

## DEPARTMENT OF HEALTH SERVICES

714/744 P STREET  
SACRAMENTO, CA 95814

December 15, 1983

To: All County Welfare Directors

Letter No. 83- 81

## STATE CORRECTIVE ACTION INITIATIVE - MEDI-CAL CARD STUFFER

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

Quality Control (QC) Error

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

Corrective Action

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

County Action

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

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

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

Sincerely,

ORIGINAL SIGNED BY

Caroline Cabias, Chief  
Eligibility Branch

Attachment

cc: Medi-Cal Liaisons  
Medi-Cal Program Consultants

INSTRUCTIONS:

Attachment I

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

2. Home Address Number Street City ZIP Code

Mailing address (if different from above)

Home Phone Work phone Message phone Person with whom to leave message

COUNTY USE ONLY

Case name:

State No.:

App./redetermination date

Verification of identity

Date EW

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	
			Single	Married	Divorced	Separated	Widowed	Yes	No	Yes	No
Applicant											
SS No.											
Spouse											
SS No.											

1. Date EW

Verification of SS No.

1. Date EW

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

6. \_\_\_\_\_

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

Name	Sex	Place	In School		PARENTS 1) Father's Name 2) Mother's Name	Parent is: (✓ if applies)				Child Living With Applicant		Medi-Cal Req. for Child	
			Yes	No		Deceased	Absent	Incubated	Unemployed	Yes	No	Yes	No
1.					(1)								
SS No.					(2)								
2.					(1)								
SS No.					(2)								
3.					(1)								
SS No.					(2)								
4.					(1)								
SS No.					(2)								
5.					(1)								
SS No.					(2)								
6.					(1)								
SS No.					(2)								

Tax Record Verification

3C. Did you or any family member use a different name than the one listed above when each of you applied for your Social Security number? Yes  No  If yes, list names.

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

COUNTY USE ONLY

Name	Address

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

Name	Relationship

5A. Are you or any family member requesting Medi-Cal living or currently staying outside California? Yes  No  If yes: Date left California \_\_\_\_\_ Date expected to return \_\_\_\_\_ Reason for absence: \_\_\_\_\_

B. Do you or any family member have a home outside California? Yes  No   
 If yes, are you or any family member working or looking for work in California? Yes  No   
 If no, explain why you are in California. \_\_\_\_\_

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

Name of Alien	Alien Registration Number

Where required, date CA signed.

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

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

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

- Retroactive application
- Retro only
- Retro and cont.
- Verification of disability/blindness (list)

8. If you or any family member were *not* receiving Medi-Cal in the last three months, did you or those family members receive any medical care? Yes  No  If yes:

Name of Person Receiving Medical Care	Month(s) of Care	Payments Made For Care		Do You Wish Medi-Cal For Those Months	
		Yes	No	Yes	No

Retroactive application  
 Retro only   
 Retro and cont.

9A. Are you or any family member requesting Medi-Cal:  
 65 or over? Yes  No  If yes, name(s) \_\_\_\_\_  
 Blind? Yes  No  If yes, name(s) \_\_\_\_\_

B. Do you or any family member have a physical or emotional problem which makes it difficult to work or take care of your needs? Yes  No  If yes:

Family Member(s)	Type of Problem(s)	Beginning Date of Problem(s)

Date Verified \_\_\_\_\_ EW

Disability ref.

