DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814
(916) 445-1912

March 12, 1981

To: All County Welfare Directors Letter No. 81-11

REVISION OF MC 210

The Statement of Facts, form MC 210 has been revised to incorporate changes in the Medi-Cal program. A copy of this revision, dated October 1980, is attached. The form is already in use in some of the counties that have converted to the Simplified Medi-Cal Disability Referral System (SMDRS). This form will be available to all counties on April 1.

This revision of the MC 210 includes the following major changes:

1. Question 3c has been added to gather information necessary for Social Security Number validation. The Social Security Number Validation procedures are explained in All County Letter No. 81-8.

2. Question 5b asks whether a person who maintains a home in another state is working or looking for work in California. There are proposed regulations which would allow these persons to be eligible for Medi-Cal. It is anticipated that these regulations will be effective in September, 1981. Until that time, this question has no impact on a person's eligibility.

3. Question 9b has been revised as part of SMDRS. Those counties who are not yet using SMDRS for disability determinations should continue with the standard procedures given in Eligibility Manual Section 4A, if the client answers "yes" to this question.

4. Question 24 asks for information about self-employment that is necessary to determine if the property listed in this question, and if property listed in Question 20, can be exempt as business property in accordance with Section 50485.

5. Question 27 implements Section 50554 (MFBU regulations) which allows AFDC-MN and MI persons a deduction for child support and alimony.

6. Question 30 (and part of Question 8) ask for information regarding any funds a person has paid toward the cost of health care received in a month for which the person is now requesting Medi-Cal. The question is part of a planned process being developed to ensure that Medi-Cal does not pay for care which the applicant paid for or should have paid for in order to reduce his/her property to within the property limits. Until you receive further instructions on this process, take no action on Question 30 and the portion of Question 8 involved.

7. Question 31 has been added to determine whether Medi-Cal eligibles may be eligible for V.A. benefits. See Procedure 10J for steps to be followed in completing and processing the CA 5.

8. Question 32 implements Section 50816, which requires that Medi-Cal applicants and beneficiaries must take any action necessary to obtain unconditionally available income.

Because of the major changes to the MC 210, we would like all counties to begin using it by May 1, 1981 whether or not you have used up your entire supply of any prior version of the form. Because of the current limited supply of the MC 210, we are asking that each county order only a three month supply. Additional forms will be available in June.

If you have any questions, contact your program consultant at (916) 445-1912.

Sincerely,

Original signed by

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

Attachment
cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

Expiration Date: June 30, 1981

TEMENT OF FACTS FOR MEDI-CAL

INSTRUCTIONS:

Your eligibility will be decided on the information you give on this form. Be sure to read and answer every item. If you need extra space for any item, see page 9.

If you are completing this form on someone else's behalf, the terms "applicant" and "you" apply to the person you are applying for.

"Family member" means applicant, spouse, applicant's or spouse's children under 21.

PLEASE USE INK

1. Applicant's Name (Print) First Middle Last

2. Home Address Number Street City Zip Code

Mailing address (if different from above)

Home phone Work phone Message phone Person with whom to leave message

COUNTY USE ONLY

Case Name:

State No.:

App/Redetermination Date:

3. FAMILY MEMBERS

3a. List yourself and your spouse if he/she is in the home or Medi-Cal is being requested in his/her behalf.

Verification of SS #

Date E.W.

Name (First, Middle, Last) / Social Security (SS) No.	Sex	Birthdate (Mo/Day/Yr.) / Birthplace	Marital Status: Single	Married	Divorced	Separated	Widowed	Living With Applicant: Yes	No	Medi-Cal Requested: Yes	No
1. Applicant SS #		Birthplace				Date					
2. Spouse SS #		Birthplace				Date					

3b. List all your and your spouse's unmarried children under 21 (including unborns) living in the home. Also list those out of the home for whom you are requesting Medi-Cal.

	Sex		In School: Yes	No	PARENTS (1) Father's Name (2) Mother's Name	Parent is: (✓ if applies) Deceased	Absent	Incapacitated	Unemployed	Child Living With Applicant: Yes	No	Medi-Cal Req. for Child: Yes	No
1. SS #		Place			(1) (2)								
2. SS #		Place			(1) (2)								
3. SS #		Place			(1) (2)								
4. SS #		Place			(1) (2)								
5. SS #		Place			(1) (2)								
6. SS #		Place			(1) (2)								

Did you or any family member use a different name than the one listed above when each of you applied for your Social Security Number?

Yes ☐ No ☐ If yes, list names.

