# VX 520 Device System Transactions: Child Health and Disability Prevention Program Gateway

This section details the procedures for completing a Child Health and Disability Prevention (CHDP) Program Gateway transaction. The following steps are discussed in this section:

- Entering information from a completed *Child Health and Disability Prevention (CHDP) Program Pre-Enrollment Application* (DHCS 4073, rev. 10/13) into each screen of the Point of Service (POS) device
- Receiving and printing response messages
- Reviewing example response messages

If you have questions regarding the operation of the POS device, call the Telephone Service Center (TSC) at 1-800-541-5555, option 4, followed by option 2.

**Pre-Enrollment Transaction**

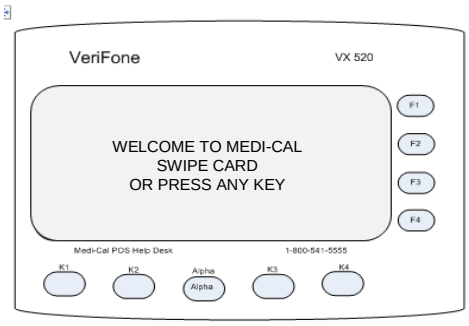
To begin a CHDP Gateway transaction on the POS device, the parent, legal guardian or emancipated minor must first complete the *Child Health and Disability Prevention (CHDP) Program Pre-Enrollment Application* (DHCS 4073). The English version of the form can be downloaded from the "CHDP Downloads" Web page after logging onto the "Transaction Services" area of the Medi-Cal website *(www.medi-cal.ca.gov)*. The form can be downloaded in English and other languages from the Medi-Cal website by clicking the "Programs" tab, then clicking "CHDP Provider Manuals and Bulletins" and finally, selecting "Appendix: Supplemental Materials."

**Infant Enrollment Transaction**

The CHDP Gateway process also allows the same CHDP Gateway transaction to automatically enroll eligible infants under 1 year of age into Medi-Cal without their parent(s) having to complete a *Single Streamlined Application* (CCFRM604). Eligible infants are those whose mothers had Medi-Cal eligibility at the time of delivery and continue to reside in California. Eligible infants receive full-scope, no-cost Medi-Cal until their first birthday.

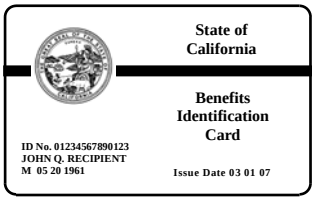
## CHDP Gateway Transaction

When you are instructed to press <ENTER>, you can press the <ENTER> key on the keyboard or on the device.

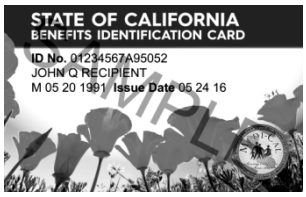


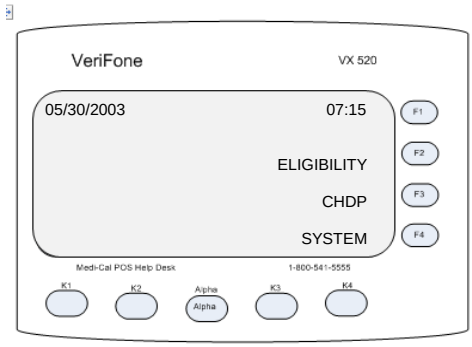

**1.** The first screen on the POS device is the Welcome screen. To get started, swipe the patient's Benefits Identification Card (BIC) (if available) through the card reader or press any key. The Main Menu screen displays.

Sample BIC:

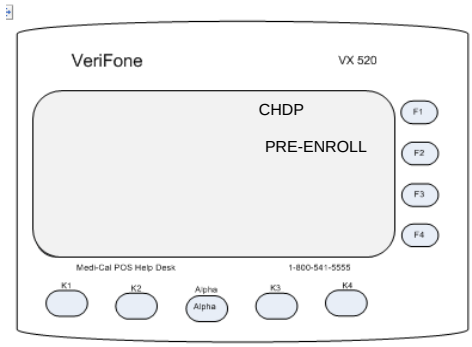



Sample Redesigned BIC:



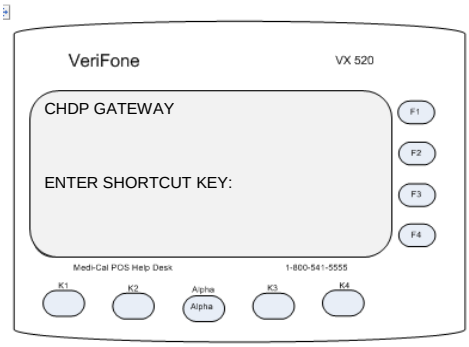




**2.** To begin a POS transaction, press the function <F> key corresponding to CHDP. In this example, press F3. If the CHDP option is not displayed and you see the (⬇) character on the screen, press <K2> (NEXT) until the CHDP option displays, then press the corresponding <F> key.




**3.** After selecting the CHDP option in Step 2, the CHDP suite menu screen displays. Currently, "PRE-ENROLL" is the only available option.

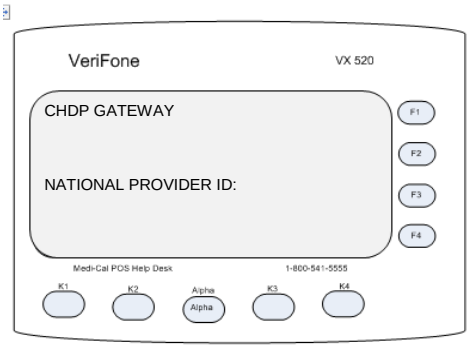
Press the F-key that corresponds to "PRE-ENROLL." In this example, press <F2>.




**4.** If you have established a shortcut key, type it and press <ENTER>. A shortcut key is a code that corresponds to your nine-digit Medicaid Provider ID or 10-digit National Provider ID (NPI). If the shortcut key entered is associated with a NPI, the next screen displayed will be the NPI screen. If the shortcut key entered is associated with a Medicaid Provider ID, the next screen displayed will be the Medicaid Provider ID screen.

You can establish a shortcut key when you configure your POS device or at any time during use. For more information, refer to “Device Setup Transaction” in the *VX 520 Device System Transactions* section. You may press <ENTER> to bypass this screen, and the NPI entry screen will be displayed.

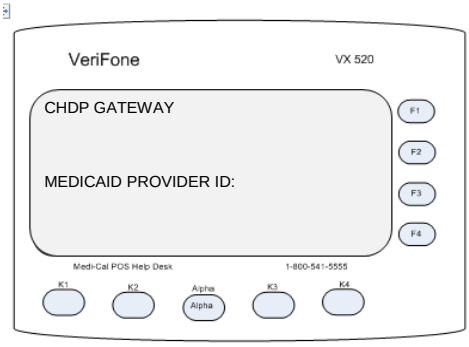
Help is not available for the shortcut key field.




**5.** If you entered a shortcut key associated with a NPI in the previous field, your NPI will display, and you can press <ENTER> to confirm the value, or you may type in another NPI value and press <ENTER>.

If you did not enter a shortcut key, type your NPI and press <ENTER>. Otherwise, with the NPI field blank, press <ENTER> to display the Medicaid Provider ID screen.

For help on this screen, press <F1>.

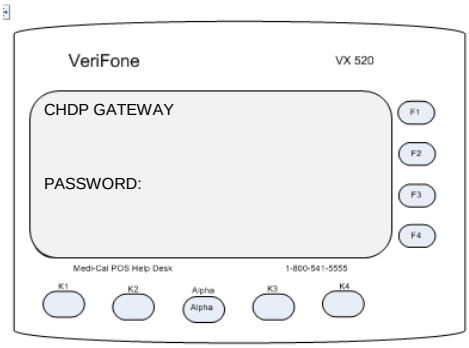



**5.1.** If you entered a shortcut key associated with a Medicaid Provider ID in the Shortcut Key screen, this screen will automatically display your Medicaid Provider ID. Press <ENTER> to accept the displayed value, or you may type in another Medicaid Provider ID and press <ENTER>.

If the NPI screen had an empty entry, this screen must have a value before proceeding. If you would like to enter a NPI value, press the <K1> (PREV) key function to go to the NPI entry screen.

If this screen was validated and you would rather use an NPI value, leave the value in this screen as is. Press the <K1> (PREV) key to go to the NPI entry screen. After you validate an NPI entry by pressing <ENTER>, the value in this screen will be purged.

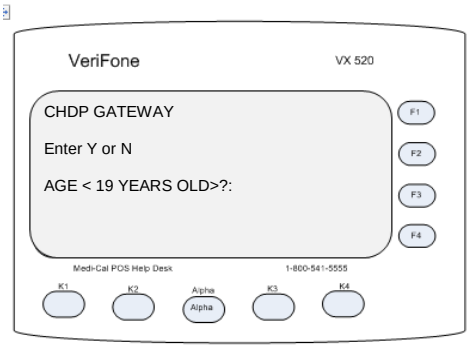
For help on this screen, press <F1>.




**6.** Enter your password. Use the Provider Identification Number (PIN) that corresponds to your NPI or Medicaid Provider ID and press <ENTER>. For security, an asterisk displays when each character is entered.

Press the <K1> (PREV) key to go to the prior field entered. If valid data was entered in the Medicaid Provider ID field, pressing the <K1> (PREV) key displays the Medicaid Provider ID. If valid data was entered in the National Provider ID field, pressing the <K1> (PREV) key displays the National Provider ID.

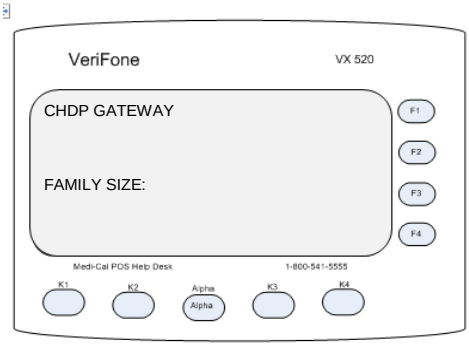
For help on this screen, press <F1>.




**7.** Type “Y” if the patient is younger than 19 years of age and press <ENTER>. If you type “Y,” you will advance to the next field.

Type “N” if the patient is 19 years of age or older. If you type “N,” you will not be allowed to proceed with the transaction. Patients 19 years of age or older are not eligible to participate in the CHDP program. You must cancel the transaction by pressing <CANCEL> twice.

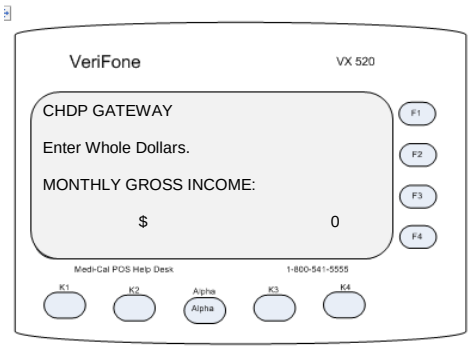
For help on this screen, press <F1>.




**8.** Type the number of people in the patient’s family and press <ENTER>. If the family consists of the patient only, type “1” and press <ENTER>.

For help on this screen, press <F1>.

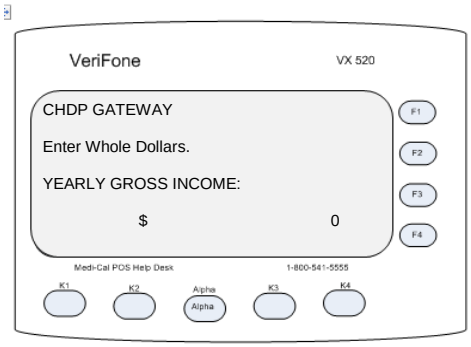
**Note:** For Fields 9 and 10, enter either the monthly **or** the yearly income amount. You may enter an amount in both fields, but only one is required (if the applicant does not indicate any income amount on the *Child Health and Disability Prevention (CHDP) Program Pre-Enrollment Application* (DHCS 4073, rev. 10/13), enter “1” for monthly income and press <ENTER>; when the yearly income field displays, press <ENTER> to bypass it).




**9.** To enter a monthly gross income amount, type the amount and press <ENTER>. Use whole dollars only, up to $99,999.

If the applicant indicated only a yearly gross income amount, press <ENTER> to bypass this field.

