

DEPARTMENT OF HEALTH SERVICES

714/744 P STREET
SACRAMENTO, CA 95814

November 16, 1984

To: All County Welfare Directors

Letter No. 84- 42

SURVEY -- USE OF THE MONTHLY REPORT FORM (CA-7) IN THE MEDI-CAL PROGRAM

Recently Fresno County requested the Department of Health Services to develop a common monthly report form for the Food Stamp, AFDC and Medi-Cal programs. It was suggested that we combine the Department of Social Services' CA-7 and the Medi-Cal MC 176S into one form to eliminate eligibility workers' and recipients' time spent in duplicate reporting.

In order to evaluate the feasibility of consolidating forms, we are asking for your comments in the attached questionnaire. Your participation in this survey will be very helpful to us in developing a better recipient reporting system. Please complete and return the attached questionnaire by November 30, 1984.

Please direct any questions regarding this subject to RaNae Hamby of my staff at (916) 324-4955, (ATSS) 8-454-4955.

Sincerely,

Original signed by

Doris Z. Soderberg, Chief
Medi-Cal Eligibility Branch

Attachments

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

CG417RH.1

County _____

Contact Person _____

Phone _____

Date Completed _____

REPORTING FORM QUESTIONNAIRE

1. Does your county require Medi-Cal beneficiaries to complete and return a Status Report monthly? (See Title 22, CAC, Section 50191.)

Yes _____

No, we require a status report each _____ (specify time period, e.g., quarter).

2. Do your Medi-Cal eligibility workers also have continuing (i.e., post-intake) caseloads in other programs? (Check one)

Yes _____

No, they only handle Medi-Cal _____.

If yes, what other program(s) do E/ws handle? (e.g., Non-Assistance Food Stamps (NAFS), or NAFS and AFDC, etc.):

3. If recipients were only required to fill out one form, such as a modified CA-7, for Medi-Cal, AFDC and NAFS, how would you ensure that the eligibility workers in each program receive and process the form? What problems and solutions do you envision?

4. What impact might a combined form have on error rates?

5. What impact might a combined form have on recipients?
6. What impact might a combined form have on eligibility workers?
7. What impact might a combined form have on administrative and program costs?
8. What else should we consider in evaluating this proposal?
9. Do you support this proposal?
10. Would your county be willing to work on a task force to design such a form?

(Please attach other pages as needed)

Return to:

RaNae Hamby
Medi-Cal Eligibility Branch
714 P Street, Room 1692
Sacramento, CA 95814

2. I/We paid work, college or training program expenses. Yes No If "Yes", complete the following.

PERSON CLAIMING EXPENSE	TRANSPORTATION EXPENSES				Child Care Expenses Attach Receipt	Other Work, College, or Training Expenses	
	Method (Car, Car Pool, Bus, Etc.)	Days Using This Method This Week	Daily Cost Round Trip	Daily Miles Round Trip		(Describe)	Amount

3. I/We had a change in real or personal property during the time specified. Yes No
 If "Yes", complete the following, including any item bought or sold or given away such as land, houses, automobiles, boats, etc., and any change in your checking or savings accounts, life insurance policies, etc.

ITEM	WHAT HAPPENED	DATE	CURRENT VALUE	MONEY RECEIVED	MONEY OWED	OWNER

4. I/We had changes affecting the people in our family or household during the time specified. Yes No. If "Yes" complete the following, including information on someone who moved into or out of your home; entered or left a hospital; became pregnant; gave birth or otherwise ended pregnancy; entered or left school; recovered from a major illness; became disabled or disabled again; began, changed or terminated employment.

PERSON	WHAT HAPPENED	DATE	RELATIONSHIP	DATE OF BIRTH	INCOME	PROPERTY

5. I/We now have Medicare Coverage Yes No Medicare Number _____ Part A Yes No
 Part B Yes No

I/We have Health Insurance coverage privately or through our employer. Yes No
 If "Yes", complete the following:

PERSONS INSURED	INSURANCE COMPANY	GROUP/PRIVATE	PREMIUM PAID		EFFECTIVE DATE
			AMOUNT	WHEN	

6. Do you expect changes in any of the above or do you have any other information affecting Medi-Cal eligibility to report?
 Yes No
 If "Yes", please provide that information in the space provided below.

I DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING IS TRUE AND CORRECT.

SIGNATURE OR MARK	DATE SIGNED	COMPLETE IF ADDRESS HAS CHANGED STREET AND NUMBER
SIGNATURE OF SPOUSE/PARENT IN HOME	TELEPHONE	CITY AND ZIP CODE
SIGNATURE OF WITNESS, INTERPRETER OR PERSON COMPLETING FORM FOR BENEFICIARY	TELEPHONE	COMPLETE IF HOME ADDRESS IS DIFFERENT THAN MAILING ADDRESS/STREET & NUMBER

MONTHLY ELIGIBILITY REPORT

for Cash Aid and Food Stamps

THIS REPORT IS FOR THE MONTH OF: _____

Complete, sign, date and return this form AFTER the last day of: _____

- You must complete this report and return it by the 5th of the month. If this report is not received by the 11th of the month or is incomplete, your Cash Aid, Cash-based Medi-Cal and/or Food Stamps may be delayed, decreased or discontinued.
- If you do not ATTACH proof of reported income, your benefits may be discontinued. If you do not ATTACH proof of expenses, your benefits may be decreased or discontinued.
- Call your worker if you need help completing the form. Attach a separate sheet of paper if needed.

Worker: _____ Phone: _____

NOTE: If you or your family no longer want Cash Aid, Medi-Cal or Food Stamps check this box , state the reason and type(s) of assistance no longer wanted, complete the signature block and return the form by the due date.

Reason and Type(s) of assistance: _____

you receive cash aid or food stamps, answer 1 through 9. Answer for everyone in your household if you receive food stamps. If you do not receive food stamps, answer for everyone receiving cash aid, the aided children's parents, stepparents, and your spouse if in your home.

1) Did anyone receive income, money, or benefits in the month, such as: earnings, training payments, earned income tax credit, strike benefits, social security, railroad retirement, unemployment/disability insurance, interest, worker's compensation, SSI/SSP (gold checks), child/spousal support, loans, grants, tax refund, cash, gifts, free housing/utilities, etc.? YES NO

If YES, complete section below. ATTACH PAYSTUBS or other proof of earnings each month. ATTACH PROOF for any other income only when it starts and when it changes. If anyone is self-employed, list business expenses on a separate sheet of paper and ATTACH PROOF of income and expenses each month. (If you receive cash aid and you fail to report or ATTACH PROOF of earned income by the 11th of the month, the standard work expense, dependent care, and when eligible for it, the \$30 and 1/3 disregard will not be allowed.)

Who Received Income, Money or Benefits?	Source (If Earnings, List Name of Employer)	Enter below dollar amounts and actual dates received. If earnings, enter gross amount before deductions.					If Earnings:	
		Amount \$	Amount \$	Amount \$	Amount \$	Amount \$	Number of Days Worked in Month	Number of Hours Worked in Month
Name		Date	Date	Date	Date	Date		
Name		Date	Date	Date	Date	Date		
Name		Date	Date	Date	Date	Date		

2) Did anyone pay for the care of a child or disabled adult so that someone in the home could go to work, training or look for a job? YES NO

If YES, complete below and ATTACH a receipt for each person receiving care.

Who Received Care?	Cost of Care	Who Received Care?	Cost of Care
	\$		\$
	\$		\$

- 3) Did anyone move into your home (including a new born), move out, get married, or die? YES NO
- 4) Did anyone become disabled or recover from a disability? YES NO
- 5) Did anyone start, refuse, lose, quit or change a job/training, or go on strike? YES NO
- 6) Did anyone start, stop or change school or college? YES NO
- 7) Did anyone receive, buy, sell or give away any property such as a house, land, motor vehicle, camper, boat, etc.? YES NO

If YES, to any of the changes, give name of person, date of change and explain the change. If property change, give value of item.

COMMUNITY USE ONLY

E.W. INITIALS

DATE:

8 Did anyone have a checking, savings or credit union account open at the end of the month? YES NO

If YES, complete below.

