STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY PETE WILSON, *Governor*

DEPARTMENT OF HEALTH SERVICES
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October 29, 1993

TO: ALL HOLDERS OF THE MEDI-CAL ELIGIBILITY MANUAL Letter No.: 123

SUBJECT: Medi-Cal Eligibility Manual - Article 4 Procedures (Forms Section)
Implementation of the Medi-Cal Statement of Facts, (MC 210) and the MC 210 Supplementals

Enclosed are new procedures to Article 4, Application Process, of the Medi-Cal Eligibility Manual. These instructions which have not been previously issued, provide a replacement of the Statement of Facts MC 210 form and add new documents to the Forms section of the Eligibility Procedures Manual.

Statement of Facts (Sections 50159 and 50161)

According to CCR, Title 22, Section 50159, the Statement of Facts (MC 210) application form, shall be used by the county department in the determination of the applicant's eligibility, share of cost and other health coverage. Currently, the MC 210 application consists of 15 pages. Over the past two years, the Department of Health Services has been involved in a pilot project to streamline and simplify this form.

Based upon the pilot results and county comments, the enclosed MC 210 and the MC 210 supplemental forms have been developed.

FORMS PROCEDURES

Provided is a list of revised and new forms that are attached to be placed in your MEM Manual. Please see Section F of the Medi-Cal Procedures if you have questions on how to reorder or make revisions to existing forms.

Obsolete Forms:	Replaced By:
MC 210 (3/92)	MC 210 (8/93)
Coversheet to MC 210	MC 219 (11/93)
MC 210 B Supplement to MC 210 (Pickle)	Incorporated into MC 210
MC 212	Incorporated into MC 210
MC 213	Incorporated into the MC 210 S-I
MC 214	Incorporated into the MC 219

Filing Instructions

Remove Pages:	Insert Pages:
Table of Contents PTC 5	Table of Contents PTC 5
Article 4 Table of Contents, third and fourth pages	Article 4 Table of Contents, third and fourth pages
	Pages 4S-1 through 4S-28

If you have any questions, please contact Mr. Tony Plescia at (916) 657-3185 or Ms. Sherilyn Walden (916) 657-3091.

Sincerely,

Original signed by
Angeline Mrva for

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Enclosures

4L -- RSDI/UI/DI REPORTS

I. BACKGROUND

II. INSTRUCTIONS FOR INTERPRETING THE REPORT OF RSDI

III. INSTRUCTIONS FOR INTERPRETING THE UI/DI FORMATS ON THE REPORT OF RSDI/UI/DI

4M -- VERIFICATION OF UNCONDITIONALLY AVAILABLE INCOME

4N -- TIMELY REPORTING BY PUBLIC GUARDIANS/CONSERVATORS OR BENEFICIARY REPRESENTATIVES

4O -- ONE MONTH EXTENDED ELIGIBILITY (EDWARDS V. MYERS)

4P -- CHILD HEALTH AND DISABILITY PREVENTION (CHDP) PROGRAM

I. INFORMING

II. DOCUMENTATION AND REFERRAL RESPONSIBILITIES

4Q -- PROCEDURES FOR LONG-TERM CARE (LTC) ADMISSIONS AND DISCHARGES FOR SSI/SSP AND MEDI-CAL RECIPIENTS

I. BACKGROUND INFORMATION

II. ADMISSIONS PROCEDURES

III. DISCHARGE PROCEDURES

4R -- PROCEDURES FOR MEDICAL SUPPORT ENFORCEMENT PROGRAM

I. BACKGROUND

II. PURPOSE

III. IMPLEMENTATION

IV. CONDITION OF ELIGIBILITY

A. Medi-Cal Only
B. AFDC/Medi-Cal

V. GOOD CAUSE FOR NONCOOPERATION

VI. PETITION TO THE COURT

A. Pregnant Women

B. OBRA Referrals

C. Continuing Eligibility

D. Adult Children

E. Foster Care Children

VII. MEDICAL SUPPORT REFERRAL PROCESS

A. Forms Referral

B. Forms Referral Chart

VIII. HEALTH INSURANCE ASSIGNMENTS

IX. NOTICES OF ACTION

X. DEPARTMENT OF SOCIAL SERVICES (DSS) CHILD SUPPORT PROCEDURES

4S. INSTRUCTIONS FOR THE MC 210 AND SUPPLEMENTS TO THE MC 210

4S--Instructions for the MC 210 and Supplements to the MC 210

MC 210

The revision date for the MC 210 is August 1993. This Streamlined revision to the Statement of Facts is a result of a six month pilot which now includes the recent residency regulations implemented early this year. The residency regulations had resulted in several new forms: the MC 212, MC 213, and MC 214. However, to ensure the amount of paperwork required at application was kept to a minimum, the MC 212 has been incorporated into the newly revised MC 210. Counties will no longer need to order the MC 212. The MC 213 and MC 214 have also been absorbed into other forms as described below. A copy of the MC 210 is enclosed. Please place it into the forms section of your Procedure Manual as a replacement to the old form.

MC 219

The MC 219 (11/93) was formerly the Cover Sheet to the MC 210. This form discusses the Rights and Responsibilities of an applicant as well as the "Citizenship/Immigration Status Information....". This set of forms is now separate from the MC 210. The MC 214, "Declaration For Medi-Cal Applicants Who Do Not Have One Of The Specified Residency Verification Documents", has been absorbed into the MC 219. This now makes the MC 214 obsolete. Please place the MC 219 into the forms section of your Procedure Manual as a replacement to the Cover Sheet.

MC 210 SUPPLEMENTAL FORMS

The following are instructions to be used in determining whether a supplemental form should be given to an applicant. County personnel will notice that the Supplemental forms to the MC 210 are numbered MC 210 S-C, S-E, S-I, S-P, and S-W. The "S" represents Supplement; the -C, -E, -I, etc. refer to the title of the form as detailed below. Not all of the supplemental forms listed below are mandated for use by the Department. The descriptions below will explain whether a form is mandatory. If the form is not mandatory, counties may substitute one of their own, once it has been approved by the Department.