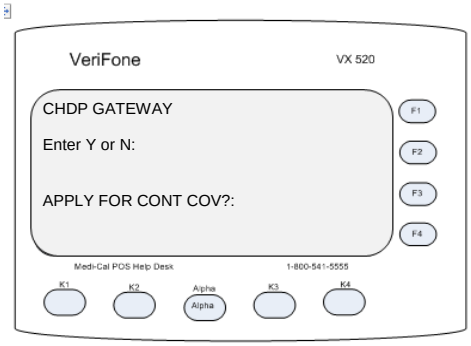
For help on this screen, press <F1>.




**10.** To enter a yearly gross income amount, type the amount and press <ENTER>. Use whole dollars only, up to $999,999.

Otherwise, press <ENTER> to bypass this field.

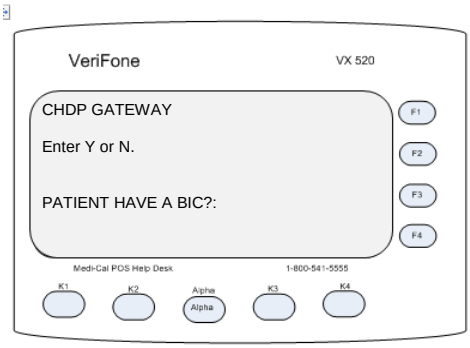
For help on this screen, press <F1>.




**11.** Type “Y” if the patient wants to apply for continuing coverage through the Medi-Cal program. Type “N” if the patient does not want to apply for continuing coverage. Next, press <ENTER>.

Patients who indicate “Yes” will receive a *Single Streamlined Application* (CCFRM604) form within 10 business days.

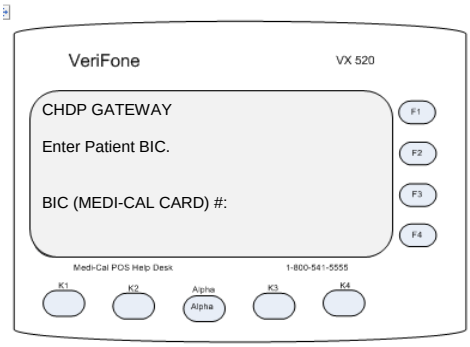
For help on this screen, press <F1>.




**12.** Type “Y” if the patient has a BIC or “N” if the patient does not have a BIC, then press <ENTER>.

**Note:** If you began the CHDP Gateway transaction by swiping the patient’s BIC, this field will display a default value of “Y,” and you can press <ENTER> to confirm the value.

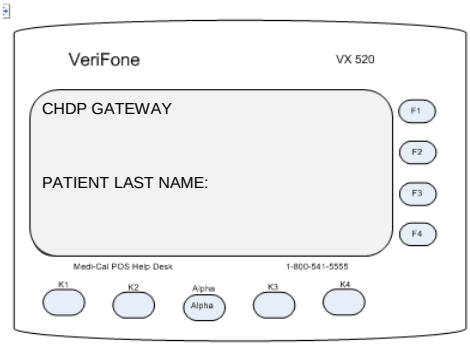
For help on this screen, press <F1>.




**13.** This field is optional. If the patient has a BIC, type the BIC number and press <ENTER>. If the patient does not have a BIC, press <ENTER> to bypass this field.

**Note:** If you began the CHDP Gateway transaction by swiping the patient’s BIC, this field will display the BIC number, and you can press <ENTER> to confirm the value.

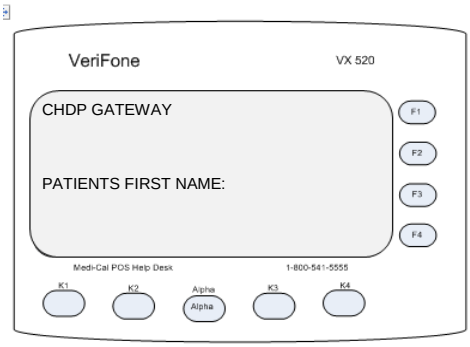
For help on this screen, press <F1>.




**14.** Type the patient’s last name or the patient’s single name (if the patient has a single name only), then press <ENTER>.

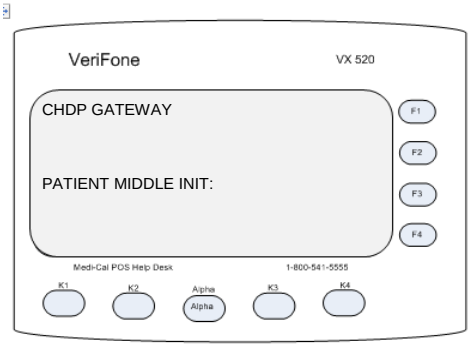
**Note:** Name entries can exceed the screen width but only 21 characters will appear on your screen. If this happens, the input line shifts to the left as you type. You can use the LEFT ARROW and RIGHT ARROW keys to scroll through your entry.

For help on this screen, press <F1>.



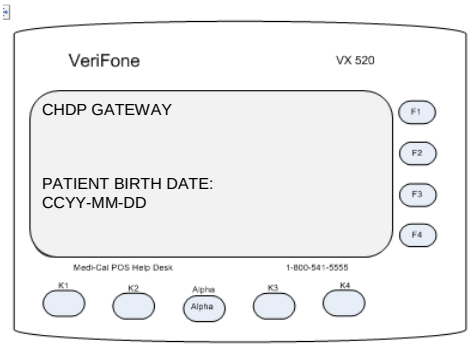

**15.** Type the patient's first name (if the patient has a first and last name) and press <ENTER>. If the patient has a single name, type "none" and press <ENTER>.

For help on this screen, press <F1>.




**16.** This field is optional. Type the patient's middle initial and press <ENTER> or press <ENTER> to bypass this field.

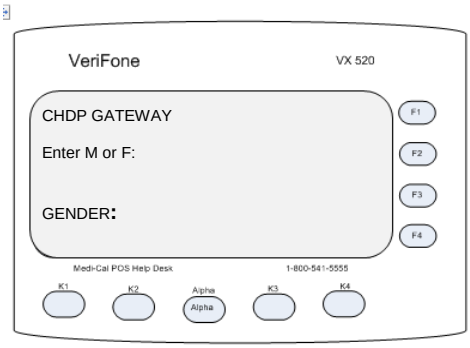
For help on this screen, press <F1>.




**17.** Type the patient's birth date in the format "CCYYMMDD" and press <ENTER>. For example, type "20030130" for January 30, 2003. Do not include hyphens, they will appear automatically. The date entry will not be accepted if you do not enter it in the proper format.

**Note:** If you began the CHDP Gateway transaction by swiping the patient's BIC, this field will display the patient's birth date, and you can press <ENTER> to confirm the value.

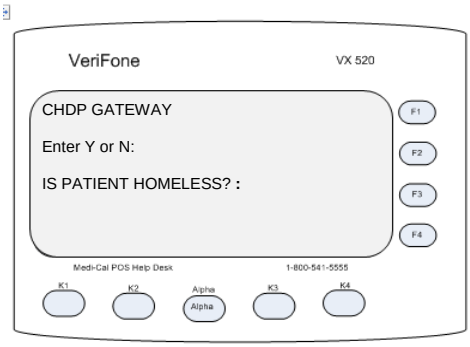
For help on this screen, press <F1>.




**18.** Type “M” or “F” for gender, then press <ENTER>.

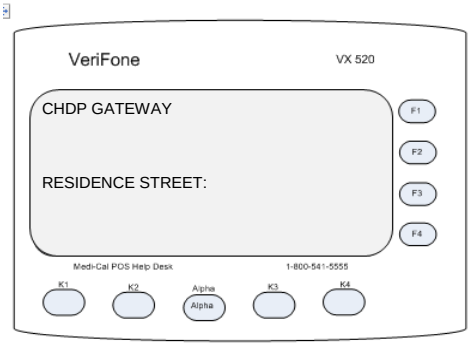
For help on this screen, press <F1>.

**Note:** If you began the CHDP Gateway transaction by swiping the patient’s BIC, this field will display the patient’s gender, and you can press <ENTER> to confirm the value.




**19.** This field displays a default value of “N.” If the patient is homeless, type “Y” and press <ENTER>. Otherwise, press <ENTER> to confirm the default value.

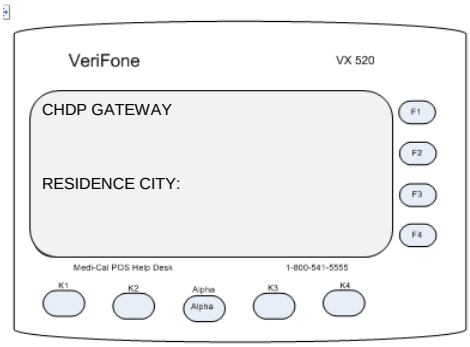
For help on this screen, press <F1>.




**20.** Type the patient’s residential street address. If the patient is homeless, enter the general street location. Press <ENTER> when finished. This field is required even if the patient is homeless. Invalid addresses are the following: General Delivery, PO Box, P.O. Box, PO. Box and Post Office Box.

**Note:** Address field entries can exceed the screen width; however, only 21 characters will appear on your screen. If this happens, the input line shifts to the left as you type. You can use the LEFT ARROW and RIGHT ARROW keys to scroll through your entry.

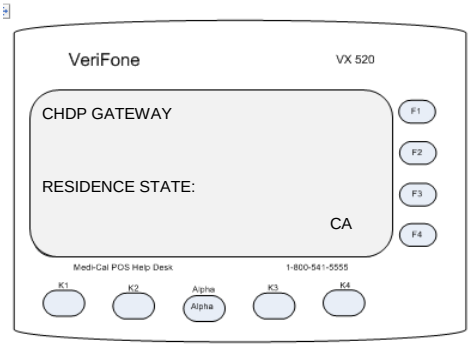
For help on this screen, press <F1>.




**21.** Type the patient's city of residence and press <ENTER>. This field is required even if the patient is homeless.

**Note:** Even if the patient is homeless, residence and mailing address information is still required.

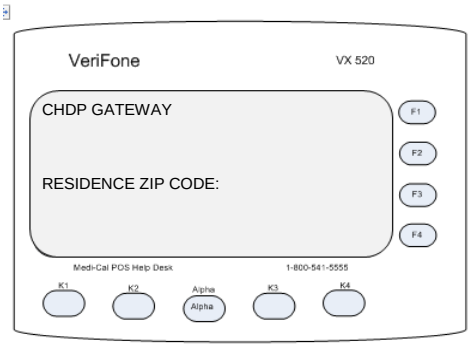
For help on this screen, press <F1>.




**22.** This field displays a default value of "CA." Verify that the patient resides in California, then press <ENTER> to confirm the default value. This field is required even if the patient is homeless.

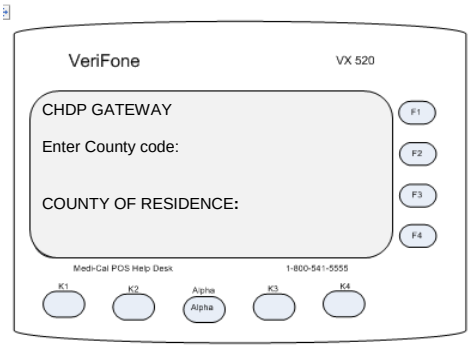
**Note:** Patients residing outside of California are not eligible to participate in the CHDP program. If you enter a response other than "CA," you will not be allowed to proceed further. Cancel the transaction by pressing <CANCEL> twice.

For help on this screen, press <F1>.



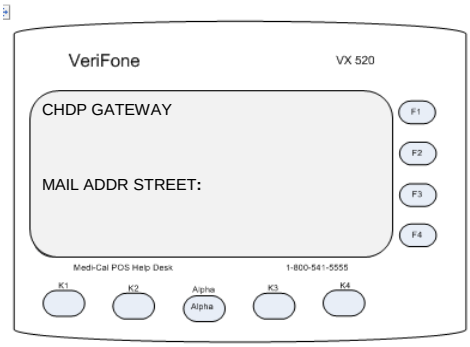

**23.** This field is optional. Type the five-digit ZIP code and press <ENTER>.

For help on this screen, press <F1>.




