

DEPARTMENT OF HEALTH SERVICES

714/744 P STREET
SACRAMENTO, CA 95814
(916) 445-1912



March 12, 1981

To: All County Welfare Directors

Letter No. 81-11

REVISION OF MC 210

The Statement of Facts, form MC 210 has been revised to incorporate changes in the Medi-Cal program. A copy of this revision, dated October 1980, is attached. The form is already in use in some of the counties that have converted to the Simplified Medi-Cal Disability Referral System (SMDRS). This form will be available to all counties on April 1.

This revision of the MC 210 includes the following major changes:

1. Question 3c has been added to gather information necessary for Social Security Number validation. The Social Security Number Validation procedures are explained in All County Letter No. 81-8.
2. Question 5b asks whether a person who maintains a home in another state is working or looking for work in California. There are proposed regulations which would allow these persons to be eligible for Medi-Cal. It is anticipated that these regulations will be effective in September, 1981. Until that time, this question has no impact on a person's eligibility.
3. Question 9b has been revised as part of SMDRS. Those counties who are not yet using SMDRS for disability determinations should continue with the standard procedures given in Eligibility Manual Section 4A, if the client answers "yes" to this question.
4. Question 24 asks for information about self-employment that is necessary to determine if the property listed in this question, and if property listed in Question 20, can be exempt as business property in accordance with Section 50485.
5. Question 27 implements Section 50554 (MFBU regulations) which allows AFDC-MN and MI persons a deduction for child support and alimony.
6. Question 30 (and part of Question 8) ask for information regarding any funds a person has paid toward the cost of health care received in a month for which the person is now requesting Medi-Cal. The question is part of a planned process being developed to ensure that Medi-Cal does not pay for care which the applicant paid for or should have paid for in order to reduce his/her property to within the property limits. Until you receive further instructions on this process, take no action on Question 30 and the portion of Question 8 involved.

7. Question 31 has been added to determine whether Medi-Cal eligibles may be eligible for V.A. benefits. See Procedure 10J for steps to be followed in completing and processing the CA 5.
8. Question 32 implements Section 50816, which requires that Medi-Cal applicants and beneficiaries must take any action necessary to obtain unconditionally available income.

Because of the major changes to the MC 210, we would like all counties to begin using it by May 1, 1981 whether or not you have used up your entire supply of any prior version of the form. Because of the current limited supply of the MC 210, we are asking that each county order only a three month supply. Additional forms will be available in June.

If you have any questions, contact your program consultant at (916) 445-1912.

Sincerely,

Original signed by

Barbara V. Carr, Acting Chief
Medi-Cal Eligibility Branch

Attachment

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

Expiration Date: June 30, 1981

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.

STATEMENT OF FACTS FOR MEDI-CAL

PLEASE USE INK

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

3. 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)	Sex	Birthdate (Mo/Day/Yr.)	Marital Status					Living With Applicant		Medi-Cal Requested		Date	E.W.
			Single	Married	Divorced	Separated	Widowed	Yes	No	Yes	No		
1. Applicant													
SS #													
2. Spouse													
SS #													

3b. List all your and your spouse's unmarried children under 21 (including unborns) living in the home. Also list those out of the home for whom you are requesting Medi-Cal.

	Sex	Birthdate (Mo/Day/Yr.)	In School		PARENTS		Parent Is: (if applicable)				Child Living With Applicant		Medi-Cal Req. for Child	
			Yes	No	1 Father's Name	2 Mother's Name	Deceased	Absent	Incapacitated	Unemployed	Yes	No	Yes	No
1.					(1)									
SS #					(2)									
2.					(1)									
SS #					(2)									
3.					(1)									
SS #					(2)									
4.					(1)									
SS #					(2)									
5.					(1)									
SS #					(2)									
6.					(1)									
SS #					(2)									

If 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.

[REMEMBER: FAMILY MEMBERS INCLUDE ALL THOSE PEOPLE LISTED IN 3A AND 3B]

3. Complete for persons listed in 3a or 3b who are not living with you.

COUNTY USE ONLY

Name	Address

Is there anyone other than you or your family members listed in 3a or 3b living with you? Yes No If yes:

Name	Relationship

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:

Do you or any family member maintain 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.

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

Name of Alien	Alien Registration Number

Where required, date CA 5 signed

Have you or any family member ever received or applied for welfare payments, food stamps and/or medical assistance from a county welfare office or another state or have you applied for SSI/SSP (gold check) from Social Security? Yes No If yes:

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

- Receiving or applied for cash grant or Medi-Cal around August 1972? If yes, check for 20% SS increase eligibility
- 4 month continuing eligibility?
- SGA disabled?
- Title II disregarded?
- 30 + 1/3 earnings exemption?

