STATE OF CALIFORNIA--HEALTH AND HUMAN SERVICES AGENCY GRAY DAVIS Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P Street
P.O. Box 942732
Sacramento, CA 94234-7320
(916) 657-2941

October 14, 1999

Medi-Cal Eligibility Branch Information Letter No.: I99-15

TO: All County Medi-Cal Program Specialists/Liaisons

MEDI-CAL APPLICATION MATERIAL FOR REVIEW AND COMMENT

You are being asked to review the enclosed forms and respond with your comments and suggestions at the southern County Workgroup scheduled for October 19, 1999. If you are unable to attend this meeting or if you plan on attending the northern County Workgroup rescheduled for November 3, 1999, it is important that you respond in writing to the Medi-Cal Eligibility Branch with your comments and suggestions by October 22, 1999.

The enclosed material reflects an effort to streamline the Medi-Cal application process, and to allow for the process to work in a 'seamless' manner with other closely related programs. The enclosed 'Health Care Application' is intended to be mailed to a central clearinghouse where it will then be forwarded to the proper county for processing. The county would then contact the individual for follow-up Medi-Cal information if necessary, and forward the application to other programs if an interest has been expressed by the applicant.

Other items enclosed for your review are the 'Procedures For Health Care Application,' a revised 'Property Supplement' form, a revised 'Medi-Cal Status Report' form, and an 'Additional Household Members' supplement.

As a reminder, the southern region County Workgroup meeting is scheduled for October 19, 1999 from 10:00 a.m. to 3:00 p.m. in the Auditorium (Room 1138), located at 107 South Broadway, Los Angeles, California 90012. Please note that the start time has been changed from 9:00 a.m. to 10:00 a.m. The northern region meeting has been rescheduled to November 3, 1999, from 10:00 a.m. to 3:00 p.m. in the OB 9 Auditorium located at 744 P Street, Sacramento, California 95814.

Should you need any further information, please contact Nicholas Bowen of my staff at (916) 657-3184, 714 P Street, Room 1650, or by e-mail at NBowen@dhs.ca.gov.

Sincerely,

Original signed by

Glenda Arellano for
Angeline Mrva, Chief
Medi-Cal Eligibility Branch

Enclosures

(DRAFT)

SECTION 1: Tell us about the person making this application

1. Last Name	First Name	Middle Initial	2. sex. Male❑ Female❑	*3. County Number (Official use)*
34 Home Address (number and street) Do not use a P.O. Box		Apartment Number		5. Home Phone # ( ) -
56 City	7. Zip Code	8. County		9. Work Phone # ( ) -
10 Mailing Address (number and street) if different from above		Apartment Number		11. Message Phone # ( ) -
12. City	13. Zip code	134 County		15. What primary language do you speak?

DRAFT

16. Indicate other program(s) that you want to apply for (see instructions for explanation of programs):

❑Food Stamps ❑WIC ❑CHDP ❑CCS ❑Healthy Families ❑IHSS ❑ CalWORKs (Cash Assistance)

SECTION 2: Tell us about members of the household. If you have more than 2 adults or 3 Children, ask for additional forms.

	Adult 1	Adult 2	Child 1/ Unborn	Child 2	Child 3
17. Name Last					
First					
Middle					
18 Sex:	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female
19. Date of Birth:	/ / MO DATE YR	/ / MO DATE YR	/ / MO DATE YR	/ / MO DATE YR	/ / MO DATE YR
20. Place of Birth: County or State or Country if outside the U.S.					
21. Ethnic Code:					
22. Wants Medi-Cal?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
23. Relationship to person in Section 1:					
24. Social Security #:					

Social Numbers are not required for persons who want emergency or pregnancy related services only.

