STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY EDMUND G. BROWN JR., Governor

DEPARTMENT OF HEALTH SERVICES
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January 18, 1980

To: County Welfare Directors
County Data Processing Officers

Letter No. 80-3

IMPLEMENTATION OF NEW STATE STATUTES

The purpose of this letter is to provide counties with information necessary to implement recently passed state legilstion. Attached are advance copies of the regulations, procedures and forms to be used in this implementation process. These regulations are being filed on an emergency basis to become effective January 1, 1980. Upon adoption and filing with the Secretary of State, they will be issued to all holders of the Medi-Cal Eligibility Manual. Regardless of the filing dates, these regulations will be effective January 1, 1980. Regulations implementing AB 381, which change the time period for State (Fair) Hearing Appeals from one year to 90 days, are being completed by the Department of Social Services. Therefore, they are not included in this letter. However, instructions for changing forms and publications to conform with this statute change can be found in DHS Letter No. 79-29.

The regulations included herein have been reviewed and modified by the Medical Care Committee of the County Welfare Directors Association. Due to their emergency status however, they could not be routed to all counties for review.

There are other recently passed statutes with an effective date of January 1, 1980, whose provisions do not authorize adoption of implementing regulations on an emergency basis. The provisions and impact of those statutes, along with draft regulations, will be discussed in future letters.

The attached material is organized by item of legislation. The items of legislation affecting Medi-Cal eligibility are:

AB 275 - Dialysis Program expansion and revision

AB 378 - New "SGA Disabled" eligibility category

AB 613 - Expanded property exemptions: Burial Trust and Insurance

AB 1251 - Adults eligible as MN not entitled to choose MI eligibility instead

AB 1257 - Cooperation of authorized representative

AB 887 and AB 1004 - Mobile homes as real property

An overview of each statute precedes the relevant regulation(s), procedures and/or forms. The overviews describe the statutes' provisions and purposes and describe departmental implementation steps that affect counties or are of interest to counties.

In addition, certain of the statutes require adjustments in internal county processing as part of implementation. For example: AB 378 and AB 275 have both generated new aid codes. The statute overviews point out such processing impacts, where they have been identified as having statewide application.

If you have any questions regarding implementing these changes, please contact your Medi-Cal field representative. Thank you for your assistance.

Sincerely,

Original signed by

Doris Z. Soderberg, Chief
Medi-Cal Eligibility Branch

Attachments
cc: Medi-Cal Liaisons
Medi-Cal Field Representatives

Expiration Date: July 31, 1980

AB 378 -- SGA Disabled Program

Assembly Bill 378, effective January 1, 1980, reviews the Medi-Cal definition of disability to include former SSI/SSP recipients who become ineligible for SSI/SSP benefits due to employment. The legislation provides that such a discontinued SSI/SSP recipient will be eligible for Medi-Cal-only as disabled if the person still has the same medical impairment that existed during the period of SSI/SSP eligibility.

CAC, Title 22, Sections 50167, 50223 and 50249, have been revised and 50203 and 50217 have been deleted to reflect the expanded definition of disability. The new disabled group is referred to in regulations, and procedures as "SGA disabled". A new aid code, 65, has been assigned to this group in order to charge its Medi-Cal costs to the funds appropriated by AB 378, and in order not to claim federal funds for those costs. Aid code 65 applies both to no-cost SGA Disabled individuals. Procedures section 5c of the Medi-Cal Eligibility Manual has been revised to incorporate the new aid code. Procedures section 4a now contains the steps necessary to process a disability determination referral for SGA-Disabled applicants. A copy of the revised procedures is in the AB 1251 part of this letter, since AB 1251 also generated a change to those procedures.

(2) Complete the Statement of Facts based upon the findings of the diligent search.

(3) Establish disability in accordance with Section 50167 (a) (1).

50167. Verification - Prior to Approval. (a) With regard to information on the Statement of Facts, the county department shall obtain verification of the following items in the manner specified below, prior to approval of eligibility:

(1) Blindness as determined in accordance with Section 50219 and federal disability, as determined in accordance with Section 50223 (a) (1) or (b) shall be verified by any of the following methods:

(A) By determining that the person was eligible as an MN person on the basis of blindness or disability in December 1973, and that there has been continuing eligibility since that time.

(B) By obtaining verification that a prior determination of blindness or disability is still valid. This shall be obtained by viewing any of the following or similar items:

1. A Social Security Administration Title II or SSI/SSP award letter indicating receipt of disability benefits provided the reexamination date has not passed or a reexamination date is not indicated.

2. A Social Security Administration notification that disability benefits have been increased or decreased.

3. A Railroad Retirement Board notification of a disability award.

4. A signed statement from the Social Security Administration that states that the person is eligible for Title II benefits on the basis of a disability.

5. Documentation of a prior determination of disability under the EVH or MN program, if the determination was done after December 1973.

6. Data on the SDX which shows that a person entering LTC was discontinued from SSI/SSP for reasons other than cessation of disability.

(C) By viewing a Social Security Administration Title II check that states that the payment is on the basis of disability. In this case, disability shall be further verified within 60 days by one of the methods specified in (B) or (E) of this section.

(D) By obtaining a letter from a physician verifying any one of the following conditions, provided the procedures specified in (E) are followed after eligibility is determined.

1. Terminal cancer.

2. Paraplegia or quadriplegia.

3. Absence of both eyes.

4. IQ of less than 50.

5. Absence of more than one limb.

(E) By following procedures established by the Department of Social Services' Disability Evaluation Division. All necessary information shall be submitted to the Department not later than 10 days after the receipt of the Statement of Facts by the county, except in the event of a delay due to circumstances beyond the control of the county.

(2) Incapacity shall be verified by viewing one of the following:

(A) A current Medical Report, form CA 341, or written statement signed by a physician, licensed or certified psychologist or authorized member of their staff which documents that incapacity exists and gives the expected duration of the condition.

(B) A current Certificate of Disability, form DM 3 or MC 221.

(C) Documentation of current receipt of Title II or Railroad Retirement disability benefits.

(D) Documentation of current receipt of SSI/SSP benefits based on disability or blindness.

(E) Documentation of current receipt of State Disability Insurance (SDI) or Worker's Compensation.

(F) If form CA 341 or a written statement cannot be obtained without delay, and no other verification of incapacity exists, a verbal statement from one of the persons specified in (A) shall be accepted as verification for up to 60 days pending receipt of written verification.

