STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

PETE WILSON, *Governor*

DEPARTMENT OF HEALTH SERVICES
4/744 P STREET
O. BOX 942732
AMENTO, CA 94234-7320
657-2941

October 20, 1993

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

Letter No.: 93-75

IMPLEMENTATION OF THE MEDI-CAL STATEMENT OF FACTS, (MC 210) AND THE MC 210 SUPPLEMENTALS

REF.: E-MAIL (EMC2 DHS #93105) DATED JULY 16, 1993 AND E-MAIL (EMC2 DHS #93167) DATED SEPTEMBER 29, 1993

The purpose of this letter is to inform counties that the implementation of the revised Statement of Facts form, MC 210 (August 93), is effective November 1, 1993. (Enclosed is an advanced copy.) Counties may begin using this new version as soon as the advanced shipment arrives. Please refer to the Department's E-Mail (EMC2 DHS No. 93105), dated July 16, 1993 which provides instructions for ordering the revised MC 210 and also information regarding the rescheduling of MC 210 training. This information was also referenced in the E-Mail (EMC2 DHS No. 93167) dated September 30, 1993 which provided the upcoming training schedule outlined below.

TRAINING

Although training on the revised MC 210 was conducted during April and May 1993, a variety of suggestions were received which resulted in further refinements to the core document, (MC 210), and the supplemental forms. To provide an overview of the latest MC 210 revision and the supplements, MC 210 Update Training has been scheduled as follows:

- Southern Region 1
  Training Date: September 21;
  Training Location: Los Angeles (completed)
- Bay Area Region
  Training Date: October 1;
  Training Location: San Francisco (completed)
- Valley Mountain Region
  Training Date: October 5;
  Training Location: Rocklin (completed)
- Northern Region
  Training Date: October 13;
  Training Location: Redding
  (postponed from September 28)
  2460 Breslauer Way, Cascade Room (Room 55)
  Time: 10:00 a.m. - 2:00 p.m.

- Valley Region — Training Date: October 21;
  Training Location: Fresno (Address to be announced)
  (postponed from September 30)
  Time: 10:00 a.m. - 2:00 p.m.

- Southern Region 2 — Training Date: October 27:
  Training Location: San Diego (Address to be announced)
  (postponed from October 13).
  Time: 10:00 a.m. - 2:00 p.m.

If your county had planned on attending one of the postponed training sessions, or your staff is unable to attend the new training scheduled for your region you may attend one of the sessions provided in another region.

At the MC 210 update training, counties will have an opportunity to review the most recent MC 210 changes, ask questions, and receive individual instruction as needed. We encourage counties to ensure the appropriate staff attend these training sessions. Please contact Tony Plescia at (916) 657-3185 or Sherilyn Walden at (916) 657-3091 to let us know which training session your county will attend and the number of staff attending that training session.

FORMS PROCEDURES

As the structure of the revised MC 210, and the creation of various supplemental forms, result in a notable change to the current form, related procedures will be released shortly. These procedures outline the proper use of the core document (MC 210); and provide an explanation on the use of each supplemental form, if needed, to gather further information at the face to face interview. Instructions on the use of these forms will also be discussed and reviewed at the training sessions.

ORDERING

As mentioned earlier in this letter, EMC2 No. 93105 asked counties to submit to the Medi-Cal Eligibility Branch (MEB) an estimated monthly usage amount, (2 month maximum), of the MC 210 and a projected amount for the supplementals. If your county did not place an order for the MC 210, a minimum of 100 or a camera ready copy will be shipped. (Smaller counties will receive 100 copies of the MC 210; larger counties will receive a camera ready copy.) Also, if your county did not place an order for the MC 210 supplementals or the MC 219 (formerly the cover sheet to the MC 210) from the MEB, you will need to order directly from the warehouse.

If you have any questions, please contact Leanna Pierson at (916) 654-0630 or Sherilyn Walden at (916) 657-3091.

Sincerely,

ORIGINAL SIGNED BY

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Enclosures

READ THIS FIRST

USE THESE INSTRUCTIONS TO HELP YOU FILL OUT THE ATTACHED MEDI-CAL STATEMENT OF FACTS

1. Read the Statement of Citizenship, Alienage, and Immigration Status (MC 13) for important information regarding restricted benefits and alien status.
2. ***Print*** all answers in ink (black ink is best).
3. Please note the following:

"Applicant" means: a) you, if you are applying for yourself and you are an adult or a child applying for minor consent services; or, b) the person in long term care.

"Caretaker" means a relative other than a parent who is applying on behalf of children under 21 years. A caretaker may ask to be included in the children's Medi-Cal case.

"Family Member" means: a) you - even if you are a single person; b) your spouse or other parent of the children, living with you; c) your children under 21 years, who are living with you or are away at school; d) your spouse's or other parent's children under 21 years, who are living with you or are away at school; e) your unborn child.

4. If you answer ***"Yes"*** to any question from 23 through 39, you must give proof.
5. If you have a problem with any question, ***ask your worker for help.***
6. If you need more space to answer any question, ***use question 40.***

State of California—Health and Welfare Agency

Department of Health Services

STATEMENT OF FACTS (MEDI-CAL)

ADDRESS (MEDI-CAL APPLICANT)

(1) Home address | Number | Street | City | Zip Code

Mailing address (If different from above)

(Area Code) Home phone ( ) | (Area Code) Work phone ( ) | (Area Code) Message phone ( ) | Person with whom to leave message:

COUNTY USE ONLY

Case Name: _____

Case No.: _____

Worker No.: _____

Date: _____

If any alien is asking for restricted Medi-Cal benefits, DO NOT fill in the shaded area below for Social Security Number.

