STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY GRAY DAVIS, Governor

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October 15, 2001

MEDI-CAL ELIGIBILITY PROCEDURES MANUAL LETTER NO.: 252

TO: All Holders of the Medi-Cal Eligibility Procedures Manual

ARTICLE 22C-2 – DETERMINING SUBSTANTIAL GAINFUL ACTIVITY (SGA)

Enclosed is an update to Article 22C-2 regarding SGA. This section was updated to reflect the following changes:

1. Beginning January 1, 2001, the SGA amount for individuals with impairments other than blindness has been increased from $700 to $740. The Social Security Administration published final regulations in the Federal Register that require annual adjustments to the SGA amount to be based on the average wage index.

   Since future adjustments to the SGA will most likely occur annually, the new SGA amount will only be stated on the first page of the SGA section in the Medi-Cal Eligibility Procedures Manual. Other references to the SGA amount will note "the current SGA amount."

2. The MC 272 (SGA Worksheet) and the MC 273 (Work Activity Report) has also been revised so that the actual SGA amount is no longer printed. Blank spaces have been inserted so that county staff will be able to insert the current SGA amount (the amount that is applicable at the time).

3. Section 4E was revised to clarify when in-kind income is considered as earned income for purposes of computing SGA.

4. All references, in this section, to SP-DED have been changed to reflect their current division name which is State Programs-Disability and Adult Programs Division (SP-DAPD).

Filing Instructions:

Remove Pages:	**Insert Pages:**
Article 22	Article 22
Pages 22C-2.1 through 22C-2.13	Pages 22C-2.1 through 22C-2.14b
Page 22C-4.11b	Page 22C-4.11b and 22C-4.11c
Pages 22C-4.27 through 22C-4.29	Pages 22C-4.27 through 22C-4.29

If you have any questions, please contact Mr. Terry Durham, at (916) 657-2701.

Sincerely,

Original signed by

Shar Schroepfer, Chief
Medi-Cal Eligibility Branch

Enclosure

22 C-2 -- DETERMINING SUBSTANTIAL GAINFUL ACTIVITY

1. BACKGROUND

Section 435.540 of the Code of Federal Regulations (42 CFR) requires Medi-Cal to use the Supplemental Security Income (SSI) definition of disability to decide if a client is eligible for Medi-Cal disability.

To be considered disabled, SSI requires that an individual be:

"unable to engage in **Substantial Gainful Activity** (SGA), due to a medically determined physical or mental impairment, which is expected to result in death, or which is expected to last for a continuous period of 12 months".

A client who performs SGA is not disabled, even if a severe physical or mental impairment exists.

2. THE CURRENT SGA AMOUNT

The SGA amount is based on the average wage index effective January 1, 2001. Due to this change, the SGA amount may be adjusted annually.

- Using the new formula, the SGA increased from $700 to $740 per month effective January 1, 2001.

NOTE: Since the SGA amount may change annually, future revisions to the actual SGA amount will only be reflected in this section. The sections following this section to the SGA procedures will only state "current SGA amount" and no dollar figure will be noted.

3. WHEN TO USE THESE PROCEDURES

These procedures will be used when a client:

- files for Medi-Cal disability, states on the MC 223 that he or she is working, and has gross earnings of more than the current SGA amount per month, or
- meets the criteria for Presumptive Disability (PD), but earns over the current SGA per month. PD should NOT be approved until an SGA determination is made.

NOTE: These procedures **do not** apply to clients who are blind or to beneficiaries who return to work after disability has been approved. If an SGA evaluation was not performed because the client alleged blindness, and State Program – Disability and Adult Programs Division (SP-DAPD) found that the client was disabled but not blind, an SGA evaluation must be performed before eligibility as a disabled person can be established.

4. PROCEDURES

A. SGA DETERMINATIONS

The EW shall determine whether client is performing SGA when client has earned income of over the current SGA amount per month. The EW shall:

1. *Obtain*: Client's gross monthly earnings (if irregular, earnings should be averaged). Earnings derived from In-Home Supportive Services are treated as earned income.

2. *Determine*: Whether there are impairment-related work expenses (IRWEs) or subsidies that can reduce earnings below the SGA amount. (A discussion of IRWEs and subsidies follows.)

3. *Deny*: If disability "net countable earnings" are over the current SGA amount.

4. *Submit*: A full disability packet to SP-DAPD, including an MC 220, MC 221, and MC 223, only if "net countable earnings" are at the current SGA amount or less.

5. *Alert*: SP-DAPD via a DED Pending Information Update Form (MC 222) when a disability packet was sent to SP-DAPD and client is subsequently found to be engaging in SGA. SP-DAPD will stop case development and return case to the county.

Work Activity Report form (MC 273, Exhibit 2) should be provided to client whose earnings are over the SGA amount to help in making SGA determinations.

B. IMPAIRMENT-RELATED WORK EXPENSES

Impairment-related work expenses (IRWEs) are certain expenses which are incurred and paid by an impaired client to enable him/her to work.

1. SGA Determination

IRWEs can be deducted from gross earnings to arrive at "net countable earnings". If "net countable earnings" are over the SGA amount, deny the application. For self-employment, IRWEs can be deducted from net income, if not already deducted from gross income as a business expense.

