STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF HEALTH SERVICES

714/744 P STREET
SACRAMENTO, CA 95814

August 8, 1983

To: All County Welfare Directors

Letter No. 83-51

BELTRAN V. MYERS

Reference: All County Welfare Directors (ACWD) Letters 82-24, 82-30 and 83-43

In accordance with the July 28, 1983 order of the United States District Court in the Beltran v. Myers lawsuit, counties shall immediately begin: 1) to determine retroactive eligibility for those persons whose cases were flagged previously as potential class members; and, 2) to identify potential class members who applied for Medi-Cal on or before June 30, 1981 and were either denied or terminated as a result of a transfer of resources per Section 50408 and 50409 of Title 22 of the California Administrative Code (22 CAC).

Persons Already Identified as Potential Class Members

The court order requires that those persons whose case was flagged as a potential class member (refer to ACWD Letters No. 82-24 and 82-30) and for whom retroactive eligibility has not yet been evaluated, shall be re-evaluated immediately. In addition, all persons who have contacted the county as a result of recent news articles regarding this lawsuit, must also be evaluated for eligibility. Counties must, therefore, immediately send (in a forwardable envelope) the Beltran application information letter (Attachment I), the court-ordered notice (Attachment II), the Beltran application (Attachment III), and a postage paid envelope to these potential class members. A list of all persons to whom this package is sent must be submitted to this Department within 10 days of the date of this letter (Attachment IV). Specific instructions on determining retroactive eligibility (e.g., a description of past eligibility criteria) will be transmitted within the next two weeks.

The Department of Health Services (DHS) is finalizing reimbursement procedures to be followed by the Beltran class members, counties and the State. These procedures will be transmitted with the letter containing instructions on determining retroactive eligibility.

Identification and Notification of Potential Class Members

Counties must immediately begin to identify those ABD-MN persons who applied for Medi-Cal on or before June 30, 1981 and were denied or terminated due to a transfer of resources (exempt or non-exempt, real or personal property). This may be accomplished by computer identification of all closed ABD-MN cases listed on the master index, a review of closed cases, or a combination of these methods. Counties must inform the DHS immediately of the method they will use to identify these persons.

Each potential Beltran class member identified must be provided with a copy of the court-ordered notice in both English and Spanish. In addition, DHS has developed a cover letter (see Attachment V) to be sent with the required notice explaining: 1) that requests for retroactive coverage must be received within 90 days of the issuance of the court-ordered notice; 2) that present Medi-Cal eligibility will not be affected by whether or not the potential class member responds to this notice; 3) basic verification requirements; and 4) that any information provided will be kept confidential. This cover letter must be sent to each potential class member.

The cover letter, court-ordered notice and a postage-paid return envelope must be mailed (in a forwardable envelope) to the last known address shown in the case record for the potential class member. In addition, these items should also be sent to the last known authorized representative shown in the case record.

Should any of these notices be returned by the postal service as nondeliverable, the county should verify that the notice was sent to the correct address as shown in the case record. If the notice was sent to an incorrect address it must be reissued to the correct address. If it was sent to the correct address, the returned notice should be filed in the case. The case may be returned to closed files but must be kept segregated and must not be destroyed pending further instructions from the DHS.

If the county is notified that the potential class member is deceased, reasonable efforts should be made to contact the estate representative of the deceased. This may include reviewing the case record to determine if there is the name and address of a relative to whom the notice can be sent. Any attempts to locate an estate should be documented in the case record.

The order also requires DHS to provide to the court a certification setting forth the names and addresses of all persons and estates so notified. Accordingly, the names and addresses of all individuals and estates to whom a notice was sent, should be provided to the Department no later than the 15th of each month until the county has completed its notification responsibilities. (See Attachment VI.)

County Administrative Expenses

The Department wishes to maintain an accurate record of all the costs associated with implementing the court's decision. Therefore, counties should track these costs separately and have them available if the Department should need them.

The Department is seeking funding to forward to the counties to perform the notification requirement. Advances will begin as soon as the estimated costs are determined and funding is obtained.