25.. Mother's Name Last					
First					
Middle					
Check all that applies to the mother. *(Absent parents will be referred for medical support)*			❑ In home ❑ Unemployed ❑ Incapacitated ❑ Absent ❑ Deceased	❑ In home ❑ Unemployed ❑ Incapacitated ❑ Absent ❑ Deceased	❑ In home ❑ Unemployed ❑ Incapacitated ❑ Absent ❑ Deceased
26. Fathers Name Last					
First					
Middle					
Check all that applies to Father. *(Absent parents will be referred for medical support)*			❑ In home ❑ Unemployed ❑ Incapacitated ❑ Absent ❑ Deceased	❑ In home ❑ Unemployed ❑ Incapacitated ❑ Absent ❑ Deceased	❑ In home ❑ Unemployed ❑ Incapacitated ❑ Absent ❑ Deceased
27. U.S Citizen or National? If No, please write date of entry into U.S.	❑ Yes ❑ No / / MO DATE YR	❑ Yes ❑ No / / MO DATE YR	❑ Yes ❑ No / / MO DATE YR	❑ Yes ❑ No / / MO DATE YR	❑ Yes ❑ No / / MO DATE YR
28. Is person in school?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
29. If pregnant show expected date of birth.	/ / MO DATE YR	/ / MO DATE YR	/ / MO DATE YR	/ / MO DATE YR	/ / MO DATE YR

30. Marital Status	❑Married❑Divorced ❑ Single ❑Separated		❑Married❑Divorced ❑ Single ❑Separated		❑Married❑Divorced ❑ Single ❑Separated		❑Married❑Divorced ❑ Single ❑Separated		❑Married❑Divorced ❑ Single ❑Separat	
31. Has other health, dental or vision insurance?	❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes	❑ No
32. California Resident?	❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes	❑ No
33. Claimed as tax dependent by someone not in home?	❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes	❑ No
34. Filed a lawsuit because of accident or injury?	❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes	❑ No
35. Wants 3 month retro?			❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes	❑ No
Check "Yes" for person(s) that have medical expenses that are for months 3 months prior to this application and want Medi-Cal for those months										
36. Self or family member in U.S. military?	❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes	❑ No
37. In nursing home, hospital or board and care home?	❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes	❑ No
If Yes, Name of Facility:				Date Entered:				Intend to Return Home: ❑ Yes ❑ No		
38. Asked or gotten aid benefits, including Medi-Cal or diversion payment or services from county	❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes	❑ No
If YES. Where (county, state, country):				When:				Type(s) of benefit:		

SECTION 3: Employment

1. Are any family members working? ❑ Yes ❑ No

List Name _____ Hours per month_____ Looking for more work ❑ Yes ❑ No

List Name _____ Hours per month_____ Looking for more work ❑ Yes ❑ No

2. Has any member family member worked in the past two years? ..... ❑ Yes ❑ No

List Name _____

List Name _____

SECTION 4. List the monthly gross income (before taxes) of persons listed in section 2.

NAME OF PERSON(s) WITH INCOME	SOURCE OF INCOME	HOW OFTEN RECEIVED	AMOUNT
1.			
2.			
3.			
4.			

SECTION 5: Deductions from Income. The answers in this section will help determine what amounts may be deducted from income.

TYPE OF PAYMENT YOUR FAMILY MAKES	NAME OF PERSON WHO PAYS	MONTHLY AMOUNT PAID
1. Child Support		
2. Alimony/Spousal Support		
3. Health Insurance		
4. Educational Expenses		

CHILD CARE OR DEPENDENT CARE *(List Child's Name)*	AGE	MOTHLY AMOUNT PAID
a.		
b.		
c.		
d.		

Do you or any family member have a physical or emotional problem which makes it difficult to work, take care of self or care for their own children or that you consider to be a disability?..... ❑ Yes ❑ No

a. If yes, name(s) _____
b. Is disability or emotional problem expected to last at least a year? ..... ❑ Yes ❑ No
c. Is the physical or emotional problem a result of an injury or accident? ..... ❑ Yes ❑ No

SECTION 7: Property of applicant; parent, stepparent, child, spouse or caretaker of an applicant.
Complete property supplement form if "Yes" to any of these questions(do not need to complete supplement if only have cash).

