State of California—Health and Human Services Agency
Department of Health Services

California Department of Health Services
SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

June 24, 2004

Medi-Cal Eligibility Branch Information Letter No.: I 04-02

TO: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIAISONS

SUBJECT: REVISION OF FORMS DHS 7068 AND DHS 7068S
RESPONSIBILITIES OF PUBLIC GUARDIANS/CONSERVATORS OR APPLICANT/BENEFICIARY REPRESENTATIVES

The purpose of this letter is to advise counties that the DHS 7068 (English) and DHS 7068S (Spanish) have been revised to update the mailing address for the Department of Health Services (DHS) Recovery Section. The new address is:

Department of Health Services
Recovery Section
P.O. Box 997425
Sacramento, CA 95899-7425

The DHS Warehouse will continue to distribute the DHS 7068 (3/99) for approximately six months or until stock is depleted. Mail will be forwarded from the old address to the new address until at least December 31, 2004. The DHS 7068S (2/04) maybe ordered from the DHS Warehouse now.

Enclosed are camera-ready copies of the DHS 7068 (2/04) and DHS 7068S (2/04) for county use. Additionally, copies of these forms may be downloaded from the DHS website at http://www.dhs.ca.gov/publications/forms/Medi-Cal/medi-cal.htm. For questions regarding this notice, contact Ms. Susan Jackson at sjackson@dhs.ca.gov at (916) 552-9458.

Original signed by

Beth Fife, Chief
Medi-Cal Eligibility Branch

Attachments

1501 Capitol Avenue, Suite 71.4001, MS 4600, P.O. Box 997417
Sacramento, CA 95899-7417

RE: _____
Case Name

Case Number

_____
Worker Number

RESPONSIBILITIES OF PUBLIC GUARDIANS/CONSERVATORS OR APPLICANT/BENEFICIARY REPRESENTATIVES

You have accepted the responsibility to act on behalf of _____. State law and regulation require you to report to the county welfare department any changes in the circumstances of the applicant/beneficiary within ten calendar days following the date the change occurred. You must also cooperate fully on behalf of the beneficiary in any review that may be required for quality control purposes.

Changes which must be reported within ten days include, but are not limited to:

1. A change in the beneficiary's property, including community property.
2. A change in the beneficiary's income.
3. Entitlement to Veteran's Benefits or an increase in Veteran's Benefits.
4. Changes in health insurance coverage including enrollment in available health insurance or the discontinuance of health insurance.
5. A change in the beneficiary's living arrangement, household members, or residence.
6. The death of the applicant/beneficiary.
7. A change in guardianship/conservator or representative status.
8. Any other change in circumstances which may affect eligibility or share of cost.

You are also required (pursuant to Probate Code, Section 700.1, and Welfare and Institutions Code, Section 14009.5) to report the death of the beneficiary within 90 days of the date of death to:

Department of Health Services
Recovery Section
P.O. Box 997425
Sacramento, CA 95899-7425

Refer to "***IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL***" (MC 219) for a more complete list of your reporting responsibilities.

I hereby state, under penalty of perjury, that the information on this form has been reviewed by me and that I fully understand my responsibilities as the guardian, conservator or representative of

_____
Name of Beneficiary

Signature of Guardian/Conservator or Representative	Date
Address of Guardian/Conservator or Representative	Telephone Number of Guardian/Conservator or Representative

Original—Case File *Copy—Guardian/Conservator or Representative*

RE:_____
Case Name

_____
Case Number

_____
Worker Number

RESPONSABILIDADES DE GUARDIÁNES PÚBLICOS/CONSERVADORES O REPRESENTANTES DE LOS SOLICITANTES/BENEFICIARIOS

Ud. ha aceptado la responsabilidad de actuar en el nombre de_____. Leyes estatales y regulaciónes requieren que Ud. reporte al departamento de bienestar del condado cualquier cambio en las circunstancias del solicitante/beneficiario en diez días calendarios siguendo la fecha que el cambio ocurrió. Ud. también debe de cooperar enteramente en nombre del beneficiario en cualquier revisión que pueda ser requerida por razónes de control de calidad.

Cambios deben ser reportados dentro de diez días y incluyendo pero no limitados a:

1. Un cambio en la propiedad del beneficiario, incluyendo la propiedad en común.
2. Un cambio en ingreso del beneficiario .
3. Derechos o aumentos en Beneficios de Veteranos.
4. Cambios en la cobertura, inscripción, o descontinuación del seguro de salud.
5. Cambio de arreglo de vivir, miembros del hogar, o residencia del beneficiario.
6. La muerte del solicitante/beneficiario.
7. Cambio en la tutela legal/conservador o condición representativa.
8. Cualquier otro cambio en circunstancias que pueden afectar la elegibilidad o la parte del costo.

Además, a usted se le exige (en conformidad con la sección 700.1 del Código Testamentario y la sección 14009.5 del Código de Bienestar e Instituciones) reportar la muerte del beneficiario, en un plazo de 90 días a partir de la fecha de la muerte, a:

Department of Health Services
Recovery Section
P.O. Box 997425
Sacramento, CA 95899-7425

Referirse a la **"INFORMACIÓN IMPORTANTE PARA PERSONAS SOLICITANDO MEDI-CAL"** (MC 219) para una lista más completa de sus responsabilidades.

Por este medio declaro, bajo la pena de perjurio, que la información en esta forma ha sido revisada por mí y que yo entiendo completamente mis responsabilidades como el guardián, conservador o representante de

_____
Nombre del Beneficiario

Firma del Guardián/Conservador or Representante	Fecha
Dirección del Guardián/Conservador or Representante	Número de Teléfono del Guardián/Conservador o Representante

Original—Case File Copy—Guardian/Conservator or Representative