Example: If SGA is $740, and client earns $950 per month and has $200 worth of IRWEs for special transportation costs to go to work, and for medications needed to control a seizure condition. In this example the "net countable earnings" are $750 per month. "As net countable earnings" are $750 per month, the client is performing SGA and application is denied.

Note: Do NOT apply ABD-MN or AFDC MN/MI earned income deductions when determining SGA.

2. Allowable IRWE Deductions

Deductions are allowed when the following conditions exist:

a. Disabled client needs the item/service in order to work. The need must be verified by the prescribing source (e.g. doctor, Vocational Rehabilitation [VR]). The cost must also be verified.

b. Cost is paid by disabled client and not reimbursed by another source (e.g. Medicare, VR). The cost must be paid in cash, including checks or money orders, and not in kind.

c. Expense is "reasonable". It represents comparable charges for the item/service in the community. Sources such as a medical supplier or VR may be contacted.

Example: Client states he or she needs an attendant to assist in activities to prepare for work. Client has a family member perform the services and is charged $15 per hour. If Personal Care Services provided through In-Home Supportive Services allows a payment of $4.25 per hour, only $4.25 per hour should be allowed as a deduction.

3. Budgeting of IRWE

Payment must be made after client became disabled in order for cost to be deducted. Payment is computed in the following ways:

a. Recurring and Non-Recurring IRWEs

1. Recurring costs, such as monthly payments for a wheelchair: the amount paid monthly is deductible.

2. Non-recurring down payments, or full purchase price paid for an item: a lump sum payment may be prorated over 12 months.

b. Cost Incurred Before or After Work

1. Before work started: Prorate the cost over a 12 month period; deduct only the balance of the 12 months while the client is working.

Example: Client paid $600 in January for an item. Work started in April. Prorate the cost over 12 months. IRWE applies to the balance of the 12 months of employment, or $50 per month for April through December.

2. After work ended: Deduct IRWE from the last month earned income is received.

4. IRWE Categories

DEDUCTIBLE	***NON DEDUCTIBLE***
Attendant Care Services	*Attendant Care Services*
• Performed in work setting or in process of assisting in preparations for work, the trip to/from work and after work (e.g., bathing, dressing, cooking, eating).	• Performed on non-workdays or involving shopping or general homemaking (e.g., cleaning, laundry).
• Services which incidentally benefit the family (e.g., cooking meal for individual also eaten by family).	• Services performed for someone in the family other than the beneficiary (e.g., babysitting).
• Services performed by a family member for a cash fee where the family member suffers an economic loss by reducing or terminating work to perform such services.	• Services performed by a family member for a cash fee where the family member suffers no economic loss.
• Requires verification of duties, of amount of time spent, that they were paid for in cash, and that payment is made on a regular basis.	
Transportation Costs	*Transportation Costs*
• Structural or operational modifications to vehicle, needed to drive to work or be driven to work, even if also used for non-work purposes.	• Cost of a vehicle whether modified or not.

• Driver assistance or taxicabs where such special transportation is not generally required by unimpaired individuals in the community.	• Cost of modification to a vehicle not directly related to the impairment or critical to the operation of the vehicle (e.g., paint or decor preferences).
• Mileage expense limited to travel related to employment.	• Cost of travel related to obtaining medical items or services.
DEDUCTIBLE	***NON DEDUCTIBLE***
Medical Devices	*Medical Devices*
• Wheelchairs, hemodialysis equipment, pacemakers, respirators, traction equipment, braces (arm, leg, neck, back).	• Any device not used for a medical purpose.
Work-Related Equipment and Assistants	*Work-Related Equipment and Assistants*
• One-handed typewriters, typing aids (e.g., page-turning devices), electronic visual aids, telecommunications devices for people with hearing impairments and special work tools.	• Any work-related device not paid for by the person with a disability or, in the case of a self-employed individual, equipment previously deducted as a business expense.
• Expenses for a person who serves as a reader for a visually impaired person, expenses for an interpreter for a deaf person, and expenses for a job coach.	
Prosthesis	*Prosthesis*
• Artificial hip and artificial replacement of an arm, leg or other part of the body.	• Any prosthetic device that is primarily for cosmetic purposes.
Residential Modifications	*Residential Modifications*
• Individual Employed Outside	• Individual Employed Outside Home:

Home: Modifications to exterior of house to allow access to street or transportation (e.g., exterior ramps, exterior railings, pathways, etc.).

Modifications to the house primarily intended to facilitate functioning in the home environment (e.g., enlargement of interior door frames, lowering of kitchen appliances and bathroom facilities, interior railings, stairway chairlift, etc.).

- Individual Self-Employed at Home: Modifications made inside home to accommodate impairment (e.g., enlargement of a doorway leading into an office, etc.).
- Individual Self-Employed at Home: Any modification expenses previously deducted as a business expense in determining SGA.

DEDUCTIBLE

Routine Drugs/Medical Services

- Regularly prescribed medical treatment or therapy that is necessary to control a disabling condition (even if unsuccessful), such as anti-convulsant drugs or blood level monitoring, radiation treatment or chemotherapy, corrective surgery for spinal disorders, anti-depressant medication, etc. The physician's fee relating to these services is deductible.