**24.** Type the code of the California county where the patient resides, then press <ENTER>. Refer to the "POS Device Transaction Codes Key Language" at the end of this section for a list of accepted values.

For help on this screen, press <F1>.

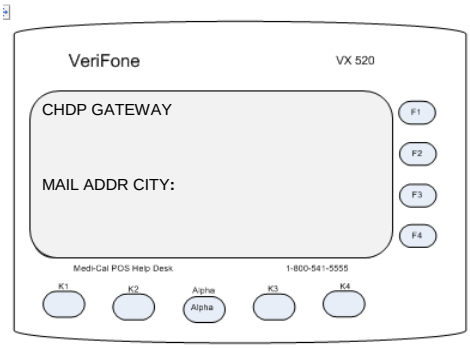



**25.** This field and the other mailing address fields are required if you enter a "Y" in Field 19 (*Is Patient Homeless?*) **or** if the patient has indicated a mailing address that is different from the residence address. If this field is required, type the patient's mailing street and press <ENTER>.

If this field is not required, you can press <ENTER> to bypass it or enter a mailing street.

**Note:** If this field is not required and you complete it, you must also complete the *Mailing Address City* and *State* fields.

For help on this screen, press <F1>.

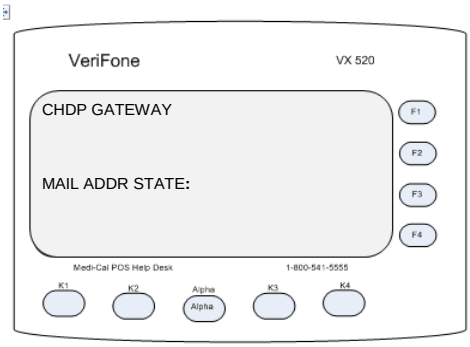



**26.** This field is required if Field 25 was required. Type the name of the city where the patient receives mail and press <ENTER>.

If this field is not required, you can press <ENTER> to bypass it or enter a mailing city.

**Note:** If this field is not required and you complete it, you must also complete the *Mailing Address Street* and *State* fields.

For help on this screen, press <F1>.

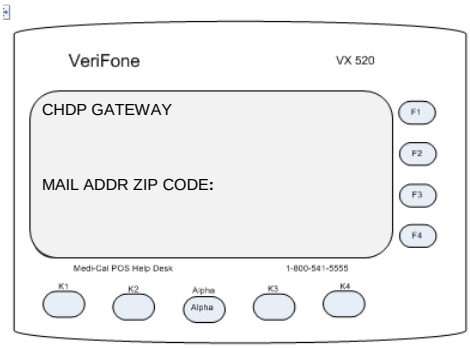



**27.** This field is required if Field 25 (*Mailing Address Street)* and Field 26 (*Mailing Address City*) were required. Type the two-character abbreviation of the state where the patient receives mail and press <ENTER>. Refer to the "POS Device Transaction Codes Key Language" at the end of this section for a list of accepted values. The mailing address state can be outside of California but it must be a valid state or the District of Columbia (DC).

If this field is not required, you can press <ENTER> to bypass it or enter a mailing state.

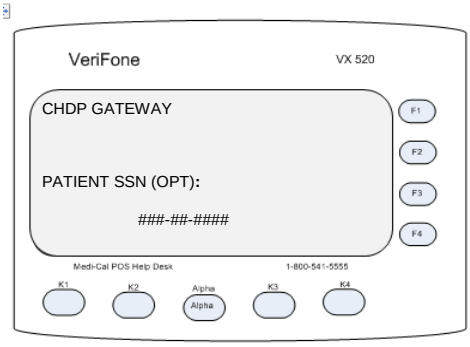
**Note:** If this field is not required and you complete it, you must also complete the *Mailing Address Street* and *City* fields.

For help on this screen, press <F1>.



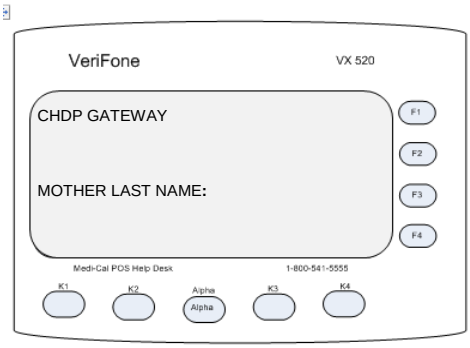

**28.** This field is optional. Type the five-digit ZIP code where the patient receives mail and press <ENTER> or leave it blank and press <ENTER> to bypass this field.

For help on this screen, press <F1>.



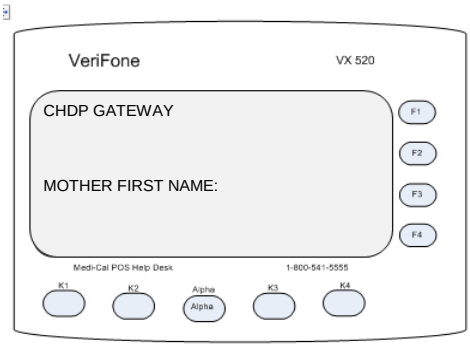

**29.** This field is optional. Type the patient's nine-digit Social Security Number (SSN) and press <ENTER> or leave it blank and press <ENTER> to bypass this field. Do not include hyphens; they will appear automatically.

For help on this screen, press <F1>.



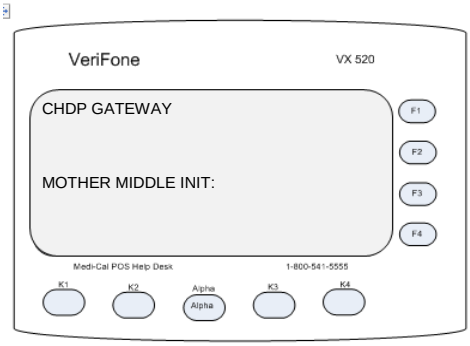

**30.** Type the last name of the patient's mother and press <ENTER>.

For help on this screen, press <F1>.



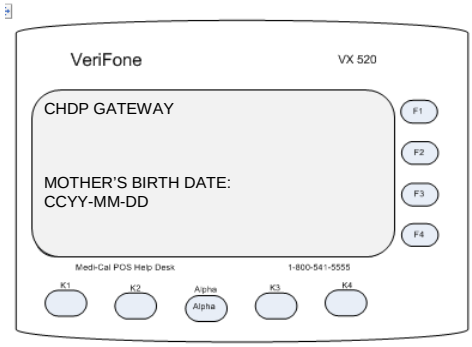

**31.** Type the first name of the patient's mother and press <ENTER>.

For help on this screen, press <F1>.



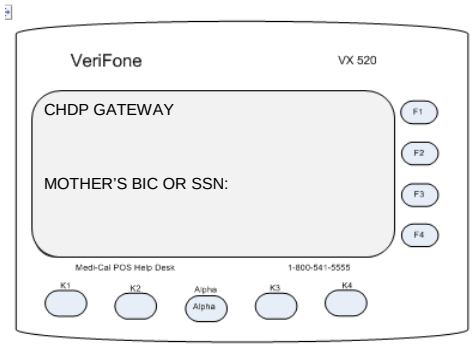

**32.** This field is optional. Type the middle initial of the patient's mother and press <ENTER>.

For help on this screen, press <F1>.



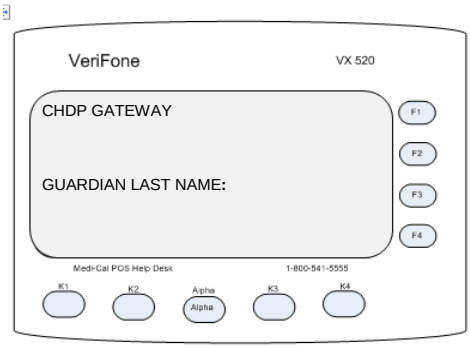

**33.** This field is required for patients under 1 year of age; otherwise the field is optional. Type the mother's birth date and press <ENTER> or press <ENTER> to bypass this field.

For help on this screen, press <F1>.



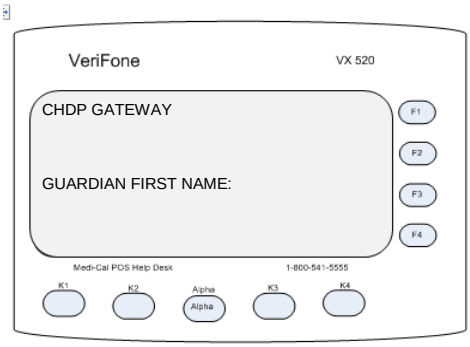

**34.** This field is required for patients under 1 year of age; otherwise the field is optional. Type the mother's BIC or SSN and press <ENTER> or press <ENTER> to bypass this field.

For help on this screen, press <F1>.



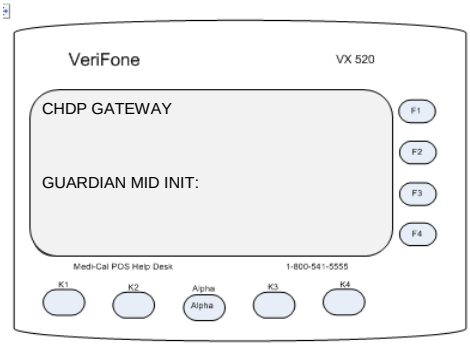

**35.** Type the last name of the patient's parent or legal guardian. If the patient is an emancipated minor, type the patient's last name and press <ENTER>.

For help on this screen, press <F1>.



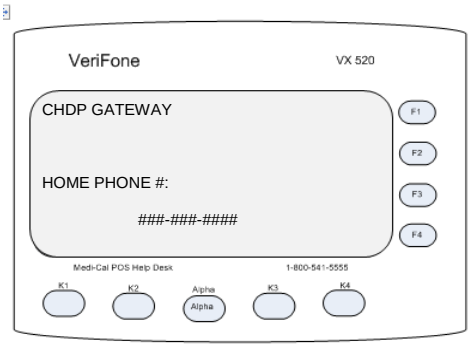

**36.** Type the first name of the patient's parent or legal guardian. If the patient is an emancipated minor, type the patient's first name and press <ENTER>.

For help on this screen, press <F1>.



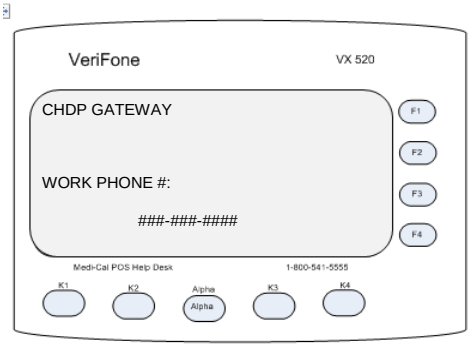

**37.** This field is optional. Press <ENTER> to bypass this field, or type the middle initial of the patient's parent or legal guardian. If the patient is an emancipated minor, type the patient's middle initial and press <ENTER>.

For help on this screen, press <F1>.



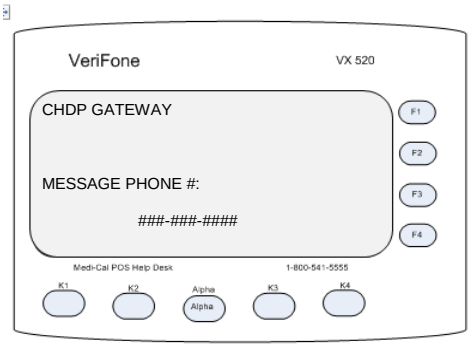

**38.** This field is optional. Press <ENTER> to bypass or type the patient's 10-digit home telephone number and press <ENTER>. Do not enter hyphens or parentheses. Hyphens will appear automatically.

For help on this screen, press <F1>.



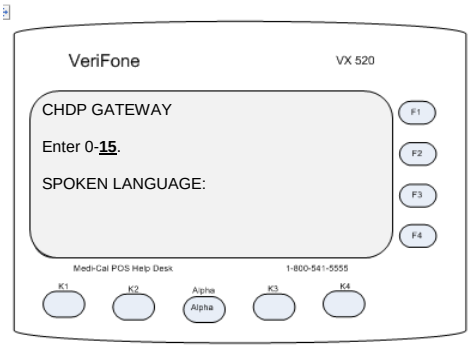

**39.** This field is optional. Press <ENTER> to bypass or type the patient's 10-digit work telephone number (if applicable) and press <ENTER>. Do not enter hyphens or parentheses. Hyphens will appear automatically.