Other Information

It is possible that further court procedings in the Lynch v. Dawson (Title II Disregard) lawsuit may also result in an order to search all open and closed ABD-MN case files back to April 1977. Therefore, in those counties that must manually search closed ABD-MN files as required by Beltran, counties should also flag cases in which: 1) Title II (OASDI) and SSI/SSP income were received concurrently at any time since April 1977 (including Ramos cases); and 2) Medi-Cal was received under aid code 16, 26, or 66 and later transferred to MN.

If you should have any questions regarding Beltran v. Myers, please contact Marie Harder at (916) 445-1797. Any questions regarding Lynch v. Dawson should be directed to Kristi Banion at the same number. Questions of a fiscal nature can be referred to the County Administrative Expense Unit at (916) 322-3390.

Sincerely,

ORIGINAL SIGNED BY

Caroline Cabias, Chief
Eligibility Branch

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

MEDI-CAL
BELTRAN v. MYERS
APPLICATION INFORMATION

Date: ____________________

State No: ________________

District: ________________

In a recent court decision called Beltran v. Myers we were ordered to notify you regarding your potential eligibility to have the Medi-Cal program pay for some of your past medical expenses. IMPORTANT-READ THE ATTACHED NOTICE.

After reading the attached notice, if you wish to apply for retroactive Medi-Cal coverage, please complete the attached application form and return to us within within 90 days of the date shown above. A self-addressed envelope is enclosed for your convenience. YOU WILL NOT BE ALLOWED TO APPLY FOR RETROACTIVE MEDI-CAL UNDER BELTRAN V. MYERS UNLESS YOU RESPOND TO THIS NOTICE WITHIN 90 DAYS. If you are receiving Medi-Cal now, your present eligibility will not be affected by whether or not you respond to this notice.

To determine your eligibility for those months for which you request retroactive coverage, you or your representative will be required to attend an interview with an Eligibility Worker. After we receive your application, we will schedule an interview for you and send you notification of the date and time you are to come in. At the interview, you may be required to provide verification of such things as the amount of income and resources you had and the type and cost of any medical services received and for which you request reimbursement. As such, you should only request retroactive coverage for those months in which you incurred medical expenses and for which you can verify the type of service received, its cost and how much, if any, you paid.

IMPORTANT NOTICE

YOU MAY BE ELIGIBLE TO BE REIMBURSED FOR MEDICAL COSTS THAT WERE PAID OR ARE OWED FOR NECESSARY HEALTH CARE WHICH SHOULD HAVE BEEN PAID FOR BY MEDI-CAL.

California has a rule -- known as a "transfer of assets" rule -- by which state officials have denied Medi-Cal eligibility to people who transferred or gave away property before applying for Medi-Cal. Our records indicate that you may be one of those people.

A federal court in Los Angeles has recently declared that state rule invalid. THE COURT ORDERED THE STATE TO NOTIFY PEOPLE WHO WERE DENIED ELIGIBILITY IN THE PAST BECAUSE OF THIS RULE THAT THEY MAY BE ABLE TO RECOVER AMOUNTS WHICH WERE SPENT OR OWED IN THE PAST which the Medi-Cal program should have been paying for. If you have ever been denied Medi-Cal because you transferred, sold, or gave away property to someone else, there are steps you can take which could lead to your recovering for the bills you incurred during the period when the State said you were ineligible for Medi-Cal. You could be eligible to recover these past amounts <u>even if you are now eligible for and receiving Medi-Cal</u>.

In accordance with the court's order, the Department of Health Services is obligated to redetermine whether you would have been eligible for Medi-Cal if the State had not been using the "transfer of assets" rule. In order to determine what amount, if any, you (or your doctor, pharmacist, nursing home, etc.) are entitled to, you should contact your local Medi-Cal district office and arrange for a new determination of your past eligibility. You or your representative should be prepared to bring any records which would indicate the nature and amount of medical expenses which you, your relatives, or friends may have incurred as a result of the State previously denying your application.

If you are dissatisfied with the new determination, either because the State says that you were still ineligible for that period or because the State decides to repay you less than the amount you think is right, you will have an opportunity to seek a fair hearing and to otherwise contest the State's decision, just as you would in any other situation where the State decides against you.

Although you are under no obligation to take any action in reponse to this letter, <u>it is to your benefit to do so</u>. You may be eligible to be reimbursed for bills you have already paid, or to have outstanding bills paid for under Medi-Cal.