Diagnostic Procedures

- Objective of procedure must be related to the control, treatment or evaluation of a

NON DEDUCTIBLE

Routine Drugs/Medical Services

- Drugs and/or medical services used for only minor physical or mental problems (e.g., routine physical exams, allergy treatment, dental exams, optician services, etc.).

Diagnostic Procedures

- Procedures paid for by other sources (e.g., VR, Medicare) or not related to a disabling condition (e.g., allergy

disabling condition (e.g., electroencephalograms. brain scans, etc.).

Non-Medical Appliances/Devices

- In unusual circumstances, when devices or appliances are essential for the control of disabling condition either at home or in the work setting (e.g., an electric air cleaner for a client with severe respiratory disease); the need is verified by a physician.

Other Items/Services

- Medical supplies of an expendable nature (e.g., incontinence pads, elastic stockings, catheters).
- The cost of a guide dog, including food, licenses, and veterinary services.

testing).

Non-Medical Appliances/Devices

- Devices used at home or at the office which are not ordinarily for medical purposes (e.g., portable room heaters, air conditioners, humidifiers, dehumidifiers, etc.) and the client has no verified medical work-related need.

Other Items/Services

- An exercise bicycle or other device used for physical fitness unless verified as necessary by a physician.

C. SUBSIDIES

An employer may because of a benevolent attitude toward a handicapped individual subsidize the employee's earnings by paying more in wages than the reasonable value of the actual services performed. When this occurs, the excess will be regarded as a subsidy rather than earnings and should be deducted from the gross earnings. Subsidies:

1. *May involve*: giving the impaired worker the same pay but more supervision or fewer/simpler tasks than other non-impaired workers.

2. *May result in*: more pay than the actual work is worth. Workers in sheltered workshops or settings are generally subsidized.

3. *Are deducted*: from gross earnings to arrive at "net countable earnings" for SGA eligibility determinations but are not considered an earned income exemption for budget determinations, once a medical decision is made. They are considered unearned income.

4. _Should be verified_: by an employer contact to confirm a subsidy exists and determine the value of the subsidy.

Example: Employer states that the value of client's work is half the actual earnings. Client earns $800 per month. As half the work is subsidized, $400 is considered the real value of work and client is not engaging in SGA. ***NOTE****: $800 is the non-exempt income for CWD use in computing client's budget.*

D. SPECIAL WORK CONSIDERATIONS

If client is forced to stop working after a short time due to an impairment, the work is generally considered an unsuccessful work attempt (UWA) and earnings from that work will not show ability to do SGA.

1. UNSUCCESSFUL WORK ATTEMPT (UWA) REQUIREMENTS

All of the following must be present for work to be considered an UWA:

- there is a break in client's employment of 30 days or more, and
- work lasted less than six months, and
- work stopped due to client's impairments.

2. EVALUATING UNSUCCESSFUL WORK ATTEMPTS

The following are examples of possible situations which might be encountered when evaluating work activity. How the EW analyzes the situation and what action the EW takes are also provided below.

EXAMPLE A: *Client worked from 12/1/92 to 6/30/94. Work stopped due to his impairment. He returned to work on 8/5/94 and stopped again on 9/1/94 due to his impairment. He applied on 9/2/94 with a request for retro back to 7/94.*

EW's Analysis

- There is a break in employment of over 30 days between 6/30 and 8/5.
- Work lasted less than six months from 8/5 to 9/1.
- Work stopped due to client's impairment.

EW's Actions

- In Item 10 of MC 221, indicate "work after 6/94 is an UWA."
- In Item 6 of MC 221, list retro months of 7/94 and 8/94.

EXAMPLE B: *Client worked sporadically from 10/93 to 12/93, 3/94 to 4/94 and 6/94 to 7/94 because of his mental illness. He applies on 7/10/94, asking for retro back to 4/94.*

EW's Analysis

- There is a break in employment of over 30 days between each work period.
- Work lasted less than six months for each employment period.
- Work stopped due to client's impairment.

EW's Actions

- In Item 10 of MC 221, indicate "work prior to application is an UWA".
- In Item 6 of MC 221, list retro months 4/94, 5/94 and 6/94.

EXAMPLE C: *Client worked until 5/30/94 and applied on 7/7/94, requesting retro onset to 4/94. CWD determined that client was engaging in SGA in 4/94 and 5/94. In Item 6 of MC 221 that was sent to SP-DAPD, EW Indicated "6/94", and indicated in Item 10 "client engaged in SGA in 4/94 and 5/94". On 8/31/94, client reports a return to work for 8/94 only, but stopped because of her impairment.*

EW's Analysis

- There is a break in employment over 30 days from 5/30 and 8/1.
- Work in 8/94 lasted less than six months.
- Work stopped due to client's impairment.

EW's Actions

- Complete and send MC 222, DED Pending Information Update form to SP-DAPD.
- Indicate in Item 9 that client's return to work in 8/94 was an UWA, and that client is no longer working.