1. Does anyone have cash (amount of cash $_____), or own any items of value such as accounts, bonds, retirement funds, trusts, real estate, motor or recreational vehicles, life insurance, burial items or funds, oil or mineral rights? ❑ Yes ❑ No
2. Have any items such as those listed above been spent or used in payment or security for medical expenses? .... ❑ Yes ❑ No
3. Does anyone have a court-ordered settlement, judgement, order for child/spousal support or premuptial or post-nuptial agreement? ..... ❑ Yes ❑ No
4. Does anyone have long-term care insurance? ..... ❑ Yes ❑ No
5. Has any of the individuals above transferred, sold, traded or given away any items such as those listed above within the last 30 months? ..... ❑ Yes ❑ No

SECTION 8: Declaration

I declare under penalty of perjury under the laws of the State of California that the answers I have given in this application and the documents submitted are correct and true to the best of my knowledge and belief. I declare that I have read and understand the application instructions, the declarations, and all information printed on this application.

Signature:

_____ **Date:**_____

Witness _____ **Date:**_____
(If person signed with a mark)
Authorized Representative _____ **Date**_____

PROCEDURES FOR 'HEALTH CARE APPLICATION'

REF.: All County Welfare Directors Letter (ACWDL) Nos. 95-28, 95-52, 97-48, 98-06, 98-09, 98-16, 98-19, 98-39, 98-42, 99-01 and EMC2 DHS #98104

Welfare and Institutions Code Section 14011.1 mandates a simplified Medi-Cal application package and mail-in process for adults and families. The intent of this legislation is to provide easy access for this population to apply for and receive Medi-Cal benefits as quickly as possible.

The purpose of this letter is to provide counties with policies and instructions, which are effective July 1, 2000. These policies and procedures apply to all Medi-Cal applications.

PENDING: The new mail-in application will be mailed by the applicant to a central clearinghouse. The central clearinghouse will determine the correct county of residence and forward the application to that county for a determination.

I. COUNTY ACTION UPON RECEIPT OF "NEW" MAIL-IN APPLICATION

A. After reviewing the application for completeness, obtain additional information as needed by telephone or mail. As of July 1, 2000, State law prohibits counties from making a mandatory face-to-face interview a routine application requirement.

B. Before a Notice of Action (NOA) can be issued to deny a new applicant Medi-Cal benefits, the county must meet the "second contact" requirement (SEE ACWDL 97-48).

REMINDER: Do not ask for property information or verification for pregnant women and children if they qualify for Medi-Cal percent programs. The resource waiver applies to children up to age 19 and to pregnancy-related benefits only for pregnant women. IF income from property is reported, the mount of income must be verified. Counties are NOT to require property information to determine if there is income from property if no such income is reported or indicated through another means, such as an Income Eligibility Verification System (IEVS) match. (See AC@L 95-28 and 95-52)

II. REQUIRED VERIFICATION TO DETERMINE MEDI-CAL ELIGIBILITY.

A. Social Security Numbers

1. Social security numbers are required ONLY for those persons for whom benefits are being requested.

2. Persons applying for restricted, emergency or pregnancy-related Medi-Cal benefits are not required to provide social security numbers (SSNs).

3. If the person for whom benefits are requested does not have a SSN, counties must process the application and allow the applicant 60 days to provide the number.

4. The SSN does not have to be sight-verified. IEVS validation is acceptable as proof of the SSN. If the applicant previously received benefits and can be identified in MEDS with a MEDS validated SSN, the SSN is considered to be verified.

