STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY EDMUND G. BROWN JR., Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814
6) 445-1912

March 10, 1981

To: All County Welfare Directors
FORMS PROCESSING UNIT

Letter No. 81-10

NEW FORM AVAILABILITY

This is to notify you that form MC 262 (11/80) REDETERMINATION FOR M/C
(number) (name)

RECIPIENTS is now available at the Department of Health Services

Warehouse. The form is packaged in:

☐ Cartons of _____

☐ Pads of _____

☒ Single sheets

Form requisitions should be sent to:

Department of Health Services Warehouse
1723 20th Street
Sacramento, CA 95814

Please allow at least 20 working days for delivery.

Sincerely,

Original signed by

Barbara V. Carr, Acting Chief
Medi-Cal Eligibility Branch

Attachment

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

REDETERMINATION FOR MEDI-CAL BENEFICIARIES IN LONG-TERM CARE WITHOUT A SPOUSE AND/OR CHILDREN UNDER 21

INSTRUCTIONS: *Your continuing eligibility will be decided on the information you give on this form.*
If you are completing this form on someone else's behalf, the term "you" applies to that person.

1. Name (First, Middle, Last)	Date of Birth Mo. Day Yr. / /	Social Security Number
2. Long-Term Care Facility	Marital Status	Medicare Claim Number

3. Facility Address (Number, Street, City, Zip Code)

4. Name of Person Helping Complete Form(s)	Relationship	Telephone

5. Address of Person Helping with Form (If information regarding beneficiary should be sent to this person)

6. Do you own any real property, have an interest in real property or own a trailer or mobile home taxed as real property? Yes ☐ No ☐ If yes,

Description of property: _____

Address of property: _____

Owner(s): _____

Full value (from tax statement) $ _____ Amount owed $ _____

Rent collected each month $ _____

Expenses on property

Interest $ _____ Yearly ☐ Monthly ☐ Insurance $ _____ Yearly ☐ Monthly ☐

Taxes and Assessments $ _____ Yearly ☐ Monthly ☐ Upkeep and

Utilities $ _____ Yearly ☐ Monthly ☐ Repairs $ _____ Yearly ☐ Monthly ☐

COUNTY USE ONLY

State No:

7. Do you have a life estate in any property? Yes ☐ No ☐ If yes, describe:

8. Do you own a note, mortgage or deed of trust? Yes ☐ No ☐ If yes,

Appraised value $ _____ Monthly payment $ _____

Interest rate _____ %

9. Do you have any checks or money on hand, in a bank or savings and loan, being held for you by anyone, or being kept anywhere for you? Yes ☐ No ☐ If yes,

Location of money:	Amount
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____

10. Have you sold, transferred or given away any property (including money) since you first applied for Medi-Cal or at any time in the two years prior to that? Yes ☐ No ☐ If yes:

DESCRIPTION	Date of Transfer Sale or Gift	Value	Amount Received
		$	$
		$	$
		$	$

11. Do you own any of the following items of property? Check yes or no. If yes, provide the other information requested

	Yes	No	Purchase Price	Current Value	Amount Owed
A. Stocks or bonds			$	$	$
B. Jewelry valued over $100 (other than wedding or engagement rings or heirlooms)			$	$	$
C. Burial reserve or trust			$	$	$
D. Burial plot, vault or crypt			$	$	$
E. Business equipment, tools, inventory or material			$	$	$
F. Other			$	$	$

12. Do you own any life insurance policies insuring yourself or anyone else? Yes ☐ No ☐ If yes:

Insurance Company	Person Insured	Face Value	Current Cash Value
A.		$	$
B.		$	$

13. Do you own a motor vehicle (car, truck, etc); or a boat, camper, or motor home; or mobile home or trailer not taxed as real property. Yes ☐ No ☐ If yes:

Description	Class (From Registration)	Year	Purchase Price	Amount Owed	Used to Provide You With Transportation	
					Yes	No
			$	$		
			$	$		

14. Do you receive any income? Yes ☐ No ☐
If yes, list the source and amount of income received each month. If income is received less often than monthly, indicate how often received. Attach verification of this income.

Social Security	$
Railroad Retirement	$
Veterans Benefits (including Aid and Attendance payments)	$
Retirement or Pension	$
Interest Income or Dividends	$
Contributions (including those from relatives)	$
Other (describe)	$

15. Have you applied for or do you think you are eligible for any payments you are not now receiving? Yes ☐ No ☐ If yes:

Kind of Payment	Date Applied For	Date Expected

CA5 (if not already completed)

16. Do you have health or hospitalization insurance? Yes ☐ No ☐ If yes:

Insurance Company _____

Premium you pay $ _____ How often: Monthly ☐ Quarterly ☐ Yearly ☐

17. Would you like to speak to a social worker about services available to you? Yes ☐ No ☐

If yes, explain the services you wish to discuss:

Referral Yes ☐ No ☐

18. Additional Information:

BE SURE YOU HAVE READ EVERY ITEM AND ANSWERED ALL THE QUESTIONS.
READ THE FOLLOWING CAREFULLY BEFORE SIGNING.

I DECLARE UNDER PENALTY OF PERJURY THAT THE ANSWERS I HAVE GIVEN ARE CORRECT AND TRUE TO THE BEST OF MY KNOWLEDGE.

I AGREE TO TELL THE COUNTY WELFARE DEPARTMENT WITHIN 10 DAYS IF THERE ARE ANY CHANGES IN MY (OR THE PERSON'S ON WHOSE BEHALF I AM ACTING) INCOME, POSSESSIONS OR EXPENSES, OR A CHANGE IN MY LIVING SITUATION. I AGREE TO MEET ALL THE OTHER RESPONSIBILITIES EXPLAINED IN THE "MEDI-CAL RESPONSIBILITIES CHECKLIST" I RECEIVED AT THE TIME OF MY APPLICATION FOR MEDI-CAL. (A NEW "RESPONSIBILITIES CHECKLIST" WILL BE PROVIDED IF THERE IS A CHANGE IN THE PERSON ACTING ON BEHALF OF THE BENEFICIARY.)

I UNDERSTAND THAT I MAY BE ASKED TO PROVE MY STATEMENTS, BUT THAT THE COUNTY IS REQUIRED BY LAW TO KEEP THEM CONFIDENTIAL.

I UNDERSTAND THAT IF I AM DISSATISFIED WITH ACTIONS TAKEN BY THE COUNTY WELFARE DEPARTMENT, I HAVE THE RIGHT TO A FAIR HEARING.

I REALIZE THAT IF I DELIBERATELY MAKE FALSE STATEMENTS OR WITHHOLD INFORMATION, I (OR THE PERSON ON WHOSE BEHALF I AM ACTING) MAY LOSE MY (OR HIS/HER) MEDI-CAL CARD AND/OR BE PROSECUTED FOR FRAUD.

Signature of Beneficiary	Date
Signature of Person Acting For Beneficiary	Date
ature of Witness (if beneficiary signed with mark)	Date
E. W. Signature	Date

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY EDMUND G. BROWN JR., Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
CRAMENTO, CA 95814
16) 445-1797

April 2, 1981

ERRATA NOTICE

ALL COUNTY WELFARE DIRECTORS

Letter No. 81-6

SGA DISABLED -- DEDUCTION FOR IHSS COSTS

In the first paragraph of the above mentioned letter, Section 50245(a)(2) should be changed to read Section 50223(a)(2).

ALL COUNTY WELFARE DIRECTORS

Letter No. 81-11

REVISION OF MC 210

On the second page of the above mentioned letter, number eight, Section 50816 should be changed to read Section 50186.

Medi-Cal Eligibility Branch