E. In-Kind Income As Earned Income "For SGA Determinations"

Earned income may be in cash or in kind. In kind income may include value of food, clothing, or shelter, or other items provided instead of cash. If food and/or shelter is NOT a condition of employment, the current market value of the food, clothing, and/or shelter counts as wages (earned income) and would be considered in an SGA determination.

EXAMPLE: Mrs. B. manages an apartment complex. In addition to her salary of $500 per month, she receives free use of an apartment where she lives. It is verified by the owner of the complex that he furnishes the apartment to Mrs. B. so that she will be available for emergencies. The owner would also expect Mrs. B. to respond to emergencies during her off-duty hours. The owner states that Mrs. B. is not required to live in the apartment provided, but would not have hired someone who lived more than two to three miles away. Similar apartments to Mrs. B's rent for $500 per month.

Since the shelter is not a condition of employment, the current market value of the shelter is considered as earned income. In this example, the MC 272 (SGA Worksheet) would need to be completed with $500 used as payment in kind under number one. Therefore $500 would be inserted as a monthly earning plus another $500 as payment in kind. If the total of these two incomes, less any IRWEs, is more than the current SGA amount, the individual is considered to be engaging in SGA.

F. NOTIFICATION

1. Notifying SP-DAPD

If CWD has evaluated client's earnings for SGA and the client has gross monthly earnings over the current SGA amount, the CWD must include a copy of the SGA Worksheet (MC 272) in the disability packet. If the CWD determines that the individual is not performing SGA, the CWD must annotate in Item 10 (County Worker Comment) of the MC 221 that there is *"no SGA issue."*

If CWD has already sent the disability packet to SP-DAPD, and an SGA issue has been clarified, SP-DAPD should be informed of the evaluation of client's work activity via an MC 222, DED Pending Information Update form along with a copy of the MC 272.

If SP-DAPD returns a disability packet to the county as a Z56 for an SGA determination, the CWD must complete an SGA determination. Should the CWD determine that the client is not performing SGA, a **new** MC 221 MUST be completed and resubmitted with a copy of the MC 272.

2. Notifying Client

If client's application is denied due to performance of SGA, client should be sent a Notice of Action (NOA) informing him/her of the reason for the denial. The NOA may contain the following sample statement:

"The reason why you are not entitled to Medi-Cal based on disability is because your earning of $______ are over the current SGA monthly amount. This means that your net countable earnings are over the current SGA monthly amount of $______, which is the earnings limit if you are working and applying as a disabled person."

NOTE: The Title 22 reference section is: **50224**

G. FORMS

1. SGA Worksheet, Form MC 272 (Exhibit 1):

   May be used to compute client's earnings and IRWE/Subsidy deductions.

   a. **Net earnings of current SGA amount or less**: process application in the usual manner.

   b. **Net earnings more than current SGA amount per month**: deny claim as client is engaging in SGA.

   c. Whenever the gross monthly earnings are more than the current SGA amount per month and the CWD determines that there is no SGA issue, a copy of the MC 272 must be included in the disability packet. Item 10 of the MC 221 must indicate that there is *"no SGA issue."*

2. Work Activity Report, Form 273 (Exhibit 2):

   Should be used to determine what client's earnings are and whether the client's gross earnings can be reduced by the amount of any applicable IRWE or subsidy.

3. DED Pending Information Update, Form MC 222:

   Must be sent if a disability packet is pending at SP-DAPD, and client is subsequently found to be engaging in SGA. The MC 272 must also be included.

9. **MC 272 – SGA WORKSHEET**

This worksheet is used when applicant has gross earned income over the current SGA amount.

Section 1 Add gross average earnings. Include in-kind payments received, such as room and board (which is not condition of employment) and any other income such as tips.

Section 2 Compute allowable Impairment- Related Work Expenses (IRWE explained in detail in Article 22 C-1 –Determining SGA) and deduct from gross earnings.

Section 4 If applicant's work is subsidized (as specified in Article 22 C-1), indicate what subsidy is worth.

Section 5 "Net countable earnings" , after deductions, should be current SGA amount or less in order for case to be referred to SP-DAPD. If above current SGA amount client is performing SGA and ineligible for Disabled-MN.

10. **MC 273 – WORK ACTIVITY REPORT (ENGLISH/ SPANISH)**

Form is provided to applicant to inform him/her about the SGA limit. It gives applicant the opportunity to provide information leading to IRWE or subsidy deductions.

Items 1to 9 Applicant completes these items.

"Check List For County Use Only"

This is a check list for the EW to determine whether the applicant has any subsidies or IRWEs that can be deducted from gross wages. After the subsidies and IRWEs have been deducted, the EW indicates whether the applicant is engaging in SGA.

Space is provided if explanations are necessary.

11. **MC 4033 – UPDATE TO DISABILITY LIAISON LISTS**

CWD completes MC 4033 to notify the state of any updates needed for designated liaisons and mailing lists for either:

- MEDI-CAL LIAISON(S) FOR DISABILITY ISSUES, or
- MEDI-CAL LIAISON(S) FOR QUARTERLY STATUS LISTINGS FOR PENDING AND CLOSED DISABILITY CASES.