B. Proof of identity. A California Drivers License or California Identification Card is preferred. If the individual is without a California Drivers License or California Identification Card, a copy of the following examples are acceptable:

1. I.D. that has a picture of the person is preferred
2. United States Citizenship or Alien Status Documents (passport)
3. Birth certificate
4. Social Security card or document containing a Social security number
5. Marriage record
6. Divorce decree
7. Work badge, building pass
8. Adoption record
9. Court order of name change
10. Church membership or baptism/confirmation record
11. Any other document which appears to be valid and establishes identity.
12. If the documents listed above are not available, the county shall ask the person to sign and date an affidavit under penalty of perjury stating the person's name, date of birth, where he/she was born, and current address.

C. Proof of pregnancy. Acceptable pregnancy verification is a written statement from:

1. A physician
2. A physician's assistant
3. A certified nurse midwife
4. A nurse practitioner

D. Proof of income.

NOTE: This section applies to income of all children under 21 living in the home or away at school and claimed as a tax dependent, the child's parents if in the home, the pregnant woman, the pregnant woman's spouse if in the home, and all adults

1. Copies of pay stubs or a signed statement from the employer giving gross monthly income amount.

2. If self-employed, previous year's income tax return, including Schedule C or last three-month profit and loss statements.

3. An award letter or bank statement showing direct deposit amounts for unearned income such as UIB, SDI, or Social Security or retirement/pension benefits.

4. Signed statement from persons or organizations providing the income.

5. If child support and/or spousal support received, canceled checks, receipts, or payment statement from the District Attorney's Family Division.

6. If the family has income producing property, the county shall require documentation of this income, not property. (See ACWDL 95-52)

NOTE: Do NOT request documentation if no income from property is reported on the application or indicated through an IEVS match or other source.

7. If required verification is not available, obtain a signed and dated affidavit under penalty of perjury from the person completing the application which lists the amounts of any earned or unearned income received.

8. For fluctuating income, actual income shall be used if it is known at the time of the monthly share of cost determination. If actual income is unknown, an estimate shall be made based on all of the following:

   a. The income pattern over the last year.
   b. The actual income received in the last month.
   c. A statement of anticipated income.

NOTE: The goal in determining Medi-Cal income eligibility for cases with fluctuating income is to use evidence of income and income patterns over past months to estimate future share of cost.

E. Proof of deductions/Expenses

   1. Child and dependent care receipts or canceled checks.

   2. If court ordered spousal and/or child support paid, canceled checks or pay stubs showing support deductions.

F. Proof of alien status.

1. Immigration Status Documentation Requirements

a. **For Full-Scope Medi-Cal** -- An alien must claim satisfactory immigration status (SIS) (and be otherwise eligible) to receive full-scope Medi-Cal benefits. An Immigration and Naturalization Service (INS) document that shows immigration status is required for aliens who claim to have a satisfactory immigration status. Aliens with satisfactory immigration status for Medi-Cal include lawful permanent residents, aliens permanently residing in the United States Under Color of Law (PRUCOL), and amnesty aliens with a valid and current I-688. A list of the most common documents that lawful permanent resident and Permanent Residency Under Color of Law aliens may have are listed in Title 22, California Code of Regulations, Sections 50301.2 and 50301.3, respectively. These lists are not comprehensive. Counties should accept the immigration status claimed by the alien along with whatever documentation is provided (if required) and rely on INS verification via Systematic Alien Verification For Entitlements (SAVE) to ultimately determine an alien's immigration status.

NOTE: Undocumented aliens who claim PRUCOL are not required to provide INS documentation. Category "P" PRUCOL aliens are eligible for full-scope Medi-Cal if they meet all eligibility requirements.

a. SAVE -- The immigration status of aliens who claim satisfactory immigration status must be verified using the SAVE system. If an alien's document has an alien number it can be verified using "primary" SAVE. If the document does not have an alien number it must be verified using secondary SAVE. For secondary SAVE verification a copy of the document is sent to the INS along with form G-845. The G-845 is used any time the INS must view an immigration document for verification purposes, or when they must determine whether an undocumented alien has PRUCOL status. (See All County Welfare Directors Letter 92-48 for more information on SAVE and use of the G-845.)