For help on this screen, press <F1>.



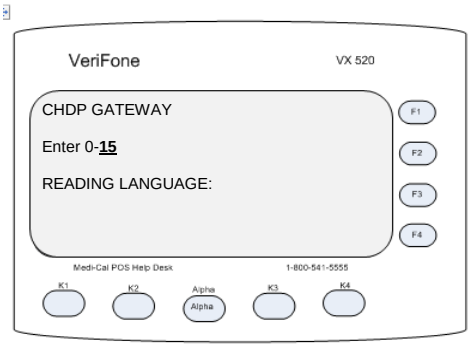

**40.** This field is optional. Press <ENTER> to bypass or type the patient's 10-digit message telephone number (if applicable) and press <ENTER>. Do not enter hyphens or parentheses. Hyphens will appear automatically.

For help on this screen, press <F1>.




**41.** If the patient has indicated a spoken language, type the code of the language and press <ENTER>. If the patient has indicated a language for which no code exists, type “0”.

You can press <F1> to view a list of language codes. Press (K2) <NEXT> to scroll down the list until the correct code displays. Note the code, and then press <CANCEL> to return to this field and type in the code. You can also press <K3> (PRINT) to print the list of codes for future reference, or refer to the “POS Device Transaction Codes Key Language” at the end of this section for a list of accepted codes.

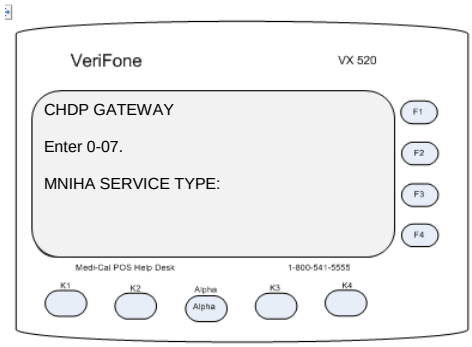



**42.** This field is optional. If the patient has indicated a reading language, type the code of the language and press <ENTER>.

If the patient has indicated a language that does not have a code or no language at all, type “0”.

You can press <F1> to view a list of language codes. Press (K2) <NEXT> to scroll down the list until the correct code displays. Note the code, and then press <CANCEL> to return to this field and type in the code. You can also press <K3> (PRINT) to print the list of codes for future reference, or refer to the “POS Device Transaction Codes Key Language” at the end of this section for a list of accepted codes.

A patient who wishes to continue Medi-Cal coverage will receive a *Single Streamlined Application* (CCFRM604) form in his/her reading language.



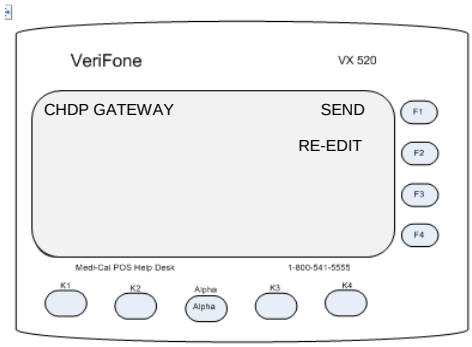

**43.** This field is optional. It indicates the reason for a visit that is outside the CHDP periodicity schedule (a visit for a Medically Necessary Interperiodic Health Assessment [MNIHA]).

If the patient's visit is within the periodicity schedule, type "0" and press <ENTER>.

If the visit is outside the periodicity schedule, type the code indicating the MNIHA service type and press <ENTER>.

You can press <F1> to view a list of MNIHA service type codes. Press <K2> (NEXT) to scroll down the list until the correct code displays. Note the code, and then press <CANCEL> to return to this field and type in the code. You can also press <K3> (PRINT) to print the list of codes for future reference, or refer to the "POS Device Transaction Codes Key" at the end of this section for a list of accepted codes.

**CAUTION: <F1> does not take you to the Help Screen for the next step (Step 44). Pressing <F1> during Step 44 submits the application.**

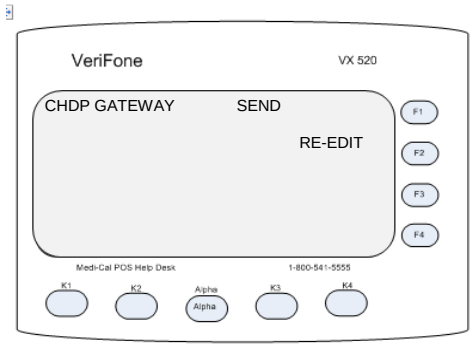



**44.** After you complete or bypass Step 43 and press <ENTER>, the Send/Re-Edit screen displays.

**Before submitting, review your entries to ensure accuracy. Refer to the following pages for instructions about reviewing and correcting the transaction.**

## Review and Edit the Transaction

Before submitting the transaction, you may review entries to confirm that the information is accurate and that no keying errors were made. This will ensure that the transaction is processed without delay. You may review your entries on the POS screen or a hard copy printout by starting at the Send/Re-Edit screen.




**1.** To review and edit your entries on the POS screen, press <F2> (RE-EDIT). The first field of the Gateway transaction displays. Press <K2> (NEXT) to scroll through the fields. Press the <K1> (PREV) key to return to a previous field. If you need to correct an entry, refer to Step 2.

You may find it easier to review your entries using a printed summary. To review a printed summary of your entries, press <K3> (PRINT).

**2.** Edit Entries:

- To change an entire entry, scroll to the field, type in a new entry and press <ENTER>. The new entry replaces the previous entry.
- To change single characters in an entry, press <BACKSPACE> on the keyboard or keypad. This will enable you to delete the entry one character at a time until you delete the incorrect character. Re-type the entry from that character forward.

**3.** Continue to press <K2> (NEXT) to review and correct entries, as needed, until the Send/Re-Edit screen displays.

Conditional Re-Edit Error Message

If you receive the error message below, the transaction cannot be submitted until you return to the indicated field(s) and provide the missing information.

**Error Message:**

***Re-edit error***
*Required data is now missing.  You must correct one or more of the following before sending:*

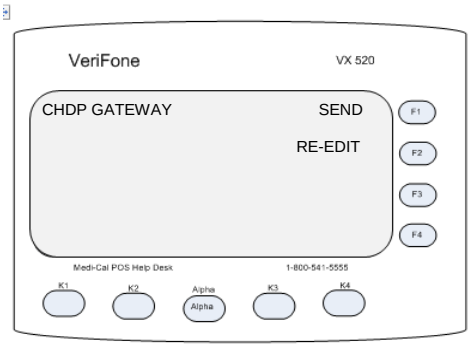
*Monthly and yearly income cannot both be zero.*
*If homeless = Y mail addr street, city and state required.*
*Mother DOB must be older than Patient DOB.*

In order to send this transaction, you need to re-edit the appropriate fields by following these steps:

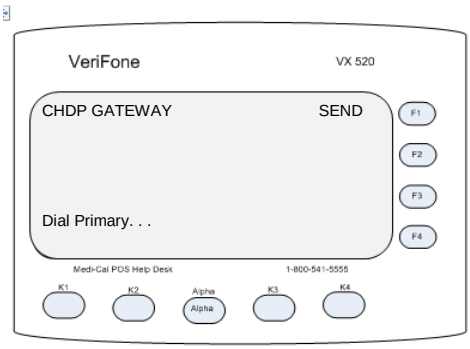
1. Scroll to the end of the message screen to return to the Send/Re-Edit screen.
2. Press <F2> to “RE-EDIT”
3. Press <K2> (NEXT) to scroll through the fields.
4. Edit the necessary fields and press <ENTER> to confirm the values.
5. When all of the fields are correct, press <EXIT> to return to the Send/Re-Edit screen.

## Submit the Transaction

After reviewing your entries, submit the POS transaction for processing.

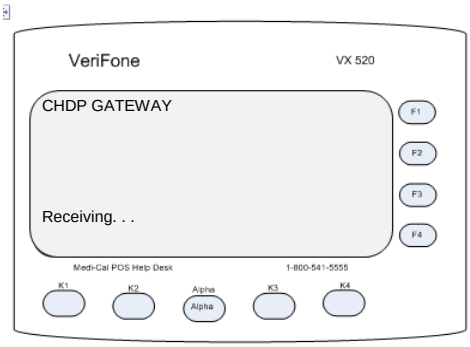



**1.** When you are ready to submit the transaction, press <F1> (SEND) in the Send/Re-Edit screen.




**2.** After you press <F1>, the POS device sends the transaction to the Medi-Cal Eligibility Data System, which determines the patient's pre-enrollment eligibility.

The screens at left display while the transaction is processing.



## Possible Error Messages

After you press <F1> (SEND), your entries are verified before being sent to the Medi-Cal Eligibility Data System. In addition, the connection between your device and the Medi-Cal Eligibility Data System is verified.

If the system detects a problem with an entry or if the connection is temporarily down, an error message will be returned to your device screen. You may be required to correct an entry and resubmit the transaction, or wait until a later time to submit the transaction.

The following table describes possible error messages, the reasons for the errors, and the necessary corrective action. If the message indicates you must correct one or more entries, you need to re-edit the appropriate fields by following these steps:

1. Scroll to the end of the message screen to return to the Send/Re-Edit screen.
2. Press <F2> (RE-EDIT).
3. Press <K2> (NEXT) to scroll through the fields.
4. Edit the necessary fields and press <ENTER> to confirm the values.
5. When all of the fields are correct, press <EXIT> to return to the Send/Re-Edit screen.

| ERROR MESSAGE RESPONSE | DESCRIPTION OF ERROR | CORRECTIVE ACTION |
|---|---|---|
| `APPLICANT OVER INCOME FOR PROGRAM ELIGIBILITY.` | The income amount entered exceeds the maximum amount allowed for the CHDP Program. | The applicant does not qualify for the CHDP Program. Cancel the transaction. |
| `ERROR: SPACE(S) ONLY WAS ENTERED IN THE FOLLOWING FIELD(S). THIS ENTRY IS NOT ALLOWED. PLEASE CORRECT ENTRY AND RESUBMIT.`<br>`PATIENT LAST NAME, PATIENT FIRST NAME, RESIDENCE STREET, RESIDENCE CITY, MAIL STREET, MAIL CITY, MAIL STATE, MOTHERS LAST NAME, MOTHERS FIRST NAME, GUARDIAN LAST NAME, GUARDIAN FIRST NAME`<br>**Note:** Only fields containing all spaces will be listed in the error message. The example above lists all potential fields. | At least one required name or address field contains only spaces. | Review the fields listed in the error message and ensure they do not contain only spaces. |

| ERROR MESSAGE RESPONSE | DESCRIPTION OF ERROR | CORRECTIVE ACTION |
|---|---|---|
| `ERROR: INVALID DATA WAS ENTERED IN THE FOLLOWING FIELD(S). PLEASE CORRECT ENTRY AND RESUBMIT.`<br>`PATIENT LAST NAME, PATIENT FIRST NAME, RESIDENCE STREET, RESIDENCE CITY, MAIL STREET, MAIL CITY, MOTHERS LAST NAME, MOTHERS FIRST NAME, GUARDIAN LAST NAME, GUARDIAN FIRST NAME`<br>**Note:** Only fields containing invalid data will be listed in the error message. The example above lists all potential fields. | At least one name or address field contains only special characters. Special characters include, but are not limited to, the following:<br>• Ampersand (&)<br>• Dash (-)<br>• Period (.)<br>• Slash (/)<br>Residence address cannot contain any of the following:<br>• General Delivery<br>• PO Box<br>• POBox<br>• P.O. Box<br>• PO. Box<br>• Post Office Box | Review the fields listed in the error message and ensure they do not contain only special characters. |
| `ERROR: THE WORD "SAME" WAS ENTERED IN THE FOLLOWING FIELD(S). THIS ENTRY IS NOT ALLOWED. PLEASE CORRECT ENTRY AND RESUBMIT.`<br>`PATIENT LAST NAME, PATIENT FIRST NAME, RESIDENCE STREET, RESIDENCE CITY, RESIDENCE STATE, MAIL STREET, MAIL CITY, MAIL STATE, MOTHERS LAST NAME, MOTHERS FIRST NAME, GUARDIAN LAST NAME, GUARDIAN FIRST NAME`<br>**Note:** Only fields containing the word "SAME" will be listed in the error message. The example above lists all potential fields. | At least one name or address field contains the word "SAME." | Review the fields listed in the error message and ensure they do not contain the word "SAME." |
| `ERROR: WHEN THE MAILING ADDRESS IS ENTERED, IT MUST CONTAIN THE STREET, CITY, AND STATE FIELDS. YOU HAVE NOT COMPLETED ALL THREE FIELDS. PLEASE ENTER VALID DATA IN ALL 3 FIELDS OR LEAVE ALL 3 FIELDS BLANK, THEN RESUBMIT.` | When the mailing address is optional, the Mailing Street, City and State fields follow an all-or-none principle. At least one mailing address field was completed and at least one of the other mailing address fields was left blank. | Review these fields to ensure they are either all completed or all blank. |