Check appropriate listings being changed. Specify items being updated. Complete a separate form for each representative and corresponding information being updated. Print or type the information. Send form to DHS-MEB.

12 DHS 7035A / DHS 7035 C – MEDICAL REPORT ON ADULT/CHILD WITH ALLEGATIONS OF HIV

DHS 7035A is used for an adult, and DHS 7035 C for a child, who alleges HIV, AIDS or ARC. These are completed by a medical source when client alleges having Human Immunodeficiency Virus (HIV) infection, Acquired Immune Deficiency Syndrome (AIDS), or AIDS-Related Complex (ARC). Upon receipt of form, CWD processes case under Presumptive Disability (PD) criteria.

Article 22 C-2 -- Determining Presumptive Disability discusses in detail how this form is used and evaluated.

13 DHS 7045 – WORKER OBSERVATIONS – DISABILITY

CWD staff should use form to record comments on an individual's physical , mental, and /or emotional problems. If DHS 7045 is not used to record observations, CWD should provide observations in Item 10, " County Worker Comments" section of MC 221. Article 22 C-4 – Providing CWD Worker Observations provides guidelines in assisting Ews in providing observations to SP-DAPD.

DHS 7045 may be submitted to SP-DAPD with the disability packet or at a later date, should EW have additional observations to provide.

State of California—Health and Human Services Agency | Department of Health Services

Name of disabled person	Social security number

SGA WORK SHEET
(Used when gross earned* income is over the current SGA amount.)

1. Earned Income
   a. Gross average monthly earnings $__________
   b. Payment in kind (e.g., room and board) which is *not* a condition of employment (use current market value) __________
   c. Other __________
   d. **TOTAL GROSS EARNINGS** (add a, b, and c) $__________
2. Impairment-Related Work Expenses (IRWEs) (see MEPM, Article 22, 22C-2)
   a. Attendant care services $__________
   b. Transportation costs __________
   c. Medical devices __________
   d. Work-related equipment __________
   e. Prosthesis __________
   f. Residential modifications __________
   g. Routine drugs and routine medical services __________
   h. Diagnostic procedures __________
   i. Nonmedical applications and devices __________
   j. Assistants (e.g., if visually impaired, cost to hire reader) __________
   k. Other items and services __________
3. **TOTAL IRWEs:** Add (total of 2a through 2k) $__________
4. **TOTAL SUBSIDY** (e.g., some employers employ disabled persons and subsidize their wages by paying them the same wages as a nondisabled employee though they may be performing less strenuous work, or working less hours) (from MC 273, number 7) $__________
5. **NET COUNTABLE EARNINGS** (subtract 3 and 4 from 1d) $__________
   - Are current countable earnings greater than $ __________ (Insert current SGA amount)? ☐ Yes ☐ No
   - If the answer is No, send a disability referral to SP-DAPD. In Item 10 of the MC 221, Disability Determination and Transmittal, write in "No SGA issue." Attach copy of MC 272 to the MC 221.
   - If the answer is Yes, the client is engaging in SGA. Deny the disability claim. (Evaluate client for the Working Disabled Program.)

*NOTE: Income information obtained from completed MC 273 (Work Activity Report).

Eligibility Worker signature	Worker number	Date completed

MC 272 (8/01)

State of California—Health and Human Services Agency

Department of Health Services

WORK ACTIVITY REPORT

This report is for:	
Month	Year

You may be considered disabled for Medi-Cal if you cannot do any kind of work for which you are suited, and only if you cannot work for at least a year or your condition will result in death.

If your gross earnings are more than $____________ *(current SGA amount)* per month, you might not be considered disabled. Work expenses and special work considerations related to your disability may be deducted in figuring whether your earnings meet the earnings limit. For this reason, information about your work activity is needed.

The information you provide about your work activity will be used in making a decision on your case. Your employer may be contacted to verify the information you provide.

Name of disabled person			Social security number	
Employer's name			Employer's telephone number ( )	
Employer's address (number, street)	City		State	ZIP Code
Title or name of your job	Rate of pay	Hours worked per week	Dates worked (month/year) From: ________	To: ________
Employer's name			Employer's telephone number ( )	
Employer's address (number, street)	City		State	ZIP Code
Title or name of your job	Rate of pay	Hours worked per week	Dates worked (month/year) From: ________	To: ________

1. **Gross Earning**—What is your gross monthly pay? (If pay is irregular, you do not need to enter the amount.) Attach your pay stubs.

   ____

   ____

2. **Other Payments**—Specify other payments you receive, such as tips, free meals, room, or utilities. Indicate what you were given and estimate the dollar value and how frequently you receive them.

   ____

   ____

3. **Special Employment Situations**

	Yes	No
After you became ill, did your job duties lessen?	☐	☐
If yes, did you get to keep your same pay?	☐	☐
Are you employed by a friend or relative?	☐	☐
Are you in a special training or rehabilitation program?	☐	☐

4. **Job Requirements**—Are your job duties listed below different from those of other workers with the same job title?

