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

California Department of Health Services

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Director

ARNOLD SCHWARZENEGGER
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May 10, 2006

TO: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY ADMINISTRATIVE OFFICERS
ALL COUNTY MEDI-CAL PROGRAM SPECIALIST/LIAISONS
ALL COUNTY HEALTH EXECUTIVES
ALL COUNTY MENTAL HEALTH DIRECTORS

Letter No.: 06-17

SUBJECT: MEDI-CAL ANNUAL REDETERMINATION FORM

The purpose of this letter is to transmit the new Medi-Cal Annual Redetermination form (MC 210 RV, rev. 01/06) and the instructions on processing the information received on the form. The new MC 210 RV was designed in collaboration with counties and consumer advocates. The new form is more user-friendly, shorter and easier for the beneficiaries to complete. See Enclosure A (English) and Enclosure B (Spanish).

The new MC 210 RV replaces the old MC 210 RV (08/99). Counties are instructed to begin using the new MC 210 RV form 60 days from the release of this All County Welfare Directors Letter (ACWDL), and discard their existing stock of the old MC 210 RV forms. If counties have prepared Annual Redetermination packets containing the old MC 210 RV forms, the old form must be removed from the packets and replaced with the new form before they are mailed to the beneficiaries.

Currently, the MC 210 RV is available in English and Spanish and it is being translated into the other threshold languages. Counties will be notified with e-mails and Medi-Cal Eligibility Branch Information Letters as the form becomes available in other threshold languages at the California Department of Health Services' (CDHS) warehouse. In the meantime, follow the procedure used for the old version of the MC 210 RV when a beneficiary has a primary language other than English or Spanish. The new MC 210 RV will also be available for downloading from the CDHS Medi-Cal forms website at www.dhs.ca.gov/publications/forms/Medi-Cal/eligibilitybynumber.htm.

In general, all Medi-Cal only beneficiaries are required to complete an MC 210 RV form at their Annual Redetermination, with the exception of the following groups:

1. Beneficiaries receiving Medi-Cal benefits in the Long Term Care (LTC) aid codes. LTC beneficiaries are in their own Medi-Cal Family Budget Unit (MFBU) with income, property, and needs allocations that are computed differently from other Medi-Cal cases. Counties shall continue to use the Annual Redetermination for Medi-Cal Beneficiaries, LTC in their own MFBU (MC 262) form that is specifically designed for LTC cases. See Enclosure C.

2. Beneficiaries receiving Medi-Cal benefits in the Former Foster Care Children (FFCC) Program, aid code 4M.

   FFCC beneficiaries do not have an income or property test and they do not have a share-of-cost (SOC). The only requirement for FFCC beneficiaries at the Annual Redetermination is that they must indicate they still want Medi-Cal. Counties can obtain the continued Medi-Cal request by contacting the beneficiary by telephone or mailing the Application and Statement of Facts for an individual who is over 18 and under 21 and who was in Foster Care placement on his/her eighteenth birthday (MC 250 A) (11/01). See Enclosure D.

3. Beneficiaries receiving Medi-Cal benefits through the public cash assistance programs such as:

   - Supplemental Security Income/State Supplementary Payment program;
   - California Work Opportunity and Responsibility to Kids program;
   - Foster Care Assistance program; or
   - Aid for Adoption of Children program.

The Medi-Cal Annual Redetermination is a full eligibility review and nonexempt individuals must cooperate and meet all eligibility requirements for Medi-Cal to continue. The new MC 210 RV has not changed the Medi-Cal Annual RV requirements and each case record must contain adequate information with supportive documentation to verify an individual's eligibility.

The ACWDL that provides counties with policy clarifications and instructions on the Annual Redetermination process will be released under separate cover. The new

MC 210 RV form reflects those implementation instructions, including that the beneficiaries are not required to provide information that is not subject to change, such as social security number (SSN) and date of birth at their Annual Redetermination.

