STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814

December 15, 1983

To: All County Welfare Directors Letter No. 83- 81

STATE CORRECTIVE ACTION INITIATIVE - MEDI-CAL CARD STUFFER

Over the past several months, Department of Health Services (DHS) has issued a series of letters dealing with Quality Control and Corrective Action. This letter is another in the series.

Quality Control (QC) Error

Medi-Cal beneficiaries fail to report changes in income, living arrangements, or other eligibility factors timely to county welfare departments. This causes eligibility or share-of-cost errors.

Corrective Action

DHS has produced a Medi-Cal card stuffer which reminds beneficiaries of their reporting responsibilities. Attached is a draft (Attachment 1) of the stuffer. The stuffer will be sent to all Medi-Cal eligibles, with the exception of SSI/ SSP beneficiaries (aid codes 10, 20, 60), with their January 1984 Medi-Cal cards.

County Action

Because this initiative is part of our federal QC Corrective Action Plan, it is necessary that we have sufficient information to evaluate the impact of the stuffer. Therefore, we request the county to evaluate whether the warning stuffer appears to cause an increase in the number of beneficiaries who report changes timely. Please distribute copies of the attached evaluation sheet (Attachment 2) to appropriate staff. The information should then be consolidated and returned by March 15, 1984 to:

Corrective Action Unit
Eligibility Branch
714 P Street, Room 1692
Sacramento, CA 95628

If you have any questions, please contact the Corrective Action Unit analyst assigned to you. Thank you for your assistance and feedback.

Sincerely,

ORIGINAL SIGNED BY

Caroline Cabias, Chief
Eligibility Branch

Attachment

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

Attachment I

STATEMENT OF FACTS FOR MEDI-CAL

PLEASE USE INK

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.

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

Verification of identity

Date EW

Verification of SS No.

1. Date EW
2.
3.
4.
5.
6.

Tax Record Verification

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.

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 No.						Date					
2. Spouse SS No.						Date					

3B. List all your and your spouse's unmarried children under 21 (be sure to list unborn children). Also, include any children out of the home for whom you are requesting Medi-Cal or whom you claim as a deduction for income tax purposes.

	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
SS No. 3.		Place			(1) (2)								
SS No. 4.		Place			(1) (2)								
SS No. 5.		Place			(1) (2)								
SS No. 6.		Place			(1) (2)								
SS No. 7.		Place			(1) (2)								
8.		Place			(1) (2)								

3C. 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.

3D. List the names and addresses of all persons listed in 3A or 3B if they are not living in your home.

Name	Address

4. Is there anyone other than you or your immediate family members living with you, such as roommate, housemate, or relative? Yes ☐ No ☐ If yes:

Name	Relationship

5A. 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:

B. Do you or any family member have 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.

6. ARE ANY OF THE PERSONS LISTED IN 3A OR 3B ALIENS? Yes ☐ No ☐
If YES, complete:

Name of Alien	Alien Registration Number

7. Have you or any family member ever applied for or received in California or any other state:
AFDC Cash Assistance Yes ☐ No ☐ Medi-Cal Yes ☐ No ☐ Food Stamps Yes ☐ No ☐
SSI/SSP Gold Check Yes ☐ No ☐ Other Welfare Benefits Yes ☐ No ☐
If you answered yes on any item, complete the following:

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

8. 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 Those 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)

C. If the problem described in 9B was caused by an injury or accident, are you seeking compensation through an insurance settlement or lawsuit? Yes ☐ No ☐

COUNTY USE ONLY

Where required, date CA E signed.

- Receiving or ar for cash grant or -Ca around August 1972? I yes, check for 20% SS increase eligibility.
- Four-month continuing eligibility?
- SGA disabled?
- Title II disregard?
- 30 + 1/3 earnings ex emption?

Retroactive application

Retro only ☐
Retro and cont. ☐

☐ Verification of disability/blindness (list)

Date Verified EW

☐ Disability ref

Date Sent

☐ Referral to Medi-Cal recovery

10. Complete the following information about your living arrangements:

- ☐ Rent a room, apartment, house, or trailer $_____ Rent
- ☐ Pay for room and board $_____ 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 _____
- ☐ 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 $_____ Monthly payment $_____
- ☐ 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 $_____ Monthly payment $_____
  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:

COUNTY USE ONLY

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

Verification of property

Date Verified EW

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 ☐

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 ☐			

Verification of "good cause" for unutilized property

Date Verified EW

Verification of income and expenses (list)

Date Verified EW

12. Do 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
				$		
				$		
				$		
				$		
				$		

Verification of nonexempt vehicles

Date Verified EW

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
				$	$		
				$	$		
				$	$		
				$	$		

Verification of personal property

Date Verified EW

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. DO YOU OR YOUR FAMILY HAVE ANY OF THE RESOURCES LISTED BELOW? Check each item. If YES, explain below.