| ERROR MESSAGE RESPONSE | DESCRIPTION OF ERROR | CORRECTIVE ACTION |
|---|---|---|
| ERROR: THE VALUE YOU ENTERED IS NOT A VALID SSN. PLEASE CORRECT OR REMOVE THE ENTRY AND RESUBMIT THE TRANSACTION. | The SSN field contains an invalid Social Security Number. | Review the patient's SSN on the DHCS 4073. Retype the SSN if an entry error was made. If the SSN still is not accepted, delete the entry and leave this field blank. |
| ERROR: YOU ENTERED AN INVALID MAILING ADDRESS STATE ABBREVIATION. PLEASE CORRECT THE ENTRY AND RESUBMIT THE TRANSACTION. | The Mailing State field contains an invalid two-character state abbreviation. | Ensure the *Mailing State* field contains a valid two-character state abbreviation or DC (for District of Columbia). |
| ERROR: THE VALUE YOU ENTERED IS NOT A VALID MOTHERS SSN. PLEASE CORRECT THE ENTRY AND RESUBMIT THE TRANSACTION. | The Mother BIC or SSN field contains an invalid Social Security Number. | Review the mother's SSN on the DHCS 4073. Retype the SSN if an entry error was made. If the SSN still is not accepted, delete the entry and leave this field blank. |
| AN ERROR OCCURRED WHILE PROCESSING ELIGIBILITY FOR THIS APPLICANT. PLEASE CONTACT THE POS/INTERNET HELP DESK BETWEEN THE HOURS OF 6AM AND 12AM. | An unknown error occurred in the Medi-Cal Eligibility Data System. | Print the error message by pressing the K3 (PRINT) key, then call the Telephone Service Center (TSC), option 4, followed by option 2. The help desk will ask for specific transaction information from the printout. Please have the printout ready when you call TSC. |
| SYSTEM NOT AVAILABLE.<br>or<br>SYSTEM IS NOT AVAILABLE. TRY AGAIN LATER. | The system is temporarily unavailable. This could be caused by downed phone lines or by scheduled system maintenance.<br>(**Note:** System maintenance always occurs nightly from midnight to 2 a.m., but unscheduled maintenance may be necessary at other times.) | If you are attempting to submit a transaction between midnight and 2 a.m., wait until after 2 a.m., and then retry your transaction. Otherwise, wait a few minutes and try again. |

**Response Messages Overview**

Shortly after submitting the transaction, the POS device will display a message indicating that it has received a response from the Medi-Cal Eligibility Data System. Response messages contain important information about the patient's pre-enrollment eligibility.

The response message will indicate one of the following:

- The establishment of temporary Medi-Cal or CHDP eligibility
- The establishment of full-scope, no-cost Medi-Cal eligibility
- The program for which the patient is temporarily eligible or currently enrolled or
- A denial reason

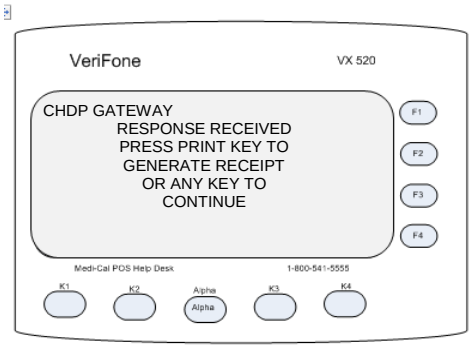
Providers must print the response message, give the original printout to the parent, legal guardian or emancipated minor, and keep a photocopy for the patient's file. Providers should also retain the original *Child Health and Disability Prevention (CHDP) Program Pre-Enrollment Application* (DHCS 4073) signed by the parent, guardian or emancipated minor in the patient's file.

**IMPORTANT:** If the client signature line appears in the response message, the response message must be printed and used as an *Immediate Need Eligibility Document* until a permanent BIC is received in the mail. The parent, legal guardian or emancipated minor must sign the *Immediate Need Eligibility Document* on the client signature line. If necessary, the patient can use the printout through the expiration date printed on the response message. The patient should discontinue using the *Immediate Need Eligibility Document* when a permanent BIC is received.

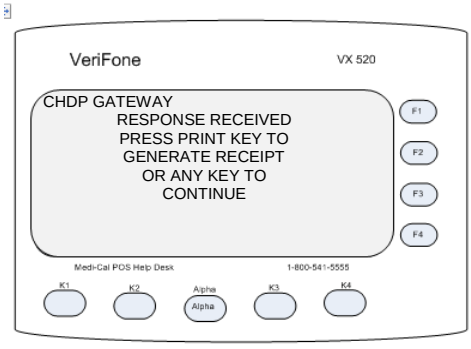
## Print a Response Message

Response message printouts consist of two parts: a summary of your transaction, followed by the response from the Medi-Cal Eligibility Data System. The transaction summary and response message are separated on the printout by a dashed line.

It is recommended that POS printouts be photocopied because the ink on the thermal paper used by the POS device may fade with time.




**1.** When the POS device indicates it has received a response message, press any key to view the response.




**2.** To print the response message, press <K3> (PRINT). Print the message twice. Give one printout to the parent, legal guardian or emancipated minor and keep the other for the patient's file.

| | |
|---|---|
| Messages Approving Pre-Enrollment | If the patient's pre-enrollment through the CHDP Gateway is approved, the response message will indicate that temporary Medi-Cal or CHDP eligibility is established. The message will also specify the date through which eligibility is valid. Providers should print two copies of the approval message. One copy is given to the parent, legal guardian or emancipated minor and one copy is kept for the patient's file. The following pages contain examples of response messages that approve CHDP Gateway pre-enrollment. |
| Messages Denying Pre-Enrollment | If the patient's pre-enrollment through the CHDP Gateway is not approved, the response message will indicate the program for which the patient is currently enrolled or a denial reason. The following pages contain examples of response messages that deny CHDP Gateway pre-enrollment. |
| Message Approving Infant Enrollment | If the infant's enrollment through the CHDP Gateway is approved, the response message will indicate that Medi-Cal eligibility has been established. Providers should print two copies of the approval message. One copy is given to the parent or legal guardian and one copy is kept for the patient's file. |

**Example:** Response message indicating CHDP Gateway pre-enrollment eligibility for CHDP services. This message requires the patient's signature. **This document is an Immediate Need Eligibility Document.**

```
              CALIFORNIA
  DEPARTMENT OF HEALTH CARE SERVICES
         MEDI-CAL POS NETWORK

   12/19/2002          12:02:17 PM

TERMINAL: V123456789
SOFTWARE: ZZACH30

MEDICAID PROVIDER ID:  CHA123456

        CHDP GATEWAY
      PRE-ENROLLMENT
          INPUT

AGE < 19 YEARS OLD?:                Y

FAMILY SIZE:                       03

MONTHLY GROSS INCOME:               $

YEARLY GROSS INCOME:          $20,000

APPLY FOR CONT COV?:                Y

PATIENT HAVE A BIC?:                N

BIC (MEDI-CAL CARD)#:

PATIENT LAST NAME:               JOSS

PATIENT FIRST NAME:            ANDREW

PATIENT MIDDLE INIT:                M

PATIENT BIRTH DATE:        1996-01-01

GENDER:                             M

IS PATIENT HOMELESS?:               N

RESIDENCE STREET:     123 TEST STREET
```

*(printout continues)*

```
RESIDENCE CITY:   RANCHO CORDOVA

RESIDENCE STATE:              CA

RESIDENCE ZIP CODE:        95670

COUNTY OF RESIDENCE:          34

MAIL ADDR STREET:

MAIL ADDR CITY:

MAIL ADDR STATE:

MAIL ADDR ZIP CODE:

PATIENT SSN (OPT):

MOTHER LAST NAME:          DESAI

MOTHER FIRST NAME:         MEENA

MOTHER MIDDLE INIT:            A

MOTHER'S BIRTH DATE:

MOTHER'S BIC OR SSN:

GUARDIAN LAST NAME:        DESAI

GUARDIAN FIRST NAME:     MIRACLE

GUARDIAN MID INIT:             B

HOME PHONE #:       916-111-2222

WORK PHONE #:

MESSAGE PHONE #:

SPOKEN LANGUAGE:              01

READING LANGUAGE:             00

MNIHA SERVICE TYPE:           01

   PATIENT TRANSACTION RESPONSE BELOW
```

*(printout continues on next page)*

*(continued from previous page)*

```
              CALIFORNIA
  DEPARTMENT OF HEALTH CARE SERVICES
        MEDI-CAL POS NETWORK


   12/19/2002          12:04:22 PM

TERMINAL: V123456789
SOFTWARE: ZZACH30

MEDICAID PROVIDER ID:  CHA123456

        CHDP GATEWAY
       PRE-ENROLLMENT
          RESPONSE

PATIENT NAME:
ANDREW M JOSS

PATIENT BIRTH DATE:
1996-01-01

GENDER:
M

BIC ID#:
1234567890

GOOD THRU DATE:
2003-01-31

ISSUE DATE:
2002-12-19

YOU ARE TEMPORARILY ELIGIBLE FOR CHDP
SERVICES THROUGH 01/31/2003. USE THIS
DOCUMENT TO ACCESS CHDP AND EMERGENCY
MEDI-CAL SERVICES UNTIL YOUR BENEFITS
IDENTIFICATION CARD ARRIVES.

X_______________________________
 CLIENT SIGNATURE

      <<SYSTEM MESSAGE(S) FROM >>
          << PROVIDER MAIL >>

               THANK YOU!
```

**Example:** Response message indicating CHDP Gateway pre-enrollment eligibility for full-scope Medi-Cal services. The patient already has a BIC. This message does not require the patient's signature.

```
              CALIFORNIA
  DEPARTMENT OF HEALTH CARE SERVICES
         MEDI-CAL POS NETWORK

   12/19/2002          12:02:17 PM

TERMINAL: V123456789
SOFTWARE: ZZACH30

MEDICAID PROVIDER ID:  CHA123456

        CHDP GATEWAY
      PRE-ENROLLMENT
          INPUT

AGE < 19 YEARS OLD?:                Y

FAMILY SIZE:                       03

MONTHLY GROSS INCOME:               $

YEARLY GROSS INCOME:          $20,000

APPLY FOR CONT COV?:                Y

PATIENT HAVE A BIC?:                Y

BIC (MEDI-CAL CARD)#:      1234567890

PATIENT LAST NAME:               JOSS

PATIENT FIRST NAME:            ANDREW

PATIENT MIDDLE INIT:                M

PATIENT BIRTH DATE:        1996-01-01

GENDER:                             M

IS PATIENT HOMELESS?:               N

RESIDENCE STREET:     123 TEST STREET
```

*(printout continues)*

```
RESIDENCE CITY:
                       RANCHO CORDOVA
RESIDENCE STATE:
                                   CA
RESIDENCE ZIP CODE:
                                95670
COUNTY OF RESIDENCE:
                                   34
MAIL ADDR STREET:

MAIL ADDR CITY:

MAIL ADDR STATE:

MAIL ADDR ZIP CODE:

PATIENT SSN (OPT):

MOTHER LAST NAME:
                                DESAI
MOTHER FIRST NAME:
                                MEENA
MOTHER MIDDLE INIT:
                                    I
MOTHER'S BIRTH DATE:

MOTHER'S BIC OR SSN:

GUARDIAN LAST NAME:
                                DESAI
GUARDIAN FIRST NAME:
                             MIRACLE
GUARDIAN MID INIT:
                                    B
HOME PHONE #:
                         916-111-2222
WORK PHONE #:

MESSAGE PHONE #:

SPOKEN LANGUAGE:
                                   01
READING LANGUAGE:
                                   00
MNIHA SERVICE TYPE:
                                   01

   PATIENT TRANSACTION RESPONSE BELOW
```