If you have any questions about this letter and the procedure it discusses, you should contact your attorney, or your nearest legal aid or legal assistance for the elderly office, or your local county welfare office. You can also contact your local Medi-Cal office if you want to ask about the situation.

PETER RANK, DIRECTOR
CALIFORNIA DEPARTMENT OF HEALTH SERVICES

AVISO IMPORTANTE

USTED PUEDE SER ELEGIBLE PARA QUE SE LE REEMBOLSE POR GASTOS MEDICOS
EN QUE INCURRIO PARA EL CUIDADO DE LA SALUD
LOS CUALES FUERON PAGADOS O ESTAN PENDIENTES
Y DEBERIAN HABER SIDO PAGADOS POR MEDI-CAL.

California tiene un reglamento — conocido como el reglamento de "transferencia de bienes" -- por el cual los funcionarios del Estado han negado la elegibilidad para Medi-Cal a personas que transfirieron o regalaron propiedades antes de solicitar Medi-Cal. Nuestros registros indican que Ud. puede ser una de esas personas.

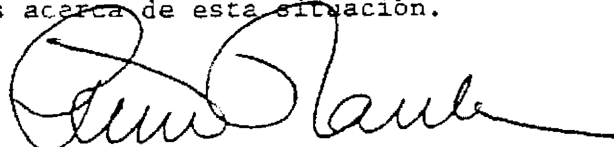
La corte federal en Los Angeles recientemente ha declarado sin efecto este reglamento. LA CORTE ORDENO AL ESTADO NOTIFICAR A LAS PERSONAS A QUIENES SE LES NEGO LA ELEGIBILIDAD EN EL PASADO DEBIDO A ESTE REGLAMENTO, QUE ELLAS PUEDEN ESTAR CAPACITADAS PARA RECOBRAR LAS SUMAS QUE GASTARON O QUE DEBEN POR ESE TIEMPO por las cuales el programa de Medi-Cal debería haber pagado. Si a Ud. se le ha negado alguna vez Medi-Cal porque transfirió, vendió o regaló una propiedad a alguien, hay pasos que Ud. puede seguir que lo pueden conducir a recobrar los gastos en que incurrió durante el período en que el Estado le informó que Ud. era inelegible para Medi-Cal. Usted puede ser elegible para recuperar esas sumas que gastó en el pasado <u>aún si Ud. es elegible para Medi-Cal y ahora lo está recibiendo</u>.

De acuerdo a la orden de la corte, el Departamento de Servicios de Salud está obligado a determinar de nuevo si Ud. habría sido elegible para Medi-Cal en caso que el Estado no hubiera usado el reglamento de "transferencia de bienes". A fin de determinar que suma, si hay alguna, Ud. puede recibir, Ud. (o su médico, farmacéutico o los servicios de residencia con cuidado médico, etc.) debe ponerse en contacto con su oficina local de Medi-Cal del distrito y arreglar para una nueva determinación de su elegibilidad en el pasado. Usted o su representante deben estar preparados para traer cualquier documento que indique la naturaleza y la cantidad de los gastos médicos que Ud., sus familiares o amigos pueden haber incurrido como resultado de la negativa del Estado a su anterior solicitud.

Si Ud. no está de acuerdo con la nueva determinación, ya sea porque el Estado todavía dice que es inelegible por ese período o porque el Estado decide pagarle menos de la suma que Ud. piensa es la correcta, Ud. tendrá la oportunidad de solicitar una audiencia y así debatir la decisión del Estado, tal como lo haría en cualquier otra situación cuando el Estado decida en contra de usted.

Aunque Ud. no está obligado(a) a tomar cualquier acción con respecto a esta carta, <u>es en su propio beneficio el hacerlo</u>. Usted puede ser elegible para que Medi-Cal le reembolse por facturas que Ud. ya ha pagado o por facturas pendientes de pago.

Si Ud. tiene algunas preguntas acerca de esta carta y del procedimiento sobre el cual trata, Ud. debe ponerse en contacto con su abogado o con la oficina de ayuda legal más cercana o con la oficina de asistencia legal para gente de edad o con su oficina local de bienestar del condado. Usted también puede ponerse en contacto con su oficina local de Medi-Cal si Ud. desea saber más acerca de esta situación.