ADULT FAMILY MEMBERS

LIST ADULTS HERE

(2) Applicant or Caretaker's Name (First, Middle, Last)	Relationship to Applicant					
Social Security Number	Marital Status (check one) ☐ Married ☐ Never Married ☐ Common Law ☐ Widowed ☐ Divorced ☐ Separated (Date)_____		Sex ☐ Male ☐ Female	Linkage	Citizen/ Immig. MC 13	SSN / Prog / ID
Birthdate	Is the Person Blind or Disabled ☐ Yes ☐ No	Pregnant ☐ Yes ☐ No	Medi-Cal Requested ☐ Yes ☐ No			
(3) Spouse/Other Parent (First, Middle, Last)	Relationship to Applicant			Linkage	Citizen/ Immig. MC 13	SSN / Prog / ID
Social Security Number	Marital Status (check one) ☐ Married ☐ Never Married ☐ Common Law ☐ Widowed ☐ Divorced ☐ Separated (Date)_____		Sex ☐ Male ☐ Female			
Birthdate	Is the Person Blind or Disabled ☐ Yes ☐ No	Pregnant ☐ Yes ☐ No	Medi-Cal Requested ☐ Yes ☐ No			

CHILDREN

LIST CHILDREN/UNBORN CHILDREN HERE

(4) Child's Name (First, Middle, Last) or "unborn"	Relationship to Applicant			Linkage	Citizen/ Immig. MC 13	SSN / Prog
Social Security Number	In School ☐ Yes ☐ No		Sex ☐ Male ☐ Female			
Birthdate or date unborn is due	Is the Person Blind or Disabled ☐ Yes ☐ No		Pregnant ☐ Yes ☐ No			
Father's Name	Is Either Parent (✓) ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed		Medical Support ☐ YES ☐ NO Not in home, 18 - 21 & tax dep.? CA 2.1 ☐			
Mother's Name	Child Living in Home ☐ Yes ☐ No	Medi-Cal Requested ☐ Yes ☐ No				
(5) Child's Name (First, Middle, Last) or "unborn"	Relationship to Applicant			Linkage	Citizen/ Immig. MC 13	SSN / Prog
Social Security Number	In School ☐ Yes ☐ No		Sex ☐ Male ☐ Female			
Birthdate or date unborn is due	Is the Person Blind or Disabled ☐ Yes ☐ No		Pregnant ☐ Yes ☐ No			
Father's Name	Is Either Parent (✓) ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed		Medical Support ☐ YES ☐ NO Not in home, 18 - 21 & tax dep.? CA 2.1 ☐			
Mother's Name	Child Living in Home ☐ Yes ☐ No	Medi-Cal Requested ☐ Yes ☐ No				
(6) Child's Name (First, Middle, Last) or "unborn"	Relationship to Applicant			Linkage	Citizen/ Immig. MC 13	SSN / Prog
Social Security Number	In School ☐ Yes ☐ No		Sex ☐ Male ☐ Female			
Birthdate or date unborn is due	Is the Person Blind or Disabled ☐ Yes ☐ No		Pregnant ☐ Yes ☐ No			
Father's Name	Is Either Parent (✓) ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed		Medical Support ☐ YES ☐ NO Not in home, 18 - 21 & tax dep.? CA 2.1 ☐			
Mother's Name	Child Living in Home ☐ Yes ☐ No	Medi-Cal Requested ☐ Yes ☐ No				

IF YOU HAVE MORE THAN 3 CHILDREN LIST HERE.

LIST NAMES ONLY AND TELL YOUR WORKER: _____

☐ MC 210 S-C

☐ Potential Spouse

CHECK EACH ITEM - YES OR NO	YES	NO	COUNTY USE
ARRANGEMENT			
(7) Is there anyone living in your home that you did not list?			Relationship:
List Name(s):			☐ LTC return home in 6 mos?
(8) Is any family member living in a nursing home, hospital or board and care home?			☐ MC 176 W.1
Name of person:			☐ Excess B & C Amount:
Name of Home/Facility:			
Date Entered:			
Intend to return home?			
DEPENDENT			
(9) Are you or any family member claimed as a tax dependent by a person not living with you?			☐ Tax dependent letter sent Date: MC 21
Name and address of person claiming the tax deduction:			
RESIDENCE			
(10) Do you or any family member have a home outside California?			Calif. Resident? ☐ Yes ☐ No
(11) Are you or any family member living outside California?			
(12) Do you and your family plan to stay in California?			
QUESTIONS			
(13) Are you or any family member on strike?			☐ Under 100 hours
List Name(s):			
(14) Are you, your spouse or the other parent in the home working?			☐ If U-Parent MC 210 S-W
List Name: Hours Per Week:			
List Name: Hours Per Week:			
(15) Are the person(s) in (14) looking for work or more hours of work?			☐ UIB Referral
(16) Have you, your spouse, other parent or any children worked in the last 2 years?			Redetermination: Fed ____ Eligibility determined per MC 210 dated:
List Name(s):			
RETRO			
(17) Did you or any family member get medical care or pregnancy care in the last three months? List Name(s):			☐ MC 210A Retro: Mo. Mo. Mo.
DED. TPL			
(18) Do you or any family member have a physical or emotional problem which makes it difficult to work or take care of personal needs?			☐ DED Packet ☐ Other Verif
List Name(s):			
(19) Was the physical or emotional problem caused by an injury or accident?			☐ CWC 6041
FA UK OTHER PA			
(20) Have you or any family member ever applied for or received assistance such as AFDC, Food Stamps, Medi-Cal, SSI/SSP, or other benefits?			☐ Pickle Screening: ☐ SGA ☐ Post MC ☐ 30 + 1/3
List what kind:			
List where received:			
List when received:			
MILITARY SERVICE			
(21) Have you or any family member ever been in U.S. military service?			☐ CA 5
List Name(s):			
(22) Are you or any family member the spouse, parent, or child of a person who has been in U.S. military service?			
List Name(s):			

Do you or any family member have any of the PROPERTY/RESOURCES listed below?

