CMSP

GOVERNING BOARD

CMSP Letter No: 14-04
Issue Date: April 17, 2014

TO: All County Welfare Directors

SUBJECT: CMSP 215 - Supplemental Application; CMSP 216 – Telephonic Signature Declaration

The purpose of this letter is to provide counties with the new CMSP 215 Supplemental Application (see attached). All counties are directed to begin using this new form by May 1, 2014.

On March 27, 2014, the CMSP Governing Board approved use of the new CMSP 215 form. The form is described as a "supplemental application" because the form is designed to be a supplement to the application process for Medi-Cal and/or Covered California and collect only the additional information that is not otherwise collected. This additional information is to be submitted by the applicant on the new CMSP 215 *after* the county makes a determination that the applicant is not eligible for Medi-Cal and a complete determination for Covered California has been made according to ACL 14-02.

In making the change to the CMSP 215 Supplemental Application, CMSP will no longer use the CMSP 210 "Application for CMSP" form, the CMSP 219 "Rights and Responsibilities" form, and the CMSP 1153 "Medi-Cal Linkage Evaluation" form. All necessary information for a CMSP determination has been incorporated into the new CMSP 215 Supplemental Application.

In addition, because the Medi-Cal application process allows for use of a telephonic signature by the applicant, the Governing Board has approved the use of telephonic signature on the CMSP 215 Supplemental Application.

Change in CMSP Application Process

Prior to implementation of the Affordable Care Act (ACA), applicants for CMSP were able to apply for CMSP benefit coverage using either a Medi-Cal application or the CMSP 210 application. With the implementation of the ACA and the expansion of health coverage under Medi-Cal and Covered California, the pathway for CMSP eligibility has changed. Effective May 1, 2014, applicants for CMSP may no longer

apply for CMSP using a CMSP 210 application. Instead, applicants for CMSP must take two steps.

First, they must apply for Medi-Cal and be determined ineligible. Second, they must apply for Covered California and have their eligibility determined. The second of these steps is affected by the open and closed enrollment periods for Covered California.

Open and Closed Enrollment Periods for Covered California

CMSP Eligibility Processing During an Open Enrollment Period.

Following the determination of ineligibility for Medi-Cal, a determination for Covered California will need to be made. If the applicant is not eligible for either Medi-Cal or Covered California during this open enrollment period, then eligibility for CMSP shall be considered when requested by the applicant. The CMSP 215 Supplemental Application should then be completed.

Additionally, an applicant that is determined eligible for Covered California may request CMSP for the month(s) prior to the applicant's enrollment in Covered California. Since Covered California can never begin earlier than the month after the application is submitted, Covered California beneficiaries may apply for CMSP coverage for the one or two months prior to the beginning of Covered California coverage. The CMSP 215 Supplemental Application should then be completed.

CMSP Eligibility Processing During a Closed Enrollment Period.

Following the determination of ineligibility for Medi-Cal during a Covered California closed enrollment period, the county will need to determine if the applicant meets any of the exception criteria that would allow the applicant to enroll in Covered California during the closed enrollment period. If the applicant qualifies for an exception, the applicant will need to apply for Covered California and be determined ineligible in order for CMSP eligibility to be considered. If the applicant is eligible for Covered California, the rules described above would apply. If the applicant is not eligible for Covered California, then eligibility for CMSP shall be considered when requested by the applicant. The CMSP 215 Supplemental Application should then be completed.

It is not the Governing Board's intention that the CMSP 215 form be sent out to any/all applicants for Medi-Cal and/or Covered California that are determined ineligible. This would be impractical since the segment of those individuals that are potentially eligible for CMSP is much smaller than the overall population that will be denied for Medi-Cal. Most enrollment in CMSP will be for persons with incomes between 139-200% FPL or those that do not meet the 5-year bar. Accordingly, it is the Governing Board's intention that the CMSP 215 is to be made available to all applicants that request participation in CMSP following determination of ineligibility for Medi-Cal and determination of eligibility for Covered California.

Application Pathway and Completion of the CMSP 215

With the ACA, there are several different application pathways for Medi-Cal and Covered California that can ultimately lead an applicant to CMSP. These pathways are outlined on the attached flow chart. Counties will need to verify the pathway that has been taken by each CMSP applicant and make a determination regarding the information that is required by the county for the CMSP eligibility determination to be made.