	YES	NO		YES	NO
A. Checks (at home or elsewhere)	☐	☐	I. Notes, mortgages, trust deeds, sales contracts	☐	☐
B. Cash (on hand or elsewhere)	☐	☐	J. Trust fund	☐	☐
C. Checking account	☐	☐	K. Stocks, bonds, or certificates	☐	☐
D. Savings account	☐	☐	L. Other resources which can be quickly changed into cash (specify)_____	☐	☐
E. Credit union account	☐	☐			
F. Certificates of deposit	☐	☐			
G. Treasury bills	☐	☐			
H. Money market funds	☐	☐			

Type of Resource	Owner	Current Value	Name and Address of Banks, etc.	Account Number
		$		
		$		
		$		

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_____

Estimated 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.	$	$

COUNTY USE ONLY

For A, B, C, D, and/or E Income in the month included? Yes ☐ No ☐ If yes amount:

$_____

For A, B, and/or C Income from business or self-employment included? Yes ☐ No ☐ If yes amount:

$_____

(See 26C)

Date Verified EW

Total CSV $_____

Date Verified EW

Current value

$_____

Date Verified EW

Heirlooms?

Appraised value

$_____

or poultry not for personal use)? Yes ☐ No ☐ If yes, list:

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

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. If yes, explain below. Include loans, date loan received, and whether or not loan is repayable in "Other."

A. TYPE OF INCOME

	Yes	No
Cash grant (welfare), e.g., SSI/SSP (gold check), AFDC, GR, or GA	☐	☐
Social Security: i.e., Retirement, Survivors, Disability	☐	☐
Railroad Retirement	☐	☐
Nonmilitary retirement or pension	☐	☐
Unemployment Insurance Benefits (UIB)	☐	☐
bility insurance: check one: state ☐ private	☐	☐
Workers' Compensation	☐	☐
Veteran's benefits including GI Bill	☐	☐
Military retirement	☐	☐
Military allotment	☐	☐
Child support	☐	☐
Alimony	☐	☐
Payment from roomers	☐	☐
Monetary gifts/contributions	☐	☐
Interest income and dividends	☐	☐
Other (itemize)	☐	☐

B. Name of Person Receiving Income	Type of Income	Date Received (or Expected)	Amount	How Often? (Weekly, Monthly)

C. Do you receive or expect to receive a cost-of-living increase to this income one or more times a year? Yes ☐ No ☐ If yes, give date of last and next cost-of-living increase.
Last _____ Next _____

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

A. Rent 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:

24. 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

COUNTY USE ONLY

Disposition of proceeds:

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

Type of cash grant:

Verification (list):

Date Verified EW

Verification (list):

Date Verified EW

Yes ☐ No ☐ If yes, complete the following:

COUNTY USE ONLY

A.	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. 26.	$	$	$
	9. Occupation			

Verification (list)

☐ Wage stubs

☐ Tips

B. 1. Do you pay child care necessary for work? Yes ☐ No ☐ $_____ monthly amount

2. Do 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 _____

Verification of dependent care

_____ _____
Date Verified EW

C. 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 Month 3.

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

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

26. Are you or any family member self-employed? Yes ☐ No ☐ If yes, complete the following. If no, proceed to question 27.

Verification
☐ Tax return
☐ Business records

A. Name of business _____

Type of business _____

Location _____

_____ _____
Date Verified EW

B. Adjusted Gross Income From Last Tax Statement	Has Income Changed Since Last Tax Statement		If No Tax Statement or Change in Income:	
	Yes	No	Estimated Yearly Gross Profit	Estimated Yearly Business Expenses
$			$	$

Net profit from self-employment:

$

C. Cash on Hand for Business	Money in Checking Accounts for Business	Average Monthly Cash Expenditures for Business
$	$	$

~~SKIP IF THE FAMILY INCLUDES CHILDREN UNDER 21.~~

Is a parent living in the home unemployed or working less than 100 hours per month? If yes, COMPLETE THE FOLLOWING FOR THE CHILD(REN)'S PARENT(S) WHO IS/ARE LIVING IN THE HOME:

A. FIRST PARENT (name _____). List employment and training history for the past five years. Begin with this person's last job or training.

	Name of Employer or Training Program	Work or Training ✓ Check	When Employed From / / mo dy yr To / /	Amount Paid	Name of Employer or Training Program	Work or Training ✓ Check	When Employed From / / mo dy yr To / /	Amount Paid
1.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	7.	☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly
2.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	8.	☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly
3.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	9.	☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly
4.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	10.	☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly
5.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	11.	☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly
6.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	12.	☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly

B. SECOND PARENT OR OTHER SPOUSE for whom aid is requested (name _____). List employment and training history for the past five years. Begin with this person's last job or training.