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 Want Medi-Cal For These Months	
		Yes	No	Yes	No

- Retroactive Application Retro only
- Retro and Cont.
- Payments reduced property to within property limits? 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) _____

Verification of Disability/blindness (list)

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)

Date Verified _____ E.W. Disability referral

10. Complete the following information about your living arrangements:

- Rent a room, apartment, house or trailer
- Pay for 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 \$ _____

- 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 \$ _____

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: _____

Verification that will return home in six months
Yes No

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 Income (list)

Date Verified _____ E.W. _____

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	No
A.				\$		
B.				\$		
C.				\$		
D.				\$		
E.				\$		

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	No
A.				\$	\$		
B.				\$	\$		
C.				\$	\$		
				\$	\$		

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. List all your assets and the assets of all family members. If none, check the box marked "None".

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

For a, b, c and/or d
Income in the month included?
Yes No If yes, amount: \$ _____

For a and/or b
Income from business or self-employment included?
Yes No If yes, amount: \$ _____
(See 24C)

16. Do you or any family member have life insurance? Yes No If yes, list:

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

COUNTY USE ONLY

Heirlooms?

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

20. Do you or any family member own business equipment, tools, inventory or material (including livestock or poultry not for personal use)? Yes No If yes, list:

Description	Estimated Value	Amount Owed
A.	\$	\$
B.	\$	\$
C.	\$	\$

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:

Disposition of proceeds:

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

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

22. Do you or any family member have any of the following sources of income. Check yes or no for each item and fill in the amounts received.

TYPE OF INCOME	Yes	No	FAMILY MEMBERS				
			Applicant	Spouse	CHILDREN		
					Name:	Name:	Name:
Cash Grant (welfare), e.g., SSI/SSP (gold check) AFDC, GR or GA			\$	\$	\$	\$	\$
Social Security: Type _____			\$	\$	\$	\$	\$
Railroad Retirement			\$	\$	\$	\$	\$
Nonmilitary Retirement or Pension			\$	\$	\$	\$	\$
Unemployment			\$	\$	\$	\$	\$
Disability Insurance: Check one: <input type="checkbox"/> State <input type="checkbox"/> Private			\$	\$	\$	\$	\$
Worker's Compensation			\$	\$	\$	\$	\$
Veteran's Benefits including GI Bill			\$	\$	\$	\$	\$
Military Allotment			\$	\$	\$	\$	\$
Child Support			\$	\$	\$	\$	\$
Alimony			\$	\$	\$	\$	\$
Payment from roomers			\$	\$	\$	\$	\$
Monetary gifts/contributions			\$	\$	\$	\$	\$
Interest income and dividends (Itemize)			\$	\$	\$	\$	\$
			\$	\$	\$	\$	\$

Type of Cash Grant:

Verification (List):

Date Verified E.W.

23. Have you or any family member been employed at any time during this month? Yes No If yes, complete the following:

COUNTY USE ONLY

A. 1. Working Member's Name			
2. Name of Employer			
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 24.	\$	\$	\$

Verification (list)

Deductions/Expenses (per pay period)			
1. Federal Income Tax	\$	\$	\$
2. State Income Tax	\$	\$	\$
3. Social Security	\$	\$	\$
4. Mandatory Retirement	\$	\$	\$
5. State Disability (SDI)	\$	\$	\$
6. Mandatory Union Dues	\$	\$	\$
7. Mandatory deduction for meals	\$	\$	\$
8. Cost of tools, clothing, licenses or materials required solely for work	\$	\$	\$
9. Child Care necessary for work	\$	\$	\$
10. Other (except transportation) List:			

Date Verified E.W.

Transportation cost allowed (Show Computation)

... Transportation to Work and for Child Care.			
a. Round trip miles per day.			
b. Type of transportation used (own car, someone else's car, car pool, bus, etc.)			
c. Costs (per pay period)			
- Amount paid by employee (if doesn't use own car)	\$	\$	\$
- Amount paid by riders	\$	\$	\$
- Amount paid by employer	\$	\$	\$
d. Cost per pay period for parking, tolls, etc.	\$	\$	\$
e. Is public transportation (bus, train, etc.) available?	Yes <input type="checkbox"/> No <input type="checkbox"/> \$	Cost Yes <input type="checkbox"/> No <input type="checkbox"/> \$	Cost Yes <input type="checkbox"/> No <input type="checkbox"/> \$

24. Are you or any family member self-employed? Yes No If yes, complete the following.

Verification

- Tax return
- Business records

A. Name of business:	_____
Type of business:	_____
Location:	_____

Date Verified E.W.