Date Sent \_\_\_\_\_

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

Referral to Medi-Cal recovery

- Complete the following information about your living arrangements:
- Rent a room, apartment, house, or trailer \$ \_\_\_\_\_ Rent \_\_\_\_\_
  - Pay for room and board \$ \_\_\_\_\_ Room and board \_\_\_\_\_
  - Work in exchange for room and board
  - Receive free room
  - Receive free room and board
  - Live in a board and care facility
  - Live in a nursing home or hospital

Date entered \_\_\_\_\_ Date expected to return home \_\_\_\_\_

Live in and own/buying a trailer, mobile home, boat, or motor vehicle which is *not* taxed as real property by the county.  
 Description: \_\_\_\_\_  
 Estimated value \$ \_\_\_\_\_ Amount owed \$ \_\_\_\_\_ Monthly payment \$ \_\_\_\_\_

Live in and own/buying a home or a trailer or mobile home which is taxed as real property by the county.  
 Assessed value \$ \_\_\_\_\_ (from tax statement) Amount owed \$ \_\_\_\_\_ Monthly payment \$ \_\_\_\_\_  
 Land home is located on includes more than one parcel. Yes  No  If yes, complete 11.  
 Land home is located on includes more than one acre. Yes  No  If yes, complete 11.

Other living arrangements. Describe: \_\_\_\_\_

Verification that will return home in six months  
 Yes  No

Verification of property  
 \_\_\_\_\_  
 Date Verified \_\_\_\_\_ EW \_\_\_\_\_

11. Do you or any member of your family own real property which you do not now live in (for example, land or buildings) or a trailer or mobile home which is taxed as real property by the county and which you do not now live in? Yes  No  If yes:

Description: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Owner: \_\_\_\_\_ Used in part as a home? Yes  No

Full value (from tax statement) \$ \_\_\_\_\_ Amount owed \$ \_\_\_\_\_ Rent collected each month \$ \_\_\_\_\_

Expenses on property:

Interest	\$ _____	Yearly <input type="checkbox"/> Monthly <input type="checkbox"/>	Insurance	\$ _____	Yearly <input type="checkbox"/> Monthly <input type="checkbox"/>
Taxes and Assessments	\$ _____	Yearly <input type="checkbox"/> Monthly <input type="checkbox"/>	Upkeep and Repairs	\$ _____	Yearly <input type="checkbox"/> Monthly <input type="checkbox"/>
Utilities	\$ _____	Yearly <input type="checkbox"/> Monthly <input type="checkbox"/>			

Verification of "good cause" for unutilized property  
 \_\_\_\_\_

Date Verified \_\_\_\_\_ EW \_\_\_\_\_

Verification of income and expenses (list)  
 \_\_\_\_\_

Date Verified \_\_\_\_\_ EW \_\_\_\_\_

12. Do you or any family member have a life estate (right to the use of) in any property? Yes  No   
 If yes, describe: \_\_\_\_\_

Revocable  
 Irrevocable

13. Do you or any family member own a motor vehicle (including cars, trucks, motorcycles, etc.)? Yes  No  If yes, list:

Make and Model	Year	Class (From Registration)	Owner	Amount Owed	Used for Transportation	
					Yes	No
				\$		
				\$		
				\$		
				\$		
				\$		

Verification of nonexempt vehicles  
 \_\_\_\_\_

Date Verified \_\_\_\_\_ EW \_\_\_\_\_

14. Do you or any family member own boats, campers (do not include trucks), motor homes, mobile homes, or trailers which are not used as a home and are not taxed as real property by the county? Yes  No  If yes, list:

Description	Year	Class (If Registered)	Owner	Purchase Price	Amount Owed	Only Means of Transportation	
						Yes	No
				\$	\$		
				\$	\$		
				\$	\$		
				\$	\$		

Verification of personal property  
 \_\_\_\_\_

Date Verified \_\_\_\_\_ EW \_\_\_\_\_

NOTE: If you think the value the Department of Motor Vehicles will give the items listed in 13-14 will be too high, you may provide three appraisals of the actual value and the average will be used.

15. DO YOU OR YOUR FAMILY HAVE ANY OF THE RESOURCES LISTED BELOW?

Check each item. If YES, explain below.