[REMEMBER: FAMILY MEMBERS INCLUDE ALL THOSE PEOPLE LISTED IN 3A AND 3B]

3. Complete for persons listed in 3a or 3b who are not living with you.

Name	Address

Is there anyone other than you or your family members listed in 3a or 3b living with you? Yes ☐ No ☐ If yes:

Name	Relationship

Are you or any family member requesting Medi-Cal living or currently staying outside California? Yes ☐ No ☐ If yes:
Date left California _____ Date expected to return _____
Reason for absence:

Do you or any family member maintain a home outside California? Yes ☐ No ☐
If yes, are you or any family member working or looking for work in California? Yes ☐ No ☐
If no, explain why you are in California.

Are you and all family members requesting Medi-Cal U.S. citizens? Yes ☐ No ☐ If no:

Name of Alien	Alien Registration Number

Have you or any family member ever received or applied for welfare payments, food stamps and/or medical assistance from a county welfare office or another state or have you applied for SSI/SSP (gold check) from Social Security? Yes ☐ No ☐ If yes:

Name Of Person(s) Who Applied For Or Received Aid	Type of Aid	Date of App. Mo/Day/Yr.	Place of App.	Date Last Received (If no longer receiving) Mo/Day/Yr.	Reason For Discontinuance

If you or any family member were not receiving Medi-Cal in the last three months, did you or those family members receive any medical care? Yes ☐ No ☐ If yes:

Name of Person Receiving Medical Care	Month(s) of Care	Payments Made For Care		Do You Wish Medi-Cal For These Months	
		Yes	No	Yes	No

9a. Are you or any family member requesting Medi-Cal:
65 or over? Yes ☐ No ☐ If yes, name(s)_____
Blind? Yes ☐ No ☐ If yes, name(s)_____

b. Do you or any family member have a physical or emotional problem which makes it difficult to work or take care of your needs?
Yes ☐ No ☐ If yes:

Family Member(s)	Type of Problem(s)	Beginning Date of Problem(s)

COUNTY USE ONLY

Where required, date CA 6 signed

- Receiving or applied for cash grant or Medi-Cal around August 1972? If yes, check for 20% SS increase eligibility
- 4 month continuing eligibility?
- SGA disabled?
- Title II disregard?
- 30 + 1/3 earnings exemption?

Retroactive Application
Retro only ☐
Retro and Cont. ☐

Payments reduced property to within property limits? Yes ☐ No ☐

☐ Verification of Disability/blindness (list)

Date Verified E.W.
☐ Disability referral

Date Sent

10. Complete the following information about your living arrangements:

COUNTY USE ONLY

- ☐ Rent a room, apartment, house or trailer
- ☐ Pay for room and board
- ☐ Work in exchange for room and board
- ☐ Receive free room
- ☐ Receive free room and board
- ☐ Live in a board and care facility
- ☐ Live in a nursing home or hospital

  Date entered _____ Date expected to return home _____

Verification that will return home in six months
Yes ☐ No ☐

- ☐ Live in and own/buying a trailer, mobile home, boat or motor vehicle which is not taxed as real property by the county.

  Description: _____

  Estimated value $ _____ Amount owed $ _____
- ☐ Live in and own/buying a home or a trailer or mobile home which is taxed as real property by the county.

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

  Land home is located on includes more than one parcel. Yes ☐ No ☐ If yes, complete 11.

  Land home is located on includes more than one acre. Yes ☐ No ☐ If yes, complete 11.
- ☐ Other living arrangements. Describe:

11. Do you or any member of your family own real property which you do not now live in (for example, land or buildings) or a trailer or mobile home which is taxed as real property by the county and which you do not now live in? Yes ☐ No ☐

If yes:

Description: _____

Address: _____

Owner: _____ Used in part as a home Yes ☐ No ☐

Verification of Income (list)

Date Verified _____ E.W. _____

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 Repairs $_____ Yearly ☐ Monthly ☐

Utilities $_____ Yearly ☐ Monthly ☐

) you or any family member have a life estate (right to the use of) in any property? Yes ☐ No ☐ If yes, describe:

☐ Revocable
☐ Irrevocable

13. Do you or any family member own a motor vehicle (including cars, trucks, motorcycles, etc)? Yes ☐ No ☐ If yes, list:

Make and Model	Year	Class (From Registration)	Owner	Amount Owed	Used For Transportation Yes	Used For Transportation No
A.				$		
B.				$		
C.				$		
D.				$		
E.				$		

14. Do you or any family member own boats, campers (do not include trucks) motor homes, mobile homes, or trailers which are not used as a home and are not taxed as real property by the county? Yes ☐ No ☐ If yes, list:

Description	Year	Class (If Registered)	Owner	Purchase Price	Amount Owed	Only Means Of Transportation Yes	Only Means Of Transportation No
A.				$	$		
B.				$	$		
C.				$	$		
				$	$		

NOTE: If you think the value the Department of Motor Vehicles will give the items listed in 13 – 14 will be too high, you may provide three appraisals of the actual value and the average will be used.