Net profit from self-employment:

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
\$			\$	\$
Cash On Hand For Business	Money in Checking Accounts for Business		Average Monthly Cash Expenditures for Business	
\$	\$		\$	

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

1. Rent or housing	Yes <input type="checkbox"/> No <input type="checkbox"/>	Who receives:	From whom:
2. Food	Yes <input type="checkbox"/> No <input type="checkbox"/>	Who receives:	From whom:
3. Utilities	Yes <input type="checkbox"/> No <input type="checkbox"/>	Who receives:	From whom:
4. Clothing	Yes <input type="checkbox"/> No <input type="checkbox"/>	Who receives:	From whom:

Verification (list):

Date Verified _____ E.W. _____

26. Are you or any family member in college or attending a similar educational institution?
Yes No If yes, complete the following:

	Student:	Student:	Student:
1. Name of institution			
2. Status of student	Grad <input type="checkbox"/> Undergrad. <input type="checkbox"/>	Grad <input type="checkbox"/> Undergrad. <input type="checkbox"/>	Grad <input type="checkbox"/> Undergrad. <input type="checkbox"/>

Verification (list):

Date verified _____ E.W. _____

1. Grants, loans, scholarships, fellowships

1. Amount received	\$	\$	\$
2. Source(s) of grants, loans, etc.			
3. How often received			

Exempt:
 Entire amount
 Only expenses

2. 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 <input type="checkbox"/> No <input type="checkbox"/>	Cost \$	Yes <input type="checkbox"/> No <input type="checkbox"/>

Transportation costs allowed:
(Show computation)

7. 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

8. Do you or any family member have health or hospitalization insurance, including insurance paid by an employer or absent parent? Yes No If yes, complete the following:

Coverage (Check)	Person(s) Insured	Monthly Premium Paid
<input type="checkbox"/> CHAMPUS		\$
<input type="checkbox"/> Veterans Administration coverage (including CHAMPVA & VA outpatient)		\$
<input type="checkbox"/> Kaiser		\$
<input type="checkbox"/> Ross - Loos		\$
<input type="checkbox"/> Blue Shield		\$
<input type="checkbox"/> Blue Cross		\$
<input type="checkbox"/> Other _____		\$

29. 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 <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
B.		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
C.		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Date Verified E.W.

30. 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
\$		

Payment used to bring property within property limits Yes No

If yes:
 Notice to Provider

31. A. Have you or any family member ever been in the military service? Yes No
 B. Are you or any family member the spouse, parent or child of a person who has been in the military services?
 Yes No

CA 5
 CA 5

32. 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/Date/Year
Social Security			
Disability Payments			
Veteran's Payments			
Unemployment Benefits			
Worker's Compensation			
Medicare			
Pending suit or insurance settlement for accident or injury			
Describe			

Date of accident/injury

COMPLETE ONLY IF THE FAMILY INCLUDES CHILDREN UNDER 21
 33. Is a parent living in the home unemployed or working less than 100 hours per month?
 Yes No If yes, complete the following:

A. If Unemployed, Last Day Worked	Working Less Than 100 Hours		In School Or Training		Actively Seeking Full-Time Employment		Date Began Seeking Employment	
	Month / Day / Year	Yes	No	Yes	No	Yes	No	Month / Day / Year
/ /								/ /

B. In the last 30 days has the unemployed parent:
 Quit a job or employment related training? Yes No
 Refused a job or employment related training? Yes No If yes, explain why:

Good cause
 Yes No

C. Did the unemployed parent receive or was he/she eligible to receive unemployment insurance benefits within the last 12 months?
 Yes No

Did the unemployed parent earn \$50 or more or attend 5 days or more of work training in the last 20 quarters?
 Yes No If yes, complete the following:
 (Enter the year and check the appropriate quarters)

YEAR	19				19				19				19			
	Jan. Mar.	Apr. Jun.	Jul. Sep.	Oct. Dec.	Jan. Mar.	Apr. Jun.	Jul. Sep.	Oct. Dec.	Jan. Mar.	Apr. Jun.	Jul. Sep.	Oct. Dec.	Jan. Mar.	Apr. Jun.	Jul. Sep.	Oct. Dec.
Work training																