Depending on the application pathway that has been taken, the applicant for CMSP will need to complete either Part A or Parts A, B & C of the CMSP 215 Supplemental Application. Part A pertains to Rights and Responsibilities. Parts B and C pertain to Income and Property. For CMSP eligibility to be determined by the county, the county must assure that it receives all necessary information from the CMSP Supplemental Application.

Telephonic Signature

As referenced above, beginning May 1, 2014, counties may use a telephonic signature on the new CMSP 215 Supplemental Application. The county representative must read the enclosed CMSP 216 Statement to the applicant (see attached), receive a verbal agreement from the applicant, check the box on the telephonic signature declaration page, and image the document into the case. The Governing Board will be working with the CalWIN and C-IV consortias to have telephonic signature integrated into the systems at a future date.

Effective Date

All counties are directed to begin using the new CMSP 215 Supplemental Application no later than May 1, 2014. Telephonic signatures for this application may also be accepted beginning May 1, 2014. Additionally, the CMSP 210 Application as well as the CMSP 219 will not be accepted after June 30, 2014.

The new CMSP 215 Supplemental Application and CMSP 216 Telephonic Signature Declaration are posted on the CMSP Governing Board's website at www.cmspcounties.org under Forms. The CMSP 210, 219 and 1153 will be removed from the website on June 30, 2014.

It is longstanding Governing Board policy that CMSP applicants must apply for all other publicly funded health coverage prior to applying for CMSP and that CMSP is the program of last resort. This policy has been continued with the implementation of the ACA and use of the new CMSP 215 Supplemental Application.

Thank you for your attention to this matter. If you have questions, please contact Kalleen Lyman at (916) 649-2631, ext. 15, or by email at klyman@cmspcounties.org.

Sincerely,

Kari A. Brownstein
Director of Finance and Administration

Enclosures

cc: Chair and Members, CMSP Governing Board
Cathy Deubel Salenko, General Counsel

COUNTY MEDICAL SERVICES PROGRAM (CMSP)
SUPPLEMENTAL APPLICATION

APPLICANT TO COMPLETE: PART A ☐ PART B & C ☐

PART A - RIGHTS & RESPONSIBILITIES

Print name of applicant	Date
Print name of person acting for applicant	Relationship to applicant

Be sure you have read every item, and sign and date. Read the following carefully before signing.

- I understand that I am applying for the County Medical Services Program (CMSP) and that the county may review my application for other federal, state and local programs, and I consent to my eligibility being determined for these other programs. I must apply for all other available medical aid programs such as Medi-Cal and offered through Covered California before CMSP eligibility will be considered.
- I understand that I am not eligible for CMSP if I am fleeing to avoid prosecution, custody or confinement after conviction for a crime that is a felony under the laws of the place that I am fleeing, or violating a condition of probation or parole imposed under Federal or State Law.
- I understand that I have declared citizenship or immigration status on an application form or MC 13 statement of citizenship. I understand that my declaration of citizenship or immigration status for Medi-Cal or Covered California eligibility will also be used in determining my CMSP eligibility.

CMSP RIGHTS, RESPONSIBILITIES, AND OTHER INFORMATION

You have the right to:

- Ask for an interpreter to help you in applying for CMSP benefits if you have difficulty in speaking or understanding the English language.
- Be treated fairly and equally regardless of your race, color, religion, national origin, sex, age, sexual orientation, marital status or political beliefs.
- Apply for CMSP benefits and to be told in writing whether or not you qualify for CMSP, even if the county representative tells you during the interview that it appears that you are, or are not now, eligible.
- Review manuals containing the rules of CMSP if you want to question the basis on which your eligibility is approved or denied.
- Receive a Benefits Identification Card (BIC) as soon as possible if you have a medical emergency and qualify for CMSP.
- Have all information you give to the county department kept in the strictest confidence.
- Qualify for CMSP by reducing your property reserve to within the CMSP property limit by the last day of any month, including the month of application.
- Receive an explanation of possible ways that you may spend your excess property as long as you receive adequate consideration.
- Speak to a social service worker about other public or private services or resources that may be available to you.
- Request a hearing from the county if you are dissatisfied with an action taken, or not taken, by the county Department of Social Services. If you wish such a hearing, you must request one within 30 days of the date the Notice of Action was mailed to you. If you do not receive a Notice of Action, you must request the hearing within 30 days of the date that you became aware of the action of which you are dissatisfied.
- Have someone accompany you or represent you at the hearing.
- Disenroll from CMSP upon request.