MC 210 S-C ADDITIONAL CHILDREN

The MC 210 S-C is given to a client if he/she has indicated on the MC 210 that the family has more than three children. The information for each child should be filled in completely. If the client is requesting restricted benefits the shaded portion for **SSN** should NOT be completed. This form is mandatory for use by the county. Please place the copy of this form in your manual.

MC 210 S-E STUDENT EDUCATIONAL EXPENSES

This form is given to the client if the MC 210 indicates any family member is attending college or a similar educational institution. Information is requested on whether the client is receiving a grant, scholarship, or loan, and if there are any student expenses or transportation costs. This form is not mandatory for use by the county. Please place a copy of this form in your manual.

MC 210 S-I INCOME IN-KIND/HOUSING VERIFICATION

The Income In-Kind and Housing Verification form has a two-fold purpose: First, it should be used if the client has in-kind income, and does not agree with the chart value given by the eligibility worker. If the client does not agree, he/she may use this form as signed verification from the individual providing/sharing housing, utilities, food, clothing, etc. that a different amount is correct. Second, the client is residing with

a relative, is paying that relative rent, and has no other verification of residency. If a client is using this form solely for the purpose of verifying in-kind income, it is not a mandatory form. However if the client wishes to use this form as verification of residency, it is mandatory. Counties may not use any other form as verification of residency for rent receipt from a relative. The MC 213, "Statement of Rent Receipt From A Relative", is now obsolete as it has been absorbed into the MC 210 S-I and the MC 213 is now obsolete. Please place a copy of this form in your manual.

MC 210 S-P Property/Resources

This form will be used by a client if certain Property/Resource questions on the MC 210 require additional information. For example, if a client has answered yes to owning, or having title to, property in another state on the MC 210, this supplemental form should be completed. The MC 210 S-P, will ask if there are expenses on that property, the address of the property, value, etc. Please place a copy of this form in your manual. This form is not considered mandatory.

MC 210 S-W Work History (Earnings and Expenses)

This form is used to capture a person's work history, if the client is applying as an unemployed parent, or if certain income questions on the MC 210 require additional information, such as expenses against income. Please place a copy of this form in your manual. This form is not considered mandatory.

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 OF 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	COUNTY USE ONLY: Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID
Social Security Number	Marital Status (check one) ☐ Married ☐ Never Married ☐ Common Law ☐ Widowed ☐ Divorced ☐ Separated (Date)_____					
Birthdate	Is the Person Blind or Disabled ☐ Yes ☐ No / Pregnant ☐ Yes ☐ No	Sex ☐ Male ☐ Female / Medi-Cal Requested ☐ Yes ☐ No				

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

⑤ 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				

⑥ 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				

IF YOU HAVE MORE THAN 3 CHILDREN-LIST HERE.
LIST NAMES ONLY AND TELL YOUR WORKER: _____

☐ MC 210 S-C
☐ Potential Sneede

MC 210 (5/83)

If you answer "YES" to certain questions about residency, property/resource, income, or work hist
you may be asked to give more detailed information before your application is approved.

	CHECK EACH ITEM "YES" OR "NO"	YES	NO	COUN USE
LIVING ARRANGEMENT	(7) a. Is there anyone living in your home that you did not list?			Relationship:
	List Name(s):			
	b. Do you pay for room and board or rent a room, apartment, house, or trailer?			☐ MC 210S-I
	(8) Is any family member living in a nursing home, hospital or board and care home?			☐ LTC return home in 6 mos?
	Name of person:			☐ MC 176 W.1
	Name of Home/Facility:			☐ Excess B & C
	Date Entered:			Amount: $
	Intend to return home?			
TAX DEPENDENT	(9) Are you or any family member claimed as a tax dependent by a person not living with you?			☐ Tax dependent letter sent
	Name and address of person claiming the tax deduction:			Date:
				☐ CA 2.1
RESIDENCE	(10) a. Do you or any family member own, lease or maintain a home outside California?			☐ Property
	b. Are you or any family member currently receiving public assistance from outside California?			☐ PA
	(11) Are you or any family member living outside California?			Calif. Resident?
	(12) a. Are you or any family member planning to leave California for more than 60 days?			☐ Yes ☐ No
	b. Do you and your family plan to stay permanently in California?			
EMPLOYMENT 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
	List Name(s):			☐ Other Verif
	(19) Was the physical or emotional problem caused by an injury or accident?			☐ CWC 6041
PA OR 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: MC 210B
	List what kind:			☐ SGA
	List where received:			☐ Post MC
	List when received:			☐ 30 + 1/3
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:
	Item / Date: ☐ Transferred ☐ Sold ☐ Traded ☐ Closed ☐ Given Away					☐ Verification ☐ List Other Trans. in # 40
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 $_____

MC 210 (8/93)

Do you or any family member get, expect to get, or has anyone applied for any of the following 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
EARNED INCOME	(30) Money from a job? (including occasional work).....						☐ MC 210 S-W Use copy of award letter or check or other verification.
	If yes, how many people in your home work? _____						☐ Weekly (4.33) ☐ Bi-Weekly (2.167) ☐ Monthly ☐ Twice Monthly ☐ Actual ☐ Other:
	Do you expect a change in your job? ..... (Hours or money)						
	Explain: _____						
SELF 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 INCOME	(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: Free / Work For Housing (Room and Board) ☐ ☐ Utilities ☐ ☐ Food ☐ ☐ Clothing ☐ ☐				Value $ $ $ $		☐ Chart Value ☐ MC 210 S-I ☐ Sneede

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?					☐ MC 210S-E
(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:___ $_____ ☐ SSA Referral
Is health/medical insurance available through employment?					
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)