*(printout continues on next page)*

*(continued from previous page)*

```
              CALIFORNIA
  DEPARTMENT OF HEALTH CARE SERVICES
         MEDI-CAL POS NETWORK


    12/19/2002          12:04:22 PM

TERMINAL: V123456789
SOFTWARE: ZZACH30

MEDICAID PROVIDER ID:  CHA123456

        CHDP GATEWAY
       PRE-ENROLLMENT
         RESPONSE

PATIENT NAME:
ANDREW M JOSS

PATIENT BIRTH DATE:
1996-01-01

GENDER:
M

BIC ID#:
1234567890

GOOD THRU DATE:
2003-01-31

ISSUE DATE:
2002-12-19

IMPORTANT NOTICE: THE TEMPORARY
ELIGIBILTY END DATE FOR FULL SCOPE
MEDI-CAL CAN CHANGE IF THE INDIVIDUAL
SUBMITS A SINGLE STREAMLINED
APPLICATION (CCFRM604) SINCE TEMPORARY
MEDI-CAL ELIGIBILITY ENDS ON THE
APPLICATION DETERMINATION DATE
(APPROVED OR DENIED). PROVIDERS,
PLEASE VERIFY ELIGIBILITY.
YOU ARE TEMPORARILY ELIGIBLE FOR FULL
SCOPE MEDI-CAL UNTIL YOUR TEMPORARY
ELIGIBILITY END DATE 01/31/2003. USE
YOUR BENFITS IDENTIFICATION CARD TO
ACCESS MEDI-CAL SERVICES. TO CONTINUE
YOUR COVERAGE, YOU MUST RETURN A
COMPLETED APPLICATION (CCFRM604)
BEFORE 01-31-2003.  IF YOU DO NOT
RECEIVE THE APPLICATION IN THE MAIL
WITHIN 10 DAYS, CALL 1-800-300-1506.

      <<SYSTEM MESSAGE(S) FROM >>
          << PROVIDER MAIL >>

              THANK YOU!
```

**Example:** Message denying Gateway pre-enrollment and indicating the program for which the patient is currently eligible. This message requires the patient's signature. **This document is an Immediate Need Eligibility Document.**

```
              CALIFORNIA
  DEPARTMENT OF HEALTH CARE SERVICES
         MEDI-CAL POS NETWORK

   12/19/2002          12:02:17 PM

TERMINAL: V123456789
SOFTWARE: ZZACH30

MEDICAID PROVIDER ID:  CHA123456

        CHDP GATEWAY
      PRE-ENROLLMENT
          INPUT

AGE < 19 YEARS OLD?:

FAMILY SIZE:                      03

MONTHLY GROSS INCOME:             $0

YEARLY GROSS INCOME:          $20,000

APPLY FOR CONT COV?:               Y

PATIENT HAVE A BIC?:               N

BIC (MEDI-CAL CARD)#:

PATIENT LAST NAME:              JOSS

PATIENT FIRST NAME:           ANDREW

PATIENT MIDDLE INIT:               M

PATIENT BIRTH DATE:        1996-12-12

GENDER:                            M

IS PATIENT HOMELESS?               N

RESIDENCE STREET:     123 TEST STREET
```

*(printout continues)*

```
RESIDENCE CITY:   RANCHO CORDOVA
RESIDENCE STATE:              CA
RESIDENCE ZIP CODE:        95670
COUNTY OF RESIDENCE:          34
MAIL ADDR STREET:
MAIL ADDR CITY:
MAIL ADDR STATE:
MAIL ADDR ZIP CODE:
PATIENT SSN (OPT):
MOTHER LAST NAME:          DESAI
MOTHER FIRST NAME:         MEENA
MOTHER MIDDLE INIT:            I
MOTHER'S BIRTH DATE:
MOTHER'S BIC OR SSN:
GUARDIAN LAST NAME:        DESAI
GUARDIAN FIRST NAME:     MIRACLE
GUARDIAN MID INIT:             B
HOME PHONE #:       916-111-2222
WORK PHONE #:
MESSAGE PHONE #:
SPOKEN LANGUAGE:              01
READING LANGUAGE:             00
MNIHA SERVICE TYPE:           01

   PATIENT TRANSACTION RESPONSE BELOW
```

*(printout continues on next page)*

*(continued from previous page)*

```
                    CALIFORNIA
       DEPARTMENT OF HEALTH CARE SERVICES
              MEDI-CAL POS NETWORK


        12/19/2002          12:04:22 PM

TERMINAL: V123456789
SOFTWARE: ZZACH30

MEDICAID PROVIDER ID:  CHA123456

            CHDP GATEWAY
           PRE-ENROLLMENT
              RESPONSE

PATIENT NAME:
ANDREW M JOSS

PATIENT BIRTH DATE:
1996-12-12

GENDER:
M

BIC ID#:
1234567890

GOOD THRU DATE:
2002-12-31

ISSUE DATE:
2002-12-10

YOU CURRENTLY HAVE FULL SCOPE MEDI-CAL
ELIGIBILITY.  USE THIS DOCUMENT TO ACCESS MEDI-
CAL SERVICES UNTIL YOUR BENEFITS IDENTIFICATION
CARD ARRIVES.

X_________________________________
 CLIENT SIGNATURE


          <<SYSTEM MESSAGE(S) FROM >>
              << PROVIDER MAIL >>

                   THANK YOU!
```

**Example:** Response message indicating that infant's enrollment through the CHDP Gateway is approved. This message requires a signature. **This document is an *Immediate Need Eligibility Document*.**

```
              CALIFORNIA
  DEPARTMENT OF HEALTH CARE SERVICES
         MEDI-CAL POS NETWORK

   06/01/2004          12:02:17 PM

TERMINAL: V123456789
SOFTWARE: ZZACH30

MEDICAID PROVIDER ID:  CHA123456

        CHDP GATEWAY
      PRE-ENROLLMENT
          INPUT

AGE < 19 YEARS OLD?:                Y

FAMILY SIZE:                       03

MONTHLY GROSS INCOME:               $

YEARLY GROSS INCOME:          $20,000

APPLY FOR CONT COV?:                Y

PATIENT HAVE A BIC?:                N

BIC (MEDI-CAL CARD)#:

PATIENT LAST NAME:           REYNOLDS

PATIENT FIRST NAME:           LORETTA

PATIENT MIDDLE INIT:                T

PATIENT BIRTH DATE:        2003-09-13

GENDER:                             F

IS PATIENT HOMELESS?                N

RESIDENCE STREET:     123 TEST STREET
```

*(printout continues)*

```
RESIDENCE CITY:   RANCHO CORDOVA

RESIDENCE STATE:              CA

  RESIDENCE ZIP CODE:        95670

COUNTY OF RESIDENCE:          57

MAIL ADDR STREET:

MAIL ADDR CITY:

MAIL ADDR STATE:

MAIL ADDR ZIP CODE:

PATIENT SSN (OPT):

MOTHER LAST NAME:          DESAI

MOTHER FIRST NAME:         MEENA

MOTHER MIDDLE INIT:            A

MOTHER'S BIRTH DATE:
                       01-01-1975

MOTHER'S BIC OR SSN:  55544466U1

GUARDIAN LAST NAME:        DESAI

GUARDIAN FIRST NAME:     MIRACLE

GUARDIAN MID INIT:             B

HOME PHONE #:       916-111-2222

WORK PHONE #:

MESSAGE PHONE #:

SPOKEN LANGUAGE:              01

READING LANGUAGE:             00

MNIHA SERVICE TYPE:           01

   PATIENT TRANSACTION RESPONSE BELOW
```

*(printout continues on next page)*

*(continued from previous page)*

```
              CALIFORNIA
  DEPARTMENT OF HEALTH CARE SERVICES
        MEDI-CAL POS NETWORK


   06/01/2004          12:03:22 PM

TERMINAL: V123456789
SOFTWARE: ZZACH30

MEDICAID PROVIDER ID:  CHA123456

        CHDP GATEWAY
       PRE-ENROLLMENT
          RESPONSE

PATIENT NAME:
LORETTA T REYNOLDS

PATIENT BIRTH DATE:
2003-09-13

GENDER:
F

BIC ID#:
12334000A9

GOOD THRU DATE:
2004-06-30

ISSUE DATE:
2004-06-01

YOUR INFANT IS ELIGIBLE FOR FULL-
SCOPE, NO-COST MEDI-CAL BACK TO THE
DATE OF BIRTH.  NO SINGLE STREAMLINED
APPLICATION (CCFRM604) IS NEEDED. YOU
WILL RECEIVE ADDITIONAL INFORMATION
FROM YOUR COUNTY. USE THIS DOCUMENT TO
ACCESS MEDI-CAL SERVICES UNTIL THE
INFANT'S BIC ARRIVES.



X_________________________________
 CLIENT SIGNATURE


      <<SYSTEM MESSAGE(S) FROM >>
          << PROVIDER MAIL >>

              THANK YOU!
```

**Example:** Denial message indicating patient ineligibility.

```
              CALIFORNIA
  DEPARTMENT OF HEALTH CARE SERVICES
         MEDI-CAL POS NETWORK

   12/19/2002          12:02:17 PM

TERMINAL: V123456789
SOFTWARE: ZZACH30

MEDICAID PROVIDER ID:  CHA123456

        CHDP GATEWAY
       PRE-ENROLLMENT
           INPUT

AGE < 19 YEARS OLD?:                Y

FAMILY SIZE:                       03

MONTHLY GROSS INCOME:              $0

YEARLY GROSS INCOME:          $20,000

APPLY FOR CONT COV?:                Y

PATIENT HAVE A BIC?:                N

BIC (MEDI-CAL CARD)#:

PATIENT LAST NAME:               JOSS

PATIENT FIRST NAME:            ANDREW

PATIENT MIDDLE INIT:                M

PATIENT BIRTH DATE:        1983-01-01

GENDER:                             M

IS PATIENT HOMELESS?:               N

RESIDENCE STREET:    123 TEST STREET
```

*(printout continues)*

```
RESIDENCE CITY:   RANCHO CORDOVA

RESIDENCE STATE:              CA

RESIDENCE ZIP CODE:        95670

COUNTY OF RESIDENCE:          34

MAIL ADDR STREET:

MAIL ADDR CITY:

MAIL ADDR STATE:

MAIL ADDR ZIP CODE:

PATIENT SSN (OPT):

MOTHER LAST NAME:          DESAI

MOTHER FIRST NAME:         MEENA

MOTHER MIDDLE INIT:            I

MOTHER'S BIRTH DATE:
1996-12-12

MOTHER'S BIC OR SSN:  1234567895

GUARDIAN LAST NAME:        DESAI

GUARDIAN FIRST NAME:     MIRACLE

GUARDIAN MID INIT:             B

HOME PHONE #:       916-111-2222

WORK PHONE #:

MESSAGE PHONE #:

SPOKEN LANGUAGE:              01

READING LANGUAGE:             00

MNIHA SERVICE TYPE:           01

   PATIENT TRANSACTION RESPONSE BELOW
```

*(printout continues on next page)*

*(continued from previous page)*

```
              CALIFORNIA
  DEPARTMENT OF HEALTH CARE SERVICES
        MEDI-CAL POS NETWORK


   12/19/2002          12:04:22 PM

TERMINAL: V123456789
SOFTWARE: ZZACH30

MEDICAID PROVIDER ID:  CHA123456

        CHDP GATEWAY
       PRE-ENROLLMENT
          RESPONSE

PATIENT NAME:
ANDREW M JOSS

PATIENT BIRTH DATE:
1983-01-01

GENDER:
M

BIC ID#:
1234567890

ISSUE DATE:
2002-12-10

DHCS RECORD INDICATES APPLICANT IS
OVER AGE FOR PROGRAM ELIGIBILITY.


      <<SYSTEM MESSAGE(S) FROM >>
          << PROVIDER MAIL >>

              THANK YOU!
              <Footer 4>
```