(3) Pregnancy shall be verified only if the inclusion of the unborn would reduce the share of cost of the MFBU. Verification shall consist of a signed statement from a physician or a clinical laboratory report. The statement or report shall provide evidence of pregnancy and, if possible, the expected date of delivery.

(4) Alien status shall be verified in accordance with the alienage verification and documentation procedures described in Article 7.

(5) The fact that the parents and a public or private agency will not accept legal responsibility for a child shall be verified by documented verbal or written communication with the parents and agencies, if the child is applying alone on the basis that neither the parents nor an agency will accept legal responsibility.

(6) The fact that the parent refuses to apply for Medi-Cal shall be verified by documented verbal or written communication with the parent, if the 18 to 21 year old child, who would be an AFDC-MN child if the parent applied, is applying as an MI person.

(7) SGA disability, as determined in accordance with Section 50223 (a) (2), shall be verified by following procedures established by the Department of Social Services' Disability Evaluation Division. All necessary information shall be submitted to the Department of Social Services by the county not later than 10 days after the receipt of the Statement of Facts by the county, except in the event of a delay due to circumstances beyond the control of the county.

50168. Verification - Within 60 Days. (a) With regard to information on the Statement of Facts, the county department shall obtain verification of the following items in the manner specified below, within 60 days of the date of initial application, but not necessarily prior to approval of eligibility:

(1) Unearned income shall be verified by viewing any of the following:

(A) Checks or copies of checks.

(B) Award letters.

(C) Signed statements from persons or organizations providing the income.

(D) Check stubs.

Article 5. Medi-Cal Programs

50201. Medi-Cal Programs -- General. (a) A person or family may be eligible for Medi-Cal under one of the following programs.

(1) Aid to Families with Dependent Children (AFDC).

(2) Supplemental Security Income/State Supplemental Program (SSI/SSP).

(3) Aid to the Potentially Self-Supporting Blind (APSB).

(4) Other Public Assistance (Other PA).

(5) Medically Needy (MN).

(6) Medically Indigent (MI).

(7) Special Programs.

50205. Linkage to AFDC. (a) Linkage to AFDC exists if a child is living with a relative or placed in foster care and is deprived of parental support or care. Deprivation shall be established if all conditions of any one of the following sections are met at any time during the month:

(1) Deprivation - Relinquishment for Adoption, Section 50207.

(2) Deprivation - Deceased Parent, Section 50209.

(3) Deprivation - Physical or Mental Incapacity of a Parent, Section 50211.

(4) Deprivation - Absent Parent, Section 50213.

(5) Deprivation - Unemployed Parent, Section 50215.

(b) A child who is linked under more than one of the sections listed in (a) shall have eligibility determined on the basis of the section listed first except that (a) (3) shall not be used if there is absent parent deprivation and the parent in the home does not have a spouse in the home.

50207. Deprivation - Relinquishment for Adoption. (a) Deprivation of parental support or care exists if the child has been relinquished for adoption and either of the following conditions is met:

(1) Relinquishment of a child to a county adoption agency has been signed.

(2) Relinquishment of a child to a private adoption agency has been signed and either of the following is true:

(A) The child was receiving AFDC at the time of relinquishment.

(B) The agency has certified in writing that the child cannot be placed for adoption.

(b) Deprivation because of relinquishment for adoption no longer exists when:

(1) The child is placed for adoption.

(2) Relinquishment is terminated.

(c) A parent of a child relinquished for adoption shall not be linked to AFDC on the basis of this deprivation factor.

50209. Deprivation - Deceased Parent. (a) Deprivation of parental support or care exists if either of the child's parents is deceased.

(b) Children of a deceased parent and the remaining parent living with the child shall be linked to AFDC on the basis of this deprivation factor.

50211. Deprivation — Physical or Mental Incapacity of a Parent. (a) Deprivation of parental support or care exists if either of the child's parents is physically or mentally incapacitated.

(b) A parent is incapacitated if such parent has a physical or mental illness, defect or impairment that is expected to last at least 30 days and does either of the following:

(1) Reduces substantially or eliminates the parent's ability to support or care for the child.

(2) Causes one of the following situations:

(A) The parent is prevented from working full-time at a job in which customarily engaged, or for which equipped by education, training or experience or which could be learned by on-the-job training.

(B) Employers refuse to employ the parent for work the parent could do and is willing to do, because of behavioral or other disorders which interfere with the securing and maintaining of employment.

(C) The parent is prevented from accomplishing as much on a job as a regular employee and, as a result, is paid on a reduced basis.

(D) The parent is blind or disabled in accordance with Section 50223 (a) (1) or (b).

(E) The parent has qualified for and is employed in a job which is rehabilitative or therapeutic or is in a sheltered workshop, and which is not considered to be full-time.

(c) The following persons shall be linked to AFDC on the basis of this deprivation factor:

(1) Children of an incapacitated parent.

(2) The incapacitated parent.

(3) The spouse of the incapacitated parent.

(8) Child care arrangements could not be made.

(9) The individual was without a means of getting to or from the place of employment or training.

50219. Blindness. (a) Persons shall be considered to be blind if there has been a medical determination that they have either of the following conditions:

(1) Central visual acuity of no more than 20/200 with correction.

(2) Tunnel vision, which is a limited visual field of 20 degrees or less.

50221. Age. (a) Persons are aged if they are 65 years of age or older. Persons are considered to be 65 years of age on the first day of the month in which they reach age 65.

50223. Disability. (a) Persons over 18 years of age are disabled if they meet the definition in (1) or the definition in (2):

(1) Federally disabled persons are persons who are unable to engage in substantial gainful activity which is within their competence because of any medically determinable physical or mental impairment that meets one of the following conditions:

(A) Can be expected to result in death.

(B) Has lasted continuously for at least one year.

(C) Can be expected to last continuously for at least one year.

(2) SGA-disabled persons are persons who were once determined to be disabled in accordance with the provisions of the SSI/SSP program (Section 1614, Part A, Title XVI, Social Security Act) and meet both of the following conditions:

(A) Were eligible for SSI/SSP but became ineligible because of engagement in substantial gainful activity as defined in Title XVI regulations.

(B) Continue to suffer from the physical or mental impairment which was the basis of the disability determination.

(b) Children who are 18 years of age or less shall be considered to be disabled if they have any medically determinable physical or mental impairment of comparable severity to that which would make an adult disabled in accordance with (a) (1) or (2).

(c) Eligibility or share of cost determinations effective on or after January 1, 1980 shall be based on the provisions of this Section.

50227. Public Assistance Cash Grant Programs. (a) Public assistance cash grant programs include the following programs:

(1) AFDC.