_____

_____

_____

_____

SERVICES: YOUR ANSWERS TO THESE WILL NOT AFFECT YOUR ELIGIBILITY FOR MEDI-CAL

	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 Date: _____ ☐ Referral
• Do you want more information about CHDP Services?			
• Do you want CHDP medical or dental services?			
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?			☐ WIC referral
Have you given birth within the last three months?			
• 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 and any of its supplemental form(s) that I may be asked to complete 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 WORKER

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				
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				
(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				
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				

MC 210S-C (8/93)

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF HEALTH SERVICES
MEDI-CAL PROGRAM

NIÑOS ADICIONALES

(SUPLEMENTO A LA DECLARACION DE DATOS DE MEDI-CAL - MC 210)

SI TIENE MAS DE TRES NIÑOS, ANOTELOS AQUI Y DELE ESTA FORMA A SU TRABAJADOR(A)

Si algún extranjero está solicitando beneficios restringidos de Medi-Cal, NO complete el área sombreada con relación al Número del Seguro Social.

PARA USO DEL CONDADO

Case Name: _____

Case No.: _____

Worker No.: _____

Date: _____

(A) Nombre del niño (Nombre, Inicial, Apellido) o "por nacer"	Parentesco con el solicitante		Linkage	Citizen/ Immig. MC 13	SSN	Preg	
Número del Seguro Social	¿Asiste a la escuela? ☐ Sí ☐ No	Sexo ☐ Masc. ☐ Fem.					
Fecha de nacimiento o fecha en que se espera nacerá el bebé	¿Está la persona ciega o incapacitada? ☐ Sí ☐ No	¿Embarazada? ☐ Sí ☐ No					
Nombre del padre	¿Está cualquiera de los padres (✔) ☐ Muerto ☐ Incapacitado ☐ Ausente ☐ Desempleado?		Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18 - 21 & tax dep.?				
Nombre de la madre	¿Vive el niño en el hogar? ☐ Sí ☐ No	¿Solicitó Medi-Cal? ☐ Sí ☐ No					
(B) Nombre del niño (Nombre, Inicial, Apellido) o "por nacer"	Parentesco con el solicitante		Linkage	Citizen/ Immig. MC 13	SSN	Preg	
Número del Seguro Social	¿Asiste a la escuela? ☐ Sí ☐ No	Sexo ☐ Masc. ☐ Fem.					
Fecha de nacimiento o fecha en que se espera nacerá el bebé	¿Está la persona ciega o incapacitada? ☐ Sí ☐ No	¿Embarazada? ☐ Sí ☐ No					
Nombre del padre	¿Está cualquiera de los padres (✔) ☐ Muerto ☐ Incapacitado ☐ Ausente ☐ Desempleado?		Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18 - 21 & tax dep.?				
Nombre de la madre	¿Vive el niño en el hogar? ☐ Sí ☐ No	¿Solicitó Medi-Cal? ☐ Sí ☐ No					
(C) Nombre del niño (Nombre, Inicial, Apellido) o "por nacer"	Parentesco con el solicitante		Linkage	Citizen/ Immig. MC 13	SSN	Preg	
Número del Seguro Social	¿Asiste a la escuela? ☐ Sí ☐ No	Sexo ☐ Masc. ☐ Fem.					
Fecha de nacimiento o fecha en que se espera nacerá el bebé	¿Está la persona ciega o incapacitada? ☐ Sí ☐ No	¿Embarazada? ☐ Sí ☐ No					
Nombre del padre	¿Está cualquiera de los padres (✔) ☐ Muerto ☐ Incapacitado ☐ Ausente ☐ Desempleado?		Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18 - 21 & tax dep.?				
Nombre de la madre	¿Vive el niño en el hogar? ☐ Sí ☐ No	¿Solicitó Medi-Cal? ☐ Sí ☐ No					
(D) Nombre del niño (Nombre, Inicial, Apellido) o "por nacer"	Parentesco con el solicitante		Linkage	Citizen/ Immig. MC 13	SSN	Preg	
Número del Seguro Social	¿Asiste a la escuela? ☐ Sí ☐ No	Sexo ☐ Masc. ☐ Fem.					
Fecha de nacimiento o fecha en que se espera nacerá el bebé	¿Está la persona ciega o incapacitada? ☐ Sí ☐ No	¿Embarazada? ☐ Sí ☐ No					
Nombre del padre	¿Está cualquiera de los padres (✔) ☐ Muerto ☐ Incapacitado ☐ Ausente ☐ Desempleado?		Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18 - 21 & tax dep.?				
Nombre de la madre	¿Vive el niño en el hogar? ☐ Sí ☐ No	¿Solicitó Medi-Cal? ☐ Sí ☐ No					
(E) Nombre del niño (Nombre, Inicial, Apellido) o "por nacer"	Parentesco con el solicitante		Linkage	Citizen/ Immig. MC 13	SSN	Preg	
Número del Seguro Social	¿Asiste a la escuela? ☐ Sí ☐ No	Sexo ☐ Masc. ☐ Fem.					
Fecha de nacimiento o fecha en que se espera nacerá el bebé	¿Está la persona ciega o incapacitada? ☐ Sí ☐ No	¿Embarazada? ☐ Sí ☐ No					
Nombre del padre	¿Está cualquiera de los padres (✔) ☐ Muerto ☐ Incapacitado ☐ Ausente ☐ Desempleado?		Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18 - 21 & tax dep.?				
Nombre de la madre	¿Vive el niño en el hogar? ☐ Sí ☐ No	¿Solicitó Medi-Cal? ☐ Sí ☐ No					
(F) Nombre del niño (Nombre, Inicial, Apellido) o "por nacer"	Parentesco con el solicitante		Linkage	Citizen/ Immig. MC 13	SSN	Preg	
Número del Seguro Social	¿Asiste a la escuela? ☐ Sí ☐ No	Sexo ☐ Masc. ☐ Fem.					
Fecha de nacimiento o fecha en que se espera nacerá el bebé	¿Está la persona ciega o incapacitada? ☐ Sí ☐ No	¿Embarazada? ☐ Sí ☐ No					
Nombre del padre	¿Está cualquiera de los padres (✔) ☐ Muerto ☐ Incapacitado ☐ Ausente ☐ Desempleado?		Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18 - 21 & tax dep.?				
Nombre de la madre	¿Vive el niño en el hogar? ☐ Sí ☐ No	¿Solicitó Medi-Cal? ☐ Sí ☐ No					

MC 210 S-C (SP) (8/93)

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF HEALTH SERVICES
MEDI-CAL PROGRAM

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):

MC 210 S-P (8/93)

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.

