STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY PETE WILSON, Governor

DEPARTMENT OF HEALTH SERVICES
1/744 P STREET
. BOX 942732
SACRAMENTO, CA 94234-7320

September 18, 1992

TO: All County Welfare Directors
All County Administrative Officers
All County Medi-Cal Program Specialists/Liaisons

Letter No.: 92-55

SUBJECT: "STATEMENT OF FACTS (MC 210)"

This is to inform counties that there is an error in the Statement of Facts (MC 210, attached in pertinent part) in block 27, part "C" at the top of page 10. The intent of the two questions requesting the applicant to enumerate his/her children into two age groups is to facilitate counties' calculation of the maximum income deductions for dependent care for which the family may qualify under 22 CCR Section 50553.5. This regulation allows two different maximum dependent care deductions: a maximum of $200 for children under two years of age, and a maximum of $175 for children age 2 or over. The identified questions on the MC 210 incorrectly request the applicant to divide his/her children into a group, age 2 or under, and a group, age 3 or over.

To correspond to Section 50553.5, the printed entry at the top of page 10 of the MC 210, which presently reads, "Name of person (age 2 or under) receiving care," should read, "Name of person (under age 2) receiving care." The next row at the top of page 10, which presently reads, "Name of person (age 3 or over) receiving care," should read, "Name of person (age 2 or over) receiving care."

Unless the county elects to correct this section of the MC 210 before the applicant completes it, the county must have the beneficiary separately identify which children listed in the first row at the top of page 10 are 2 years of age so that the $175 maximum (see Section 50553.5(b)(2)) can be applied to these children.

Please direct questions on this matter to Dave Rappolee (916) 657-0163 of my staff.

Sincerely,
ORIGINAL SIGNED BY

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Enclosure

(26) 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," please complete the following:

Amount paid: $ _____ By whom: _____

Date last paid: _____ To whom: _____

COUNTY USE ONLY

COURT ORDER

Amount $_____

Date: _____

☐ Verification of payment

(27) A. Are you or any family members working or expecting to work in the next two (2) months? ☐ Yes ☐ No

If "Yes," please complete the information below.

NOTE: If self-employed, complete (27) B below.

Person Working			
Employers Name			
Days Worked Weekly			
Hours Worked Weekly			
How Often Paid			
Day of Week Paid			
Gross Earnings (Before deductions) (Include tips/commissions)	$	$	$
Occupation/Job Title			

VERIFICATION (List):

☐ Wage stubs

☐ Tips

☐ Child in school

☐ Exempt earnings

Conversion Factor:

☐ Actual
☐ 4.33
☐ 2.167

ANTICIPATED INCOME. If your income changes from month to month, show your actual income for the current month in "Month 1" below, 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
	$	$	$
	$	$	$
	$	$	$

B. If self-employed, please complete the following:

NET PROFIT FROM SELF-EMPLOYMENT

Adjusted gross income from last federal tax return: $_____

Has income changed since last federal tax return? ☐ Yes ☐ No

☐ Tax return on file

If income changed or no tax return, what was:

- Gross profit per year: $_____
- Business expenses per year: $_____

Cash on hand for business: $_____

Money in checking accounts for business: $_____

Average monthly cash expenditures for business: $_____

Average monthly cash drawn from business: $_____

C. Does anyone who works pay for care of a child or disabled [illegible]
- If "Yes," please complete the information below.

who could provide care (MEM 50553.5)

Name of person (age 2 or under) receiving care			
Name of person (age 3 or over) receiving care			
Name of person paying for care			
Amount of payment and how often paid	$_____ every ☐ day ☐ week ☐ month	$_____ every ☐ day ☐ week ☐ month	$_____ every ☐ day ☐ week ☐ month

☐ Verified amount paid and age of person receiving care

D. If you are a working disabled person, do you have any medically-related expenses which are necessary for your employment, such as a wheelchair, etc.? ☐ Yes ☐ No

☐ IRWE (QMB only)

- If "Yes," please list any medically-related expenses below.

Type of Expense	Amount
	$
	$
	$

(28) Have you or any family member stopped work or training in the last 30 days? ☐ Yes ☐ No

- If "Yes," please complete the following.

Name of Person	Hours of Work/Training in the Last 30 Days
Name and Address of Employer/Training Program	
Reason for Leaving Job/Training	Date Last Paycheck Received/Expected
Name of Person	Hours of Work/Training in the Last 30 Days
Name and Address of Employer/Training Program	
Reason for Leaving Job/Training	Date Last Paycheck Received/Expected

☐ Employer statement

☐ Good cause determination required

(29) Are you or any family member participating in a labor strike? ☐ Yes ☐ No

☐ Strike regulations apply

- If "Yes," please complete the following:

Name of Striker:	Date Strike Began
Name of Union:	
Name of Employer:	
Address of Employer:	

(30) Has anyone applied for or received Unemployment Insurance Benefits (UIB) in the last 12 months? ☐ Yes ☐ No

- If "Yes," please complete the following:

Name	Date Applied	Where? (County/State)	Date Last Received