REDETERMINATION FOR MEDI-CAL BENEFICIARIES (LONG-TERM CARE IN OWN MFBU)

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. ***ALL QUESTIONS MUST BE ANSWERED.***

1. Name (first, middle, last)	Date of birth (month, day, year)		Social security number
2. Long-term care facility name	Marital status		Medicare claim number
Facility address (number, street)	City		ZIP code
3. Name of spouse	Social security number		Telephone ( )
Address of spouse (number, street)	City	State	ZIP code
4. Name of person helping complete form	Relationship		Telephone ( )
5. Address of person helping with form (if information regarding beneficiary should be sent to this person)			
Number, street	City	State	ZIP code

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:
   a. Is this property your former home? ☐ Yes ☐ No
      If yes, do you intend to return to that property to live in the future? ☐ Yes ☐ No
      (If this intent changes, you must notify the county within 10 days.)
      If you do not intend to return to that property, does anyone else live there now? ☐ Yes ☐ No
      If yes, enter name: ____________ Relation to you: ____________
      Basis of dependency (financial, medical, etc.) ____________
      How long have they lived there? ____________
   b. Is this property currently listed for sale? ☐ Yes ☐ No
      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 repairs $__________ ☐ Yearly ☐ Monthly
      Utilities $__________ ☐ Yearly ☐ Monthly

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 banks, savings and loans, or credit unions, etc. (checking or savings accounts), or a patient trust account, or a trust or agreement where money or property is being held for your benefit or being held for you by anyone, or being kept anywhere for you? ☐ Yes ☐ No
   If yes:
   a. On hand? ____________ Location / Amount / Account number
   b. In bank or savings? ____________ Location / Amount / Account number
      ____________ Location / Amount / Account number
   c. Held or kept for you by anyone? ____________ Location / Amount / Account number

COUNTY USE ONLY

PR ☐ Yes ☐ No

☐ DHCS 7014

Utilized ☐ Yes ☐ No

$__________

Current month income included ☐ Yes ☐ No

$__________

$__________

$__________

$__________

10. Have you sold, transferred, or given away any property (including money) at any time in the past year? ❒ Yes ❒ No

If yes:

Description	Date of Transfer, Sale, or Gift	Value	Amount Received
		$	$
		$	$
		$	$

❒ Verification

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, certificates of deposit, money market, or mutual fund account			$	$	$	$________
b. Jewelry valued over $100 (other than wedding or engagement heirlooms)			$	$	$	❒ Exempt
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 annuities or life insurance policies or long-term care insurance policies for yourself or anyone else? ❒ Yes ❒ No

If yes:

Company	Name of Insured or Annuitant	Face Value	Current Cash Value
a.		$	$
b.		$	$
c.		$	$

Verification of CSV on file?
$________
Copy of annuity on file?
❒ Yes ❒ No
State certified LTC policy?
❒ Yes ❒ No
Amount paid out $________
DHCS 6155 completed
❒ Yes ❒ No

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 Code (From Registration)	Year	Purchase Price	Amount Owed
			$	$
			$	$

Exempt ❒ Yes ❒ No

14. Do you or your spouse 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.

$________
Use copy of award letter or check or other verification

	When Paid/How Often	Applicant	Spouse	
Social Security (green check)		$	$	$________
SSI/SSP		$	$	$________
Railroad retirement		$	$	$________
Veterans benefits (including Aid and Attendance payments)		$	$	$________
Retirement or pension		$	$	$________
Annuities		$	$	$________
Interest income or dividends		$	$	$________
Contributions (including those from relatives)		$	$	$________
Earnings (gross)		$	$	$________
Other (include lump sum payments, inheritance, etc.)		$	$	$________

15. 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

CA5 (if not already completed)

16. 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

17. Do you have Medicare coverage? ❒ Yes ❒ No

If yes:

Name	Medicare claim number	Monthly premium
		Deduction from check? ❒ Yes ❒ No Paid by you? ❒ Yes ❒ No

_______________ Date verified

18. Do you have health or hospitalization insurance? ❒ Yes ❒ No

If yes:

Name of insurance company

Premium you pay	How often?
$	❒ Monthly ❒ Quarterly ❒ Yearly

DHCS 6155 completed? ❒ Yes ❒ No

OHC Code _______________

19. 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:

Service Referral ❒ Yes ❒ No

20. Additional information

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 ten 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 "Important Information for Persons Requesting Medi-Cal" (MC 219) I received at the time of my application for Medi-Cal. (A new "Important Information for Persons Requesting Medi-Cal" (MC 219) will be provided if there is a change in the person acting on behalf of the beneficiary.)

I understand that Section 1137 of the Social Security Act requires that I provide my Social Security number (SSN). My SSN will be verified and will be used in a computer match to check the income and resources I report with information from welfare, state employment, income tax, Social Security Administration, and other agencies.

I understand that Sections 215, 9202, and 9203 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 55 from the estate of a Medi-Cal beneficiary if there is no surviving spouse, minor children, or blind or totally disabled children, or it would create a hardship for my heirs. After the death of my surviving spouse, the State has the right to claim from the part of his/her estate received from me, all Medi-Cal benefits I received after age 55 up to the amount of property my spouse received from my estate.

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 any action or inaction taken by the county welfare department, I have the right to a state hearing which I may request from the county welfare department within 90 days after the action or inaction with which I am dissatisfied.

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.

Signature of beneficiary	Date
Signature of person acting for beneficiary	Date
Signature of witness (if beneficiary signed with mark)	Date
E.W. signature	Date

PRIVACY STATEMENT

- **Medi-Cal Confidentiality Notice:** The information given in this application is private and confidential under Welfare and Institutions Code, Section 14100.2. This information will be disclosed only in accordance with those laws.
- **Medi-Cal Privacy Notice:** This information may be shared with federal, state, and local agencies for purposes of verifying eligibility and for other purposes related to the administration of the Medi-Cal program, including confirmation with the INS of the immigration status of only those persons seeking full scope Medi-Cal benefits. (Federal law says the INS cannot use the information for anything else except cases of fraud.)
- **Information required by this form is mandatory**, with the exception of ethnicity information, and any other item marked voluntary or optional.