VEHICLES

③ 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 any 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 any 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
$	$		
$	$		
$	$		

BUSINESS

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.

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 ☐ ☐ $_____

☐ Revocable
☐ Irrevocable
☐ Designated Funds
Current Value $_____

MC 210 S-P (8/93)

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF HEALTH SERVICES
MEDI-CAL PROGRAM

EARNINGS AND EXPENSES

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

COUNTY USE ONLY

Case Name: _____

Case No.: _____

Worker No.: _____

Date: _____

1. **Person No. 1** - Name : _____

Occupation/Job Title: _____ Work Phone # : ( ) _____

Address: _____ Hours Worked per Week: _____

Date Employment Began: ___/___/___ Hours Worked per Month: _____

Person No. 2 - Name : _____

Occupation/Job Title: _____ Work Phone # : ( ) _____

Address: _____ Hours Worked per Week: _____

Date Employment Began: ___/___/___ Hours Worked per Month: _____

2. 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	Month 1	Month 2	Month 3
	$	$	$
	$	$	$

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 costs per year (Example: salaries to employees, equipment):	$	Average monthly cash paid out:	$
Cash on hand for business:	$	Average monthly cash drawn from business:	$

4. 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: _____

5. Is there a non-working member of the family (parent, sister/brother of child, spouse or child of a disabled adult) living in the home who is able to take care of the child or disabled adult? ☐ Yes ☐ No

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

If "Yes", list below:

Type of Cost	Amount
	$
	$

7. 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
$		/ /	

VERIFICATION (List):

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

Conversion Factor:

- ☐ Actual
- ☐ 4.33 (Weekly)
- ☐ 2.167 (Bi-Weekly)
- ☐ Twice Monthly

☐ Tax Return
Schedule C
Business Ledgers

☐ Verification amount paid and age of person receiving care

☐ Other person in MFBU who could provide care MEM 50553.5

☐ IRWE (QMB/SLMB)

COURT ORDER

Amount $_____

☐ Verification of payment

Page 1 of 2

VOCATIONAL AND WORK HISTORY

1. **Person No. 1 - 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 / /	$

2. **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."

Signature:_____ Date:_____

MC 210 S-W (9/93)

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF HEALTH SERVICES
MEDI-CAL PROGRAM

INGRESOS GANADOS Y GASTOS

(Suplemento a la Declaración de Datos de Medi-Cal - MC 210)

PARA USO DEL CONDADO

Case Name: _____

Case No.: _____

Worker No.: _____

Date: _____

1. **Persona No. 1** - Nombre : _____
   Ocupación/Empleo Puesto: _____ No. de Tel. en el Trabajo: ( ) _____
   Dirección: _____ Horas Trabajadas por Semana: _____
   Fecha en que Comenzó el Empleo: ____/____/____ Horas Trabajadas por Mes: _____

   Persona No. 2 - Nombre : _____
   Ocupación/Empleo Puesto: _____ No. de Tel. en el Trabajo: ( ) _____
   Dirección: _____ Horas Trabajadas por Semana: _____
   Fecha en que Comenzó el Empleo: ____/____/____ Horas Trabajadas por Mes: _____

2. Si sus ingresos cambian de mes a mes, muestre sus ingresos reales para el mes actual en "Mes 1" en seguida, y sus ingresos brutos calculados para los siguientes dos meses en "Mes 2" y "Mes 3".

Nombre	Mes 1	Mes 2	Mes 3
	$	$	$
	$	$	$

3. Si tiene negocio propio, complete lo siguiente: Ingresos ajustados de la última declaración de impuestos federales: $_____
   ¿Han cambiado los ingresos? ☐ Sí ☐ No
   Si han cambiado los ingresos o no hay declaración de impuestos, qué fue(ron):

Ingresos que Cambiaron	Cantidad	Ingresos que Cambiaron	Cantidad
Ganancias brutas por año o pago en efectivo proveniente de negocio propio:	$	Cuenta de cheques del negocio:	$
Costos del negocio por año (Ejemplo: salarios de los empleados, equipo):	$	Promedio mensual de efectivo que se pagó:	$
Efectivo a la mano para el negocio:	$	Promedio mensual de efectivo retirado del negocio:	$

4. ¿Paga alguien que trabaja para que se cuide a un niño o a un adulto incapacitado? ☐ Sí ☐ No
   Si es así, por favor complete lo siguiente:

	Persona 1	Persona 2	Persona 3
Nombre de la persona que se cuida			
Edad de la persona que se cuida			
Cantidad del pago y frecuencia del mismo	$_____ cada ☐ día ☐ semana ☐ mes	$_____ cada ☐ día ☐ semana ☐ mes	$_____ cada ☐ día ☐ semana ☐ mes

¿A quién le paga por el cuidado? Nombre: _____
Dirección: _____

5. ¿Vive en el hogar algún miembro de la familia que no trabaja (padre/madre, hermano/hermana del niño, esposo(a) o hijo(a) de un adulto incapacitado) quien puede cuidar ese niño(a) o adulto incapacitado? ☐ Sí ☐ No

6. Si usted es una persona incapacitada que trabaja, ¿tiene gastos médicos que son necesarios para su empleo, como una silla de ruedas, etc.? ☐ Sí ☐ No
   Si es así, anótelos abajo:

