

DEPARTMENT OF HEALTH SERVICES

714/744 P STREET
SACRAMENTO, CA 95814
(916) 445-1797



August 1, 1984

To: All County Welfare Directors

Letter No. 84-36

REVISED STATEMENT OF FACTS FOR MEDI-CAL (MC 210)

The purpose of this letter is to:

1. Provide you with a sample copy of the revised Statement of Facts for Medi-Cal (MC 210) together with a description of the changes.
2. Request your comments or suggestions for future revisions.

Revised MC 210

The MC 210 has been revised to reflect program changes and to provide documentation of mandated verifications. The most significant changes include the addition of a question on page one regarding dependency for income tax purposes, revision of the property transfer question on page five, and the lien provision added to page ten.

Because of the cost of a production order, current supplies of the MC 210 must be exhausted before the new revision will be available. We anticipate that this version will be available by the end of this year.

We would appreciate your written comments and suggestions on how this form can be improved in the future.

Sincerely,

Original signed by

Caroline Cabias, Chief
Medi-Cal Eligibility Branch

Attachment

cc: MEDS Liaisons
MEDS Consultants

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 (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: _____

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
Yourself											
SS No.											
Your Spouse											
SS No.											

Verification of identity
 Date _____ EW _____

Verification of SS No.
 1. Date _____ EW _____
 2. _____
 3. _____
 4. _____
 5. _____
 6. _____

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.

Child's Name	Sex	Birthdate	In. School	PARENTS		Parent is: (✓ if applies)				Child Living With Applicant		Medi-Cal Req. for Child	
				1) Father's Name	2) Mother's Name	Deceased	Absent	Incapacitated	Unemployed	Yes	No	Yes	No
Child's Name		Birthdate	Yes	No	(1)								
SS No.		Place			(2)								
Child's Name		Birthdate			(1)								
SS No.		Place			(2)								
Child's Name		Birthdate			(1)								
SS No.		Place			(2)								
Child's Name		Birthdate			(1)								
SS No.		Place			(2)								
Child's Name		Birthdate			(1)								
SS No.		Place			(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(s)? Yes No If yes, list names.

3D. Are you or any family member for whom you are requesting Medi-Cal claimed as a deduction for income tax purposes by someone else? Yes No

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

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

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:

Name of Person(s) Who Applied For or Received Aid	Type of Aid	Date of App. (Mo/Day/Yr)	Place of App.	Date Last Re- ceived (if no longer receiving) (Mo/Day/Yr)	Reason For Discontinuance

7. 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

A. 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)

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

COUNTY USE ONLY

Where required, date CA 6 signed.

• Receiving or applied for cash grant or Medi-Cal 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?

Retroactive application

Retro only
 Retro and cont.

Verification of disability/blindness (list)

Date Verified EW

Disability referral

Date Sent

Referral to Medi-Cal recovery

10. 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: _____

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

2. Do you or any family member have a life estate (right to the use of) in any property? Yes No

If yes, describe: _____

3. 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
				\$		
				\$		
				\$		
				\$		
				\$		

4. 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
				\$	\$		
				\$	\$		
				\$	\$		
				\$	\$		

OTE: 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.

COUNTY USE ONLY
(For LTC Applicants)

Verification of exemption as "principal residence"

Date Verified _____ EW _____

Verification that will return home in six months
Yes No

Verification of property

Date Verified _____ EW _____

Verification of "good cause" for unutilized property

Date Verified _____ EW _____

Verification of income and expenses (list)

Date Verified _____ EW _____

Revocable
 Irrevocable

Verification of nonexempt vehicles

Date Verified _____ EW _____

Verification of personal property

Date Verified _____ EW _____

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"/>
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"/>
D. 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: \$ _____

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

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

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. _____	\$ _____			\$ _____

Date Verified _____ EW _____

Total CSV \$ _____

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 _____

Date Verified _____ EW _____

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 \$ _____

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

COUNTY USE ONLY

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

21. Have you or any family member transferred, sold, or given away any property (including money) during the past two years? 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 income 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
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: <input type="checkbox"/> state <input type="checkbox"/> private	<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):

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

2. 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 _____

Date Verified EW

3. 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:
1. Rent or housing			
2. Food			
3. Utilities			
4. Clothing			

Date Verified EW

4. 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:

COUNTY USE ONLY

A.