**Example:** Infant error message indicating invalid street address.

```
              CALIFORNIA
  DEPARTMENT OF HEALTH CARE SERVICES
         MEDI-CAL POS NETWORK

   04/22/2004          11:08:43 AM

TERMINAL: 024698622
SOFTWARE: ZZACH30

MEDICAID PROVIDER ID:  CHA123456

        CHDP GATEWAY
       PRE-ENROLLMENT
           INPUT

AGE < 19 YEARS OLD?:                Y

FAMILY SIZE:                       03

MONTHLY GROSS INCOME:             $33

YEARLY GROSS INCOME:         $000,000

APPLY FOR CONT COV?:                Y

PATIENT HAVE A BIC?:                N

BIC (MEDI-CAL CARD)#:

PATIENT LAST NAME:               MOSS

PATIENT FIRST NAME:              DREW

PATIENT MIDDLE INIT:                C

PATIENT BIRTH DATE:        2004-03-01

GENDER:                             M

IS PATIENT HOMELESS?:               N

RESIDENCE STREET:         PO BOX 2468
```

*(printout continues)*

```
RESIDENCE CITY:   RANCHO CORDOVA

RESIDENCE STATE:              CA

RESIDENCE ZIP CODE:        95670

COUNTY OF RESIDENCE:          34

MAIL ADDR STREET:

MAIL ADDR CITY:

MAIL ADDR STATE:

MAIL ADDR ZIP CODE:

PATIENT SSN (OPT):

MOTHER LAST NAME:         DESSIL

MOTHER FIRST NAME:        TWEENA

MOTHER MIDDLE INIT:            R

MOTHER'S BIRTH DATE:
1986-12-12

MOTHER'S BIC OR SSN:  1234567895

GUARDIAN LAST NAME:         SAIZ

GUARDIAN FIRST NAME:        RAYC

GUARDIAN MID INIT:             B

HOME PHONE #:       916-111-2222

WORK PHONE #:

MESSAGE PHONE #:

SPOKEN LANGUAGE:              01

READING LANGUAGE:             00

MNIHA SERVICE TYPE:           01

   PATIENT TRANSACTION RESPONSE BELOW
```

*(printout continues on next page)*

*(continued from previous page)*

```
              CALIFORNIA
  DEPARTMENT OF HEALTH CARE SERVICES
         MEDI-CAL POS NETWORK


   04/22/2004          11:08:43 AM

TERMINAL: 024698622
SOFTWARE: ZZACH30

MEDICAID PROVIDER ID:  CHA123456

        CHDP GATEWAY
       PRE-ENROLLMENT
         RESPONSE

PATIENT NAME:
DREW C MOSS

PATIENT BIRTH DATE:
2004-03-01

GENDER:
M

ERROR: INVALID DATA WAS ENTERED IN THE
FOLLOWING FIELD(S). PLEASE CORRECT
ENTRY AND RESUBMIT. RESIDENCE ADDR
STREET



        HOST DATE - 04/22/2004
        HOST TIME - 11:08:15 AM

          SYSTEM DOWN: 23:59

         HOST NAME - ACSCICM1



              THANK YOU!
```

**Confirm Eligibility**

Before exiting the POS transaction, providers **must** confirm the services for which the patient is eligible by performing an Eligibility Inquiry. The Eligibility Inquiry is the only way providers will receive the Eligibility Verification Confirmation (EVC) number that is used for billing purposes. Upon completion of the Eligibility Inquiry, the system will provide an Eligibility Inquiry Response. **Providers must retain for their records:**

1. **A copy of the POS Eligibility Inquiry Response document.**
2. **The original copy of the *Child Health and Disability Prevention (CHDP) Program Pre-Enrollment Application* (DHCS 4073) signed by the parent, guardian or emancipated minor on which the POS transaction was based.**

For instructions about how to perform an eligibility transaction, refer to the *VX 520 Eligibility Transaction Procedures* section.

**Example:** Eligibility Inquiry Response

CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES
MEDI-CAL POS NETWORK

03/01/2003 12:02:17 PM

TERMINAL: V123456789
SOFTWARE: **ZZAEL33**

MEDICAID PROVIDER ID: CHA123456

**ELIGIBILITY INQUIRY**

SUBSCRIBER ID:
1234567890

BIRTH DATE:
1990-01-01

ISSUE DATE:
2003-03-01

SERVICE DATE:
2003-05-31

LAST NAME: JONES EVC#: 5467MQ4TVWSP
CNTY CODE: 19 PRMY AID CODE: 10
MEDI-CAL ELIGIBLE W/NO SOC.

HOST DATE – 03/01/2003
HOST TIME – 13:37:49 PM

THANK YOU!

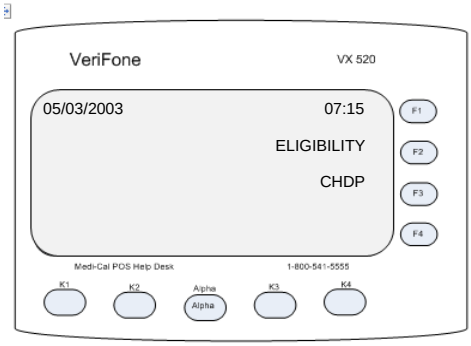
Patient Identification Number

EVC Number

Aid Code

## Conclude the CHDP Gateway Transaction

To conclude the CHDP Gateway transaction, you must return to the Main Menu screen, where you begin all POS device transactions. If you do not return to this screen, the POS device retains the entries from your most recent CHDP Gateway POS transaction, and you will not be able to initiate a new CHDP Gateway transaction.




To return to the Main Menu screen, press <CANCEL> or <EXIT> until the Main Menu screen displays. Once the Main Menu screen displays, you can initiate another Gateway transaction or any other POS transaction that you are allowed to access.

**Response Messages Reference Guide**

After submitting an application through the CHDP Gateway, you may receive one of the following response messages. The following information describes the meaning of each response message and the appropriate steps to take.

| MESSAGE | MEANING | NEXT STEPS |
|---|---|---|
| *You currently have full-scope Medi-Cal eligibility. Use your Benefits Identification Card to access Medi-Cal services.* | This means that the patient is known to the Medi-Cal system, is a full-scope Medi-Cal subscriber and currently has a BIC. | Complete the second step to check the child/youth's eligibility. Enter the BIC located on the subscriber's BIC card to find out the services for which the child/youth is eligible. |
| *You currently have full-scope Medi-Cal eligibility. Use this document to access Medi-Cal services until your Benefits Identification Card arrives.*<br><br>*Client Signature:*<br>_____ | This means that the patient is known to the Medi-Cal system, is a full-scope Medi-Cal beneficiary and does not currently have a BIC. | 1. Keep a copy for your files.<br>2. Have the parent/guardian or emancipated minor sign the printout.<br>3. Staple the printout with the original signature to the brochure and give it to the parent/ guardian or emancipated minor.<br>4. Check the child/youth's eligibility. Enter the BIC located on the bottom of the *Immediate Need Eligibility Document* to find out the services for which the child/youth is eligible. |
| *You currently have CHDP coverage. Use your Benefits Identification Card to access CHDP and emergency Medi-Cal services.* | This means that the patient currently has a BIC and is known to the Medi-Cal system. This patient is eligible for CHDP services under the CHDP program as well as emergency Medi-Cal services. | Check the child/youth's eligibility. Enter the BIC located on the subscriber's BIC card to find out the services for which the child/youth is eligible. |
| *You currently have CHDP coverage. Use this document to access CHDP and emergency Medi-Cal services until your Benefits Identification Card arrives.*<br><br>*Client Signature:*<br>_____ | This means that the patient does not currently have a BIC but is known to the Medi-Cal system. This patient is eligible for CHDP services under the CHDP program as well as emergency Medi-Cal services. | 1. Keep a copy for your files.<br>2. Have the parent/guardian or emancipated minor sign the printout.<br>3. Give the printout with the original signature to the parent/guardian or emancipated minor.<br>4. Check the child/youth's eligibility. Enter the BIC located on the bottom the *Immediate Need Eligibility Document* to find out the services for which the child/youth is eligible. |

| MESSAGE | MEANING | NEXT STEPS |
|---|---|---|
| *You are currently enrolled in Healthy Families. Contact your Healthy Families health plan provider or call 1-866-848-9166 if you need assistance.* | This means that the patient is known to the Medi-Cal system and is currently enrolled in Healthy Families. | Refer the child/youth to their existing health plan for screening. |
| *You are temporarily eligible for full scope Medi-Cal **until your temporary eligibility end date on "MM/DD/CCYY."** Use your **BIC** to access Medi-Cal services. To continue your coverage, you must return a completed **application (CCFRM604)before "MM/DD/CCYY."** If you do not receive the application in the mail within 10 days, call 1-800-300-1506.* | This means that the patient met the eligibility requirements for pre-enrollment through the CHDP Gateway, already has a BIC and elected to apply for continuing coverage from Medi-Cal or premium assistance programs under Covered California. | 1. Encourage parent/guardian or emancipated minor to fill out the *Single Streamlined Application* (CCFRM604) form that will be sent with them and mail in before the end of the next month (expiration of CHDP Gateway services).<br>2. Check the child/youth's eligibility. Enter the BIC located on the subscriber's BIC card to find out the services for which the child/youth is eligible. |
| *You are temporarily eligible for full scope Medi-Cal **until your temporary eligibility end date on** "MM/DD/CCYY." Use this document to access Medi-Cal services until your **BIC** arrives. To continue your coverage, you must return a completed application (CCFRM604). **Before "MM/DD/CCYY."** If you do not receive the application **in the mail** within 10 days call, 1-800-300-1506.*<br><br>*Client Signature:*<br>_____ | This means that the patient met the eligibility requirements for pre-enrollment through the CHDP Gateway, does not already have a BIC and elected to apply for continuing coverage from Medi-Cal or premium assistance programs under Covered California. | 1. Keep a copy for your files.<br>2. Have the parent/guardian or emancipated minor sign the printout.<br>3. Staple the printout with the original signature to the brochure and give it to the parent/ guardian or emancipated minor.<br>4. Encourage parent/guardian or emancipated minor to fill out the *Single Streamlined Application* (CCFRM604) form that will be sent with them and mail in before the end of the next month (expiration of CHDP Gateway services).<br>5. Check the child/youth's eligibility. Enter the BIC located on the bottom of the Immediate Need Eligibility Document to find out the services for which the child/youth is eligible. |

| MESSAGE | MEANING | NEXT STEPS |
|---|---|---|
| *You are temporarily eligible for CHDP services through MM/DD/CCYY. Use your Benefits Identification Card to access CHDP and emergency Medi-Cal services.* | This means that the patient met the eligibility requirements for CHDP services only through the CHDP Gateway, already has a BIC, and can only access CHDP and emergency Medi-Cal services. | Check the child/youth's eligibility. Enter the BIC located on the subscriber's BIC card to find out the services for which the child/youth is eligible. |
| *You are temporarily eligible for CHDP services through MM/DD/CCYY. Use this document to access CHDP and emergency Medi-Cal services until your Benefits Identification Card arrives.*<br><br>*Client Signature:*<br>_____ | This means that the patient does not currently have a BIC but is known to the Medi-Cal system. This patient is eligible for CHDP services under the CHDP program as well as emergency Medi-Cal services. | 1. Keep a copy for your files.<br>2. Have the parent/guardian or emancipated minor sign the printout.<br>3. Give the printout with the original signature to the parent/guardian or emancipated minor.<br>4. Check the child/youth's eligibility. Enter the BIC located on the bottom of the *Immediate Need Eligibility Document* to find out the services for which the child/youth is eligible. |
| *You are temporarily eligible for full scope Medi-Cal **until your temporary eligibility end date on "MM/DD/CCYY."** Use your **BIC** to access Medi-Cal services. If you want coverage to continue after **"MM/DD/CCYY",** call 1-800-300-1506 to request **an application** (CCFRM604).* | This means that the patient met the eligibility requirements for pre-enrollment through the CHDP Gateway, already has a BIC and did not elect to apply for continuing coverage from Medi-Cal or premium assistance under Covered California. | 1. Encourage parent/guardian or emancipated minor to call the toll-free number, request a *Single Streamlined Application* (CCFRM604) form and mail in before the end of the next month (expiration of CHDP Gateway services) to continue health coverage.<br>2. Check the child/youth's eligibility. Enter the subscriber's BIC number to find out the services for which the child/youth is eligible. |