(2) SSI/SSP.

(3) APSB.

(4) Cuban Refugee Cash Grant.

(5) Indochinese Refugee Cash Grant.

50249. Medically Needy Program. (a) A person's eligibility shall be determined under the Medically Needy program if that person is any of the following:

(1) An aged, blind or disabled person who is linked to SSI/SSP in accordance with Section 50217 and who meets one of the following conditions:

(A) Is not eligible for or does not want to receive assistance as a PA or Other PA recipient.

(B) Has an application pending for SSI/SSP.

(2) A child or family member who is both:

(A) Linked to AFDC in accordance with Section 50205.

(B) Not eligible for or does not want to receive assistance as a PA or Other PA recipient.

(3) A caretaker relative who chooses to be included in a child's MFBU in accordance with Section 50371 (a) (9).

(b) A person who meets the conditions of more than one of the following categories shall have eligibility determined on the basis of the category listed first unless the person requests otherwise:

(1) Blindness, as defined in Section 50219.

(2) Age, as defined in Section 50221.

(3) Disability, as defined in Section 50223.

(4) Linkage to AFDC as defined in Section 50205.

(c) In order to be eligible under this program the persons listed in (a) shall meet the property, citizenship, residence, institutional status and cooperation requirements specified in these regulations.

(d) In order to be certified and receive a Medi-Cal card under this program, the persons listed in (a) shall be determined eligible and meet the income and share of cost requirements specified in these regulations.

(e) Eligibility or share-of-cost determinations effective on or after January 1, 1980, shall be based on the provisions of this section.

AB 613 - Burial Trust and Burial Insurance

Implementing Regulations: Title 22, CAC, Sections 50025.5, 50054.5, 50476, 50479.

AB 613, effective January 1, 1980, provides that the first $1,000 paid for a burial trust shall be exempt in determining a person's eligibility for Medi-Cal.

In addition, these regulations provide that all burial insurance is exempt and that payments by the insurance company under the terms of the policy are exempt as income and property.

The intent of these changes is to allow beneficiaries to maintain certain resources, which are of negligible value in enabling them to meet their present needs and, therefore, should not be classified as available resources in determining their Medi-Cal eligibility.

50024. Beneficiary. Beneficiary means a person who has been determined eligible for Medi-Cal.

50025. Benefits Review Unit (BRU). Benefits Review Unit (BRU) means the unit in the Department which certifies for Medi-Cal persons or families who have met a share of cost, and clears claims for payment for health care services provided to such persons or families.

50025.5. Burial Insurance. Burial insurance means insurance which by its terms can only be used to pay the burial expenses of the insured.

50026. Cash Grant. Cash grant means the money payment made to a person eligible for AFDC, EVH, APSB or SSI/SSP.

50027. Certification Date for Claims Clearance. Certification date for claims clearance means the date of the most recent service listed on the Record of Health Care Costs, MC 177S or MC 177P.

50028. Certification - Effective Date. Effective date of certification for Medi-Cal means the date the person is certified to receive Medi-Cal benefits.

50029. Certification for Medi-Cal. Certification for Medi-Cal means the determination by the county department or the Department that a person is eligible for Medi-Cal and has no share of cost, has met the share of cost or is in long-term care and has a share of cost which is less than the cost of long-term care at the Medi-Cal rate.

50052. Institution-Public. Public institution means an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.

50053. Intraprogram Status Change. Intraprogram status change means a change in a person's or family's eligibility from one aid category to another aid category, in which the first digit of the aid code remains the same.

50054. Interprogram Transfer. Interprogram transfer means a transfer of eligibility from one aid category to another aid category, in which the first digit of the aid code changes.

50054.5. Life Insurance. Life insurance means a contract for which premiums are paid during the life time of the insured, and on which the insuring company pays the face amount of the policy to the beneficiary upon the death of the insured. Life insurance may also be purchased by a single premium or by letting dividends accumulate.

50055. Linked. Linked means meeting the SSI/SSP requirements of age, blindness or disability or the AFDC requirements of deprivation of parental support or care.

50473. Livestock and Poultry. (a) Livestock and poultry retained primarily for personal use shall be exempt.

(b) The net market value of livestock and poultry retained primarily for profit shall be included in the property reserve except to the extent it is exempt as business property in accordance with Section 50485.

(c) The net market value of livestock and poultry shall be the net market value listed by the applicant or beneficiary on the Statement of Facts, unless the county department determines further verification is required. If verification is required:

(1) The applicant or beneficiary shall submit three appraisals from persons or businesses dealing in livestock and poultry. The average of these appraisals shall be the market value.

(2) Subtract any encumbrances of record from the market value. This is the net market value.

50475. Life Insurance. (a) Life insurance policies on the life of any individual in the family shall be exempt if either of the following conditions are met:

(1) The life insurance has no cash surrender value.

(2) The life insurance has a cash surrender value and the combined face value of the policies on the insured individual is $1,500 or less. If the combined face value of all the policies exceeds $1,500, only those policies with a combined face value of $1,500 or less shall be exempt.

(b) The net cash surrender value of life insurance policies not exempted in (a) shall be included in the property reserve.

50476. Burial Insurance. The cash surrender value of burial insurance policies on any individual in the family shall be exempt.

50477. Burial Plots, Vaults and Crypts. (a) Any burial plot, vault or crypt retained for use by any member of the family shall be exempt.

(b) The net market value of any burial plot not exempted above is other real property and shall be subject to all conditions placed on other real property in these regulations.

(c) The net market value of any burial vault or crypt not exempted above is personal property and shall be included in the property reserve.

(d) The net market value of a burial plot, vault or crypt shall be the net market value listed by the applicant or beneficiary on the Statement of Facts, unless the county department determines further verification is required. If verification is required:

(1) The applicant or beneficiary shall submit a statement of value from the organization from which the plot, vault or crypt was purchased. This statement of value shall be the market value.

(2) Subtract encumbrances of record from the market value. This is the net market value.

50479. Burial Trust or Prepaid Burial Contract. (a) The first $1,000 paid for burial trusts and prepaid burial contracts for funeral, cremation or interment expenses for an individual shall be exempt provided trusts or contracts are:

(1) Held with one of the following:

(A) A banking institution or trust company legally authorized and empowered by the State of California to act as trustee in the handling of trust funds.

(B) Not fewer than three persons, one of whom may be an employee of the funeral director who is entering into a Preneed Funeral Arrangement.

(C) A cemetery authority empowered by Section 8775 of the Health and Safety Code to hold property in trust.