1. Working member's name			
2. Employer's name			
3. Address of employer			
4. Days of work per week		Days	Days
5. Hours of work per week		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

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

6. 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

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	
\$	\$		\$	

Net profit from self-employment:

\$

COMPLETE ONLY IF THE FAMILY INCLUDES CHILDREN UNDER 21.

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:

27(A) 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
/ /				/ /

COUNTY USE ONLY

First Parent's Earnings

QUARTER

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

Total Earnings \$ _____

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

1.	Name of Employer or Training Program	Work or Training / Check	When Employed		Amount Paid	7.	Name of Employer or Training Program	Work or Training / Check	When Employed		Amount Paid
			From	To					From	To	
		<input type="checkbox"/> Work <input type="checkbox"/> Training	From / /	To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly			<input type="checkbox"/> Work <input type="checkbox"/> Training	From / /	To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
		<input type="checkbox"/> Work <input type="checkbox"/> Training	From / /	To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly			<input type="checkbox"/> Work <input type="checkbox"/> Training	From / /	To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
		<input type="checkbox"/> Work <input type="checkbox"/> Training	From / /	To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly			<input type="checkbox"/> Work <input type="checkbox"/> Training	From / /	To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
		<input type="checkbox"/> Work <input type="checkbox"/> Training	From / /	To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly			<input type="checkbox"/> Work <input type="checkbox"/> Training	From / /	To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
		<input type="checkbox"/> Work <input type="checkbox"/> Training	From / /	To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly			<input type="checkbox"/> Work <input type="checkbox"/> Training	From / /	To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
		<input type="checkbox"/> Work <input type="checkbox"/> Training	From / /	To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly			<input type="checkbox"/> Work <input type="checkbox"/> Training	From / /	To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly

QUARTER

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

Total Earnings \$ _____

C. 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.

1.	Name of Employer or Training Program	Work or Training / Check	When Employed		Amount Paid	7.	Name of Employer or Training Program	Work or Training / Check	When Employed		Amount Paid
			From	To					From	To	
		<input type="checkbox"/> Work <input type="checkbox"/> Training	From / /	To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly			<input type="checkbox"/> Work <input type="checkbox"/> Training	From / /	To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
		<input type="checkbox"/> Work <input type="checkbox"/> Training	From / /	To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly			<input type="checkbox"/> Work <input type="checkbox"/> Training	From / /	To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
		<input type="checkbox"/> Work <input type="checkbox"/> Training	From / /	To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly			<input type="checkbox"/> Work <input type="checkbox"/> Training	From / /	To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
		<input type="checkbox"/> Work <input type="checkbox"/> Training	From / /	To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly			<input type="checkbox"/> Work <input type="checkbox"/> Training	From / /	To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
		<input type="checkbox"/> Work <input type="checkbox"/> Training	From / /	To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly			<input type="checkbox"/> Work <input type="checkbox"/> Training	From / /	To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
		<input type="checkbox"/> Work <input type="checkbox"/> Training	From / /	To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly			<input type="checkbox"/> Work <input type="checkbox"/> Training	From / /	To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly

Second Parent's Earnings

QUARTER

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

Total Earnings \$ _____

Primary Wage Earner

1st 2nd Parent

QUARTER

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

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

Quarters _____

UIB:

Eligible Referral

Eligible Referral

400. 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 <input type="checkbox"/> Quit <input type="checkbox"/> Layoff <input type="checkbox"/> Refusal <input type="checkbox"/> Fired <input type="checkbox"/> Other (list reason):	

COUNTY USE ONLY
 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)

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

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,

Payment used to bring property within property limits Yes No

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

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.
- I understand that in accordance with Section 14006(b) of the Welfare and Institutions Code, the State may record a lien against my property as reimbursement for the cost of medical care.

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 MEDICAL 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
COUNTY USE ONLY		EW Signature
		Date