Clase de gasto	Cantidad
	$
	$

7. ¿Paga usted, o cualquier miembro de la familia, mantenimiento de hijos o pensión alimenticia, conforme a una orden de la corte, o basados en un convenio con el Fiscal del Distrito? ☐ Sí ☐ No
   Si es así, por favor complete lo siguiente:

Cantidad Mensual que se Paga	¿Por Quién?	Ultima Fecha de Pago	¿A Quién?
$		/ /	

VERIFICATION (List):
- ☐ Wage stubs
- ☐ Tips
- ☐ Child in school
- ☐ Exempt earnings

Conversion Factor:
- ☐ Actual
- ☐ 4.33 (Weekly)
- ☐ 2.167 (Bi-Weekly)
- ☐ Twice Monthly

☐ Tax Return
Schedule C
Business Ledgers

☐ Verification amount paid and age of person receiving care

☐ Other person in MFBU who could provide care MEM 50553.5

☐ IRWE (QMB/SLMB)

COURT ORDER

Amount $_____

☐ Verification of payment

MC 210 S-W (SP) (3/93)

Página 1 de 2

HISTORIAL VOCACIONAL Y DE EMPLEO

1. **Persona No. 1** - Nombre : _____

A. ¿Ha trabajado usted, dejado o rehusado un empleo o entrenamiento en los últimos 30 días? ☐ Sí ☐ No

Nombre y Dirección del Patrono/Entrenamiento	Ultimo Día de Empleo/Entrenamiento Mes Día Año	Cantidad del Ultimo Cheque de Pago
		$
Horas de Trabajo/Entrenamiento en los Ultimos 30 Días	**Razón para Dejarlo o Rehusarlo**	

B. ¿Está usted buscando trabajo activamente? ☐ Sí ☐ No
C. ¿Ha recibido Beneficios del Seguro contra Desempleo (UIB) en los últimos 12 meses? ☐ Sí ☐ No
D. ¿Gana cualquier otro dinero, como propinas, comisiones, tiempo extra, diferencial por turno, etc.? ☐ Sí ☐ No
Si es así, ¿cuánto? $_____ Días trabajados a la semana: _____ Horas a la semana: _____
E. Anote su historial de empleo y entrenamiento para los últimos 5 años. Comience con el último empleo o entrenamiento.

Nombre del Patrono o Progr. de Entrenam.	Trabajo o Entrenamiento	Cuándo Trabajó (Mes/Día/Año)	Cantidad Pagada Mensualmente	Nombre del Patrono o Progr. de Entrenam.	Trabajo o Entrenamiento	Cuándo Trabajó (Mes/Día/Año)	Cantidad Pagada Mensualmente
1.	☐ Trabajo ☐ Entren.	De / / A / /	$	4.	☐ Trabajo ☐ Entren.	De / / A / /	$
2.	☐ Trabajo ☐ Entren.	De / / A / /	$	5.	☐ Trabajo ☐ Entren.	De / / A / /	$
3.	☐ Trabajo ☐ Entren.	De / / A / /	$	6.	☐ Trabajo ☐ Entren.	De / / A / /	$

2. **Persona No. 2** - Nombre : _____

A. ¿Ha trabajado usted, dejado o rehusado un empleo o entrenamiento en los últimos 30 días? ☐ Sí ☐ No

Nombre y Dirección del Patrono/Entrenamiento	Ultimo Día de Empleo/Entrenamiento Mes Día Año	Cantidad del Ultimo Cheque de Pago
		$
Horas de Trabajo/Entrenamiento en los Ultimos 30 Días	**Razón para Dejarlo o Rehusarlo**	

B. ¿Está usted buscando trabajo activamente? ☐ Sí ☐ No
C. ¿Ha recibido Beneficios del Seguro contra Desempleo (UIB) en los últimos 12 meses? ☐ Sí ☐ No
D. ¿Gana cualquier otro dinero, como propinas, comisiones, tiempo extra, diferencial por turno, etc.? ☐ Sí ☐ No
Si es así, ¿cuánto? $_____ Días trabajados a la semana: _____ Horas a la semana: _____
E. Anote su historial de empleo y entrenamiento para los últimos 5 años. Comience con el último empleo o entrenamiento.

Nombre del Patrono o Progr. de Entrenam.	Trabajo o Entrenamiento	Cuándo Trabajó (Mes/Día/Año)	Cantidad Pagada Mensualmente	Nombre del Patrono o Progr. de Entrenam.	Trabajo o Entrenamiento	Cuándo Trabajó (Mes/Día/Año)	Cantidad Pagada Mensualmente
1.	☐ Trabajo ☐ Entren.	De / / A / /	$	4.	☐ Trabajo ☐ Entren.	De / / A / /	$
2.	☐ Trabajo ☐ Entren.	De / / A / /	$	5.	☐ Trabajo ☐ Entren.	De / / A / /	$
3.	☐ Trabajo ☐ Entren.	De / / A / /	$	6.	☐ Trabajo ☐ Entren.	De / / A / /	$

Entiendo que las declaraciones que he hecho en esta forma están sujetas a investigación y verificación. "Declaro bajo pena de perjurio que las declaraciones anteriores son verdaderas y correctas."

Firma:_____ Fecha:_____

MC 210 S-W (SP) (3/93)

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF HEALTH SERVICES
MEDI-CAL PROGRAM

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: _____

MC 210 S-I (8/93)

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF HEALTH SERVICES
MEDI-CAL PROGRAM

INGRESOS – NO EN EFECTIVO/VERIFICACION DE VIVIENDA

(SUPLEMENTO A LA DECLARACION DE DATOS MC 210)

NECESITAMOS LA SIGUIENTE INFORMACION PARA DETERMINAR EL VALOR DE LA VIVIENDA/ALQUILER, SERVICIOS PUBLICOS Y MUNICIPALES, ALIMENTOS O ROPA QUE USTED RECIBE GRATIS O A CAMBIO DE TRABAJO.