15. List all your assets and the assets of all family members. If none, check the box marked "None".

ITEMS	None	FAMILY MEMBERS					
		Applicant	Spouse	CHILDREN Name:	Name:	Name:	Name:
a. Checks or money on hand or in the house		$	$	$	$	$	$
b. Money in checking account		$	$	$	$	$	$
c. Money in savings accounts, credit unions, or trust funds		$	$	$	$	$	$
d. Checks or money in safe deposit box or held for you		$	$	$	$	$	$
e. Stocks or bonds (market value)		$	$	$	$	$	$
f. Notes, mortgages, trust deeds, sales contracts (estimated market value)		$	$	$	$	$	$
g. Other -- Itemize:		$	$	$	$	$	$

COUNTY USE ONLY

For a, b, c and/or d income in the month included?
Yes ☐ No ☐ If yes, amount:
$_____

For a and/or b income from business or self-employment included?
Yes ☐ No ☐ If yes, amount:
$_____
(See 24C)

16. Do you or any family member have life insurance? Yes ☐ No ☐ If yes, list:

	INSURANCE COMPANY	1. Person Insured / 2. Policy Owned By	Face Value Of Insurance	Policy Number	Date Policy Issued	Current Cash Value
A.		1. / 2.	$			$
B.		1. / 2.	$			$
C.		1. / 2.	$			$

17. Do you or any family member own a burial reserve or trust? Yes ☐ No ☐

If Yes, Purchase price $_____ Amount owed $_____

$_____ $_____

For whom purchased _____

From whom purchased _____

18. Do you or any family member own a burial plot, vault or crypt? Yes ☐ No ☐

For use of immediate family? Yes ☐ No ☐

If for use of anyone other than a member of the immediate family, complete the following:

Description _____ Owned by _____

mated value $ _____ Amount owed $ _____

Location: _____

19. Do you or any family member own items of jewelry valued at more than $100 each? (Do not include wedding and engagement rings or heirlooms) Yes ☐ No ☐ If yes, list:

Description	Estimated Value	Amount Owed
A.	$	$
B.	$	$

20. Do you or any family member own business equipment, tools, inventory or material (including livestock or poultry not for personal use)? Yes ☐ No ☐ If yes, list:

Description	Estimated Value	Amount Owed
A.	$	$
B.	$	$
C.	$	$

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

Description of Item	Date of Transfer Sale or Gift	Value	Amount Received
A.		$	$
B.		$	$

22. Do you or any family member have any of the following sources of income. Check yes or no for each item and fill in the amounts received.

TYPE OF INCOME	Yes	No	FAMILY MEMBERS				
			Applicant	Spouse	CHILDREN Name:	Name:	Name:
Cash Grant (welfare), e.g., SSI/SSP (gold check) AFDC, GR or GA			$	$	$	$	$
Social Security: Type _____			$	$	$	$	$
Railroad Retirement			$	$	$	$	$
Nonmilitary Retirement or Pension			$	$	$	$	$
Unemployment			$	$	$	$	$
Disability Insurance: Check one: ☐ State ☐ Private			$	$	$	$	$
Worker's Compensation			$	$	$	$	$
Veteran's Benefits including GI Bill			$	$	$	$	$
Military Allotment			$	$	$	$	$
Child Support			$	$	$	$	$
Alimony			$	$	$	$	$
Payment from roomers			$	$	$	$	$
Monetary gifts/contributions			$	$	$	$	$
Interest income and dividends			$	$	$	$	$
Other: (Itemize)			$	$	$	$	$

COUNTY USE ONLY

Hairlooms?

Disposition of proceeds:

Note: Refer to transfer of property regs in Title 22.

Type of Cash Grant:

Verification (List):

Date Verified E.W.