	Yes	No
a. Shorter hours	☐	☐
b. Different pay scale	☐	☐
c. Less or easier duties	☐	☐
d. Extra help given	☐	☐
e. Lower production	☐	☐
f. Lower quality	☐	☐
g. Other differences (e.g., frequent absences)	☐	☐

5. **Explanation of Job Requirements**—Describe all "yes" answers in item 4 on page 1.

   ____

   ____

   ____

MC 273 (8/01)

Page 1 of 2

6. **Special Work Expenses**—Specify below any special expenses related to your condition which are necessary for you to work. These are things which you paid for and not things that will be paid for by anyone else.

   Specify the amount of the expenses. Attach verification of who prescribed the item or service needed and the cost paid. (We are required to verify the need for the item or service with the person who prescribed it.)

   Example: Attendant care services, transportation costs, medical devices, work-related equipment, prosthesis, modifications to your home, routine drugs and medical services necessary to control a disabling condition, diagnostic procedures, assistants (e.g., if visually impaired, the cost to hire a reader; if hearing impaired, the cost to hire a sign language interpreter), or similar items or services.

   ____

   ____

7. **Subsidies**—Some employers will support disabled individuals with subsidies. For example, the employer may subsidize the disabled employee's earnings by paying more in wages than the reasonable value of the actual work that was done. (For example, many sheltered work centers subsidize an individual's earnings.)

   Does your employer provide you with subsidies? ☐ Yes ☐ No

   If yes, please (a) tell us how much the subsidy is worth and (b) explain the type of subsidy that was given.

   a. $____________

   b. Explanation of subsidy: ____________________________

8. Use this additional space to answer any previous questions or to give additional information that you think will be helpful.

   ____

9. Please read the following statement. Sign and date the form. Provide address and telephone number.

   If my employer should need to be contacted, this also authorizes my employer to disclose any information necessary for the county to evaluate my work activity for my Medi-Cal application based on disability.

   I have completed this form correctly and truthfully to the best of my knowledge and abilities.

Signature of applicant or representative	Date	Area code and telephone number
		( )

Mailing address (number, street, apartment number, P.O. box number, or Rural Route)

City	County	State	ZIP code

CHECKLIST FOR COUNTY USE ONLY

1. Enter amount of client's gross wages. $__________
   Does the client have any of the following deductions?
   a. Subsidy (see MEPM, Article 22, 22C-2.7) ☐ Yes ☐ No If yes, enter amount: $__________
   b. Impairment-related work expenses (IRWEs) ☐ Yes ☐ No If yes, enter amount: $__________
2. Add a and b above and subtract total from number 1. Is the remainder over the current SGA amount? ☐ Yes ☐ No
   If yes, client is engaging in SGA. If any explanations are needed, please use the following space:

   ____

Eligibility Worker signature	Worker number	Date completed

MC 273 (8/01) Page 2 of 2

State of California—Health and Human Services Agency | Department of Health Services

REPORTE SOBRE LA ACTIVIDAD DE TRABAJO

This report is for:	
Month	Year

Es posible que a usted se le considere estar incapacitado(a) para fines de Medi-Cal, si usted n puede realizar ninguna clase de trabajo para el que esté capacitado(a), y solamente si usted no puede trabajar durante por lo menos un año o si su condición resultaría en muerte.

Si sus ingresos brutos son más de $____________ *(actual cantidad de SGA)* al mes, es posible que a usted no se le considere incapacitado(a). es posible que los gastos de trabajo y las consideraciones especiales de trabajo relacionadas con su incapacidad se deduzcan al determinar si sus ingresos cumplen con el límite de ingresos. Por esta razón, se necesita información sobre su actividad de trabajo.

La información que usted proporcione sobre su actividad de trabajo se utilizará al tomar una decisión sobre su caso. Es posible que se establezca contacto con su empleador, para verificar la información que usted proporcione.

Nombre de la persona incapacitada			Número de seguro social	
Nombre del empleador			Número de teléfono del empleador ( )	
Dirección del empleador (número, calle)	Ciudad		Estado	Código postal
Puesto o nombre de su trabajo	Tasa de pago	Horas trabajadas a la semana	Fechas trabajadas (mes/año) Del. ______ Al: ______	
Nombre del empleador			Número de teléfono del empleador ( )	
Dirección del empleador (número, calle)	Ciudad		Estado	Código postal
Puesto o nombre de su trabajo	Tasa de pago	Horas trabajadas a la semana	Fechas trabajadas (mes/año) Del: ______ Al: ______	

1. **Ingresos Brutos**—¿Cuál es su pago mensual bruto? (Si el pago es irregular, usted no necesita anotar la cantidad.) Adjunte sus talones de pago.

   ____

   ____

2. **Otros pagos**—Especifique otros pagos que usted reciba, como propinas, alimentos, hospedaje o servicios públicos gratuitos. Indique lo que se le dio, y calcule el valor en dólares, así como la frecuencia con que los recibe.

   ____

   ____

3. **Situaciones Especiales de Empleo**

	Sí	No
Después de que se enfermó, ¿disminuyeron sus obligaciones de trabajo?	☐	☐
Si así fue, ¿pudo mantener el mismo pago?	☐	☐
¿Está usted empleado(a) por un(a) amigo(a) o pariente?	☐	☐
¿Está usted en un programa especial de capacitación o rehabilitación?	☐	☐

4. **Requisitos de Empleo**—¿Son sus tareas de empleo enumeradas enseguida diferentes de aquéllas de otros trabajadores con el mismo puesto?