<input type="checkbox"/> Credit Union <input type="checkbox"/> Checking <input type="checkbox"/> Savings	Balance On Last Day of Report Month	Whose Account?	<input type="checkbox"/> Credit Union <input type="checkbox"/> Checking <input type="checkbox"/> Savings	Balance On Last Day of Report Month	Whose Account?
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Did you move, or do you have a new mailing address or phone number? YES NO
If YES, complete below.

Home Address (Number, Street Name, Avenue Blvd. Etc.)	Apt. No.	City	State	Zip Code	Phone No.
Mailing Address (If Different Than Home Address)		City	State	Zip Code	

If you receive food stamps, answer 10 through 13 for everyone in your household. If you do not receive food stamps, go to 14 through 17.

10 Did the household have housing costs? YES NO
If YES, enter amount billed.

Rent or Mortgage	Property Taxes or Insurance (if not in mortgage)
\$	\$

ATTACH bills only if you moved or the cost changed.

11 Did the household have utility costs? YES NO
If YES, and you moved or claim actual utility costs, complete below and ATTACH BILLS.

Gas/Fuel	Electricity	Telephone	Utility Installation	Garbage/Trash	Water	Sewage	Other (Specify)
\$	\$	\$	\$	\$	\$	\$	\$

12 Did the household share housing or utilities or did anyone help pay these costs? YES NO
If YES, list each item, amount paid, who paid and ATTACH PROOF.

13 Did anyone who is disabled or age 60 or older have any medical expenses in the month? YES NO
If YES, complete below and ATTACH BILLS for each expense.

Who Had the Expense?	Type of Expense	Amount	Who Had the Expense?	Type of Expense	Amount
		\$			\$

If you receive cash aid, answer 14 through 17 for everyone receiving cash aid, the aided children's parents, stepparents, and your spouse if in the home. If you do not receive cash aid, go to 17.

14 Did you or anyone in your family who received income pay any court ordered support in the month? YES NO
If YES, enter the amount paid and ATTACH RECEIPTS: \$

15 Did anyone start, stop or change health or hospitalization insurance coverage such as Prudential, Blue Cross, Champus, etc.? YES NO
If YES, give name of person, date and explain change.

16 Did anyone become pregnant, have a baby or terminate a pregnancy? YES NO
If YES, give name of person, date and explain change.

If you receive cash aid or food stamps, answer 17. Answer for everyone in the household if you receive food stamps. If you do not receive food stamps, answer for everyone receiving cash aid, the aided children's parents, stepparents, and your spouse if in the home.

17 Does anyone in the home have other information to report for this month or next month, such as: recent or expected changes in income, place of employment, number of working hours or days per week, place of residence, property, persons in the household, etc? YES NO
If YES, explain the change, if it is expected to be temporary or permanent and indicate the date of the change.

CERTIFICATION

- I understand that failing to report information or misrepresentation of facts for Cash Aid programs, Food Stamps or Cash-based Medi-Cal can result in the prosecution with penalties of a fine, imprisonment or both. In the Food Stamp Program the penalties can result in permanent disqualification from the Program, fine up to \$10,000 or imprisonment for up to 5 years.
- I understand that I must contact my worker to report any unexpected changes which affect my eligibility for or the amount of my Cash Aid within 5 days of the occurrence or if I have any doubt about needing to report any changes.
- I understand that reported information may result in a decrease or discontinuance of benefits.
- I understand I have the right to request a state hearing on any proposed action by the county welfare department.
- I declare that the information contained in this report is true and correct and is complete for the entire report month.

YOU MUST SIGN AND DATE THIS REPORT AFTER THE LAST DAY OF THE REPORT MONTH OR IT WILL BE CONSIDERED INCOMPLETE

For Cash Aid programs, you and your aided spouse (or the other parent of aided children) living in the home must sign the form. For the Food Stamp Program, the head of household, a household member or the household's authorized representative must sign the form.

Signature of Cash Aid Parent or Caretaker Relative and/or Food Stamp Household Member	Date Signed
Signature of Cash Aided Spouse or Other Parent of Cash Aided Children	Date Signed
Signature of Witness to Mark, Interpreter, or Other Person Completing Form	Date Signed