	Name of Employer Training Program	Work or Training ✓ Check	When Employed From / / mo dy yr To / /	Amount Paid	Name of Employer or Training Program	Work or Training ✓ Check	When Employed From / / mo dy yr To / /	Amount Paid
1.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	7.	☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly
2.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	8.	☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly
3.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	9.	☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly
4.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	10.	☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly
5.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	11.	☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly
6.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	12.	☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly

C. HAS EITHER PERSON LISTED IN 27A OR B RECEIVED UNEMPLOYMENT INSURANCE BENEFITS (UIB) WITHIN THE LAST 12 MONTHS? Yes ☐ No ☐ If YES, complete:

	Name of Person	Dates Received
1.		
2.		

COUNTY USE ONLY

First Parent's Earnings

YR.	QUARTER Jan-Mar	Apr-Jun	Jul-Sept	Oct-Dec
	EARNINGS			
	$			
	$			
	$			

Total Earnings $_____

YR.	QUARTER Jan-Mar		Apr-Jun		Jul-Sept		Oct-Dec	
	$50	Trng.	$50	Trng.	$50	Trng.	$50	Trng.

☐ Quarters _____

Second Parent's Earnings

YR.	QUARTER Jan-Mar	Apr-Jun	Jul-Sept	Oct-Dec
	EARNINGS			
	$			
	$			
	$			

Total Earnings $_____

Primary Wage Earner ☐ 1st ☐ 2nd Parent

YR.	QUARTER Jan-Mar		Apr-Jun		Jul-Sept		Oct-Dec	
	$50	Trng.	$50	Trng.	$50	Trng.	$50	Trng.

☐ Quarters _____

UIB:
☐ Eligible ☐ Referral
☐ Eligible ☐ Referral

28. Have either of the child(ren)'s parents living in the home quit or refused a job or training within the last 30 days? If yes, complete below. Yes ☐ No ☐

Parent's Name	Amount of last paycheck	Last day of job/training mo. / day / yr.	Hours of work/training in last 30 days
	$	/ /	

Name and Address of Employer/Training Program	Reason for Leaving or Refusal

B. Are you or anyone in your family participating in a labor strike? Yes ☐ No ☐ If yes, complete.

Who	Date Person Went on Strike

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

	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 $

30. Do 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 ☐
B.		Yes ☐ No ☐	Yes ☐ No ☐
C.		Yes ☐ No ☐	Yes ☐ No ☐

COUNTY USE ONLY

☐ Employer statements

☐ Determination of "good cause" required

☐ Striker(s)

Verification (list):

Date Verified EW

Exempt:
☐ Entire amount
☐ Only expenses

Transportation costs allowed: (show computation)

Date Verified EW

31. Do you or any family member have health or hospitalization insurance, including insurance paid by an employer or absent parent? This information will not affect your eligibility for Medi-Cal.
Yes ☐ No ☐ If yes, complete the following:

Coverage (Check)	Person(s) Insured	Monthly Premium Paid
☐ CHAMPUS/CHAMPVA		$
☐ Veterans Administration coverage (50% or above disability rating)		$
☐ Kaiser		$
☐ Ross-Loos (INA)		$
☐ Blue Shield		$
☐ Blue Cross		$
☐ Other		$

32. 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
$		

33A. 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 ☐

34. 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/Day/Year
Social Security			
ability payments			
veteran's payments			
Unemployment Benefits			
Workers' Compensation			
Medicare			
Pending suit or insurance settlement for accident or injury			
Other: Describe			

35. 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:

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

COUNTY USE ONLY

Date HRB 2 completed _____

☐ Other health coverage code entered

Verification (list)

_____ _____
Date Verified EW

Payment used to brin property within propert limits Yes ☐ No ☐

If yes:
☐ Notice to provider

CA 5 ☐

CA 5 ☐

_____ _____
Date Verified EW

Medi-Cal recovery referral

Date _____

Date of accident/injury

Medi-Cal recovery referral

Date _____

☐ CHDP brochure given

_____
Date

☐ CHDP referral

☐ Social services referral

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

- I agree to tell the county welfare department within TEN 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 or of 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 must report immediately the death of a member of my household or the person on whose behalf I am acting.

- I understand that the information I put on this form will be verified and that I must cooperate fully in any investigation required for quality control.

- 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 blind or totally disabled children.

- I understand that any information gathered is confidential and not open to inspection other than for purposes directly connected with the administration of the Medi-Cal program.

- I understand that if I am dissatisfied with actions taken by the county welfare department, I have the right to a state hearing.

IF YOU DO NOT UNDERSTAND THESE STATEMENTS OR IF YOU HAVE ANY QUESTIONS, ASK YOUR COUNTY WORKER TO EXPLAIN.

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.