The county will determine whether or not the resources count.

- Include all resources owned, used, controlled, shared or held jointly with or for other person(s).
- Include resources on which you or a family member are named (even for convenience only).

COUNTY USE
Obtain Verif. and enter nonexempt value _____
☐ MC 210 S-P

	CHECK EACH ITEM "YES" OR "NO"	YES	NO	WHOSE PROPERTY	VALUE	☐ Current Mo Income Included
LIQUID RESOURCES	(23) Personal checking account? Enter how many accounts: _____ Bank name: _____. Account number: _____					$_____
	Saving or credit union account or trust fund? How many? _____ Where: _____. Account number: _____					$_____
	IRA, KEOGH, deferred compensation, retirement account or annuity? ..... Enter how many accounts: _____					$_____
	Cash or uncashed checks?					$_____
	Stocks, bonds, certificates of deposit or money market accounts?					$_____
REAL ESTATE	(24) A home (whether you live in it or not)?					PR ☐ YES ☐ NO
	Other houses, land, buildings, mobile homes or life estates (in or outside the U.S.)?					$_____
	Mortgages, promissory notes, deeds of trust or sales contracts?					$_____
VEHICLES	(25) Car, truck, motorcycle, trailer (any kind), off-road vehicles, airplanes, boats, campers (running or not)? ..... Enter how many vehicles owned: _____					EXEMPT ☐ YES ☐ NO
	Do you owe money on your vehicles?					$_____
OTHER	(26) Have jewelry (not wedding/engagement or heirloom) worth more than $100?					$_____
	If you are applying under Pickle, do you own household goods or personal items valued at more than $500 per item (i.e. musical instrument)?					$_____ but, jointly owned ☐ separately owned ☐
	Life insurance? Enter how many policies owned: _____					
	Mineral rights or mining claims (oil, gas, coal, etc.)?					$_____
	Burial Trusts or contracts, insurance, money for burial or cemetery plots, caskets or other burial items?					$_____
	Enter how many: _____					
	Other assets or resources?					$_____
BUSINESS	(27) Business: checking/savings account or cash					$_____
	Business equipment, vehicles, tools, inventory or materials (including livestock or poultry not for personal use). ..... Type of Equipment:					$_____
TRANSFER	(28) Has anyone given away, transferred, sold or traded any money, vehicles, property or other resources like those listed above in the last 30 months? If yes, complete the following:					LTC only: ☐ Verification ☐ List Other Trans. in # 40
	Item / Date / ☐ Transferred ☐ Sold ☐ Traded ☐ Closed ☐ Given Away					
LIENS	(29) Have you borrowed money against your property to pay medical bills?					Brings property within limits? ☐ Yes ☐ No
	Has a lien been put on any of your property as security for medical care?					If Yes ☐ Notice to Provider
	Have you used any of the items above to pay for medical care?					

Total Nonexempt Property minus current mo. income
$_____

Answer for all family members in your home including yourself.

CHECK EACH ITEM "YES" OR "NO" → IF YES, YOU MUST COMPLETE ALL ITEMS FOR THAT INCOME.	YES	NO	Whose Income	Amount Before Taxes	How Often	COUNTY USE MC 210 S-W Use copy of award letter or check or other verification.
INCOME						
(30) Money from a job? (including occasional work).....						☐ Weekly (4.33) ☐ Bi-Weekly (2.167) ☐ Monthly ☐ Twice Monthly ☐ Actual ☐ Other:
If yes, how many people in your home work? _____						
Do you expect a change in your job? ..... (More hours or more money)						
Explain: _____						
EMPLOYED						
(31) Self-employed income (includes businesses, baby sitting, out-of-home sales, swap meets, arts, crafts & income from crops or other farm income).						☐ Tax Statement ☐ Profit/Loss
If yes, how many people are self-employed? _____						
UNEARNED IN						
(32) Social Security Benefits (Self)						$ _____
Social Security Benefits (Others)						$ _____
Social Security Benefits (Others)						$ _____
Cash Aid such as: SSI, AFDC, GR/GA or any other						$ _____
Child/Spousal Support or Alimony						$ _____ Occasional?
Money From Friends or Relatives						$ _____
Railroad Retirement						$ _____
Veteran's Benefits/Military Allotments						$ _____
Worker's Compensation						$ _____
Unemployment Benefits (Self)						$ _____
Unemployment Benefits (Others)						$ _____
Disability or Sick Benefits						$ _____
Pensions or Retirement						$ _____
Scholarships, Loans, Grants						MC 210 S-E $ _____
Interest Income or Dividends						$ _____
Income From Rent or Contracts: (Including Room and Board)						$ _____
Income from Training Program Name of Program _____						$ _____
Any Other Unearned Income: (including lottery/bingo winnings, lump sum payments)						$ _____ Inheritance, insurance, etc.
ROOM AND BOARD						
(33) Receive Rent/Housing/Food (Room and Board): If yes, check boxes:						☐ Chart Value
Housing (Room and Board) ☐ Free ☐ Work For						☐ MC 210 S-I
Utilities ☐ ☐						
Food ☐ ☐						☐ Sneede
Clothing ☐ ☐						