b. **Restricted Medi-Cal** -- Aliens who do not claim to be in a satisfactory immigration status (and are otherwise eligible) can get restricted scope Medi-Cal limited to emergency and pregnancy related services. **These aliens are not required to provide evidence of their immigration status in order to receive restricted scope Medi-Cal**

2. **Eligibility For Aliens Claiming SIS** -(For purposes of processing the mail-in application, remember the rules for aliens claiming satisfactory immigration status):

   a. Aliens who claim satisfactory immigration status are presumptively eligible for full scope Medi-Cal if they meet all other eligibility requirements.

   b. Aliens who claim satisfactory immigration status have 30 days or the time it takes to determine eligibility (whichever is longer) to provide an INS document or a receipt for the INS showing that they have applied for a replacement. For aliens who claim PRUCOL but do not have an INS document, continue to follow current procedures.

G. Proof of California residency.

Children living with their parents have their residence determined as that of their parents.

NOTE: Verification of income which shows employment in California is sufficient proof of California residency. If income verification does not indicate California employment, a copy of any of the following examples is acceptable:

1. Current rent, mortgage or utility receipt
2. Current California driver's license or California identification card
3. Current motor vehicle registration with current address
4. A document showing registration with an employment service in California
5. Evidence of children's enrollment in school in California
6. Evidence of receipt of public assistance other than Medi-Cal in California
7. Evidence of registration to vote in California
8. If none of the above, form MC 214 can be signed under penalty of perjury.

D. Retroactive Medi-Cal

1. Anyone requesting retroactive Medi-Cal using the adult and family mail-in application must complete the MC 21 OA. (Supplement to Statement of Facts for Retroactive Coverage/Restoration.) Counties must send the MC 21 OA.

IIII. COUNTY ACTION ON OTHER PROGRAM REQUEST

1. Food Stamps: **"PENDING"**
2. WIC: **"PENDING"**
3. EPSDT: **"PENDING"**
4. CCS: **"PENDING"**
5. Healthy Families **"PENDING"**

A. Per instructions issued in AC@L 98-09, counties are to include language on notices of actions informing families with potentially eligible children of the Healthy Families program and how to obtain an application if they are interested. Suggested language is included in ACWDL 98-09.

IV. COUNTY FOLLOW-UP FOR FURTHER CASE ACTION

A. If there is a yes response to question 31 on other health, dental or vision insurance and/or a yes response to question 33 on a pending lawsuit due to accident or injury, counties must follow existing procedures and complete the Health Insurance Questionnaire (DHS 6155). Counties may contact the applicant by telephone to obtain the necessary information and submit the DHS 6155 to the Department of Health services, Health Insurance Section, without the applicant's signature.

B. Medical support forms (CA2.1 and CA 2. 1 (Q))

1. Medical support referrals will NOT be made on an unborn child until the end of the 60-day postpartum period. If the mother of the unborn has other eligible children in the Medi-Cal Family Budget Unit, a medical support referral for these children will not be made until the end of the 60-day postpartum period.

2. In cases where there is an absent parent or paternity establishment is required, counties should mail the CA 2.1 and CA 2.1 (Q) to the person completing the application but shall not delay the eligibility determination for children pending the return of the forms.

3. Children cannot be denied or discontinued from Medi-Cal due to non-cooperation of the parent or caretaker relative in medical support enforcement.

B. Medi-Cal Property Supplement

1. You must complete the Medi-Cal property supplement (MC???) whenever property is held in the name of a Medi-Cal applicant, or parent, child, or spouse of a Medi-cal applicant or parent in a month for which Medi-Cal is being requested.