You have the responsibility to:

- Make a declaration about your citizenship/immigration status and provide proof if requested.
- Present when requested verification that you are a resident of the county in which you are applying for CMSP.
- Tell your medical provider (doctor, dentist, etc.) that you have applied for CMSP or are a CMSP beneficiary.
- Sign and keep your BIC and use it only to obtain medically necessary health care.
- Take your BIC to your medical provider when you receive medical care, as soon as possible if you receive services and do not have your BIC with you.
- Provide a social security number to the county or apply for one if you have legal status in the United States.
- Apply for Medicare benefits if you are blind, disabled, or aged 64 years and 9 months or older and are eligible for these benefits.
- Apply for any income which may be available to you or your family members.
- Report to the county department any health care insurance that you have or are entitled to have.
- Use any health insurance which you have before using CMSP.
- Report to the county department when CMSP benefits received are a result of an accident or injury caused by some other person's action or failure to act.
- Cooperate with the county if your case is selected for a quality control review.

- Cooperate with Medi-Cal regulations if you are potentially eligible for Medi-Cal and provide all necessary documentation to determine eligibility for Medi-Cal (this includes the disability evaluation process). If you do not cooperate and you are found ineligible for Medi-Cal due to non-cooperation, you will not be eligible for CMSP.
- Cooperate with Covered California if you are potentially eligible for Covered California and provide all necessary documentation to determine eligibility for Covered California. This includes picking a plan and continued premium payments to maintain coverage through Covered California. If you do not cooperate and you are found ineligible for Covered California due to non-cooperation, you will not be eligible for CMSP.

YOU HAVE THE RESPONSIBILITY TO NOTIFY YOUR COUNTY ELIGIBILITY WORKER WITHIN TEN DAYS WHENEVER:

- You move or plan to move to another address in your county, to another county, or to another state or country.
- You plan to be away from your home (residence) for more than 60 days.
- Any person moves into or out of your home.
- You or your spouse enters or leaves a nursing home or long-term care facility.
- You or a family member becomes a fleeing felon.
- You or a family member becomes pregnant or the pregnancy ends.
- You or a family member applies for any disability benefits, such as SSI/SSP, Social Security, Railroad Retirement, Veterans Benefits, Workers' Compensation, etc.
- You or a family member has a change in health insurance, citizenship, or immigration status.

I UNDERSTAND THAT:

- When I apply for benefits I will be evaluated for eligibility for other programs including Medi-Cal and Covered California. I must apply for other health care coverage before CMSP eligibility will be considered.
- If I am disabled or have a condition that could make me eligible for Medi-Cal because of a disability I will be required to cooperate in applying for Medi-Cal and completing the Medi-Cal disability evaluation process.
- If I obtain non-emergency medical services from a medical provider who is not a CMSP provider, I will be responsible for the cost of the services I receive.
- Based on my income, I may be billed for and have to pay for, some of my own medical expenses each month before CMSP will begin to pay.
- If I give false or incomplete information, I may be found ineligible for CMSP and I may be investigated for suspected fraud.
- The facts I give may be checked by computer with information from employers, the Franchise Tax Board, Social Security Administration, Internal Revenue Service, banks, welfare, other agencies or other sources.
- If I, or a person I am applying for, do not have documentation of satisfactory immigration status, I, or the person I am applying for, may be eligible only for emergency CMSP services.
- If I do not report changes promptly, and I receive CMSP benefits that I am not eligible for, I may have to repay those benefits.
- If I am eligible for other health insurance at no cost to me and do not apply for it or fail to keep such insurance, my CMSP eligibility may be denied or discontinued.
- If I have received emergency medical services ten days prior to the first month in which I am approved for CMSP I may apply for the Pre-Enrollment Claims Payment Authorization.
- If my medical provider accepts my CMSP for covered services, my medical provider cannot bill me for those services except for any share-of-cost that I may have.

I understand that if I make false or incomplete statements or withhold information, I (or the person on whose behalf I am acting) may lose CMSP eligibility and/or I can be prosecuted for violations of civil and/or criminal laws, including fraud.