OHC AND OTHER EXPENSES

CHECK EACH ITEM "YES" OR "NO"	YES	NO	WHO PAYS	MONTHLY AMOUNT	COUNTY USE MC 210 S-W
(34) Does the self-employed person have business expenses?					☐ Verification
(35) Does anyone in your home pay child/spousal support, alimony or make other payments (medical, dental, etc.) for someone who does not live in the home?					☐ Court Order ☐ Actual Payment $_____
(36) Does anyone in your home pay someone to care for a child, a disabled or elderly adult so that a household member can work, attend training or school or look for work? List persons cared for:					☐ Dep. Care Receipts
(37) Is anyone in your home a working disabled person who has medical expenses necessary to keep the job, such as wheelchair?					☐ Receipts $_____
(38) Is anyone paying college or educational costs?					
(39) Does anyone have health/medical insurance or Medicare? Who is insured? (List Names) _____ List Name of Insurance: _____					☐ QMB ☐ Card ☐ QDWI ☐ SLMB ☐ DHS 6155 ☐ HIPP ☐ EGHP OHC CODE:____ $_____
Is health/medical insurance available through employment?					☐ SSA Referral
Has your health/medical insurance stopped in the last 60 days?					

ADDITIONAL INFORMATION

(40) Additional Information: (List any additional information for Questions 1 through 39)

_____

_____

_____

_____

SEE YES: YOUR ANSWERS TO THESE WILL NOT AFFECT YOUR ELIGIBILITY FOR MEDICAL

	YES	NO	COUNTY USE
(41) A. Regular check-ups to help protect your family's health are available upon request through the Child Health and Disability Prevention Program (CHDP) for eligible members of your family under age 21.			☐ CHDP Brochure and Explanation Given
• Do you want more information about CHDP Services?			Date: _____
• Do you want CHDP medical or dental services?			☐ Referral
B. If you are pregnant, you can get help finding a doctor, getting transportation to see the doctor, and other help. Do you want to talk to someone about this help?			
C. Are you breastfeeding a child? Have you given birth within the last three months?			☐ WIC referral
• If you answered "YES" to either of these questions, you may be eligible for services provided by the Special Supplemental Food Program for Women, Infants and Children (WIC)			☐ Pregnant ☐ Parent or Guardian of child under 5 ☐ Breastfeeding ☐ Postpartum
D. Do you want information about Family Planning Services?			☐ Family Planning Information Given ☐ Referred Date: _____
E. Do you want to talk to a social worker about other services which may be available to you?			☐ Social Services Referral
• If "Yes," briefly describe:			

CERTIFICATION

I have read and received a copy of the MC 219.

- I am aware of, understand, and agree to meet all my responsibilities as described on the MC 219.
- I understand that all of the statements, including benefit and income information, that I have made on this form are subject to investigation and verification.
- I understand that Section 1137 of the Social Security Act requires that I provide Social Security numbers (SSNs) for myself and any family members if I/we request full Medi-Cal benefits. I understand that my/our SSNs will be verified and will be used in a computer match to check the income and resources I/we report with information from welfare, state employment, income tax, Social Security Administration, and other agencies. I understand that this is done to make sure that my/our family's eligibility and share-of-cost level, if any, are correct.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information contained in this Statement of Facts is true and correct.

Signature of Applicant	Date
Signature of Witness (If applicant signed with a mark)	Date
Signature of person helping applicant fill out the form	Date

It is the responsibility of the beneficiary and person acting for the applicant/recipient to report to the Eligibility Worker within ten (10) days any changes that occur.

Signature of Person Acting for Applicant/Beneficiary	Date
Address of Person Acting for Applicant/Beneficiary	Phone Number of Person Acting for Applicant

COUNTY USE ONLY

Supplemental Forms Issued	Client Initial	Date
EW Signature	Worker Number	Date

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF HEALTH SERVICES
MEDI-CAL PROGRAM

ADDITIONAL CHILDREN

(SUPPLEMENT TO THE MEDI-CAL STATEMENT OF FACTS - MC 210)

IF YOU HAVE MORE THAN THREE CHILDREN, LIST HERE AND GIVE THIS FORM TO YOUR ORKER

If any alien is asking for Restricted Medi-Cal benefits, DO NOT fill in the shaded area below for Social Security Number.