23. Have you or any family member been employed at any time during this month? Yes ☐ No ☐ If yes, complete the following:

COUNTY USE ONLY

A. 1. Working Member's Name			
2. Name of Employer			
Address of Employer			
4. Days of Work Per Week	Days	Days	Days
5. Hours of Work Per Week	Hrs	Hrs	Hrs
6. How Often Paid (every week, twice a month, every two weeks, etc.)			
7. Day of the Week You Are Paid			
8. Gross (total) earnings per pay period (before deductions) (include tips). If self-employed, write self-employed here and complete No 24.	$	$	$
Deductions/Expenses (per pay period)			
1. Federal Income Tax	$	$	$
2. State Income Tax	$	$	$
3. Social Security	$	$	$
4. Mandatory Retirement	$	$	$
5. State Disability (SDI)	$	$	$
6. Mandatory Union Dues	$	$	$
7. Mandatory deduction for meals	$	$	$
8. Cost of tools, clothing, licenses or materials required solely for work	$	$	$
9. Child Care necessary for work	$	$	$
10. Other (except transportation) List:			
... Transportation to Work and for Child Care.			
a. Round trip miles per day.			
b. Type of transportation used (own car, someone else's car, car pool, bus, etc.)			
c. Costs (per pay period) — Amount paid by employee (if doesn't use own car)	$	$	$
— Amount paid by riders	$	$	$
— Amount paid by employer	$	$	$
d. Cost per pay period for parking, tolls, etc.	$	$	$
e. Is public transportation (bus, train, etc.) available?	Yes ☐ No ☐ Cost $	Yes ☐ No ☐ Cost $	Yes ☐ No ☐ Cost $

Verification (list)

Date Verified E.W.

Transportation cost allowed (Show Computation)

24. Are you or any family member self-employed? Yes ☐ No ☐ If yes, complete the following.

A. Name of business: _____

Type of business: _____

Location: _____

Verification
☐ Tax return
☐ Business records

Date Verified E.W.

Net profit from self-employment:

$

B. Adjusted Gross Income From Last Tax Statement.	He Income Changed Since Last Tax Statement		If No Tax Statement or Change in Income:	
	Yes	No	Estimated Yearly Gross Profit	Estimated Yearly Business Expenses
$			$	$
Cash On Hand For Business	Money in Checking Accounts for Business		Average Monthly Cash Expenditures for Business	
$	$		$	

25. Do you or any family member receive any of the following items free or in exchange for work you do?

Verification (list):

a. nt or housing	Yes ☐ No ☐	Who receives:	From whom:	
b. Food	Yes ☐ No ☐	Who receives:	From whom:	
c. Utilities	Yes ☐ No ☐	Who receives:	From whom:	
d. Clothing	Yes ☐ No ☐	Who receives:	From whom:	

Date Verified ____ E.W. ____

26. Are you or any family member in college or attending a similar educational institution?
Yes ☐ No ☐ If yes, complete the following:

	Student:	Student:	Student:
a. 1. Name of institution			
2. Status of student	Grad ☐ Undergrad. ☐	Grad ☐ Undergrad. ☐	Grad ☐ Undergrad. ☐
b. Grants, loans, scholarships, fellowships			
1. Amount received	$	$	$
2. Source(s) of grants, loans, etc.			
3. How often received			
c. Expenses Per Term			
1. Is term a semester, quarter, year			
2. Tuition/fees	$	$	$
3. Books, equipment and supplies	$	$	$
4. Child care necessary for school	$	$	$
5. Transportation to school—child care			
a. Round trip miles per day			
b. School attended how many days per week			
c. Type of transportation used (own car, someone else's car, car pool, bus, etc.)			
d. Costs (per month) — Amount paid by student (if doesn't use own car)	$	$	$
— Amount paid by riders	$	$	$
e. Parking, tolls, etc.			
f. Is public transportation (bus, train, etc.) available	Yes ☐ No ☐ Cost $	Yes ☐ No ☐ Cost $	Yes ☐ No ☐ Cost $

Verification (list):

Date verified ____ E.W. ____

Exempt:
☐ Entire amount
☐ Only expenses

Transportation costs allowed: (Show computation)

27. Do you or any family member pay child support or alimony under a court order or based on an agreement with the District Attorney? Yes ☐ No ☐ If yes, complete the following.