I hereby state that I have read the information on this form and that I fully understand my RIGHTS AND RESPONSIBILITIES to have my eligibility determined for CMSP and to maintain that eligibility.

I certify and declare under penalty of perjury under the laws of the State of California that the answers I have given are true, correct and complete to the best of my knowledge.

Signature of applicant		Phone number ( )	Date
Signature of person acting for applicant	Relationship to applicant	Phone number ( )	Date
Signature of witness (If applicant signed with mark)		Phone number ( )	Date
Signature of Eligibility Worker (EW) (if applicable)	EW number (if applicable)	Phone number ( )	Date

Part B – Eligibility & Health Status

Tell us about your current health status

Check **Yes** or **No** for questions regarding the current health status for you, your spouse and your children who are living in your home.

1. Do you or any family member have a physical or emotional problem which makes it difficult to work or take care of your needs AND has lasted or is expected to last at least one year? ☐ Yes ☐ No

   Please provide a written explanation in additional comments with type of problem, beginning date and expected recovery date.

2. With treatment, do you expect to be able to work in the next year? ☐ Yes ☐ No
3. Have you applied for Social Security Disability? ☐ Yes ☐ No

   What is the status of your disability application?

   ☐ Never Applied ☐ Denied ☐ Appealing Denial ☐ Pending ☐ Approved
4. Have you filed a lawsuit, workers compensation, or insurance claim regarding an injury or accident for which you received medical treatment? ☐ Yes ☐ No
5. Are you or any family member fleeing to avoid prosecution, custody or confinement after conviction for a crime that is a felony under the law of the place that I or the family member is fleeing, or violating the condition of probation or parole (for a felony) imposed under Federal or State Law? ☐ Yes ☐ No

   If yes, name the person_____
6. Are you under house arrest? ☐ Yes ☐ No

Part C - Income, Deductions, and Property

Tell us about your income and income deductions

Check **Yes** or **No** for each source of income or deduction belonging to you, your spouse and your children who are living in your home.

Sources of income

Please review the income checklist below and indicate whether you or any persons with whom you live in the home collect income from any of these sources. You must provide verification of any income source which you answer ***yes*** to. Income is received monthly, twice a month, every 2 weeks, weekly, or daily.

			How Much	How Often
Employment	☐ Yes	☐ No	$_____	_____
Number of Hours per week _____ Employer _____				
Self-Employment	☐ Yes	☐ No	$_____	_____
Disability benefits	☐ Yes	☐ No	$_____	_____
Retirement benefits	☐ Yes	☐ No	$_____	_____
SSI/SSP	☐ Yes	☐ No	$_____	_____
Unemployment insurance	☐ Yes	☐ No	$_____	_____
State/private disability insurance	☐ Yes	☐ No	$_____	_____
Veteran's benefits	☐ Yes	☐ No	$_____	_____
Child support	☐ Yes	☐ No	$_____	_____
Spousal support	☐ Yes	☐ No	$_____	_____
Workers Compensation	☐ Yes	☐ No	$_____	_____
Money from an insurance settlement or lawsuit	☐ Yes	☐ No	$_____	_____
Scholarships, loans, grants	☐ Yes	☐ No	$_____	_____

Gifts ☐ Yes ☐ No $_____ _____

Loans ☐ Yes ☐ No $_____ _____

Do you have any other income? ☐ Yes ☐ No $_____ _____

If yes, what kind _____

In-kind Income

Do you or any family members receive any of the following items free or in exchange for work ? ☐ Yes ☐ No

Rent or Housing	☐ Free ☐ Work	Food	☐ Free ☐ Work
Utilities	☐ Free ☐ Work	Clothing	☐ Free ☐ Work

Income deductions

Please review the income deduction checklist below and indicate whether you or any persons with whom you live in the home have any income deductions from any of these sources. You must provide verification of any income deduction which you answer ***yes*** to.

Child support	☐ Yes	☐ No
Spousal support	☐ Yes	☐ No
Other health coverage	☐ Yes	☐ No
Medicare	☐ Yes	☐ No
Childcare	☐ Yes	☐ No
Adult care	☐ Yes	☐ No
Educational expense	☐ Yes	☐ No

Tell us about your property and possessions

Check **Yes** or **No** for each property or possession belonging to you, your spouse and your children who are living in your home.