COUNTY USE ONLY
Case Name: _____
Case No.: _____
Worker No.: _____
Date: _____

(A) Child's Name (First, Middle, Last) or "unborn"	Relationship to Applicant	Linkage	Citizen/ Immig. MC 13	SSN	Preg
Social Security Number	In School ☐ Yes ☐ No — Sex ☐ Male ☐ Female				
Birthdate or date unborn is due	Is the Person Blind or Disabled ☐ Yes ☐ No — Pregnant ☐ Yes ☐ No				
Father's Name	Is Either Parent (✓) ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed	Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18 - 21 & tax dep.?			
Mother's Name	Child Living in Home ☐ Yes ☐ No — Medi-Cal Requested ☐ Yes ☐ No				
(B) Child's Name (First, Middle, Last) or "unborn"	Relationship to Applicant	Linkage	Citizen/ Immig. MC 13	SSN	Preg
Social Security Number	In School ☐ Yes ☐ No — Sex ☐ Male ☐ Female				
Birthdate or date unborn is due	Is the Person Blind or Disabled ☐ Yes ☐ No — Pregnant ☐ Yes ☐ No				
Father's Name	Is Either Parent (✓) ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed	Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18 - 21 & tax dep.?			
Mother's Name	Child Living in Home ☐ Yes ☐ No — Medi-Cal Requested ☐ Yes ☐ No				
(C) Child's Name (First, Middle, Last) or "unborn"	Relationship to Applicant	Linkage	Citizen/ Immig. MC 13	SSN	Preg
Social Security Number	In School ☐ Yes ☐ No — Sex ☐ Male ☐ Female				
Birthdate or date unborn is due	Is the Person Blind or Disabled ☐ Yes ☐ No — Pregnant ☐ Yes ☐ No				
...er's Name	Is Either Parent (✓) ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed	Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18 - 21 & tax dep.?			
Mother's Name	Child Living in Home ☐ Yes ☐ No — Medi-Cal Requested ☐ Yes ☐ No				
(D) Child's Name (First, Middle, Last) or "unborn"	Relationship to Applicant	Linkage	Citizen/ Immig. MC 13	SSN	Preg
Social Security Number	In School ☐ Yes ☐ No — Sex ☐ Male ☐ Female				
Birthdate or date unborn is due	Is the Person Blind or Disabled ☐ Yes ☐ No — Pregnant ☐ Yes ☐ No				
Father's Name	Is Either Parent (✓) ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed	Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18 - 21 & tax dep.?			
Mother's Name	Child Living in Home ☐ Yes ☐ No — Medi-Cal Requested ☐ Yes ☐ No				
(E) Child's Name (First, Middle, Last) or "unborn"	Relationship to Applicant	Linkage	Citizen/ Immig. MC 13	SSN	Preg
Social Security Number	In School ☐ Yes ☐ No — Sex ☐ Male ☐ Female				
Birthdate or date unborn is due	Is the Person Blind or Disabled ☐ Yes ☐ No — Pregnant ☐ Yes ☐ No				
Father's Name	Is Either Parent (✓) ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed	Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18 - 21 & tax dep.?			
Mother's Name	Child Living in Home ☐ Yes ☐ No — Medi-Cal Requested ☐ Yes ☐ No				
(F) Child's Name (First, Middle, Last) or "unborn"	Relationship to Applicant	Linkage	Citizen/ Immig. MC 13	SSN	Preg
Social Security Number	In School ☐ Yes ☐ No — Sex ☐ Male ☐ Female				
...hdate or date unborn is due	Is the Person Blind or Disabled ☐ Yes ☐ No — Pregnant ☐ Yes ☐ No				
Father's Name	Is Either Parent (✓) ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed	Medical Support ☐ YES ☐ NO ☐ CA 2.1			

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF HEALTH SERVICES
MEDI-CAL PROGRAM

VOCATIONAL AND WORK HISTORY

NAME: _____ CASE NAME: _____

CASE NUMBER: _____ WORKER NO. _____ PERSON NO. _____ DATE: _____

A. Have you worked, quit a Job, or refused a job or training within the last 30 days? ☐ Yes ☐ No

Name and Address of Employer/Training	Last day of Job/Training Month Day Year	Amount of last Paycheck
		$

Hours of Work/Training in last 30 days	Reason for Leaving or Refusal

B. Are you actively seeking work.? ☐ Yes ☐ No

C. Have you received Unemployment Insurance Benefits (UIB) within the last 12 months? ☐ Yes ☐ No

D. Do you earn any other money, such as tips, commissions, overtime, shift differential, etc. ☐ Yes ☐ No
If "Yes", how much? $_____ Days worked per week: _____ Hours per week: _____

E. List your employment and training history for the last 5 years. Begin with last job or training.

Name of Employer or Training Program	Work or Training	When Employed (Mo/Day/Year)	Amount Paid Monthly	Name of Employer or Training Program	Work or Training	When Employed (Mo/Day/Year)	Amount Paid Monthly
1.	☐ Work ☐ Training	From / / To / /	$	4.	☐ Work ☐ Training	From / / To / /	$
2.	☐ Work ☐ Training	From / / To / /	$	5.	☐ Work ☐ Training	From / / To / /	$
3.	☐ Work ☐ Training	From / / To / /	$	6.	☐ Work ☐ Training	From / / To / /	$

I understand that the statements I have made on this form are subject to investigation and verification. "I declare under penalty of perjury that the foregoing statements are true and correct."