ADDITIONAL HOUSEHOLD MEMBERS

(SUPPLEMENT TO HEALTH CARE APPLICATION)

(Draft)

Applicant or Caretaker's Name (First, Middle, Last)	Applicant/Caretaker Relationship to Children	*County Number (Official use)*

ell us about additional members of the household:

	Adult 3	Adult 4	Child 4	Child 5	Child 6
17. Name Last					
First					
Middle					
[18] Sex:	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female
[19] Date of Birth:	/ / MO DATE YR	/ / MO DATE YR	/ / MO DATE YR	/ / MO DATE YR	/ / MO DATE YR
20. Place of Birth: County or State or Country if outside the U.S.					
[21] Ethnic Code:					
22. Wants Medi-Cal?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
23. Relationship to person in Section 1:					
[24] Social Security #: Social Numbers are not required for persons who want emergency or pregnancy related services only.					
25.. Mother's Name Last					
First					
Middle					
Check all that applies to the mother. *(Absent parents will be referred for medical support)*			❑ In home ❑ Unemployed ❑ Incapacitated ❑ Absent ❑ Deceased	❑ In home ❑ Unemployed ❑ Incapacitated ❑ Absent ❑ Deceased	❑ In home ❑ Unemployed ❑ Incapacitated ❑ Absent ❑ Deceased
26. Fathers Name Last					
First					
Middle					
Check all that applies to Father. *(Absent parents will be referred for medical support)*			❑ In home ❑ Unemployed ❑ Incapacitated ❑ Absent ❑ Deceased	❑ In home ❑ Unemployed ❑ Incapacitated ❑ Absent ❑ Deceased	❑ In home ❑ Unemployed ❑ Incapacitated ❑ Absent ❑ Deceased
27. U.S Citizen or National? If No, please write date of entry into U.S.	❑ Yes ❑ No / / MO DATE YR	❑ Yes ❑ No / / MO DATE YR	❑ Yes ❑ No / / MO DATE YR	❑ Yes ❑ No / / MO DATE YR	❑ Yes ❑ No / / MO DATE YR
28. Is person in school?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
29. If pregnant show expected date of birth.	/ / MO DATE YR	/ / MO DATE YR	/ / MO DATE YR	/ / MO DATE YR	/ / MO DATE YR
30 Marital Status	❑Married❑Divorced ❑ Single ❑Separated	❑Married❑Divorced ❑ Single ❑Separated	❑Married❑Divorced ❑ Single ❑Separated	❑Married❑Divorced ❑ Single ❑Separated	❑Married❑Divorced ❑ Single ❑Separated
31 Has other health, dental or vision insurance?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
32. California Resident?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
33. Claimed as tax dependent by someone not in home?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

34. Filed a lawsuit because of accident or injury?	❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes ❑ No
35. Wants 3 month retro?			❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes ❑ No
Check "Yes" for person(s) that have medical expenses that are for months 3 months prior to this application and want Medi-Cal for those months									
36. Self or family member in U.S. military?	❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes ❑ No
In nursing home, hospital, board and care home.	❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes ❑ No
If Yes, Name of Facility:			Date Entered:				Intend to Return Home: ❑ Yes ❑ No		
38. Asked or gotten aid benefits, including Medi-Cal or diversion payment or services from county	❑ Yes	❑ No	❑ Yes	☐ No	❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes ❑ No
If YES, Where (county, state, country):			When:				Type(s) of benefit:		

I certify that I have read and understand the information above. I also certify that the information I have given s true and correct.

Signature_____ **Date**_____

MEDI-CAL PROPERTY SUPPLEMENT

You must complete this supplement whenever property is held in the name of a Medi-Cal applicant, or parent, child or spouse of a Medi-Cal applicant or parent in a month for which Medi-Cal is being requested. Please mark the box under the correct response for each item listed. You must provide verification of all items of property that you check. Acceptable types of verification are listed below each item. DO NOT MAIL IN YOUR ORIGINAL DOCUMENTS.