Property or possessions

Please review the property/possessions checklist below and indicate whether you or any persons with whom you live in the home have any of the property or possessions listed. You must provide documentation of the property/possession for any items in which you answer ***yes*** to.

1. Cash ☐ Yes ☐ No
2. Uncashed checks ☐ Yes ☐ No
3. Checking account or savings account ☐ Yes ☐ No

Name of Person	*Type of Account*	*Bank*	*Account Number*	*Balance*

If more space is needed, *send copies of account statements showing current balances or include information in the "Additional comments or information" section.*

4. Shares of stock or mutual funds ☐ Yes ☐ No
   If yes, *please send a copy of the statements, or stock or mutual fund certificates showing the number of shares.*
5. Individual Retirement Accounts (IRAs, Keoghs, or work-related pension funds) ☐ Yes ☐ No
   If yes, *please send the most recent statements from your employer, financial institution, or brokerage showing the amount of principal and interest you are receiving or the cash value (after penalties for early withdrawal).*
6. Annuities ☐ Yes ☐ No
7. Burial trusts ☐ Yes ☐ No
8. Burial contracts or burial insurance ☐ Yes ☐ No

9. Trusts or agreements ☐ Yes ☐ No
(where money or property is held for the benefit of any family member in the home)
10. Blocked accounts ☐ Yes ☐ No
11. Court-ordered settlements ☐ Yes ☐ No
12. Judgments ☐ Yes ☐ No
13. Promissory notes ☐ Yes ☐ No
14. Mortgages or deeds of trust ☐ Yes ☐ No

If you answered yes to any of the questions 6 through 16, *please provide copies of policies, contracts, trusts, purchase agreements, court orders, or account documents showing investments and distributions*

15. Business accounts and property ☐ Yes ☐ No

If yes, *please send tax returns, invoices, receipts, licenses, profit-and-loss statements, or other documents showing ownership.*

16. A house, condominium, ranch, land, mobile home, or life estate that you live in now or used to live in, and now another member of your family lives in it, such as your spouse, a child under 21, a disabled son or daughter, a dependent relative, or a sibling, or the family member who lives there now has lived on the property for at least a year to care for you so that you could stay home instead of going into a nursing home. ☐ Yes ☐ No

If yes, please write the address of the property here.

_____

17. Do you own a home that you are not living in now but hope to return to someday? ☐ Yes ☐ No

If yes, please write the address of the property here. ***If no***, please send a copy of the most recent tax assessment. If you choose to, you may provide an appraisal from a qualified real estate appraiser, and that value will be used if it is lower.

_____

18. Other real estate ☐ Yes ☐ No

Examples: (condominiums, buildings, mobile homes, life estates, time-shares)

19. Oil and mineral rights ☐ Yes ☐ No

If yes, please send copies of the mortgage papers, most recent tax assessment, registration, or ownership documents.

20. Cars, motorcycles, trailers, boats, or other motorized vehicles ☐ Yes ☐ No

If yes, *please send a copy of the owner documents or most recent registrations, purchase agreements, sales receipts, or estimates of value. Any business use vehicle must be reported.*

21. Any item of jewelry worth more than $100 ☐ Yes ☐ No

If yes, *please send copies of sales receipts, appraisals, estimates of value or insurance documents. Excluded are wedding rings, engagement rings, and heirlooms.*

22. Any other real or personal property, assets, or resources worth $500 or more. ☐ Yes ☐ No

If yes, *please send statements about the property and its worth.*

23. Life insurance or long-term care insurance ☐ Yes ☐ No

If yes, *please send copies of your policies, contracts, and purchase agreements. If your policy is a certified California Partnership for Long-term Care policy, send a copy of your most recent benefit statement.* If copies have already been given to your worker, you do not need to send them again.