Signature: _____ Date: _____

Person No. 2 - Name: _____

A. Have you worked, quit a Job, or refused a job or training within the last 30 days? ☐ Yes ☐ No

Name and Address of Employer/Training	Last day of Job/Training Month Day Year	Amount of last Paycheck
		$

Hours of Work/Training in last 30 days	Reason for Leaving or Refusal

B. Are you actively seeking work.? ☐ Yes ☐ No

C. Have you received Unemployment Insurance Benefits (UIB) within the last 12 months? ☐ Yes ☐ No

D. Do you earn any other money, such as tips, commissions, overtime, shift differential, etc. ☐ Yes ☐ No
If "Yes", how much? $_____ Days worked per week: _____ Hours per week: _____

E. List your employment and training history for the last 5 years. Begin with last job or training.

Name of Employer or Training Program	Work or Training	When Employed (Mo/Day/Year)	Amount Paid Monthly	Name of Employer or Training Program	Work or Training	When Employed (Mo/Day/Year)	Amount Paid Monthly
1.	☐ Work ☐ Training	From / / To / /	$	4.	☐ Work ☐ Training	From / / To / /	$
2.	☐ Work ☐ Training	From / / To / /	$	5.	☐ Work ☐ Training	From / / To / /	$
3.	☐ Work ☐ Training	From / / To / /	$	6.	☐ Work ☐ Training	From / / To / /	$

I understand that the statements I have made on this form are subject to investigation and verification. "I declare under penalty of perjury that the foregoing statements are true and correct."

EMPLOYMENT INFORMATION CONTINUED

NAME: _____ DATE: _____

Person Number: ____ Date Employment began: ____/____/____ Work Hours: from_____ to _____

Occupation/Job Title: _____

Address: _____ Work phone # : ( )_____

Type of income (Example: Child support, grants/loans, UIB, lottery, rental, etc.)

_____ _____ _____

_____ _____ _____

_____ _____ _____

If your income changes from month to month, show your actual income for the current month in "Month 1" below, 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
	$	$	$
	$	$	$

If self-employed, complete the following: Adjusted gross income from last federal tax return: $_____

Has income changed? ☐ Yes ☐ No

If income has changed or no tax return, what was:

Changed Income	Amount	Changed Income	Amount
Gross profit per year or cash payment from self-employment	$	Business checking account:	$
Business expenses per year (Example: Salaries to employee's equipment):	$	Average monthly cash expenditures:	$
Cash on hand for business:	$	Average monthly cash drawn from business:	$

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", please complete the following:

Monthly Amount Paid	By whom	Date last paid	To whom
$		/ /	

Does anyone who works pay for care of a child or disabled adult? ☐ Yes ☐ No

If "Yes", please complete the following:

	Person 1	Person 2	Person 3
Name of person receiving care			
Age of person receiving care			
Amount of payment and how often paid	$_____ every ☐ day ☐ week ☐ month	$_____ every ☐ day ☐ week ☐ month	$_____ every ☐ day ☐ week ☐ month

Who do you pay for the care: Name_____ Address_____

Is there a non-working member of the family (parent, sister/brother of child, spouse or child of an incapacitated adult) living in the home? ☐ Yes ☐ No

Is that person able to take care of the child or incapacitated adult? ☐ Yes ☐ No

If you are a working disabled person, do you have any medically-related expenses which are necessary for your employment, such as a wheelchair, etc.? ☐ Yes ☐ No

If "Yes", list below:

Type of Expense	Amount
	$

COUNTY USE ONLY

VERIFICATION (List):

- ☐ Wage stubs
- ☐ Tips
- ☐ Child in school
- ☐ Exempt earnings

Conversation Factor:

- ☐ Actual
- ☐ 4.33
- ☐ 2.167

COURT ORDER

Amount $_____

- ☐ Verification of payment
- ☐ Other person in MFBU who could provide care
- ☐ Verification amount paid and age of person receiving care

☐ IRWE (QMB only)

MEDI-CAL U-PARENT DETERMINATION WORKSHEET

NOTE: DETERMINE THE CONNECTION WITH THE LABOR FORCE FOR THE P.W.E. ONLY.

I. Determination of Primary Wage Earner (P.W.E)

Intake:

a. Application date OR date U-Parent deprivation began.

Enter MO/YR _____

b. Month #1 - Subtract 2 years from line A. (Circle MO on chart) _____

c. Month #24 - MO/YR immediately preceeding line A _____

(Circle MO on chart)

CURRENT YEAR 19 ____ YEAR 19 ____ YEAR 19 ____

Name	DEC	NOV	OCT	SEP	AUG	JUL	JUN	MAY	APR	MAR	FEB	JAN	DEC	NOV	OCT	SEP	AUG	JUL	JUN	MAY	APR	MAR	FEB	JAN	DEC	NOV	OCT	SEP	AUG	JUL	JUN	MAY	APR	MAR	FEB	JAN	Total
Father:																																					
Mother																																					

II. Enter complete total earnings for 24 month period on the above chart. Person earning greater amount is P.W.E.

_____
NAME

1. The P.W.E. meets the definition of Unemployed-parent by either:

☐ NOT WORKING

OR

☐ WORKING LESS THAN 100 HOURS A MONTH FOR MORE THAN 30 DAYS ☐ YES ☐ NO

2. The P.W.E. has not refused an offer of employment or employment-related training or quit a job or employment training program within 30 days, without good cause. ☐ YES (Has not quit/refused w/o good cause) ☐ NO

3. The P.W.E. has applied for and accepted UIB to which entitled. ☐ YES ☐ NO

4. The AFDC-U parent has established a connection with the labor force by either:

A. ☐ Receiving, or being eligible to receive, UIB within one year before application for aid.

OR

B. ☐ Having 6 eligible quarters out of any 13 consecutive quarters in the last 17 calendar quarters before date of application for aid. (Complete Below) ☐ YES ☐ NO