PETER RANK, DIRECTOR
DEPARTAMENTO DE SERVICIOS DE SALUD DE CALIFORNIA

BELTRAN V. MYERS

Application For Retroactive Coverage

SE USE INK

Applicant's Name (Print)	First	Middle	Last	COUNTY USE ONLY
Home Address Number	Street	City	Zip Code	Case Name:
Mailing address (If different from above)				State No.:
Home phone	Work phone	Message phone	Person with whom to leave message	App/Redetermination Date:

3. I (We) incurred medical expenses in each of the following months and I (we) are requesting Medi-Cal to pay for my medical expenses (retroactive coverage) for each of the following months:

COMPLETE QUESTIONS 4–27 DESCRIBING YOUR CIRCUMSTANCES DURING THE EARLIEST MONTH FOR WHICH YOU REQUEST RETROACTIVE COVERAGE.

FAMILY MEMBERS

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

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
Applicant SS #		/ /				Date					
Spouse SS #		/ /				Date					

Verification of SS #

	Date	E.W.
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

b. List all your and your spouse's unmarried children who were under 21 (be sure to list unborn children). Also, include any children out of the home for whom you requested Medi-Cal or whom you claimed as a deduction for income tax purposes.

Tax Record Verification

	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 Ch: Yes	N
S #		/ / Place			(1) (2)								
S #		/ / Place			(1) (2)								
S #		/ / Place			(1) (2)								
S #		/ / Place			(1) (2)								

Did you or any family member have a home outside California? Yes ☐ No ☐
If yes, were you or any family member working or looking for work in California? Yes ☐ No ☐
If no, explain why you were in California.
During the month for which I am requesting retroactive coverage I lived at:

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

Name of Alien	Alien Registration Number

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

Did you or any family member have a physical or emotional problem which made 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)

Complete the following information about your living arrangements for the time you are requesting coverage:

☐ Rented a room, apartment, house or trailer $______ Rent
☐ Paid for room and board $______ Room and board
☐ Worked in exchange for room and board
☐ Received free room
☐ Received free room and board
☐ Lived in a board and care facility
☐ Lived in a nursing home or hospital
Date entered ______ Date returned home ______
☐ Lived in and owned/buying a trailer, mobile home, boat or motor vehicle which was not taxed as real property by the county.
Description:
Estimated value $ ______ Amount owed $ ______
☐ Lived in and owned/buying a home or a trailer or mobile home which was taxed as real property by the county.
Assessed value $ ______ (from tax statement) Amount owed $______
Land home was located on includes more than one parcel. Yes ☐ No ☐ If yes, complete 9.
Land home was located on includes more than one acre. Yes ☐ No ☐ If yes, complete 9.
☐ Other living arrangements. Describe:

Did you or any member of your family own real property which you did not then live in (for example, land or buildings) or a trailer or mobile home which was taxed as real property by the county and which you did not then live in? Yes ☐ No ☐
If yes:

Description:

Address:

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

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 ☐				

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

COUNTY USE ONLY

Where required, date CA 6 signed

☐ Verification of Disability/blindness (lis

Date Verified E.W.
☐ Disability referral

Date Sent

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

Verification of Property

Date Verified E.W.

Verification of "Good Cause" for unutilized property.

Date Verified E.W.

Verification of Income (li

Date Verified E.W.

☐ Revocable
☐ Irrevocable

1A. Did 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 Then Owed	Used For Transportation Yes	Used For Transportation No
A.					$		
B.					$		
C.					$		
D.					$		
E.					$		

1B. Did you or any family member own boats, campers (do not include trucks) motor homes, mobile homes, or trailers which were not used as a home and were 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.					$	$		
D.					$	$		

2. List all your assets and the assets of all family members during the first month for which you are requesting coverage. If none, check the box marked "None."