(2) Securities or debentures issued by a licensed cemetery authority which, by the terms of the securities or debentures, are convertible only into payment for funeral, cremation or interment expenses.

(b) The remainder of the amount paid for burial trusts and prepaid burial contracts not exempted in (a) shall be included in the property reserve.

50483. Loans. (a) Loans shall be exempt as property in the month in which they are any of the following:

(1) Exempt as income in accordance with Section 50533.

(2) Treated as income in the month of receipt because no repayment is required.

(b) Loans which require repayment, except those exempted in (a) (1), shall be included in the property reserve beginning in the month of receipt.

50485. Business Property. (a) Equipment, inventory, licenses and materials owned by the applicant or beneficiary which are necessary for employment, for self-support or for an approved plan of rehabilitation or self-care necessary for employment shall be exempt.

(1) Equipment, inventory, licenses and materials shall be considered necessary for employment if either of the following conditions is met:

(A) The applicant's or beneficiary's employer requires that the applicant or beneficiary provide this property as a condition of employment.

(B) The applicant or beneficiary is currently unemployed but has been required to use this property for employment in the past and can provide reasonable evidence that the applicant or beneficiary is actively seeking employment in the same field which will require the use of the same property. This property shall be exempt for a maximum of one year from the date the beneficiary became unemployed if this condition is met.

(2) Equipment, inventory, licenses and materials shall be considered necessary for self-support if the applicant or beneficiary obtains a reasonable rate of return from the use of this property.

AB 1251 MN Ineligibility as New Requirement for MI Eligibility

Implementing Regulations: Title 22, CAC, Section 50251

Assembly Bill 1251, effective January 1, 1980, amended the Medically Indigent definition in state statute to define a medically indigent person or family person as one that cannot qualify as a medically needy person or family person. The revised definition further states that, to the extent required by federal law, any person under the age of 21 who could qualify as a medically needy person may instead choose to qualify as a medically indigent person.

The intent of this legislation is threefold:

(1) To insure that disabled adults applying for Medi-Cal will apply under the most beneficial Medi-Cal program category;

(2) To maximize the amount of federal funds available to the State to match the program cost of medically needy program eligibles; and

(3) To conform to federal rules on applicant choice of Medi-Cal programs.

The disability determination procedures (Procedures Section 4A, Medi-Cal Eligibility Manual) have been modified in the following areas:

(1) All Medi-Cal applications for persons who have identified themselves as potentially disabled on the MC 210 Statement of Facts form, shall be processed as medically needy disabled applications.

(2) Applicants who have identified themselves as potentially disabled on the MC 210 form, and refuse to participate in the determination process, shall be denied Medi-Cal eligibility.

50251. Medically Indigent Program. (a) A person's eligibility shall be determined under the Medically Indigent program if that person is under 65 years of age and any of the following:

(1) A person who cannot meet the eligibility requirements as a PA or Other PA recipient, an MN person, or an MN family member.

(2) A person who is not an MN family member because of voluntary exclusion of a child from the MFBU.

(3) At least 18 but not over 21 years of age and would be linked to the AFDC program, except that the parent or parents refuse to apply for Medi-Cal.

(4) A child in foster care or in custody of the county awaiting foster care placement for whom a public agency is assuming financial responsibility in whole or in part and who is living in a:

(A) Foster family home.

(B) Home of a relative other than a parent.

(C) Group home.

(D) Private receiving home.

(E) Maternity home.

(F) Facility licensed to care for the developmentally disabled and the mentally disordered which is one of the following:

1. Small Family Home.

2. Large Family Home.

3. Group Home.

(5) A child receiving assistance under Aid for Adoption of Children.

(6) A person under 21 years of age who can qualify as an MN blind or disabled person but chooses to apply as an MI person. The choice may be made by a person acting on behalf of the person under 21 years of age.

(7) Not yet determined eligible for Medi-Cal as a PA or Other PA recipient or as an MN person because of a pending application based on blindness or disability and blindness or disability has not yet been determined.

(b) In order to be eligible under this program, the persons listed in (a) (1), (2), (3), (6) and (7) shall meet the property, citizenship, residence, institutional status and cooperation requirements specified in these regulations.

(c) In order to be certified and receive a Medi-Cal card under this program, the persons listed in (a) (1), (2), (3), (6) and (7) shall be determined eligible and meet the income and share of cost requirements specified in these regulations.

(d) Children specified in (a) (4) shall be eligible and certified for Medi-Cal:

(1) On the basis of the information provided by the public agency on form MC 250.

(2) Without considering the property or income of the child or the child's parents.

(e) The children specified in (a) (5) above shall be eligible and certified for Medi-Cal without any additional determinations by the county department.

(f) For purposes of this section:

(1) Persons are considered 21 years of age on the first day of the month following the month in which they reach age 21.

(2) Persons are considered 18 years of age on the first day of the month in which they reach age 18.

50253. Special Programs. Special programs are those specified in Sections 50255 through 50263.

50255. Repatriate Program. Persons eligible for cash payments and other assistance under the Repatriate program shall not be eligible for Medi-Cal. Medi-Cal eligibility may be established upon discontinuance from the program.

4A -- COUNTY PROCEDURES
DISABILITY DETERMINATION REFERRALS

Medi-Cal eligibility for federally disabled persons and SGA disabled persons is determined concurrently by; 1) county welfare departments, and 2) the State Programs Bureau of the Disability Evaluation Division (DED) in the State Department of Social Services. The county welfare department is responsible for the non-medical part of the eligibility determination; DED is responsible for the collection of medical data and the disability determination. (Reference: California Administrative Code, Title 22, Section 50167 (a) (1) (E), and (7).

I. Federally Disabled Persons

Background

CAC, Title 22, Section 50223, defines a person over 18 years of age as federally disabled if that person is unable to engage in substantial gainful activity (employment) because of any medically determinable physical or mental impairment that is expected to last for a year or will result in death. State law requires that Medi-Cal clients 21 through 64 years of age who meet this definition must have their eligibility evaluated under the Medically Needy (MN) Disabled program rather than the Medically Indigent (MI) Adult program. This is because:

1) The Disabled MN program is more beneficial than the MI program in terms of income deductions, for disabled adults; and

2) The Medi-Cal costs of MN eligibles are paid 50 percent by federal funds.