COUNTY USE ONLY

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

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

For A, B, and/or C  
Income from business or self-employment included?  
Yes  No  If yes amount: \$ \_\_\_\_\_  
(See 26C)

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

Date Verified \_\_\_\_\_ EW \_\_\_\_\_

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. _____				

Total CSV \$ \_\_\_\_\_

Date Verified \_\_\_\_\_ EW \_\_\_\_\_

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 \_\_\_\_\_

Current value \$ \_\_\_\_\_

Date Verified \_\_\_\_\_ EW \_\_\_\_\_

18. Do you or any family member own a burial plot, vault, or crypt? Yes  No

For use of immediate family? Yes  No

If for use of anyone other than a member of the immediate family, complete the following:

Description \_\_\_\_\_ Owned by \_\_\_\_\_  
Estimated value \$ \_\_\_\_\_ Amount owed \$ \_\_\_\_\_  
Location \_\_\_\_\_

19. Do you or any family member own items of jewelry valued at more than \$100 each? (Do not include wedding and engagement rings or heirlooms.) Yes  No  If yes, list:

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

Heirlooms?  
Appraised value \$ \_\_\_\_\_

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

21. Have you or any family member transferred, sold, or given away any property (including money) at any time since you first applied for Medi-Cal or during the two years prior to that? Yes  No  If yes, list:

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

A. TYPE OF INCOME

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

Type of cash grant:

Verification (list):

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

Date Verified EW

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

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

Verification (list):

	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Who receives:	From whom:
A. Rent or housing	<input type="checkbox"/>	<input type="checkbox"/>		
B. Food	<input type="checkbox"/>	<input type="checkbox"/>		
C. Utilities	<input type="checkbox"/>	<input type="checkbox"/>		
D. Clothing	<input type="checkbox"/>	<input type="checkbox"/>		

Date Verified EW

24. Do you or any family member pay child support or alimony under a court order or based on an agreement with the district attorney? Yes  No  If yes, complete the following:

Amount Paid	By Whom	To Whom

Yes  No  If yes, complete the following:

A. 1. Working member's name			
2. Employer's name			
3. Address of employer			
4. Days of work per week	Days	Days	Days
5. Hours of work per week	Hrs.	Hrs.	Hrs.
6. How often paid (every week, twice a month, every two weeks, etc.)			
7. Day of the week you are paid			
8. Gross (total) earnings per pay period (before deductions) (include tips). If self-employed, write self-employed here and complete No. 26.	\$	\$	\$
9. Occupation			

Verification (list)

Wage stubs

Tips

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

2. Do you pay for the care of an incapacitated adult living in your home in order to be able to work? Yes  No  \$ \_\_\_\_\_ monthly amount Name \_\_\_\_\_ Relationship \_\_\_\_\_

Verification of dependent care

C. Anticipated Income. If your income varies from month to month, show your actual gross income for the current month in Month 1 and your estimated gross income for the following two months in Month 2 and Month 3.

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

Date Verified EW

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

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

A. Name of business \_\_\_\_\_

Type of business \_\_\_\_\_

Location \_\_\_\_\_

Verification

Tax return

Business records

Date Verified EW

B. Adjusted Gross Income From Last Tax Statement	Has Income Changed Since Last Tax Statement		If No Tax Statement or Change in Income:	
	Yes	No	Estimated Yearly Gross Profit	Estimated Yearly Business Expenses
\$			\$	\$
C. Cash on Hand for Business	Money in Checking Accounts for Business		Average Monthly Cash Expenditures for Business	
\$	\$		\$	

Net profit from self-employment:

\$

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

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

Name of Employer or Training Program	Work or Training / Check	When Employed From / / To / /	Amount Paid \$ Weekly / Monthly	Name of Employer or Training Program	Work or Training / Check	When Employed From / / To / /	Amount Paid \$ Weekly / Monthly
1.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ Weekly / Monthly	7.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ Weekly / Monthly
2.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ Weekly / Monthly	8.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ Weekly / Monthly
3.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ Weekly / Monthly	9.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ Weekly / Monthly
4.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ Weekly / Monthly	10.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ Weekly / Monthly
5.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ Weekly / Monthly	11.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ Weekly / Monthly
6.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ Weekly / Monthly	12.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ Weekly / Monthly