	Sí	No
a. Horario más corto	☐	☐
b. Diferene escala de pago	☐	☐
c. Menos tareas o tareas más fáciles	☐	☐
d. Se proporciona ayuda adicional	☐	☐
e. Producción más baja	☐	☐
f. Calidad más baja	☐	☐
g Otras diferencias (por ejemplo, faltas frecuentes)	☐	☐

5. **Explicación de los Requisitos del Empleo**—Describa todas las respuestas a las que respondió "sí" en el inciso 4 en la página 1.

   ____

   ____

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6. **Gastos Especiales de Trabajo**—Especifique a continuación *cualesquier gastos especiales relacionados con su* condición, que son necesarios para que usted trabaje. Éstas son cosas que usted paga, no cosas que alguien más paga.
   Especifique la cantidad de los gastos. Adjunte comprobante de quién recetó el artículo o servicio necesario, y el costo pagado. (Se nos exige comprobar la necesidad del artículo o servicio con la persona que lo recetó.)
   Ejemplo: Servicios de cuidado de un(a) asistente, costos de transporte, aparatos médicos, equipo relacionado con el trabajo, prótesis, modificaciones a su casa, medicamentos de rutina y servicios médicos necesarios para controlar una condición incapacitante, procedimientos diagnósticos, asistentes (por ejemplo, si se tienen impedimentos de la vista, el costo para contratar a un(a) lector(a); si se tienen impedimentos del oído, el costo para contratar a un intérprete de lenguaje por señas), o artículos o servicios semejantes.
   ____
   ____

7. **Subsidios**—Algunos empleadores apoyan a las personas incapacitadas con subsidios. Por ejemplo, es posible que el empleador subsidie los ingresos de un(a) empleado(a) incapacitado(a) pagando más sueldo que el valor razonable del trabajo real realizado. (*Por ejemplo, muchos centros de trabajo protegido subsidian los ingresos de un individuo.*)
   ¿Le proporciona su empleador subsidios? ☐ Sí ☐ No
   Si así es, por favor (a) díganos de cuánto es el subsidio y (b) explíquenos la clase de subsidio que se le dio.
   a. $____________
   b. Explicación del subsidio: ______________________________

8. Utilice este espacio adicional para contestar cualesquier preguntas anteriores o para dar información adicional que usted cree que será útil.
   ____

9. Por favor, lea la siguiente declaración. Firme y feche el formulario. Proporcione la dirección y el número de teléfono.
   Si se tuviera que establecer contacto con mi empleador, esto también autoriza a mi empleador a revelar cualquier información necesaria para que el condado evalúe mi actividad de trabajo para mi solicitud de Medi-Cal basada en incapacidad.
   He completado este formulario correcta y verazmente conforme a mi leal saber y habilidades.

Firma del/de la solicitante o representante		Fecha	Código de área y número de teléfono ( )
Dirección postal (número, calle, número de departamento, número de apartado postal o ruta rural)			
Ciudad	Condado	Estado	Código postal

CHECKLIST FOR COUNTY USE ONLY

1. Enter amount of client's gross wages. $________
   Does the client have any of the following deductions?
   a. Subsidy (see MEPM, Article 22, 22C-2.7) ☐ Yes ☐ No *If yes, enter amount:* $________
   b. Impairment-related work expenses (IRWEs) ☐ Yes ☐ No If yes, enter amount: $________
2. Add a and b above and subtract total from number 1. Is the remainder over the current SGA amount? ☐ Yes ☐ No
   If yes, client is engaging in SGA. If any explanations are needed, please use the following space.
   ____

Eligibility Worker signature	Worker number	Date completed

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State of California—Health and Human Services Agency | Department of Health Services

Name of disabled person	Social security number

SGA WORK SHEET
(Used when gross earned* income is over the current SGA amount.)

1. Earned Income
   a. Gross average monthly earnings $________
   b. Payment in kind (e.g., room and board) which is *not* a condition of employment (use current market value) ________
   c. Other ________
   d. **TOTAL GROSS EARNINGS** (add a, b, and c) $________
2. Impairment-Related Work Expenses (IRWEs) (see MEPM, Article 22, 22C-2)
   a. Attendant care services $________
   b. Transportation costs ________
   c. Medical devices ________
   d. Work-related equipment ________
   e. Prosthesis ________
   f. Residential modifications ________
   g. Routine drugs and routine medical services ________
   h. Diagnostic procedures ________
   i. Nonmedical applications and devices ________
   j. Assistants (e.g., if visually impaired, cost to hire reader) ________
   k. Other items and services ________
3. **TOTAL IRWEs:** Add (total of 2a through 2k) $________
4. **TOTAL SUBSIDY** (e.g., some employers employ disabled persons and subsidize their wages by paying them the same wages as a nondisabled employee though they may be performing less strenuous work, or working less hours) (from MC 273, number 7) $________
5. **NET COUNTABLE EARNINGS** (subtract 3 and 4 from 1d) $________
   - Are current countable earnings greater than $____________ (Insert current SGA amount)? ☐ Yes ☐ No
   - If the answer is No, send a disability referral to SP-DAPD. In Item 10 of the MC 221, Disability Determination and Transmittal, write in "No SGA issue." Attach copy of MC 272 to the MC 221.
   - If the answer is Yes, the client is engaging in SGA. Deny the disability claim. (Evaluate client for the Working Disabled Program.)