Para Uso del Condado

Case Name: _____

Case No.: _____

Worker No.: _____ Date: _____

Parte I. VERIFICACION DE LOS INGRESOS NO EN EFECTIVO

A. Sección de Autorización del Cliente: (Firme esta sección si usted desea que el condado verifique los INGRESOS NO EN EFECTIVO)

Nombre(s): _____

Dirección: _____

Por medio de la presente autorizo al condado de _____ a que se comunique con _____ con relación a cualquier información que se solicita enseguida.

Firma del Solicitante: _____ Fecha: _____

B. Sección para la Declaración del Proveedor: (Declaración de la persona que da/comparte la vivienda, servicios públicos y municipales, alimentos, ropa, etc.)

1. La(s) persona(s) mencionada(s) arriba recibe(n) de mí/de mi familia:
   ☐ Vivienda/Alquiler ☐ Servicios Públicos y Municipales ☐ Alimentos ☐ Ropa ☐ Dinero en efectivo
   - Esto es ☐ Gratuito ☐ A cambio de _____.
   - He/hemos proporcionado estos artículos desde _____.
   - Espero/esperamos continuar proporcionando estos artículos hasta _____

2. Comparto/compartimos los gastos del hogar con la(s) persona(s) mencionada(s) arriba. ☐ Sí ☐ No
   (Si no es así, pase al número 3.)
   Nuestro arreglo de compartir es: _____.

3. El costo TOTAL de los gastos del hogar en la dirección anterior es:
   Vivienda_____ Alquiler_____ Servicios Públicos y Municipales_____ Alimentos_____
   Ropa_____ Dinero en efectivo_____
   - El número de personas en el hogar en la dirección anterior es: _____.

4. Mi relación/parentesco con la(s) persona(s) mencionada(s) arriba es: _____.

CERTIFICO QUE LA INFORMACION QUE CONTIENE ESTA SECCION ES VERDADERA Y CORRECTA:

Firma del Proveedor _____ Fecha: _____

Dirección: _____ Tel.: (____) _____

Parte II. VERIFICACION DE VIVIENDA

FIRME ABAJO SOLAMENTE SI USTED, EL SOLICITANTE, DESEA PROPORCIONAR INFORMACION ACERCA DE VIVIENDA GRATUITA O ALQUILER (RENTA) QUE SE LE PAGA A ALGUN PARIENTE COMO PRUEBA DE RESIDENCIA. ANTES DE FIRMAR, USTED TIENE QUE COMPLETAR LA INFORMACION SOBRE VIVIENDA QUE SE LE PIDE ARRIBA.

Entiendo que la información que yo proporcione como prueba de residencia, pudiera ser verificada por empleados del condado o del estado para tramitar mi solicitud. Estoy de acuerdo en cooperar con tal empleado en la verificación de esta información. Por medio de la presente, autorizo a los empleados del condado o del estado, que sean responsables de administrar el programa de Medi-Cal, a ponerse en contacto con _____ con relación a cualquier información que he proporcionado arriba.

DECLARO BAJO PENA DE PERJURIO, EN CONFORMIDAD CON LAS LEYES DEL ESTADO DE CALIFORNIA, QUE LA INFORMACION QUE CONTIENE ESTA DECLARACION ES VERDADERA, CORRECTA, Y COMPLETA.

Firma del Solicitante: _____ Fecha: _____

MC 210 S-I (SP) (8/93)

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF HEALTH SERVICES
MEDI-CAL PROGRAM

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):

MC 210 S-E (3/90)

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF HEALTH SERVICES
MEDI-CAL PROGRAM

Gastos Educativos de Estudiantes
(Suplemento a la Declaración de Datos de Medi-Cal - MC 210)

PARA USO DEL CONDADO

Case Name: _____

_____

Case No.: _____

Worker No.: _____

Date: _____

Si usted o cualquier miembro de la familia asiste a la universidad o una institución donde otorgan medio bachillerato (college) o una institución educativa similar, por favor complete lo siguiente:

See MEM 50447 for allowable education expenses.

EXEMPT:

☐ Entire amount
☐ Only expenses

A.	Nombre del estudiante(s):	_____	_____
	Nombre de la institución(es):	_____	_____
	Situación como estudiante(s):	☐ Tiempo compl. ☐ Medio tiempo ☐ Postgraduado ☐ Sin graduarse	☐ Tiempo compl. ☐ Medio tiempo ☐ Postgraduado ☐ Sin graduarse
B.	Subvenciones, Préstamos, Becas:	_____	_____
	Cantidad recibida:	$ _____	$ _____
	Fuente(s) de las subvenciones, préstamos, etc.:	_____	_____
	¿Con qué frecuencia se recibe?	_____	_____
C.	Gastos por Curso:		
	¿Es el curso un semestre, un trimestre, un año?	_____	_____
	Colegiatura/cuotas:	$ _____	$ _____
	Libros, equipo, y útiles:	$ _____	$ _____
	Cuidado de niños necesario para asistir a la escuela:	$ _____	$ _____
D.	Transporte a la Escuela/Guardería Infantil:		
	Millas por viaje redondo al por día:	_____	_____
	Días por semana que asiste a la escuela:	_____	_____
	Clase de transporte que se usa (auto propio, auto prestado, viaje en grupo, autobús, etc.):	_____	_____
	Gastos (por mes):	_____	_____
	• Cantidad que paga el estudiante (no en auto propio)	$ _____	$ _____
	• Cantidad que pagan las personas que viajan con usted	$ _____	$ _____
	• Estacionamiento, peaje, etc.	$ _____	$ _____
	¿Hay a la disposición transporte público (autobús, tren, etc.)?	☐ Sí ☐ No	☐ Sí ☐ No
	• Si es así, indique el costo:	$ _____	$ _____

VERIFICATION (List):

Transportation costs allowed (show computations):

MC 210 S-E (SP) (3/93)

State of California—Health and Welfare Agency

Department of Health Services
Medi-Cal Program

IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL

I, _____ am applying for Medi-Cal benefits from _____ County Welfare Department (on behalf of _____). I fully understand that I have the following **RIGHTS AND RESPONSIBILITIES** listed on this form in order to be found eligible for Medi-Cal and to maintain that eligibility.