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

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	EW Signature	
	Date	

Attachment 2

Revised Statement of Facts for Medi-Cal
Description of Changes

The format of the MC 210 has not been changed. In sequence, the format is: 1) personal identification and program identification; 2) resource identification; 3) income identification; 4) linkage to AFDC; 5) other health coverage; 6) potentially available assistance.

Please note that in the numbering sequence, questions 1 through 22 remain unchanged. However, questions 23 through 35 are rearranged as follows:

Current	Revised	Current	Revised	Current	Revised
23	25	27	24	32	34
24	26	28	31	33	27, 28
25	23	29	30	34	35
26	29	30	32	35	36
		31	33		

Page 1

County Use Column

-- Added verification of identity. Title 22 CAC 50167 (a)(6) requires verification of the identity of at least one parent or adult member of the case. Case review indicates that many eligibility workers (EWs) either fail to verify identity or fail to document such verification.

Page 2

Question 6

-- Reworded this question. The current MC 210 asks if all applicants are citizens. The actual intent is to question alien status. This revision, which is adapted from the AFDC Statement of Facts Supporting Eligibility for Assistance (CA 2), clearly identifies that the question concerns alien status.

Question 7

-- Redrafted this question to identify specific aid programs. The current MC 210 is inadequate for identifying potential Title II Disregard status.

County Use Column

-- Removed reference to property spenddown.

Question 9

-- Added new item c. This question is intended to specifically question applicants claiming disability as to whether a lawsuit/insurance settlement is pending. Quality Control (QC) reviewers have identified cases in which applicants have failed to disclose pending lawsuits. This question should increase identification of potential third party liability.

County Use Column

-- Added referral to Medi-Cal Recovery to Question 9C. to remind EWs of this requirement.

Page 3

Question 10

-- Added "monthly payment" to question regarding amount of mortgage payment. This allows comparison of monthly income to monthly expenses and can help identify discrepancies.

County Use Column

-- Added verification statements for Questions 11, 13 and 14. Title 22, CAC, 50167 requires that EWs verify the information contained in these questions. Some EWs fail to document such verification.

Page 4

Question 15

-- Revised this question in order to save space. This format is used in the CA 2 and is slightly more detailed.

County Use Column

-- Added verification statements for questions 15, 16, 17 and 19. Inappropriate treatment of these resources has caused QC errors. Some EWs fail to document verification, fail to update CSV of insurance or value of a burial reserve or trust after the initial application. In addition, verification of this information is required by 22 CAC 50167.

Page 5

Question 22

-- Rearranged this question in order to save space.

-- Added military retirement since it is not clearly identified on the current form.

-- Added sub-item C, based upon a recommendation by Quality Control and Evaluation Branch.

Question 23. (formerly question 25)

-- Moved this question in order to conserve space.

Question 24. (formerly question 27)

-- Moved this question in order to conserve space.

Page 6

County Use Column

-- Added verification instructions to questions 25 and 26 (formerly questions 23 and 24) because EWs very seldom list the type of verification provided. In addition, some EWs neglect to verify the cost of dependent care.

Page 7

Question 27 (formerly part of question 33)

-- Revised completely the question on unemployed parent(s). The current MC 210 does not contain any questions about primary wage earner. In addition, current question 33 is inadequate for identifying connection to the labor force. These two factors are a main requirement for linkage to AFDC based on an unemployed parent (22 CAC 50215 (b) and (c)). QC reviews indicate deprivation errors cause between 10 and 20 percent of the State's erroneously paid Medi-Cal dollars. Therefore, this question must be clarified.

The format for this question was adopted from AFDC's CA 2.

Page 8

Question 28 (formerly part of question 33)

-- Revised question and moved from question 33. This question also was adopted from the CA 2. Federal and State law and regulation prohibit AFDC/MN linked Medicaid/Medi-Cal coverage for persons refusing a job without good cause or for participating in a strike. (See also 22 CAC 50215 (b) and (c)).

Question 29. (formerly question 26)

No change.

Question 30. (formerly question 29)

No change.

Page 9.

Question 31. (formerly question 28)

-- Revised this question in conformity with Recovery Branch input.

County Use Column

-- Added check for coding other health coverage.

-- Added verification requirement. Title 22, CAC, Section 50167 (a)(7)(T) requires verification of available health care benefits. EWs do not always obtain the type of verification required.

-- Added referral for Medi-Cal Recovery to question 34 (formerly question 32). Title 22, CAC, Section 50771 requires county departments to notify the State of potential third party payments (TPL). The additions to the verification requirements in question 34 should remind EWs of this requirement.

Page 10. Informational Statements

-- Moved penalty of perjury statement to immediately above signature block.

-- Added phrase on other health coverage to reporting responsibilities statement.

-- Added statement on reporting death of a beneficiary.

-- Revised statement on verification of information and QC investigations.

-- Added "blind" child to statement on recovery from the estate of a decedent beneficiary.

-- Revised and limited statement on confidentiality.