24. Has anyone spent or used any of the items listed to pay for medical services, or to guarantee payment for medical services? ☐ Yes ☐ No

If yes, *please explain in the "Additional comments or information section" at the end of this form, and attach proof.*

If you owe money on anything listed above in questions 18 through 26, *please send copies of the lien, loan, or security documents.*

25. Did you or any family member in the home sell or give away any money or property in the past ***2*** months? ☐ Yes ☐ No

If yes, *please explain in the "Additional comments or information" section at the end of this form, and attach proof.*

26. Have you closed any accounts in the past 2 months? ☐ Yes ☐ No

Name of Person	***Type of Account***	***Bank***	***Account Number***	***Balance***

If more space is needed, *send copies of account statements showing current balances or include information in the "Additional comments or information" section.*

Addition comments or information

_____

_____

_____

_____

_____

_____

_____

SIGNATURE BY APPLICANT

Read the following carefully before signing

When I sign below, it means that:

I certify and declare under penalty of perjury under the laws of the State of California that the following:

- I understand that I am applying for County Medical Services Program.
- I understand that the county shall review my eligibility for other federal, state and local programs including Medi-Cal and Covered California and I consent to my eligibility being determined for these other programs.
- I understand all the questions on this application, and my answers are true, correct and complete to the best of my knowledge. If I did not know the answer, I tried to confirm the information with someone who did know the answer.
- I know that if I do not tell the truth, I may be prosecuted for violation of civil and/or criminal laws resulting in civil and/or criminal penalties, including up to four years in jail.
- I agree to tell the county worker within 10 days (in person, via email, over the phone, or by fax) if anything on this form changes or is different from what I have written or provided to the person writing on my behalf.
- I understand that I may be asked to prove my statements and that my eligibility may be subject to review.
- I understand that the county is required by law to keep all information I provide confidential.

Signature of applicant		Phone number ( )	Date
Signature of person acting for applicant	Relationship to applicant	Phone number ( )	Date
Signature of witness (If applicant signed with mark)		Phone number ( )	Date
Signature of Eligibility Worker (EW) (if applicable)	EW number (if applicable)	Phone number ( )	Date

Privacy and Confidentiality Notification

Sections 14011 and 14012 of the Welfare and Institutions Code authorize county social service/welfare departments to collect certain information from you to determine if you or the person(s) you are applying for are eligible for CMSP benefits. The information you provide is confidential and may only be disclosed to certain individuals or organizations and then only to administer CMSP. This information will be used by the county department to establish initial and ongoing CMSP eligibility; by the CMSP's fiscal intermediary for claims processing purposes; by the California Department of Healthcare Services for BIC production; by the CMSP Governing Board, Anthem Blue Cross Life & Health, MedImpact Healthcare Systems and DentaQuest for benefit administration and claims payment, health insurance identifications and overpayment recovery actions; for Medicare Buy-In and social security number verification; by the United States Citizenship and Immigration Services (USCIS) to determine noncitizen status; and by medical providers of services for eligibility verification. Providing this information is mandatory. Failure to do so will result in your ineligibility for CMSP. You have the right to look at your information and may do so upon request at the county department during regularly scheduled office hours.

CMSP Supplemental Application – Telephonic Signature Declaration

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information contained in this document is true, correct and complete.