In addition to the required disability determination for MI Adults who are potentially disabled, a determination is done on other beneficiaries who are eligible under another program (AFDC MN program, MI Child program, etc.), who allege disability, and who choose to apply or be redetermined as Disabled MN. In all cases, disability determinations occur only after Medi-Cal-only clients (applicants or beneficiaries) have identified themselves as potentially disabled through their statements on the MC 210 form or the MC 176S form. A Medi-Cal eligible may also identify himself/herself as potentially disabled through other written or oral statements.

There are methods other than the disability referral process, to confirm a client's alleged disability. The disability referral process is used only if the client's alleged disability cannot be confirmed by any of the other methods. Following are county procedures for processing disability determination referrals for potentially federally disabled persons.

I. A. Person who is not a Previous Title II/XVI Applicant and Alleges Blindness/Disability

1. Complete and transmit a disability determination packet to DED for a client who has identified himself/herself as disabled, including disability due to blindness, if the alleged disability cannot be verified per CAC, Title 22, Section 50167 (1) (A) or (B). The packet must include the following:

   a. Authorization for Release of Medical Information, MC 220 (10/78) -- three originals, each signed by the client.

   b. Disability Determination and Transmittal, MC 221 (10/78)-- original plus two copies. (Include the eligibility worker's observations in Item 9 - see Section 4B for guidelines.)

   c. Medical History and Disability Report, MC 223 (10/78) available in Spanish -- original only and signed by the client. (If the client is unable to complete the MC 223, the eligibility worker shall assist.)

   d. Any supporting documents the client presents relating to the alleged disability, e.g., a school psychologist's report brought by the parent of a developmentally disabled child. (An original and one copy is needed and this information will not be returned.)

2. If the client is alleging blindness:

   a. The MC 221 form (Item 9) must include the words "application for blind aid only".

   b. Complete the MC 223 form, Items 1 through 7. For Items 3, 4, and 5, list only optometrists, ophtalmologists, and treatments of the eye. Include the date of the last visit even if not within the last three years.

3. Submit the packet to DED no later than ten days after the completed MC 210 form, or other client statement of disability, is received by the county. If a county decision is made to deny or discontinue eligibility on the basis of non-medical information, prior to DED's receipt of the disability determination packet, notify DED by telephone immediately and follow with written confirmation (i.e., mini-memo, hand-written note, letter, etc.). DED will immediately stop processing the disability determination and return the MC 221 form to the county. The MC 221 form will note that case processing was stopped per county request.

4. Complete the Medi-Cal eligibility determination, redetermination or reevaluation for the nondisabled Medi-Cal program to which the client is eligible. Assign aid code 88 or 89 to MI Adult applicants who allege disability and convert current MI Adult eligibles who allege disability to aid code 88 or 89 pending the disability determination. Assign the appropriate aid code to eligible clients in other categories.

5. On receipt of the completed disability determination results (MC 221, filled out and returned by DED):

   a. If DED has determined that the client is federally disabled, reclassify case as Disabled MN.

   b. If DED has determined that the client is not disabled, reclassify MI Adult eligibles to aid code 84 or 85.

6. Deny or discontinue the eligibility of an MI Adult client who identifies himself/herself as potentially disabled and who then refuses to participate in the disability determination process. CAC, Title 22, Section 50175 (a) (2).

I. B. Person with Previous Title II/XVI Denial/Discontinuance Based on Disability

1. Use the county's SDX listings whenever possible to confirm a client's statement that he/she has been denied /or discontinued from SSI/SSP based on a disability.

2. When a client has been denied or discontinued from Title II or Title XVI disability benefits because he/she was found not disabled and the denial/discontinuance occured within 90 days prior to the Medi-Cal application:

   a. Advise the client of the Title II or Title XVI appeal rights and procedures for appeal.

   b. If the client became employed before Title XVI discontinuance and is employed now, process using Part II of this Section -- "SGA Disabled".

   c. If the client does not meet the test of b., do not process the application, reevaluation or redetermination for a disability determination unless:

      (1) A physical and/or medical condition has deteriorated and the client wishes to apply for Medi-Cal only. In such cases, follow procedures described in IA and include a remark in Item 9 of the MC 221 form that the client's physical and/or mental condition is alleged to have deteriorated since the Title II

or Title XVI denial.

(2) The person was employed at the time of denial/discontinuance but is not now employed. In such cases, follow the procedures in IA.

(3) A physical and/or mental condition has not deteriorated but the client insists upon a disability determination even after the eligibility worker has explained that the definitions of disability for all federal programs (Title II, Title XVI, and Title XIX) are the same. (DED will automatically deny and the client will have the right to request a fair hearing if dissatisfied with the denial.)

I. C. Persons with Title II or Title XVI Disability Evaluation Pending (Validation Cases)

1. If a client states that he/she has a Title II or Title XVI disability (including blindness) determination pending, send only a completed MC 221 form to DED. Items 8 and 9 on the form need not be completed. This form will initiate a query of SSA's Title XVI data system by DED.

2. If Title XVI disability is approved, or DED advises on the MC 221 that the applicant is already a Title XVI cash grant recipient, discontinue the Medi-Cal-only case.

3. If SSA data indicates that the client does not have a disability determination pending, follow the procedures in IA.

I. D. Disability Onset Date for Three Months Retroactive Medi-Cal Coverage of Title XVI Recipients and Medi-Cal-only Disabled Persons

1. To request disability onset dates for Title XVI disabled or blind recipients, requesting three month retroactive Medi-Cal coverage:

   a. Complete only Items 1 through 8 on the MC 221 form. Item 8 must have an entry requesting only an onset date; for example "requesting retroactive Medi-Cal coverage for months of October, November, and December 1976".

   b. Send the completed MC 221 form to the appropriate DED office (see addresses in paragraph III).

2. There is no need to request an onset date for persons whom DED has determined are Medi-Cal-only disableds; the onset date in the MC 221 for such persons is the earliest date that the person's medical history justifies.

I. E. Medical Reexaminations for Federally Disabled Persons

1. For each beneficiary with a medical reexamination date from DED on his/her completed MC 221 form (Item 12):

   a. Submit in the reexamination month, a copy of the most recent previous MC 221 form and a newly completed disability determination packet (MC 220, MC 223). Complete only the circled questions on the MC 223 form (Items 1 through 9, 13, and 17).

   b. Make appropriate status and aid code change upon receipt of the disability determination.

II. SGA Disabled Persons

Background

CAC, Title 22, Section 50223, defines an SGA Disabled person as a person who was:

1. An SSI/SSP disabled recipient;

2. Became ineligible for SSI/SSP because of SGA (employment); and

3. Still has the medical impairment which was the basis of the SSI/SSP disability determination.

The SGA Disabled program is a state funded Medi-Cal program that allows eligibles to receive the income deductions that are allowed the MN Disabled program. It provides an incentive for employment because even if a person's medical condition produces continuing high medical costs, SGA Disabled status protects more than one-half of the person's earned income from having to be used to meet those costs when the person's Medi-Cal share-of-cost is computed.