I HAVE THE RIGHT:

- To ask for an interpreter to help me in applying for Medi-Cal if I have difficulty in speaking or understanding the English language.
- To be treated fairly and equally regardless of my race, color, religion, national origin, sex, age, or political beliefs.
- To apply for Medi-Cal and to be told ***in writing*** whether or not I qualify for any Medi-Cal program, even if the county representative tells me during this interview that it appears I am not eligible at this time.
- To apply as a disabled person if I think I am disabled.
- To review manuals containing the rules and regulations of the Medi-Cal program if I want to question the basis on which my eligibility is approved or denied.
- To receive a Medi-Cal card as soon as possible if I have a medical emergency or I am pregnant.
- To have all information that I give to the county welfare department kept in the strictest confidence.
- To be told about the Child Health and Disability Prevention (CHDP) Program and the Special Supplemental Food Program for Women, Infants and Children (WIC) and to request help in receiving services under those programs.
- To be told about the rules for retroactive Medi-Cal eligibility.
- To qualify for Medi-Cal by reducing my property reserve to within the Medi-Cal property limit by the last day of any month, including the month of application, I have the right to an explanation of possible ways that I may spend my excess property as long as I receive adequate consideration in return.
- To ask for and receive information about the Family Planning Program and to be told if I am eligible for services under that program.
- To speak to a social service worker about other public or private services or resources that may be available to me.
- To be told about Medi-Cal Health Care Plans that I and other eligible members of my family may be able to join to get a doctor and other medical care; fee-for-service; and to choose the option I prefer. If I join a plan, I will get all necessary medical care from my Medi-Cal Health Plan without having to find a doctor who will take care of me.
- To lower any share of cost I may have by providing past unpaid medical bills (that I still owe).
- MY SPOUSE AND I HAVE THE RIGHT TO divide our countable (nonexempt) community property by written agreement into equal shares of separate property if either of us entered long-term care prior to September 30, 1989.

IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL (Cont.)

- If I enter long-term care on or after January 1, 1990, my spouse at home has the right to keep a certain amount of our countable separate and community property. My spouse and I have the right to be told the amount.

I HAVE THE RIGHT TO a state hearing if I am dissatisfied with an action taken (or not taken) by the county welfare department or the State Department of Health Services. If I wish to ask for a state hearing, I must do so within **90 days** of the date the Notice of Action was mailed to me. If I do not receive a Notice of Action, I must request a hearing within **90 days** from the date I discover the action or inaction with which I am dissatisfied. The date of discovery is the date I know, or should have known, of the action. The best way to request a hearing is to contact the nearest county welfare department.

MEDI-CAL APPLICANT/BENEFICIARY RESPONSIBILITIES

I HAVE THE RESPONSIBILITY TO

- complete a status report when provided by the county and to return the completed status report to the county by the deadline given on the report.
- provide evidence that I am a resident of California.

I HAVE THE RESPONSIBILITY TO notify my county representative ***WITHIN TEN (10) DAYS*** whenever:

- Income received by me or any member of my family increases, decreases, or stops. This includes Social Security payments, loans, settlements, or income from any other source.
- I plan to change or have already changed my residence or mailing address (including moving out of state) or plan to be away for more than seven (7) days.
- A person, including a newborn child, whether or not related to me or my family, moves into or out of my home.
- I, my spouse, or any member of my family enters or leaves a nursing home/long-term care facility.
- I receive, transfer, give away, or sell real or personal property (including money) or whenever someone gives me or a member of my family such things as a car, house, insurance payments, etc.
- I have any expenses which are paid for by someone other than myself.
- An absent parent returns to the home or a member of my family becomes pregnant.
- I or a member of my family becomes employed, changes employment, or is no longer employed.
- I have a change in expenses related to employment or education (for example: child care, transportation, etc.).
- I or a member of my family becomes physically or mentally impaired so that I/he/she cannot be employed (this would include a child in the family who may not seek employment in the future due to any impairment).
- I or a member of my family applies for disability benefits under the SSI/SSP program, Social Security program, VA, or Railroad Retirement.
- One of my children drops out of school or returns to school.
- The immigration status or citizenship of any family member has changed.
- I or a member of my family has a change in health insurance coverage.

IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL (Cont.)

I HAVE THE RESPONSIBILITY:

- To sign and date my Medi-Cal card when I receive it and to ensure that it is used only to obtain necessary health care services for myself.
- To apply for and provide a Social Security number for myself and/or any member of my family who wants FULL Medi-Cal benefits. I must cooperate with the Social Security Administration in clearing up any questions or my Medi-Cal eligibility will be denied or discontinued.
- To apply for Medicare benefits if I am blind, disabled, or 64 years and 9 months of age or older and eligible for these benefits. I am responsible for informing my providers that I have both Medi-Cal and Medicare coverage.
- To apply for any income which may be available to me or my family members.
- To report to the county department, and to the health care provider, any health care coverage/insurance I carry or am entitled to use. If I willfully fail to disclose this information, I am guilty of a criminal offense.
- To use any health care insurance plans I have before using Medi-Cal. Such plans include Kaiser, CHAMPUS, or any other health care plan/insurance identified by the county welfare department or the State of California. (Medi-Cal will not pay for any service paid for and/or provided by any medical insurance plans.)
- To report to the county department when Medi-Cal will be billed for health care services received as a result of an accident or injury caused by some other person s action or failure to act.
- To take my Medi-Cal card to my medical provider when I am sick or have an appointment. In emergency situations when a card is not in hand, I have the responsibility to get the card to the medical provider as soon as possible.
- To cooperate with the State of California if my case is selected for review by the quality control review team. If I refuse to cooperate, my Medi-Cal benefits will be discontinued.
- To cooperate with the State or county in establishing paternity and identifying any possible medical coverage I or my family may be entitled to, including coverage or support through an absent parent.
- To report to the county department and to my medical providers any health insurance coverage I carry and to apply for and retain any health insurance available to me and my family at no cost. I have the responsibility to enroll and remain enrolled in an employment related group health plan when Medi-Cal approves payment of plan premiums by the State of California.
- To go to a presentation, if presentations are given, and make a written choice about how I want to get my Medi-Cal benefits. If I do not go or do not make a written choice, my eligible family members and I may be signed up in a Medi-Cal Health Care Plan nearest my home.