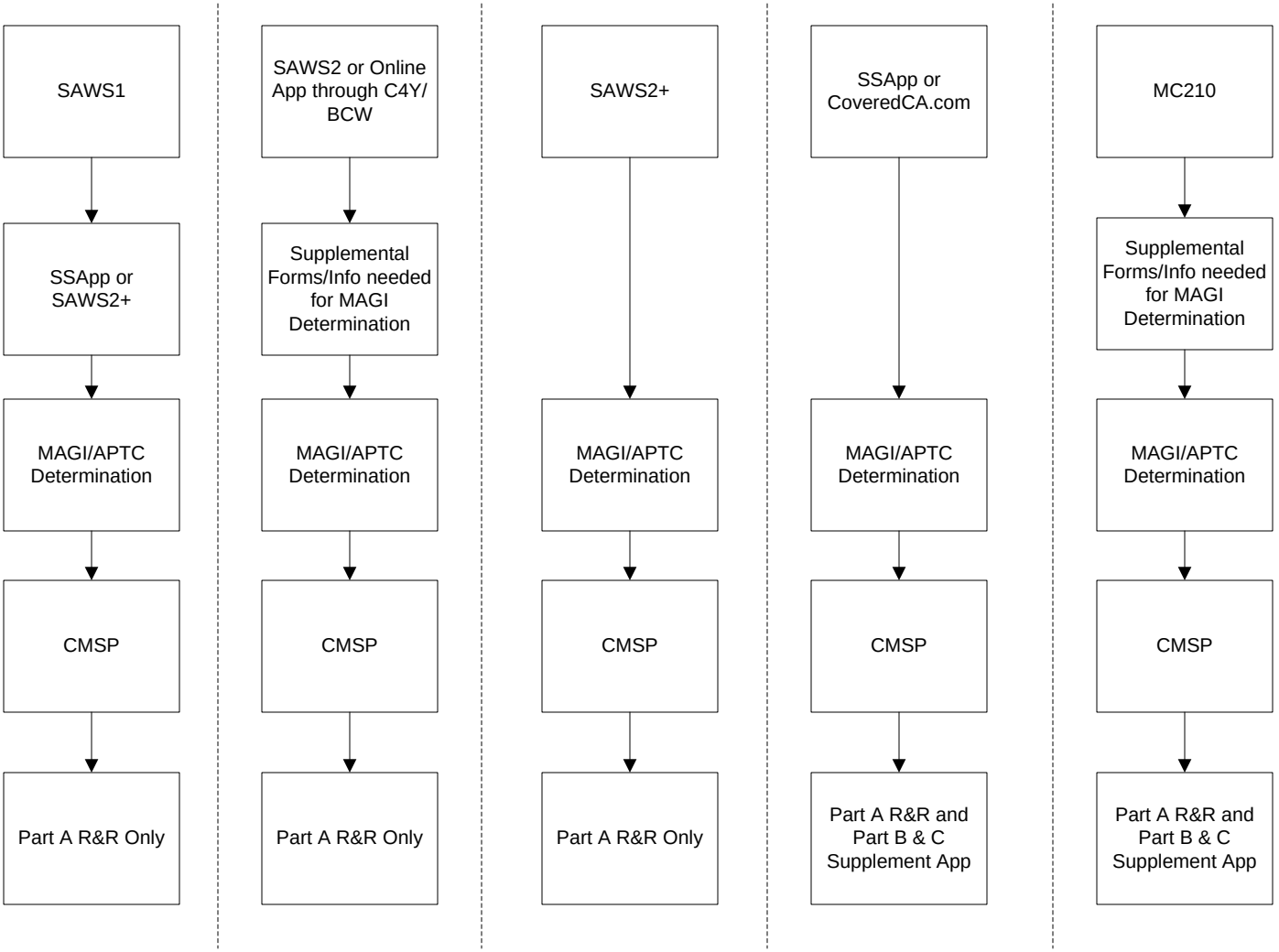
Certification

- I understand the questions and statements on this form.
- I understand that any facts that I have given, including benefit and income facts, will be matched with local, state, and federal records, such as employers, the Social Security Administration, tax, welfare, and employment agencies, etc.
- I understand that the county will send information to the U.S. Citizenship and Immigration Service (USCIS) for verification of noncitizen status, and to the Social Security Administration to check work quarters information for noncitizens applying for benefits.
- I understand that the information the county receives from USCIS and/or Social Security may affect my eligibility benefits.
- I understand information, including benefit and income facts, that I have given on this form is subject to investigation and review by county, state, and federal personnel and that if I give incorrect or incomplete facts, my benefits may be denied or stopped, and I may be prosecuted for providing false information and possibly improperly receiving benefits and fraud.
- I understand that I may be asked to prove my statements and my eligibility may be subject to review.
- I understand that I must report all changes in income, property, and/or other changes to the county within 10 days of any of these changes.
- I understand that the household, specifically any adult member of the household (even if they move out), the sponsor of a noncitizen household member or the authorized representative of residents in an eligible institution may be required to repay any benefits the household or any member of the household should not have received.
- I understand that my case may be selected for additional review to ensure that my eligibility was correctly figured and that I must cooperate fully with county, state, or federal personnel in any investigation or review, including a quality control review.
- I understand that any member of my household who is avoiding or running from the law to avoid a felony prosecution, custody or confinement after conviction or is in violation of their parole or probation is not eligible for benefits.
- I understand these statements and authorize the signature of the CMSP 215 Supplemental Application.

- ☐ Check indicates verbal agreement by applicant

County Worker:	Case Number:	Applicant Name:

Application Flow Process



R&R is Rights and Responsibilities
SSApp is Single Streamlined Application
C4Y is C4Yourself
BCW is Benefits CalWIN