	YES	NO	ITEM AND ACCEPTABLE VERIFICATION
1.	☐	☐	**Cash or checks.** If so, provide copies of any checks and list the amount of cash on the application.
2.	☐	☐	**Financial institution accounts such as, savings, checking and money market deposit accounts.** • Copies of the statements showing balances for the month that Medi-Cal is being requested.
3.	☐	☐	**Certificates of deposit, stock, shares of mutual funds or bonds.** • Statements from your financial institution as to the cash value (after penalties for early withdrawal) for the month that Medi-Cal is being requested. • Statements from your brokerage indicating the lowest closing price during the month for which Medi-Cal is being requested.
4.	☐	☐	**Individual Retirement Accounts (IRAs), Keoghs, or work-related pension funds.** • Copies or statements from your employer or financial institution or brokerage indicating their cash value (after penalties for early withdrawal). Include the dates and amounts of any payments of dividends or interest on the copies or statements.
5.	☐	☐	**Annuities.** • Copies of your contract and payment schedule. If the contract or payment schedule is unavailable, then provide a statement from your annuity company indicated the purchase price, date of purchase, cash value, and if payments are scheduled, the payment schedule and years of expected life upon which your annuity payments were scheduled.
6.	☐	☐	**House, condominium, ranch, land, mobile home or life estate that is your home that you live in, or that is your former home and is lived in by your spouse, child under 21, disabled son or daughter, dependent relative, or a sibling who lived in the property continuously and provided care for one year which enabled you to remain in the home rather than a nursing facility.** Please list address of property here.
7.	☐	☐	**If you own your home or former home and the question 6 (above) does not apply and you are absent for any reason (including admission into long-term care) but you have the intent to return home someday, please indicate that at the end of this paragraph. PLEASE NOTE:** The word "intent" in this instance is subjective and it means "desire" to return home regardless of physical or mental ability to do so. ☐ Yes, I have the intent to return home someday. ☐ No, I do not have the intent to return home someday. Please list the address of the property here.
8.	☐	☐	**Other houses, condominiums, ranches, land, buildings, mobile homes, life estates.** • If you obtain a current appraisal value from a qualified real estate appraiser and that value is lower, the county will count that amount. • Also copies of loan documents showing the amount you owe on the property. • If rented, the amount of rent and monthly or annual expenses.
9.	☐	☐	**Promissory notes, mortgages or deeds of trust.** • Copies of your documents. • List of payments received and balance owed. • If you obtain an appraisal value of the note, mortgage or deed of trust from a mortgage broker and that amount is lower than the balance owed, Medi-Cal will count the lower amount. • If you obtain statements from three brokers that they will not value such loan, then Medi-Cal will not count it.

10.	☐	☐	**Cars, trucks, motorcycles, trailers, or other motorized vehicles that are not used by you as a home.**
			• Copies of the most recent registration, pink slip or purchase document for each item.
			• If none of the above is available, provide one estimate of value from a qualified source, such as a dealer or mechanic for each item.
			• Indicate whether or not each item is used
			  • on the job, such as a taxi;
			  • to travel long distances to work, such as a truck used by a contractor working out of town;
			  • to carry the main supply of fuel or water for your home; or

- to transport a disabled or incapacitated family member living in the home.
- Indicate if the item is business property and if so provide the verification required for business property.

11. ☐ ☐ **Jewelry (not wedding rings, engagement rings or heirlooms) worth more than $100.00.**
- Statements from jewelers containing estimates of value.

12. ☐ ☐ **Oil or mineral rights or mining claims.**
- Copies of your most recent tax assessment or ownership documents.

13. ☐ ☐ **Burial trusts, burial contracts or burial insurance.**
- Copies of your trust or contract.

14. ☐ ☐ **Life Insurance.**
- Copies of all life insurance policies except term policies with no cash surrender value.

15. ☐ ☐ **Trusts or blocked accounts.**
- Copies of all trust documents.
- Copies of investments and distributions from the trust for the months that Medi-Cal is requested.
- Indicate on the copies if you have property held in trust by the United States Government for a Native American.

16. ☐ ☐ **Court-ordered settlements, judgements, orders for support, and pre-nuptial and post-nuptial agreements.**
- Copies of orders, judgements, pre-nuptial and post-nuptial agreements affecting or benefiting you or your family.