| MESSAGE | MEANING | NEXT STEPS |
|---|---|---|
| *You are temporarily eligible for full scope Medi-Cal* ***until your eligibility end date on "MM/DD/CCYY."*** *Use this* ***form*** *to access Medi-Cal services until your* ***BIC*** *arrives. If you want coverage to continue after "MM/DD/CCYY", call1-800-300-1506* ***to request an application.***<br><br>*Client Signature:*<br>_____ | This means that the child/youth met the eligibility requirements for pre-enrollment through the CHDP Gateway, did not already have a BIC, and did not elect to apply for continuing coverage from Medi-Cal. | 1. Have the parent/guardian or emancipated minor sign the printout.<br>2. Keep a copy for your files, staple the printout with the original signature to the brochure and give to the parent/guardian or emancipated minor.<br>3. Encourage parent/guardian or emancipated minor to call the toll-free number, request a joint application and mail it in before the end of the next month (expiration of CHDP Gateway services) to continue health coverage.<br>4. Complete the second step and check the child/youth's eligibility. Enter the BIC number located on the bottom of the Immediate Need Eligibility Document to find out the services for which the child/youth is eligible |
| *DHCS record indicates applicant is over the age for program eligibility* | This means that the patient was denied service through the CHDP Gateway because the patient was 19 years of age or older. | 1. The patient can be referred to the local health and welfare agency.<br>2. If the patient is younger than 19 years of age, this message indicates that the patient already has a record on the Medi-Cal system. The patient needs to go to an eligibility worker to have the information changed. |
| *Applicant is not yet due for health assessment per CHDP periodicity schedule.* | This means that the patient is currently known to the Medi-Cal system but is not eligible for services according to CHDP periodicity. | 1. The child/youth must wait to be seen until either the next scheduled periodicity checkup or until he/she has an appropriate MNIHA.<br>2. If an error was made and the patient needs a MNHIA, you can re-enter the application.<br>3. If no error was made, inform the child/youth of the date of his/her next scheduled periodicity checkup.<br>4. You may also give them a *Single Streamlined Application* (CCFRM604) form if one is available. |

| MESSAGE | MEANING | NEXT STEPS |
|---|---|---|
| *Postal records indicate applicant residence address is outside of California.* | This means that the patient does not have a California residence and therefore is not eligible for the CHDP Gateway. | Refer the patient and family to their local health and welfare agency. |
| **The following message may appear with other messages:**<br><br>*Attn: Your baby already may be eligible for Medi-Cal. Contact your worker or your County Department of Social Services before you complete the application.* | Because the patient is 12 months old or younger, the baby may already be eligible for Medi-Cal and the parent/guardian should contact their social worker or local health and welfare agency to find out about available services for the baby. | Refer the child/youth to their social worker or local health and welfare agency for continued service. |
| *Your infant is eligible for full-scope, no-cost Medi-Cal back to the date of birth. No Single Streamlined Application (CCFRM604) form is needed. You will receive additional information from your county. Use your infant's benefits Identification card to access Medi-Cal services.* | The infant met the eligibility requirement for eligibility for full-scope no-cost Medi-Cal back to the date of birth. No *Single Streamlined Application* (CCFRM604) form is needed. The pre-enrollment application indicated that the applicant already has a BIC. | 1. Keep a copy for your files, staple the printout to the infant enrollment flyer and give it to the parent/guardian.<br>2. Check the infant's eligibility. Enter the BIC located on the bottom of the Gateway response to find out the services for which the infant is eligible. |
| *Your infant is eligible for full-scope, no-cost Medi-Cal back to the date of birth. No Single Streamlined Application (CCFRM604) form is needed. You will receive additional information from your county. Use this document to access Medi-Cal services until the infant's benefits identification card arrives.*<br><br>*Client Signature:*<br>_____ | The infant met the eligibility requirement for eligibility for full-scope no-cost Medi-Cal back to the date of birth. No *Single Streamlined Application* (CCFRM604) form is needed. The pre-enrollment application indicated that the applicant does not have a BIC. | 1. Keep a copy for your files.<br>2. Have the parent/guardian sign the printout.<br>3. Staple the printout with the original signature to the infant enrollment flyer and give it to the parent/guardian.<br>4. Check the infant's eligibility. Enter the BIC located on the bottom of the *Immediate Need Eligibility Document* to find out the services for which the infant is eligible. |

| MESSAGE | MEANING | NEXT STEPS |
|---|---|---|
| *Your infant is eligible for full-scope Medi-Cal. No other application is required. Your infant has a share of cost from birth month through last month. You will receive a request for income verification and more information from your county. Beginning this month and until the county can verify your income, your infant has no share of cost. Use the infant's benefits identification card to access services.* | The infant met the eligibility requirement for eligibility for full-scope SOC Medi-Cal back to the date of birth through last month. The county will request income verification and other additional information. No *Single Streamlined Application* (CCFRM604) form is needed. The pre-enrollment application indicated that the applicant does have a BIC. | 1. Keep a copy for your files, staple the printout to the infant enrollment flyer and give it to the parent/guardian.<br>2. Check the child/youth's eligibility. Enter the BIC located on the bottom of the Gateway response to find out the services for which the child/youth is eligible. |
| *Your infant is eligible for full-scope Medi-Cal. No application is required. Your infant has a share of cost from birth month through last month. You will receive a request for income verification and more information from your county. Beginning this month and until the county can verify your income, your infant has no share of cost. Use this document to access services until the infant's benefits identification card arrives.*<br><br>*Client Signature:*<br>_____ | The infant met the eligibility requirement for eligibility for full-scope SOC Medi-Cal back to the date of birth through last month. The county will request income verification and other additional information. No joint *Single Streamlined Application* (CCFRM604) form is needed. The pre-enrollment application indicated that the applicant does not have a BIC. | 1. Keep a copy for your files.<br>2. Have the parent/guardian sign the printout.<br>3. Staple the printout with the original signature to the infant enrollment flyer and give it to the parent/ guardian.<br>4. Complete the second step and check the infant's eligibility. Enter the BIC located on the bottom of the *Immediate Need Eligibility Document* to find out the services for which the infant is eligible. |
| *Applicant over income for Program Eligibility.* | This means the patient income amount exceeds the maximum amount allowed for the CHDP Program. | The patient can be referred to the local county health and social services agency. |
| *You are not eligible for PE because you have already received 2 PE enrollments within the past 12 months. Children under 19 years old are limited to two PE enrollments within the past 12 months.* | This means that the patient was denied service through the CHDP Gateway because the patient has exceeded the allowable PE enrollment in a 12-month period. | Refer the patient and family to their local social services agency. |

| MESSAGE | MEANING | NEXT STEPS |
|---|---|---|
| ***The following message may appear with other messages:***<br>**Important Notice: The temporary eligibility end date for full scope Medi-Cal can change if the individual submits a Single Streamlined Application (CCFRM604) since temporary Medi-Cal eligibility ends on the application determination date (approved or denied). Providers please verify eligibility.** | **This means that the patient or the applicant files a full Medi-Cal application by the last day of the month following the month the PE is determined, the PE will continue until a full Medi-Cal determination is made. Once the determination is made PE eligibility will end.** | 1. **Encourage parent/guardian or emancipated minor to call the toll-free number, request a *Single Streamlined Application* (CCFRM604) form and mail in before the end of the next month (expiration of CHDP Gateway services) to continue health coverage.**<br>2. **Check the child/youth's eligibility. Enter the subscriber's BIC number to find out the services for which the child/youth is eligible** |

**POS Device Transaction Codes Key Language**

The tables below reference the County of Residence (Step 24), Spoken Language (Step 42), Reading (Step 43), MNIHA Service Type (Step 44) and Mailing State (Step 27) codes that must be entered during a CHDP Gateway POS device transaction.

### County Codes

| County | Code |
|---|---|
| Alameda | 1 |
| Alpine | 2 |
| Amador | 3 |
| Butte | 4 |
| Calaveras | 5 |
| Colusa | 6 |
| Contra Costa | 7 |
| Del Norte | 8 |
| El Dorado | 9 |
| Fresno | 10 |
| Glenn | 11 |
| Humboldt | 12 |
| Imperial | 13 |
| Inyo | 14 |
| Kern | 15 |

| County | Code |
|---|---|
| Kings | 16 |
| Lake | 17 |
| Lassen | 18 |
| Los Angeles | 19 |
| Madera | 20 |
| Marin | 21 |
| Mariposa | 22 |
| Mendocino | 23 |
| Merced | 24 |
| Modoc | 25 |
| Mono | 26 |
| Monterey | 27 |
| Napa | 28 |
| Nevada | 29 |
| Orange | 30 |

| County | Code |
|---|---|
| Placer | 31 |
| Plumas | 32 |
| Riverside | 33 |
| Sacramento | 34 |
| San Benito | 35 |
| San Bernardino | 36 |
| San Diego | 37 |
| San Francisco | 38 |
| San Joaquin | 39 |
| San Luis Obispo | 40 |
| San Mateo | 41 |
| Santa Barbara | 42 |
| Santa Clara | 43 |
| Santa Cruz | 44 |
| Shasta | 45 |

| County | Code |
|---|---|
| Sierra | 46 |
| Siskiyou | 47 |
| Solano | 48 |
| Sonoma | 49 |
| Stanislaus | 50 |
| Sutter | 51 |
| Tehama | 52 |
| Trinity | 53 |
| Tulare | 54 |
| Tuolumne | 55 |
| Ventura | 56 |
| Yolo | 57 |
| Yuba | 58 |

### Language Codes

| Language | Code |
|---|---|
| English | 1 |
| Spanish | 2 |
| Vietnamese | 3 |
| Cambodian | 4 |
| Hmong | 5 |
| Armenian | 6 |

| Language | Code |
|---|---|
| Cantonese | 7 |
| Mandarin | 8 |
| Other Chinese | 9 |
| Korean | 10 |
| Russian | 11 |
| Farsi | 12 |

| Language | Code |
|---|---|
| Lao | 13 |
| Arabic | 14 |
| Tagalog | 15 |
| None Given/Other Language | 0 |

### MNIHA Service Type Codes

| MNIHA Reason | Code |
|---|---|
| None | 0 |
| Sports or Camp Physical | 1 |
| Foster Care/Out-of-Home Placement | 2 |
| School/Preschool Entrance | 3 |

| MNIHA Reason | Code |
|---|---|
| Additional Anticipatory Guidance | 4 |
| History of Perinatal Problems | 5 |
| Significant Developmental Disabilities | 6 |
| Completion of Health Assessment Requirements | 7 |

### Mailing State Abbreviation Codes

| STATE | ABBR |
|---|---|
| Alabama | AL |
| Alaska | AK |
| Arizona | AZ |
| Arkansas | AR |
| California | CA |
| Colorado | CO |
| Connecticut | CT |
| Delaware | DE |
| Florida | FL |
| Georgia | GA |
| Hawaii | HI |
| Idaho | ID |
| Illinois | IL |
| Indiana | IN |
| Iowa | IA |

| STATE | ABBR |
|---|---|
| Kansas | KS |
| Kentucky | KY |
| Louisiana | LA |
| Maine | ME |
| Maryland | MD |
| Massachusetts | MA |
| Michigan | MI |
| Minnesota | MN |
| Mississippi | MS |
| Missouri | MO |
| Montana | MT |
| Nebraska | NE |
| Nevada | NV |
| New Hampshire | NH |
| New Jersey | NJ |

| STATE | ABBR |
|---|---|
| New Mexico | NM |
| New York | NY |
| North Carolina | NC |
| North Dakota | ND |
| Ohio | OH |
| Oklahoma | OK |
| Oregon | OR |
| Pennsylvania | PA |
| Rhode Island | RI |
| South Carolina | SC |
| South Dakota | SD |
| Tennessee | TN |
| Texas | TX |
| Utah | UT |
| Vermont | VT |

| STATE | ABBR |
|---|---|
| Virginia | VA |
| Washington | WA |
| West Virginia | WV |
| Wisconsin | WI |
| Wyoming | WY |
| District of Columbia | DC |