***NOTE:** Income information obtained from completed MC 273 (Work Activity Report).

Eligibility Worker signature	Worker number	Date completed

MC 272 (8/01)

State of California—Health and Human Services Agency | Department of Health Services

WORK ACTIVITY REPORT

This report is for:	
Month	Year

You may be considered disabled for Medi-Cal if you cannot do any kind of work for which you are suited, and only if you cannot work for at least a year or your condition will result in death.

If your gross earnings are more than $____________ *(current SGA amount)* per month, you might not be considered disabled. Work expenses and special work considerations related to your disability may be deducted in figuring whether your earnings meet the earnings limit. For this reason, information about your work activity is needed.

The information you provide about your work activity will be used in making a decision on your case. Your employer may be contacted to verify the information you provide.

Name of disabled person			Social security number	
Employer's name			Employer's telephone number ( )	
Employer's address (number, street)	City		State	ZIP Code
Title or name of your job	Rate of pay	Hours worked per week	Dates worked (month/year) From: ________ To: ________	
Employer's name			Employer's telephone number ( )	
Employer's address (number, street)	City		State	ZIP Code
Title or name of your job	Rate of pay	Hours worked per week	Dates worked (month/year) From ________ To ________	

1. **Gross Earning**—What is your gross monthly pay? (If pay is irregular, you do not need to enter the amount.) Attach your pay stubs.

____

____

2. **Other Payments**—Specify other payments you receive, such as tips, free meals, room, or utilities. Indicate what you were given and estimate the dollar value and how frequently you receive them.

____

____

3. **Special Employment Situations**

	Yes	No
After you became ill, did your job duties lessen?	☐	☐
If yes, did you get to keep your same pay?	☐	☐
Are you employed by a friend or relative?	☐	☐
Are you in a special training or rehabilitation program?	☐	☐

4. **Job Requirements**—*Are your job duties listed below different from those of other workers with the same job title?*

	Yes	No
a. Shorter hours	☐	☐
b. Different pay scale	☐	☐
c. Less or easier duties	☐	☐
d. Extra help given	☐	☐
e. Lower production	☐	☐
f. Lower quality	☐	☐
g. Other differences (e.g., frequent absences)	☐	☐

5. **Explanation of Job Requirements**—*Describe all "yes" answers in item 4 on page 1.*

____

____

____

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6. **Special Work Expenses**—Specify below any special expenses related to your condition which are necessary for you to work. These are things which you paid for and not things that will be paid for by anyone else.

   Specify the amount of the expenses. Attach verification of who prescribed the item or service needed and the cost paid. (We are required to verify the need for the item or service with the person who prescribed it.)

   Example: Attendant care services, transportation costs, medical devices, work-related equipment, prosthesis, modifications to your home, routine drugs and medical services necessary to control a disabling condition, diagnostic procedures, assistants (e.g., if visually impaired, the cost to hire a reader; if hearing impaired, the cost to hire a sign language interpreter), or similar items or services.

   ____

   ____

7. **Subsidies**—Some employers will support disabled individuals with subsidies. For example, the employer may subsidize the disabled employee's earnings by paying more in wages than the reasonable value of the actual work that was done. (For example, many sheltered work centers subsidize an individual's earnings.)

   Does your employer provide you with subsidies? ☐ Yes ☐ No

   If yes, please (a) tell us how much the subsidy is worth and (b) explain the type of subsidy that was given.

   a. $______________

   b. Explanation of subsidy: ______________________________

   ____

   ____

8. Use this additional space to answer any previous questions or to give additional information that you think will be helpful.

   ____

   ____

   ____

   ____

9. Please read the following statement. Sign and date the form. Provide address and telephone number.

   If my employer should need to be contacted, this also authorizes my employer to disclose any information necessary for the county to evaluate my work activity for my Medi-Cal application based on disability.

   I have completed this form correctly and truthfully to the best of my knowledge and abilities.

Signature of applicant or representative		Date	Area code and telephone number ( )
Mailing address (number, street, apartment number, P.O. box number, or Rural Route)			
City	County	State	ZIP code

CHECKLIST FOR COUNTY USE ONLY

1. Enter amount of client's gross wages. $______________

   Does the client have any of the following deductions?

   a. Subsidy (see MEPM, Article 22, 22C-2.7) ☐ Yes ☐ No If yes, enter amount: $______________

   b. Impairment-related work expenses (IRWEs) ☐ Yes ☐ No If yes, enter amount: $______________

2. Add a and b above and subtract total from number 1. Is the remainder over the current SGA amount? ☐ Yes ☐ No

   If yes, client is engaging in SGA. If any explanations are needed, please use the following space:

   ____

   ____

   ____

Eligibility Worker signature	Worker number	Date completed

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