PRIVACY AND CONFIDENTIALITY NOTIFICATION

Sections 14011 and 14012 of the Welfare and Institutions Code authorize county welfare departments to collect certain information from you to determine if you or the persons you represent are eligible for the Medi-Cal program. The information you provide is confidential and may only be disclosed to certain individuals or organizations and then only to administer the Medi-Cal program. This information will be used by the county welfare department to establish initial and ongoing Medi-Cal eligibility; by the State's fiscal intermediaries for claims processing; by the Department of Health Services for Medi-Cal card production, health insurance identification and overpayment recovery actions; by the United States Department of Health and Human Services for audit and quality control reviews; for Medicare Buy-In and Social Security Account Number verification; by the United States Department of Immigration and Naturalization Service for resident alien status verification; and by medical providers of services and health maintenance organizations for eligibility certification.

Providing this information is mandatory. Failure to do so will result in your ineligibility for Medi-Cal benefits. However, if you are applying for restricted Medi-Cal benefits, you may or may not have to tell us your Social Security number, birthplace, alien number, and alien/citizen status. You have the right to look at your information and may do so at the county welfare office during regularly scheduled office hours.

IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL (Cont.)

MEDI-CAL APPLICANT/BENEFICIARY UNDERSTANDING

I UNDERSTAND that failure to provide necessary information or deliberately giving false information can result in denial or discontinuance of Medi-Cal benefits and an investigation of my case for suspected fraud.

I UNDERSTAND that the information I provide will be checked by computer with information provided by employers, banks, Social Security Administration, welfare, and other agencies.

I UNDERSTAND that failure to apply for or retain no cost insurance or termination of enrollment in a State-paid employment related group health plan will result in denial or discontinuance of Medi-Cal benefits and/or eligibility.

I UNDERSTAND that if I request a Medi-Cal provider to provide a service not covered by my health insurance plan, I am responsible for obtaining written verification from my health plan that it does not offer the Medi-Cal covered services.

I UNDERSTAND that if I am receiving Medi-Cal based on disability and I apply for SSI disability benefits, I may be terminated from Medi-Cal if SSI decides that I am NOT disabled.

I UNDERSTAND that if I do not report changes promptly and, because of this, I receive Medi-Cal benefits that I am not eligible for, I may be responsible to repay the State Department of Health Services.

I UNDERSTAND that after my death the State has the right to recover from my estate all Medi-Cal benefits received after age 65 or prior to age 65 if I have been an inpatient in a nursing facility unless I leave a surviving spouse, (during his or her lifetime), minor children, blind or permanently and totally disabled children, or unless it would cause a hardship to my heirs. I understand that Probate Code Section 9202 gives the State authority to do this.

I UNDERSTAND that, upon the death of a surviving spouse, the State has the right to recover from his or her estate all Medi-Cal benefits I received after age 65 or prior to age 65 if I have been an inpatient in a nursing facility.

I UNDERSTAND that, as a condition of Medi-Cal eligibility, all rights to medical support and/or payments for myself and all others for whom I have legal authority to assign, are automatically, by operation of law, assigned to the State.

I UNDERSTAND that, as part of the Medi-Cal application process, I will be evaluated for potential eligibility under other medical assistance programs.

I UNDERSTAND that based on my income, I may be required to pay or be billed for a portion of my medical expenses before I can receive a Medi-Cal card.

I hereby state that the information on this form has been reviewed by me with the county representative and that I fully understand my rights and responsibilities to have my eligibility determined for Medi-Cal and to maintain that eligibility.

Applicant/Representative's Signature _____ Date _____

Interpreter's Signature _____ Date _____

I have explained to the applicant the rights, responsibilities, and other information listed on this form.

Eligibility Worker's Signature _____ Telephone Number _____ Date _____

MC 219 (11/93)

"IMPORTANT INFORMATION ABOUT RESIDENCY"

MEDI-CAL APPLICANTS WHO HAVE ONE OF THE ITEMS LISTED BELOW **MUST** PROVIDE IT AS EVIDENCE OF RESIDENCY. MEDI-CAL APPLICANTS WHO **DO NOT** HAVE ONE OF THE ITEMS LISTED BELOW MUST SIGN THIS PAGE **AND** PROVIDE OTHER EVIDENCE OF RESIDENCY. DO NOT SIGN THIS PAGE IF YOU HAVE ONE OF THE ITEMS LISTED BELOW.

I UNDERSTAND that the welfare department will only consider evidence other than the items listed below if I do not have one of the following items:

- A recent California rent or mortgage receipt or utility bill in my name
- A current and valid California Motor Vehicle Driver s License or California Identification Card issued by the California Department of Motor Vehicles
- A current and valid California motor vehicle registration in my name
- A document showing that I am employed in this state
- A document showing that I have registered with a public or private employment service in this state
- Evidence that I have enrolled myself or my children in a school in this state
- Evidence that I am receiving public assistance other than Medi-Cal in this state
- Evidence that I have registered to vote in this state

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT I DO NOT POSSESS ANY OF THE ITEMS LISTED ABOVE.

Applicant Signature:	Date:
Person Acting For Applicant (Signature):	Date:

MC 219 (11/93)