Amount Paid	By Whom	To Whom

28. Do you or any family member have health or hospitalization insurance, including insurance paid by an employer or absent parent? Yes ☐ No ☐ If yes, complete the following:

Coverage (Check)	Person(s) Insured	Monthly Premium Paid
☐ CHAMPUS		$
☐ Veterans Administration coverage (including CHAMPVA & VA outpatient)		$
☐ Kaiser		$
☐ Ross – Loos		$
☐ lue Shield		$
☐ Blue Cross		$
☐ Other ____		$

29. Do you or any family member have Medicare coverage? Yes ☐ No ☐ If yes, list:

Person Covered	Medicare Claim Number	Monthly Premium Deduction From Check		Monthly Premium Paid By You	
A.		Yes ☐	No ☐	Yes ☐	No ☐
B.		Yes ☐	No ☐	Yes ☐	No ☐
C.		Yes ☐	No ☐	Yes ☐	No ☐

Date Verified _____ E.W. _____

30. Have you or any family member made a down payment for medical care you will receive in the future? Yes ☐ No ☐ If yes,

Amount of Down Payment	To Whom Made	Medical Care To Be Received
$		

Payment used to bring property within property limits Yes ☐ No ☐

If yes:
☐ Notice to Provider

CA 5 ☐

CA 5 ☐

31. A. Have you or any family member ever been in the military service? Yes ☐ No ☐

B. Are you or any family member the spouse, parent or child of a person who has been in the military services? Yes ☐ No ☐

32. Have you or any family member applied for or do you or any family member think you are eligible for any payment/s you are not now receiving? Yes ☐ No ☐ If yes, complete the following.

Kind of Payment	Person Possibly Eligible	Date of Application Month/Day/Year	Date Expected Month/Date/Year
Social Security			
Disability Payments			
Veteran's Payments			
Unemployment Benefits			
Worker's Compensation			
Medicare			
Pending suit or insurance settlement for accident or injury			
Describe			

Date of accident/injury _____

COMPLETE ONLY IF THE FAMILY INCLUDES CHILDREN UNDER 21

33. Is a parent living in the home unemployed or working less than 100 hours per month? Yes ☐ No ☐ If yes, complete the following:

A. If Unemployed, Last Day Worked	Working Less Than 100 Hours		In School Or Training		Actively Seeking Full-Time Employment		Date Began Seeking Employment
Month / Day / Year	Yes	No	Yes	No	Yes	No	Month / Day / Year
/ /							/ /

B. In the last 30 days has the unemployed parent:

Quit a job or employment related training? Yes ☐ No ☐
Refused a job or employment related training? Yes ☐ No ☐
If yes, explain why:

Good cause Yes ☐ No ☐

C. Did the unemployed parent receive or was he/she eligible to receive unemployment insurance benefits within the last 12 months? Yes ☐ No ☐

D. Did the unemployed parent earn $50 or more or attend 5 days or more of work training in the last 20 quarters? Yes ☐ No ☐ If yes, complete the following:
(Enter the year and check the appropriate quarters)

YEAR	19 ____				19 ____				19 ____				19 ____				19 ____			
QUARTER	Jan. Mar.	Apr. Jun.	Jul. Sep.	Oct. Dec.	Jan. Mar.	Apr. Jun.	Jul. Sep.	Oct. Dec.	Jan. Mar.	Apr. Jun.	Jul. Sep.	Oct. Dec.	Jan. Mar.	Apr. Jun.	Jul. Sep.	Oct. Dec.	Jan. Mar.	Apr. Jun.	Jul. Sep.	Oct. Dec.
Or																				
Work Training																				

34. Services (these questions do not affect your eligibility for Medi-Cal)

a. Are you interested in physical examinations for any family member under 21 through the Child Health Disability Prevention Program? Yes ☐ No ☐

b. Are you interested in information on the Family Planning Program? Yes ☐ No ☐

c. Are you interested in talking to a Social Services worker about other services which may be available to you? Yes ☐ No ☐ If yes, explain:

☐ CHDP Brochure Given

Date

☐ CHDP Referral

☐ Social Services Referral

35. Additional information. Please give the item number in the column to the left:

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 in the number of persons in the household, or of any change of address, and I agree to meet all other responsibilities explained in the "Medi-Cal Responsibilities Checklist" I have received.
- I understand that I may be asked to prove my statements, and that my eligibility may be subject to a quality control review.
- I understand that the county is required by law to keep all information I provide confidential.
- I understand that if I am dissatisfied with actions taken by the County Welfare Department, I have the right to a State 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 MEDI-CAL CARD AND/OR I CAN BE PROSECUTED FOR FRAUD.

Signature of Applicant		Date
Signature of Person Acting For Applicant	Relationship	Date
Signature of Witness (If Applicant Signed With Mark)		Date
Signature of Person Helping Applicant Complete Form	Address	Date
COUNTY USE ONLY	E. W. Signature	
	Date	