilization review."

UTILIZATION REVIEW:

A process that assures that medically necessary acute inpatient and outpatient care has been provided in the most appropriate and cost-effective settings.

WAITING PERIODS:

The period of time required by an insurance company after a person is covered by a policy before specific health services are covered by the plan. This time can vary from a number of months to a number of years.

WAIVERS:

The result of a process that allows state Medicaid agencies to apply for and receive permission from HCFA to provide services not otherwise covered by Medicaid and/or to do so in ways not described by the Social Security Act. Most Medicaid managed care programs require Waivers. The Waivers, which can differ greatly, are known by their numbers (1115, 1119) or as home-and community-based, or as Katie Beckett waivers.

WRAP-AROUND:

A supplementary insurance plan designed to pay for additional health benefits not covered by another plan. A wrap-around policy can provide more comprehensive benefits for a person with extensive needs.

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HAS THIS BOOKLET BEEN HELPFUL?

Your feedback is important to other families and us. Help us improve our materials by completing this questionnaire and mailing it to us. Thank you very much!

Where did you receive this booklet?

This booklet has helped me –

- Obtain new services for my child
- Feel more comfortable talking with my child's provider
- Understand the agencies involved with my child
- Become more active in my child's care
- Help other parents with their child's care

My child is _____ years old and his/her special needs are:

Optional:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone: _____

Please add me to the mailing list of the Family Voices which serves my area.

I would like to become a parent-mentor or volunteer.

Please mail this survey to:

Family Voices
c/o Support for Families of Children with Disabilities
2601 Mission Street, Suite 606
San Francisco, CA 94110
Phone: 415-282-7494 ■ Fax: 415-282-1226