A beneficiary's SGA Disabled status will continue even if he/she stops working, as long as the person continues to suffer from the same medical impairment. If the beneficiary's unemployed status continues long enough, he/she may be eligible for the Medi-Cal federally disabled program or for Title XVI.

Also, SGA Disabled status may be reestablished for a former SGA Disabled beneficiary who lost SGA Disabled status because of an improvement in his/her medical impairment, if the condition of that medical impairment worsens.

The SGA Disabled program does not apply to blind individuals since persons are federally blind strictly on the basis of vision acuity.

Following are county procedures for processing disability determination referrals for SGA Disabled applications.

II. A. Referral Process

1. If an applicant identifies on the Statement of Facts for Medi-Cal, MC 210 form, that he/she has been discontinued from SSI/SSP disability but that he/she is still disabled and is working:

   a. Find out in the application interview whether the person went to work before he/she was discontinued from SSI/SSP. If he/she did not, there is no SGA Disabled eligibility. Process the case using the federal disabled procedures.

   b. If the person did go to work, check the SDX listing for the month after the last month of SSI/SSP-based Medi-Cal eligibility.

      (1) If the SDX shows the person was discontinued because his/her medical condition improved (payment status codes: N07, N34, N35, N45) process the application under the appropriate nondisability program. If the applicant says his/her medical condition has deteriorated, or insists on a disability determination, submit an SGA Disability determination packet to DED as described in "c" below. If a packet is submitted and the person would be an MI Adult if not disabled, assign aid code 88 or 89 pending the disability determination.

      (2) If the SDX shows the person was discontinued because of SGA, submit an SGA Disability determination packet to DED as described in "c" below.

      (3) If the person's SDX record shows discontinuance for reasons other than improvement in medical condition, or SGA; or no record for the person on the SDX: submit an SGA Disability determination packet as described in "c" below. Indicate that the referral is for both a federally disabled evaluation and an SGA disabled evaluation.

   c. An SGA Disability determination packet is the same as the federal disability determination packet, except:

      (1) Indicate on the MC 221 form (Item 9) that the referral is an SGA Disabled applicant and the date of SSI/SSP discontinuance.

      (2) Indicate on the MC 223 form (Item 2) what physical or emotional problem the applicant had when his/her SSI/SSP claim was approved.

d. Send the completed disability determination packet to DED no later than ten days after the completed MC 210 form has been received by the county. If the person would be an MI Adult if not disabled, assign aid code 88 or 89 pending the disability determination.

e. Make appropriate status and aid code change upon receipt of the disability determination.

II. B. Disability Onset Date for Three Month Retroactive Medi-Cal Coverage for SGA Disabled

The county shall verify three month retroactive Medi-Cal coverage fo SGA Disabled applicants or recipients who request retroactive eligibility by checking the disability onset date on the MC 221 form.

II. C. Medical Reexamination for SGA Disabled Persons

For each beneficiary with a medical reexamination date on his/her MC 221 form (Item 12):

1. Submit in the redetermination month, a copy of the most recent previous MC 221 form and a newly completed disability determination packet (MC 220, MC 223). Complete only the circled questions on the MC 223 form (Items 1 through 9, 13 and 17).

2. Make appropriate status and aid code change upon receipt of the new disability determination.

II. D. SGA Disabled Beneficiary Whose Employment Terminates

1. Advise an SGA Disabled beneficiary that has not applied for Title XVI to reapply for benefits at SSA since Title XVI disabled eligibility may be reestablished due to unemployed status.

2. Complete a disability determination packet and send to DED to verify beneficiary's SSI/SSP application and continuind disability status. Provide a statement in Item 8 of the MC 221 form requesting verification of SSI/SSP application status for the SGA Disabled beneficiary.

3. Make appropriate status and aid code change upon receipt of DED's revised determination.

II. E. SGA Disabled Beneficiary Who Reaches Age 65

Reclassify case from SGA Disabled to Aged MN, since the beneficiary is now eligible under the MN program as an aged individual.

III. Disability Evaluation Division Addresses

A. Disability determination packets and disability onset date requests for federally disabled persons and SGA Disabled persons from the following counties:

Imperial	Riverside
Los Angeles	San Bernardino
Orange	San Diego

should be sent to:

State Programs Bureau
Disability Evaluation Division
Department of Social Services
P. O. Box 30541, Terminal Annex
Los Angeles, CA 90030
(213) 852-5581

B. Disability determination packets and disability onset date requests for federally disabled persons and SGA Disabled persons from all other counties should be sent to:

State Programs Bureau
Disability Evaluation Division
Department of Social Services
P. O. Box 23645
Oakland, CA 94623
(415) 568-6900

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY
Medical Assistance Program

DEPARTMENT OF HEALTH SERVICES

STATEMENT OF FACTS REGARDING DISABILITY

CASE NUMBER		
COUNTY	AID	NUMBER

INSTRUCTIONS: This information is necessary to evaluate your disability. Complete all items. If the item does not apply to you, write "N/A". If you need space for any item, use blank paper. After you complete this form, return it to the county welfare office immediately. Any delay in returning it will delay your application for benefits.

(1.) Name

MEDICAL AND PSYCHIATRIC

(2.) Why do you believe you are disabled? When did it start?

3. If you have been discontinued from SSI/SSP, what physical or emotional problem did you have when your SSI/SSP claim was approved?

(4.) List doctors and clinics you have seen or visited during the past year:

NAME OF DOCTOR OR CLINIC	ADDRESS	DATE LAST SEEN BY DOCTOR OR CLINIC

(5.) List the times you have been hospitalized in the last three years:

NAME OF HOSPITAL	ADDRESS	REASON FOR BEING IN HOSPITAL	DATES IN THE HOSPITAL

(6.) List other agencies you have seen about your disability, such as Workmen's Compensation, Social Security District Office, etc.)

NAME OF AGENCY	ADDRESS	CLAIM OR CASE NUMBER	DATES OF VISITS

(8.) Do you take prescription medicine of any kind? ☐ Yes ☐ No If Yes, give names of medicines (usually on medicine containers), and tell what they are for.

7. (7) If a doctor has told you to restrict your activities in any way, what is the doctor's name and what did he tell you about restricting your activities?