STEP ONE:	Beginning with year of application, enter 5 consecutive years.
STEP TWO:	Enter # 1 in the quarter within which the application date falls.
STEP THREE:	Beginning with quarter # 1, number each quarter, left to right, through quarter # 17.
STEP FOUR:	From the CWD 282, check eligible quarters.
	An eligible quarter is: 1) Earning at least $50 gross in a quarter OR 2) Participating at least 5 days in an approved training program.
STEP FIVE:	**Count checkmarks in each 13 consecutive quarter grouping until the 6 eligible quarters criteria is met.**

YR.	19____ (Current Year)				19____				19____				19____				19____			
OTR.	OCT-DEC	JULY-SEPT	APR-JUNE	JAN-MAR	OCT-DEC	JULY-SEPT	APR-JUNE	JAN-MAR	OCT-DEC	JULY-SEPT	APR-JUNE	JAN-MAR	OCT-DEC	JULY-SEPT	APR-JUNE	JAN-MAR	OCT-DEC	JULY-SEPT	APR-JUNE	JAN-MAR
$50																				
TRNG																				

How many checkmarks? Quarter Grouping: 1 thru 13 ____; 2 thru 14____; 3 thru 15____; 4 thru 16____; 5 thru 17____

5. The P.W.E. is unemployed for reasons other than participation in a labor dispute. (Strike) ☐ YES ☐ NO

6. ARE QUESTIONS 1 THROUGH 6 ALL ANSWERED YES? ☐ YES ☐ NO

IF NUMBER 6 IS ANSWERED YES, THE CASE IS AFDC-MN LINKED.

IF NUMBER 6 IS ANSWERED NO, THE ENTIRE MFBU IS MI, UNLESS DEPRIVATION EXISTS.

INCOME IN-KIND/HOUSING VERIFICATION

(SUPPLEMENT TO THE MC 210 STATEMENT OF FACTS)

WE NEED THE FOLLOWING INFORMATION TO DETERMINE THE VALUE OF THE HOUSING/RENT, UTILITIES, FOOD OR CLOTHING THAT YOU ARE RECEIVING FREE OR IN EXCHANGE FOR WORK.

County Use Box

Case Name: _____

Case No.: _____

Worker No.: _____ Date: _____

Part I. IN-KIND INCOME VERIFICATION

A. Applicant Authorization Section: (Sign this section if you want the county to verify IN-KIND INCOME)

Name(s): _____

Address: _____

I hereby authorize _____ ***county to contact*** _____ ***concerning any of the information requested below.***

Applicant Signature: _____ Date: _____

B. Provider Statement Section: (Statement of person giving/sharing housing, utilities, food, clothing, etc.)

1. The person(s) named above receives from me/my family:
   ☐ Housing/Rent ☐ Utilities ☐ Food ☐ Clothing ☐ Cash
   - This is ☐ Free ☐ In exchange for _____
   - I/We have been providing these items since _____
   - I/We expect to continue to provide these items until _____

2. I/We share household expenses with the person(s) named above. ☐ Yes ☐ No
   (If no, go to number 3.)

   Our shared arrangement is: _____

3. The TOTAL cost of household items at the above address is:

   Housing_____ Rent_____ Utilities_____ Food_____ Clothing_____ Cash:_____

   - The number of people in the household at the above address is: _____

4. My relationship to the person(s) named above is: _____

I CERTIFY THAT THE INFORMATION IN THIS SECTION IS TRUE AND CORRECT:

Provider Signature _____ Date: _____

Address: _____ Phone: (____) _____

Part II. HOUSING VERIFICATION

SIGN BELOW ONLY IF YOU, THE APPLICANT, WANT TO PROVIDE INFORMATION ABOUT FREE HOUSING OR RENT PAID TO A RELATIVE AS EVIDENCE OF RESIDENCY. BEFORE YOU SIGN, YOU MUST FILL IN THE HOUSING INFORMATION REQUESTED ABOVE.

I understand that the information I provide as evidence of residency may be verified by county or state employees processing my application. I agree to cooperate with any such employee in the verification of this information. I hereby authorize any county or state employee responsible for administering the Medi-Cal program to contact _____ concerning any of the information provided above.

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE **INFORMATION CONTAINED IN THIS STATEMENT IS TRUE, CORRECT, AND COMPLETE.**

Applicant Signature: _____ Date: _____

Student Educational Expenses

(Supplement to the Medi-Cal Statement of Facts - MC 210)

COUNTY USE ONLY

Case Name: _____

Case No.: _____

Worker No.: _____

Date: _____

If you or any family member are in college or attending a similar educational institution, please fill in the following:

A.	Student's name(s):		
	Name of institution(s):		
	Status of student(s):	☐ Full-time ☐ Part-time ☐ Grad ☐ Undergrad	☐ Full-time ☐ Part-time ☐ Grad ☐ Undergrad
B.	Grants, Loans, Scholarships, Fellowships:		
	Amount received:	$	$
	Source(s) of grants, loans, etc.:		
	How often received?		
C.	Expenses Per Term:		
	Is term a semester, quarter, year?		
	Tuition/fees:	$	$
	Books, equipment, and supplies:	$	$
	Child care necessary for school:	$	$
D.	Transportation to School/Child Care:		
	Round trip miles per day:		
	School attended how many days per week:		
	Type of transportation used (own car, borrowed car, car pool, bus, etc.):		
	Costs (per month):		
	• Amount paid by student (not own car)	$	$
	• Amount paid by riders	$	$
	• Parking, tolls, etc.	$	$
	Is public transportation (bus, train, etc.) available?	☐ Yes ☐ No	☐ Yes ☐ No
	• If yes, indicate cost:	$	$

See MEM 50447 for allowable education expenses.

