STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

EDMUND G. BROWN JR., Governor

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

June 29, 1981

To: All County Welfare Directors

Letter No. 81-26

REDETERMINATION FOR PERSONS IN LONG-TERM CARE (LTC) WITHOUT A SPOUSE AND/OR CHILDREN (FORM 262)

This letter obsoletes Letter 81-10. The Department has developed a simplified Statement of Facts form to be used for redeterminations for persons in LTC who do not have a spouse and/or children. This form, MC 262, (copy attached), may not be used when the person in LTC has a spouse or children under 21 living at home. If the person in LTC does have a spouse or children under 21 at home, the MC 210 must be completed at the time of redetermination. An MC 210 is still required at the time of initial application in all LTC cases.

This LTC redetermination form was developed because of requests made by various county departments. The basis in regulations for allowing the use of this form in Title 22, CAC, Section 50113. Sections 50161 and 50189 will be revised as soon as possible to allow for use of the MC 262. Until then, this letter constitutes approval by the Department, as called for by Section 50113, for counties to use form MC 262 as described above instead of form MC 210.

Supplies of this form are available from the Department of Health Services Warehouse.

If you have any questions, please contact your program consultant.

Sincerely,

Original signed by

Madalyn M. Martinez, Chief
Medi-Cal Eligibility Branch

Attachment

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

Expiration Date: July 1, 1982

# 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:

nsurance 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.
'AD 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.

| | |
|---|---|
| gnature of Beneficiary | Date |
| gnature of Person Acting For Beneficiary | Date |
| gna' of Witness (If beneficiary signed with mark) | Date |
| W. Signature | Date |