8. (8) Describe your activities on a usual day such as, yardwork, housework, shopping, visiting, hobbies, walks, driving a car, etc.

9. (9) Do you need help in caring for your personal needs such as, bathing, dressing, eating, etc? Explain.

EDUCATION AND TRAINING

10. ~~10~~. Circle last grade completed in school.

Grade School 1 2 3 4 5 6 7 8 | High School 9 10 11 12 | College or University 13 14 15 16

11. ~~11~~.

	Yes	No		Yes	No	Specify any other language	Yes	No
Do you speak English	☐	☐	Speak Spanish	☐	☐	Speak _____	☐	☐
read	☐	☐	read	☐	☐	read	☐	☐
write	☐	☐	write	☐	☐	write	☐	☐

12. ~~12~~. Did you attend a trade school ☐ Yes ☐ No If Yes, nature of training

13. (13) Have you had special training because of your disability? ☐ Yes ☐ No If Yes, give type of training, date completed and name of agency sponsoring training. If the course was not completed, give reason.

WORK EXPERIENCE

14. ~~14~~. List your jobs for the past 10 years, the last job first. ☐ I have never worked

DATES OF EMPLOYMENT FROM Mo. Yr.	DATES OF EMPLOYMENT TO Mo. Yr.	WHAT DID YOU DO? (DESCRIBE DUTIES AND RESPONSIBILITIES)	EARNINGS (SPECIFY DAY, WEEK, MONTH OR YEAR)	EMPLOYMENT PART TIME	EMPLOYMENT FULL TIME	REASON FOR LEAVING. IF ILL, EXPLAIN NATURE OF ILLNESS, IF FIRED, GIVE REASON.

WORK (Continued)

DATES OF EMPLOYMENT FROM Mo. Yr.	DATES OF EMPLOYMENT TO Mo. Yr.	WHAT DID YOU DO? (DESCRIBE DUTIES AND RESPONSIBILITIES)	EARNINGS (SPECIFY DAY, WEEK, MONTH OR YEAR)	EMPLOYMENT PART TIME	EMPLOYMENT FULL TIME	REASON FOR LEAVING. IF ILL, EXPLAIN NATURE OF ILLNESS, IF FIRED, GIVE REASON.

15. What was your main job in the last 10 years before you became disabled? (usually this will be the kind of work that you did for the longest period of time)

A. Job Title

B. Type of business

C. In this job, what is the heaviest object you were required to move:

	Object	Weight	How Often	How Far
Lift				
Carry				
Push or Pull				

D. In this job, how many hours per day were you required to stand? _____

walk? _____

sit? _____

E. In this job, what were you required to climb?

How often? _____ How high was it? _____

F. If this job required stooping, bending, kneeling or other unusual activity, explain.

G. Describe the duties of this job on a usual workday.

H. Explain any special skills necessary for this job (use of machines, tools or equipment, special technical knowledge or skills, etc.)

I. Describe any special training required for this job (apprentice, classroom, on-the-job)

J. How does your disability prevent you from performing these job duties?

17 ~~18~~. If you needed help to fill out this form, who helped you?

☐ Relative ☐ Friend ☐ Neighbor ☐ County Welfare department ☐ Other _____

18 (17) *I certify that all the information above is true and complete to the best of my knowledge.*

SIGNATURE OF APPLICANT _____ DATE _____

SIGNATURE OF PERSON WHO HELPED COMPLETE THIS FORM _____ DATE _____

(4) A level of literacy of the beneficiary and the authorized representative which, in conjunction with other social or language barriers, precludes the beneficiary and the authorized representative from completing the status report.

(5) Failure of the county to properly process the submitted Statement of Facts or status report form.

(6) Unavailability of transporation to the county department for the face-to-face interview.

50176. Discontinuance Due to Death. Eligibility, shall be discontinued at the end of the month in which a person dies.

50177. Promptness Requirement. (a) The county department shall complete the determination of eligibility and share of cost as quickly as possible but not later than any of the following:

(1) Forty-five days following the date the application, reapplication or request for restoration is filed.

(2) Sixty days following the date the application, reapplication or request for restoration is filed when eligibility depends on establishing disability or blindness.

(b) The 45 and 60 day periods may be extended for any of the following reasons:

(1) The applicant, for good cause has been unable to return the completed Statement of Facts, Supplement to Statement of Facts for Retroactive Coverage/Restoration or necessary verification in time for the county department to meet the promptness requirement.

(2) There has been a delay in the receipt of reports and information necessary to determine eligibility and the delay is beyond the control of either the applicant or the county department.

(3) The applicant's guardian, or other person acting in the applicant's behalf, has failed to provide essential information requested by the county. The extended eligibility determination period shall not exceed three months from the date of application when this situation occurs.

(c) The determination of eligibility shall be considered complete on the date the Notice of Action is mailed to the applicant.

50179. Notice to Applicants and Beneficiaries. (a) County departments shall notify beneficiaries in writing of their eligibility or ineligibility for Medi-Cal and of any changes made in their eligibility status or share of cost.

(b) The Department shall notify those persons determined to be eligible for SSI/SSP by the Social Security Administration that they are also eligible for Medi-Cal.

(c) The Notice of Action shall be on a form prescribed by the Department and shall include the name and telephone number of the eligibility worker who completed the eligibility determination, and the date the form was completed. A copy of the Notice of Action shall be placed in the case file.

(d) The Notice of Action shall include the following:

(1) The approval or denial of eligibility or the change in the share of cost.

(2) The amount of the share of cost, if any, and the amount of the net nonexempt income used to determine the share of cost.

(3) The reason an action is being taken and the law or regulation that requires the action, if the action is an adverse action.

(4) The applicant's or beneficiary's responsibility to report to the county department not later than 10 calendar days following the date of the change, any:

(A) Change of address.

(B) Change in property or income.

(C) Change in family composition.

(D) Change in other health care coverage.

(5) The requirement to report to the county department, and to utilize fully, any contractual or other legal entitlement to health care coverage; and that willful failure to report such benefits and utilize them, when available, before obtaining Medi-Cal benefits is a misdemeanor.

(6) The right to request a fair hearing if dissatisfied with:

(A) Any action taken by the county department that affects the applicant's or beneficiary's Medi-Cal eligibility or share of cost.

(B) Any action taken by, or on behalf of, the Department that affects the applicant's or beneficiary's Medi-Cal benefits.

(7) The procedures for requesting a fair hearing and the time limits within which a fair hearing must be requested.