EXEMPT:

☐ Entire amount
☐ Only expenses

VERIFICATION (List):

Transportation costs allowed (show computations):

Property/Resources

(Supplement to the Medi-Cal Statement of Facts - MC 210)

Please fill in the following, if you answered "YES" to certain Property/Resource questions from the Statement of Facts MC 210.

LIQUID RESOURCES

① Fill in the following if more room was needed to list liquid resources (Checking/Savings/IRA'S, Stocks, etc.)

Type of Resource	Owner of Resource	Account Number	Name and Address	Current Value
				$
				$
				$

COUNTY USE ONLY

Case Name: _____

_____

Case No.: _____

Worker No.: _____

Date: _____

REAL ESTATE

② A. If you or any family member answered "YES" to owning or buying any of the items listed under the Real Estate part of the MC 210, fill in the following. List any property in any state or country and all land you own, have title to, or share title in. ITEMS: Houses, lots, land, apartments, mobile homes taxed as real property, or other.

Address or Legal Description of Property: _____

_____

Name of Owner: _____

Does anyone live there now? ☐ Yes ☐ No How long have they lived there? _____

Name of person living there: _____ Relationship to you: _____

Do you plan to return to that property to live? ☐ Yes ☐ No
(You must notify the county within ten [10] days of any change in plans for living at the property.)

Is the property currently listed for sale? ☐ Yes ☐ No

Full value of property (from tax statement): $_____ Amount owed: $_____

Rent collected each month from property: $ _____

Expenses on property:

- Interest $ _____ Yearly/Monthly
- Insurance $ _____ Yearly/Monthly
- Taxes and Assessments $ _____ Yearly/Monthly
- Upkeep and Repairs $ _____ Yearly/Monthly
- Utilities $ _____ Yearly/Monthly

B. If you or any family member answered "YES" to the life estate property question, please fill in the address of the property below.
Address: _____

_____

_____

Do you or any family member have an income interest in a life estate? ☐ Yes ☐ No

Is the life estate (producing/earning/providing/giving) income? ☐ Yes ☐ No

Verification of "Good Cause" for Nonutilization of Property

Verification of Income and Expenses (List):

If you or any family member answered "YES" to owning one or more of the items in the VEHICLE section of the Statement of Facts, MC 210, fill in the following information about each vehicle.

A. **List all** cars, trucks, motorcycles, airplanes or off-road vehicles **(even if not running)** owned by you or your family. If none, write "none."

Make and Model	Year	Class (Registration)	Owner	Amount Owed	Listed for Sale?		Used for Transportation	
					Yes	No	Yes	No
				$				
				$				
				$				
				$				
				$				
				$				
				$				
				$				
				$				
				$				
				$				
				$				
				$				

B. **List any** boats, campers (do not include trucks), motor homes, or trailers which are **not** used as a home and are not taxed as real property by the county.

Description	Year	Class (Registration)	Owner	Purchase Price	Listed for Sale?		Used for Transportation	
					Yes	No	Yes	No
				$				
				$				
				$				
				$				
				$				
				$				
				$				
				$				
				$				
				$				
				$				
				$				
				$				

Note: If you think the value the Department of Motor Vehicles will give the items listed in A and B will be too high, you may get three appraisals of the actual value and the average will be used.

COUNTY USE ONLY

List exempt vehicle

- ☐ Verification of nonexempt vehicles
- ☐ Verification of encumbrance
- ☐ Verification of personal property

If you or any family member answered "YES" to owning items in the **OTHER** or **BUSINESS** section of the Statement of Facts, MC 210, please give more detailed information about those items here.

OTHER

④ **A.** If you or any family member own items of jewelry valued at more than $100 each, or are applying under Pickle and your items are over $500, you must fill in the following :
(Do not include wedding, engagement rings, or heirlooms.)

Description	Listed for Sale? Yes	Listed for Sale? No	Amount Owed
			$
			$

B. If you or any family member answered "YES" to owning life insurance, you must fill in the following:

	Insurance Company	Person Insured / Policy Owned By	Face Value	Policy Number	Date Policy Issued	Current Cash Value
1.			$			$
2.			$			$
3.			$			$

C. If you or your family member answered "YES" to owning one or more of the following:

1. burial plot, vault, or crypt, is it for use of immediate family? ☐ Yes ☐ No

or 2. mineral rights or mining claims, is either listed for sale? ☐ Yes ☐ No

Please give more detailed information:

Description: _____

Owned by: _____

Current Value: $ _____ Amount Owed: $ _____

Location: _____

D. If you or your family member answered "YES" to owning a burial reserve or trust, please fill in the following:

Purchase Price	Amount Owed	Purchased For Whom	Purchased From Whom
$	$		
$	$		
$	$		

☐ Revocable
☐ Irrevocable
☐ Designated Funds

Current Value $_____

⑤ If you or any family member answered "YES" to owning one or more of the following types of business items: equipment, vehicles, tools, inventory or materials (including livestock or poultry not for personal use), you must give more detailed information by filling in the following.

BUSINESS

Description of Item	Estimated Value	Amount Owed
	$	$
	$	$
	$	$

COUNTY USE ONLY

Heirloom? _____
Total Nonexempt

Appraised Value $ _____

☐ Exempt

Yes No CSV

Exempt ☐ ☐ $_____

Exempt ☐ ☐ $_____

Exempt ☐ ☐ $_____

Total CSV $_____

Exempt ☐ ☐ $_____