17. ☐ ☐ **Long-term care insurance.**
- Copies of all long-term care insurance policies that you have for you and your spouse.
- If your policy is certified by the California Partnership for Long-Term Care, please provide a copy of your most benefit statement.

18. ☐ ☐ **Business accounts and property.**
- Copies of documents to show the existence of a business, such as tax returns, invoices, letterhead, receipts, licenses, leases, etc.
- If your business is not in current operation, please explain why and indicate when you intend to begin operation again. If your business is not in current operation, you must provide copies of
  - statements of all financial institution accounts,
  - all ownership documents for all property belonging to your business and/or being listed on your taxes as business property, and
  - documentation that you have that will establish the value of your business property, including statements from qualified sources.

19. ☐ ☐ **Any other real or personal property, assets, or resources. (DO NOT include personal items or household goods valued at less than $500.)**
- Copies of any ownership documents available to establish what the item is worth or
- Statements from qualified sources as verification of value.

20. ☐ ☐ **If you owe money on any of the items listed above, or if any of the items listed above have liens against them, please provide copies of the lien, loan or security documents.**

21. ☐ ☐ **If you have spent or used any real or personal property in payment or security for medical services for you or your family please provide copies of the security agreements, lien documents or receipts for medical expenses paid.**

YOUR COUNTY ELIGIBILITY WORKER MAY REQUEST ADDITIONAL VERIFICATION DEPENDING UPON YOUR SPECIFIC CIRCUMSTANCES AND PROPERTY OWNED.

MEDI-CAL STATUS REPORT

FOR THE MONTH OF: _____, 20 _____

1) Did you or any family member have changes in:

Income	☐ No	☐ Yes	If yes, complete question 2.
Expenses	☐ No	☐ Yes	If yes, complete question 3.
Resources or property	☐ No	☐ Yes	If yes, explain in question 4.
Address/shared housing	☐ No	☐ Yes	If yes, explain in question 4.
Physical/Mental Health	☐ No	☐ Yes	If yes, explain in question 4.
Marital Status	☐ No	☐ Yes	If yes, explain in question 4.
Immigration Status	☐ No	☐ Yes	If yes, explain in question 4.
Employment	☐ No	☐ Yes	If yes, explain in question 4.

IF YOU CHECKED "NO" to ALL the items listed above, you may skip questions 2, 3, and 4, and go directly to the signature and certification box. Sign, date and mail the report back to the county.

IF YOU CHECKED "YES" TO ANY of the items listed in question 1, please *GO TO* questions 2, 3 or 4. Be sure you give proof and/or more information about the changes in your family. The county will look at your case record with the new information you gave to figure out on-going Medi-Cal benefits for you and/or your family members.

2) **INCOME CHANGES** ***If reporting changes for more than 1 person, report other income in question 4.***

Whose income changed? Name(s) _____

Is this a new source of income? ☐ No ☐ Yes If yes, source of income _____

Income amount $_____

How often received? ☐ Monthly ☐ Weekly ☐ Every other week ☐ 2 times a month ☐ Other_____

3) **EXPENSES**

Child or dependent care	Payment to: Name/Amount _____
Child or spousal support	Payment to: Name/Amount _____
Self-employment or business expenses	Amount $ _____
Rental property expenses	Amount $ _____
Health, dental, medicare premium	Amount $ _____

4) Please use the space below to give more information about the changes you reported in Question 1 or report other changes in your household.

_____

_____

Certification

You must sign and date this report on or after the last day of the report month. Please return and give proof or more information about changes in your family by the due date or Medi-Cal benefits will be stopped.

I understand that I must report all income, property and/or other changes to the county within ten (10) days. I declare under penalty of perjury that all information provided are true and correct.

_____	_____	_____
Signature	Date	Telephone
_____	_____	_____
Signature of witness, interpreter or person assisting	Date	Telephone