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

Name of Employer or Training Program	Work or Training / Check	When Employed From / / To / /	Amount Paid \$ Weekly / Monthly	Name of Employer or Training Program	Work or Training / Check	When Employed From / / To / /	Amount Paid \$ Weekly / Monthly
1.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ Weekly / Monthly	7.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ Weekly / Monthly
2.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ Weekly / Monthly	8.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ Weekly / Monthly
3.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ Weekly / Monthly	9.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ Weekly / Monthly
4.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ Weekly / Monthly	10.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ Weekly / Monthly
5.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ Weekly / Monthly	11.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ Weekly / Monthly
6.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ Weekly / Monthly	12.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ Weekly / Monthly

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

Name of Person

Dates Received

2.

COUNTY USE ONLY

First Parent's Earnings

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

Total Earnings \$ \_\_\_\_\_

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

Quarters \_\_\_\_\_

Second Parent's Earnings

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

Total Earnings \$ \_\_\_\_\_

Primary Wage Earner

1st  2nd Parent

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

Quarters \_\_\_\_\_

UIB:  
 Eligible  Referral  
 Eligible  Referral

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

Parent's Name	Amount of last paycheck \$	Last day of job/training mo. day yr.	Hours of work/training in last 30 days
Name and Address of Employer/Training Program		Reason for Leaving or Refusal	

- Employer statements
- Determination of "good cause" required

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

who \_\_\_\_\_ Date Person Went on Strike \_\_\_\_\_

Striker(s)

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

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

B. Grants, loans, scholarships, fellowships

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

Verification (list): \_\_\_\_\_  
Date Verified EW

C. Expenses Per Term

1. Is term a semester, quarter, year			
2. Tuition/fees	\$	\$	\$
3. Books, equipment, and supplies	\$	\$	\$
4. Child care necessary for school	\$	\$	\$
5. Transportation to school—child care			
a. Round trip miles per day			
b. School attended how many days per week			
c. Type of transportation used (own car, someone else's car, car pool, bus, etc.)			
d. Costs (per month)			
• Amount paid by student (if doesn't use own car)	\$	\$	\$
• Amount paid by riders	\$	\$	\$
e. Parking, tolls, etc.			
f. Is public transportation (bus, train, etc.) available	Yes <input type="checkbox"/> No <input type="checkbox"/>	Cost \$	Yes <input type="checkbox"/> No <input type="checkbox"/> Cost \$

Exempt:  
 Entire amount  
 Only expenses

Transportation costs allowed: (show computation)

30. Do you or any family member have Medicare coverage? Yes  No  If yes, list:

Person Covered	Medicare Claim Number	Monthly Premium	
		Deduction From Check	Paid by You
A.		Yes <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 EW

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

Coverage (Check)	Person(s) Insured	Monthly Premium Paid
<input type="checkbox"/> CHAMPUS/CHAMPVA		\$
<input type="checkbox"/> Veterans Administration coverage (50% or above disability rating)		\$
<input type="checkbox"/> Kaiser		\$
<input type="checkbox"/> Ross-Loos (INA)		\$
<input type="checkbox"/> Blue Shield		\$
<input type="checkbox"/> Blue Cross		\$
<input type="checkbox"/> Other		\$

COUNTY USE ONLY

Date HRB 2 completed \_\_\_\_\_  
 Other health coverage code entered \_\_\_\_\_  
 Verification (list) \_\_\_\_\_  
 Date Verified \_\_\_\_\_ EW \_\_\_\_\_

32. Have you or any family member made a down payment for medical care you will receive in the future?  
 Yes  No  If yes,

Amount of Down Payment	To Whom Made	Medical Care to be Received
\$		

Payment used to bring property within property limits Yes  No   
 If yes:  
 Notice to provider

33A. Have you or any family member ever been in U. S. military service? Yes  No

CA 5

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

CA 5

34. Have you or any family member applied for or do you or any family member think you are eligible for any payment/s you are not now receiving? Yes  No  If yes, complete the following:

Kind of Payment	Person Possibly Eligible	Date of Application Month/Day/Year	Date Expected Month/Day/Year
Social Security			
Disability payments			
veteran's payments			
Unemployment Benefits			
Workers' Compensation			
Medicare			
Pending suit or insurance settlement for accident or injury			
Other: Describe			

Date Verified \_\_\_\_\_ EW \_\_\_\_\_  
 Medi-Cal recovery referral  
 Date \_\_\_\_\_  
 Date of accident/injury  
 Medi-Cal recovery referral  
 Date \_\_\_\_\_

35. Services (these questions do not affect your eligibility for Medi-Cal)

- A. Are you interested in physical examinations for any family member under 21 through the Child Health Disability Prevention Program? Yes  No
- B. Are you interested in information on the Family Planning Program? Yes  No
- C. Are you interested in talking to a social services worker about other services which may be available to you? Yes  No  If yes, explain:

CHDP brochure given  
 Date \_\_\_\_\_  
 CHDP referral  
 Social services referral

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


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

- I agree to tell the county welfare department within TEN DAYS if there are any changes in my (or the person's on whose behalf I am acting) income, possessions, or expenses or in the number of persons in the household or of any change of address or of any change in other health insurance coverage; and I agree to meet all other responsibilities explained in the "Medi-Cal Responsibilities Checklist" I have received.
- I understand that I must report immediately the death of a member of my household or the person on whose behalf I am acting.
- I understand that the information I put on this form will be verified and that I must cooperate fully in any investigation required for quality control.
- I understand that Section 700.1 of the Probate Code and Section 14009.5 of the Welfare and Institutions Code provide for the recovery of all Medi-Cal benefits received after age 65 from the estate of a Medi-Cal beneficiary if there is no surviving spouse, minor children, or blind or totally disabled children.
- I understand that any information gathered is confidential and not open to inspection other than for purposes directly connected with the administration of the Medi-Cal program.
- I understand that if I am dissatisfied with actions taken by the county welfare department, I have the right to a state hearing.

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

I REALIZE THAT IF I DELIBERATELY MAKE FALSE STATEMENTS OR WITHHOLD INFORMATION, I (OR THE PERSON ON WHOSE BEHALF I AM ACTING) MAY LOSE MY MEDI-CAL CARD AND/OR I CAN BE PROSECUTED FOR FRAUD.

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

Signature of Applicant		Date
Signature of Person Acting for Applicant	Relationship	Date
Signature of Witness (If Applicant Signed With Mark)		Date
Signature of Person Helping Applicant Complete Form	Address	Date
<b>COUNTY USE ONLY</b>		EW Signature
		Date

Revised Statement of Facts for Medi-Cal  
Description of Changes

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

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

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

Page 1

County Use Column

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

Page 2

Question 6

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

Question 7

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

County Use Column

-- Removed reference to property spenddown.

Question 9

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

County Use Column

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

Page 3

Question 10

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

County Use Column

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

Page 4

Question 15

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

County Use Column

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

Page 5

Question 22

- Rearranged this question in order to save space.
- Added military retirement since it is not clearly identified on the current form.
- Added sub-item C, based upon a recommendation by Quality Control and Evaluation Branch.

Question 23. (formerly question 25)

- Moved this question in order to conserve space.

Question 24. (formerly question 27)

- Moved this question in order to conserve space.

Page 6

County Use Column

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

Page 7

Question 27 (formerly part of question 33)

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

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

Page 8

Question 28 (formerly part of question 33)

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

Question 29. (formerly question 26)

No change.

Question 30. (formerly question 29)

No change.

Page 9.

Question 31. (formerly question 28)

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

County Use Column

-- Added check for coding other health coverage.

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

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

Page 10. Informational Statements

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

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

-- Added statement on reporting death of a beneficiary.

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

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

-- Revised and limited statement on confidentiality.