(e) The Notice of Action shall be mailed at least 10 days prior to the first of the month in which a change made by the county department in the person's or family's eligibility status or share of cost becomes effective. This requirement shall apply only when the change is an adverse action.

(f) Duplicate Notices of Action shall be mailed to the administrator of the long-term care facility in which the applicant or beneficiary resides, if the applicant or beneficiary or person acting on their behalf has made such a request.

50180. Action Prior to Denial of Application. Persons or families denied Medi-Cal eligibility under any program other than SSI/SSP shall have their circumstances evaluated by the county department prior to denial. If it appears that eligibility would exist under any program other than SSI/SSP, the application shall be processed under that program. The date of application shall be the date of the original application.

50181. Action Following Denial of an SSI/SSP Application. (a) Persons denied SSI/SSP eligibility, who then apply for Medi-Cal at the county department, shall have their application processed under the appropriate program. The date of application shall be:

(1) The date of the original application for SSI/SSP for those persons who apply at the county department within 30 days of receipt of a written notice of denial of SSI/SSP benefits.

(2) The date the person's completed application form is received by the county department for those persons who do not apply at the county department within the 30-day period specified in (1).

AB 887 and SB 1004 -- MOBILE HOMES

Implementing Regulations: CAC, Title 22, Sections 50425 and 50463

AB 887 and SB 1004, effective January 1, 1980, specify that certain mobile homes, which have previously been considered personal property for legal and taxing purposes, will now be assessed and be subject to local property taxation. In general, mobile homes will be assessed as a fixture or improvement to real property when: (1) the mobile home is purchased on or after January 1, 1980; and (2) the mobile home is installed on a foundation system for occupancy as a residence. Additionally, effective July 1, 1980, mobile homes not previously subject to local property taxation will become subject to property taxation if the owner has allowed the vehicle registration to lapse for a period of 120 days or more. As a result of these bills, Medi-Cal eligibility regulations have been changed to provide that mobile homes which are assessed by the county assessor's office as real property are other real property when not used as a home and can therefore be retained, providing the net market value is within the other real property limit and the utilization requirements are met. Of course, any mobile home used as an applicant's or beneficiary's home continues to be totally exempt.

If a Medi-Cal applicant or beneficiary reports ownership of a mobile home, counties must have the applicant state whether the mobile home is recorded with the county recorder or assessor's office. This will be pointed out in the set of instructions for the MC 210 (Statement of Facts Form) that is now being developed. Although, by and large, only mobile homes purchased on or after January 1980 are affected, it is recommended that this information be obtained for all mobile homes. There will be no need to ask the applicant or beneficiary to request an assessment since the county assessor's offices will be independently notified of those mobile homes which are subject to local property taxation. For Medi-Cal eligibility purposes, mobile homes will be considered as other real property the month in which they become subject to local property taxation, even if the tax assessment is not performed that month.

It is recommended that you contact the local recorder's and assessor's office in your county for details concerning those office's implementation of these two bills. To the extent that general rules of statewide applicability are developed, we will issue descriptions/instructions regarding the treatment of mobile homes in the procedures portion of the Medi-Cal Eligibility Manual.

50425. Property Used as a Home. (a) Real or personal property used as a home shall be exempt if any of the following situations exist:

(1) The applicant or beneficiary lives in the home.

(2) The family of the applicant or beneficiary lives in the home and Medi-Cal eligibility is determined in either of the following ways:

(A) With the applicant or beneficiary and the family in a single MFBU.

(B) With the income of the family considered in determining the applicant's or beneficiary's eligibility.

(3) The applicant or beneficiary is an LTC patient who is expected, according to a verified medical determination, to return home within six months of the date LTC status began.

(4) The applicant or beneficiary is an LTC patient and the patient's spouse or children, as defined in Section 50030, live in the home.

(b) A home may consist of real or personal property, fixed or mobile, located on land or water. The home may include land or buildings surrounding or contiguous to the residence which are:

(1) Normally used as part of the home.

(2) Not considered other real property in accordance with Sections 50427 through 50437.

(c) The following items of real property may serve as a home:

(1) A house.

(2) A portion of a multiple dwelling unit, in accordance with Section 50435.

(3) The items listed in (d) shall be considered as real property for Medi-Cal purposes when they are assessed as real property by the county assessor of the county in which the property is located.

(d) The following items of personal property may serve as a home:

(1) A mobile home.

(2) A houseboat.

(3) A motor vehicle used as a residence.

(4) Any other shelter not attached to the land and used as a residence.

(e) Two dwellings may be exempt as the home if a health condition precludes the beneficiary from living in either one throughout the year.

(f) Real property formerly used as a home shall be considered other real property, effective the first of the month following the date the property is no longer used as a home as specified in (a). Such property shall be subject to all conditions placed upon other real property in these regulations.

(g) Personal property formerly used as a home shall be evaluated as an item of personal property beginning the first of the month following the date the property is no longer used as a home as specified in (a).

50426. Property Used to Purchase a Home. (a) The proceeds from the sale of real property retained by an applicant or beneficiary who does not own a suitable home or who wishes to sell the current home and purchase a new home shall be exempt for a period of six months from the date of receipt of the proceeds so long as the proceeds from the sale of the real property are intended to be used to purchase a home. Such proceeds may also be applied to the costs of moving, necessary furnishings, and repair or alteration to the home.

(b) If a portion of the proceeds specified in (a) is diverted to some other purpose, the status of the remainder is not affected provided such remainder is being retained to apply toward the purchase of a home.

50463. Boats, Campers, Trailers. (a) The net market value of boats, campers and trailers, including mobile homes, which are not assessed as real property by the county assessor, shall be included in the property reserve unless exempt as either of the following:

(1) A home.

(2) A vehicle used for transportation.

(b) Items in (a) which are assessed as real property by the county assessor of the county in which the property is located and which are not exempt as a home shall be considered as other real property for Medi-Cal purposes and treated in accordance with Section 50427.

(c) The net market value of these items shall be determined as follows:

(1) The market value shall be any of the following:

(A) The average of three appraisals by dealers, insurance adjustors or personal property appraisers submitted to the county department by the applicant or beneficiary.

(B) The market value placed on the item by the county assessor.

(C) The market value of the item determined by use of the State Department of Motor Vehicle's license fee chart.

(D) The original purchase price of the item if the applicant or beneficiary does not wish or is unable to provide three appraisals or the market value cannot be determined in accordance with (B) or (C).

(2) The net market value shall be the market value less any encumbrances of record.

50465. Household Items. All items used to furnish and equip a home shall be exempt.