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

COUNTY USE ONL

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 (self-employment includ Yes ☐ No ☐ If yes, amount: $

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

COUNTY USE ONLY

INSURANCE COMPANY	1. Person Insured 2. Policy Owned By	Face Value Of Insurance	Policy Number	Date Policy Issued	Cash Value
	1. 2.	$			$
	1. 2.	$			$
	1. 2.	$			$

4. Did 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 ____________

5. Did 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 ____________

Estimated value $ ____________ Amount owed $ ____________

Location: ____________

6. Did 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:

Heirlooms?

Description	Estimated Value	Amount Then Owed
	$	$
	$	$

7. Did 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 Then Owed
	$	$
	$	$
	$	$

COUNTY USE ONL

18. Had you or any family member transferred, sold, or given away any property (including money) at any time since you first applied for Medi-Cal? Yes ☐ No ☐ If yes, list: Yes ☐ No ☐ If yes, list:

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

Disposition of proceed

19. Did 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. Include loans, date loan received, and whether or not loan is repayable in "Other."

TYPE OF INCOME	Yes	No	FAMILY MEMBERS		CHILDREN		
			Applicant	Spouse	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)			$	$	$	$	$

Type of Cash Grant:

Verification (List):

Date Verified E.W.

coverage? Yes ☐ No ☐ If yes, complete the following:

COUNTY USE ONLY

Verification (list)

1. Working Member's Name			
2. Employer's Name			
3. 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 21.	$	$	$
9. Occupation			

1. Did you pay child care necessary for work? Yes ☐ No ☐ $ ____________ monthly amount

2. Did you pay for the care of an incapacitated adult living in your home in order to be able to work? Yes ☐ No ☐

$ ____________ monthly amount Name: Relationship:

Anticipated Income. If your income varies from month to month, show your actual gross income for the current month in Month 1 and your estimated gross income for the following two months in Month 2 and 3.

Name and Occupation	Month 1	Month 2	Month 3
	$	$	$
	$	$	$
	$	$	$

Additional Information. Explain reasons for entries in C. Also, state any facts concerning your employment which may affect future months (for example, temporary employment).

Were you or any family member self-employed? Yes ☐ No ☐ If yes, complete the following. If no, proceed to question 22.

Name of business: ____________

Type of business: ____________

Location: ____________

Verification
☐ Tax return
☐ Business records

Date Verified ____ E.W. ____

Net profit from self-employment:

$

Adjusted Gross Income From Last Tax	If No Tax Statement or Change in Income:	
	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
$	$	$

22. Did you or any family member receive any of the following items free or in exchange for work you did?				
A. Rent or housing	Yes ☐	No ☐	Who receives:	From whom:
Food	Yes ☐	No ☐	Who receives:	From whom:
C. Utilities	Yes ☐	No ☐	Who receives:	From whom:
D. Clothing	Yes ☐	No ☐	Who receives:	From whom:

23. Were you or any family member in college or attending a similar educational institution?
Yes ☐ No ☐ If yes: ☐ Full-time ☐ Part-time

24. Did 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		$
☐ Blue Shield		$
☐ Blue Cross		$
☐ Other ______		$

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

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

26. Had 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 Received

27. A. Have you or any family member ever been in U. S. military service? Yes ☐ No ☐

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

COUNTY USE ON

Verification (list):

Date Verified E.W.

Date HRB 2 Complete

Date Verified E.W.

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

If yes:
☐ Notice to Provider

CA 5 ☐

CA 5 ☐

MPLETE THIS SECTION FOR ANY CHANGES WHICH OCCURRED AFTER THE FIRST MONTH FOR WHICH YOU ARE REQUESTING TROACTIVE COVERAGE (ATTACH ADDITIONAL SHEETS AS NECESSARY).

cumstances that are/were different: (If no change, write in "No change.")

Circumstances	Month:	Month:	Month:
nber of persons living in your ne			
ome— Specify any differences in: Amount of income Kind of income Work expenses Education expenses			

All Personal Property including motor vehicles (Lowest bank account balances should be listed for each month unless they were exactly the same as the balance listed on the Statement of Facts.)			
Real Property			
California Residence			
Other			

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 persons 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, or any change in other health insurance coverage, 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 Section 700.1 of the Probate Code and Section 14009.5 of the Welfare and Institutions Code provide for the recovery of all Medi-Cal benefits received after age 65 from the estate of a Medi-Cal beneficiary if there is no surviving spouse, minor children, or totally disabled children.
- 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

ATTACHMENT IV

Return to: Department of Health Services
714 P Street
Sacramento, CA 95814
Attn: Marie Harder

County ______________________

Contact ______________________

Phone ______________________

Date ______________________

BELTRAN CLASS MEMBERS ALREADY IDENTIFIED

Name	Address	Case Number

MEDI-CAL
BELTRAN v. MYERS
AVAILABILITY OF RETROACTIVE COVERAGE

Date: ____________________

State No: ____________________

District: ____________________

In a recent court decision called Beltran v. Myers we were ordered to notify you regarding your potential eligibility to have the Medi-Cal program pay for some of your past medical expenses. IMPORTANT - READ THE ATTACHED NOTICE.

After reading the attached notice, if you wish to apply for retroactive Medi-Cal coverage, please complete the bottom portion of this page and return to us within 90 days of the date shown above. A self-addressed envelope is enclosed for your convenience. We will send you the necessary forms to complete once you have responded to this inquiry. YOU WILL NOT BE ALLOWED TO APPLY FOR RETROACTIVE MEDI-CAL UNDER BELTRAN V. MYERS UNLESS YOU RESPOND TO THIS NOTICE WITHIN 90 DAYS. If you are receiving Medi-Cal now, your present eligibility will not be affected by whether or not you respond to this notice.

To determine your eligibility for those months for which you request retroactive coverage, you may be required to provide written verification of such things as the amount of income and resources you had and the type and cost of any medical services received and for which you request reimbursement. You do not have to submit this information until you receive further notice from us.

Any information you provide to us in response to this letter will be kept confidential in accordance with Welfare and Institutions Code, Section 14100.2.

- -

(Detach Here)

Date: ____________________

State No: ____________________

District: ____________________

I am a potential Beltran class member and request retroactive coverage.

Name ____ Phone ______________

Address ____

MEDI-CAL
BELTRAN v. MYERS
DISPONIBILIDAD DE COBERTURA RETROACTIVA

Fecha: ________________

No. del Estado: ________

Distrito: ____________

En una reciente decisión de la corte llamada Beltran v. Myers se nos ha ordenado notificar a Ud. en relación a su posible elegibilidad para que el programa de Medi-Cal le pague por alguno de sus gastos médicos en el pasado. ES MUY IMPORTANTE QUE UD. LEA EL AVISO INCLUSO.

Después de leer ese incluso, si Ud. desea solicitar la cobertura retroactiva de Medi-Cal, por favor llene la parte inferior de esta página y devuélvanosla dentro de los 90 días de la fecha arriba indicada. Le incluimos para su conveniencia un sobre ya listo para despachar. Le enviaremos los formularios necesarios tan pronto como Ud. haya contestado nuestro requerimiento. USTED NO SERA APTO PARA SOLICITAR EL PAGO RETROACTIVO DE MEDI-CAL BAJO BELTRAN v. MYERS A MENOS QUE CONTESTE ESTE AVISO DENTRO DE 90 DIAS. Si Ud. está recibiendo ahora Medi-Cal, su elegibilidad actual no será afectada ya sea que responda o no a este aviso.

Para determinar su elegibilidad por los meses por los cuales solicita cobertura retroactiva, se le puede pedir verificación escrita de ciertos datos tales como el monto de los ingresos y recursos que tenía y el tipo y costo de cualquier servicio médico recibido por los cuales está Ud. solicitando el reembolso. Usted no tiene que suministrar esta información hasta que no reciba nuevo aviso de nosotros.

Cualquier información que Ud. nos dé en respuesta a esta carta será guardada en forma confidencial de acuerdo al Código de Bienestar e Instituciones Sección 14100.2.

(Envíe esta parte)

Fecha: ________________

No. del Estado: ________

Distrito: ____________

Soy un posible candidato para el grupo Beltran y solicito cobertura retroactiva.

Nombre ______________________________ Teléfono ____________

Dirección ____

Return to: Department of Health Services
714 P Street
Sacramento, CA 95814
Attn: Marie Harder

County ______________________

Contact ______________________

Phone ______________________

Date ______________________

BELTRAN CLASS MEMBERS NOTIFIED

Name	Address	Case Number