I. The New MC 210 RV Form

The new MC 210 RV form eliminated the requirement that an individual provide a SSN and date of birth information for each household member. The new form starts with the case identifying information: case number, name, date of birth, SSN, residence and mailing address. The SSN and the date of birth information are now optional and beneficiaries are not required to provide the information because they are already in the case record. MC 210 RV forms that are otherwise complete but are missing the optional identifying information shall not be considered "incomplete" and counties must continue to process the Annual Redtermination using all other information provided by the beneficiary.

Counties are encouraged to have procedures in place to match returned forms with case files to minimize errors and misplaced forms. Counties, to the extent that it is feasible, shall explore the use of practices such as:

- Complete the case identifying information before the form is mailed to the beneficiary at Annual Redetermination.
- Preprint the MC 210 RV form with case identifying information.
- Place a label preprinted with case identifying information on the form.
- Include a label preprinted with case identifying information in the Annual Redetermination packet for beneficiaries to put directly onto the space provided.
- Use barcodes to track the MC 210 RV.
- Log the receipt of forms when they are returned from the beneficiaries.

Counties are to evaluate their own processes and use mechanisms tailored to their own specific needs that will minimize lost forms. If the county has terminated benefits on a case due to non-receipt of paperwork and that paperwork is later found to have been returned timely by the beneficiary but it was lost at the county, counties must immediately restore benefits to the beneficiary before continuing to process the annual eligibility review.

The new MC 210 RV is divided into eight sections, with each section asking the beneficiary to provide information on specific subject matters with simple instructions and examples. The beneficiary is asked to attach supporting documentation of information reported on the MC 210 RV when it is returned to the county for review.

The following highlights the purposes of each section:

Section 1. Income

Section 1 applies to income received by all MFBU members living in the home or temporarily away from home.

(a) Income.

If income is reported, the beneficiary is asked to provide documentation of all income received. The county must review the source of income and treatment of that income for exemption and deductions. If income is from employment, the county must allow work-related deductions.

If income is reported, but documentation/verification is not provided and the MC 210 RV is returned to the county timely, the county must use the SB 87 three-steps process outlined in ACWDL No. 01-36 to obtain the documentation/verification, such as using any files that are open or were closed within 45 days for all known family members as well as other data exchange methods available to verify an individual's earned and unearned income. Counties must obtain income information from the following:

- Income Eligibility Verification Systems (IEVS),
- Payment Verification System,
- Social Security Administration (SSA), and
- Employment Development Department.

Counties shall refer to the Medi-Cal Eligibility Procedures Manual (MEPM), Article 21-IEVS for detailed instructions on processing information received from IEVS.

(b) In-kind Income (IKI).

If IKI is reported, the county must contact the beneficiary to determine whether the IKI is to be counted in budget computation. If the IKI is received in exchange for work done, the county must allow the applicable work-related deduction. If additional information or clarification is needed to determine the correct value of the countable IKI, the county may use the IKI and Housing Verification form (MC 210 SI) and ask the beneficiary to complete and return it within the SB 87 timeframe. Counties shall note that the MC 210 SI is not a mandatory form and shall only be used if the beneficiary has IKI and does not agree with the chart value given by the worker. Counties shall refer to the MEPM 10-F, IKI value and policies relating to their use.

For additional information on treatment of income, counties shall reference all applicable ACWDLs and MEPM Article 10, Income and Article 5-S, for determination under Section 1931(b) program eligibility.

Section 2. Expenses and Deductions

Section 2 applies to expenses MFBU members have to pay from income received. The beneficiary must provide supporting documentation before the allowable expense can be deducted from income.

If the beneficiary reports expenses, but supporting documentation is not provided with the MC 210 RV, the county shall review the existing case file for the documentation if the expense was previously reported and the amount has not changed. If no supporting document is on file for the expense claimed, the county shall contact the beneficiary and request documentation. The county must continue to process the Annual Redetermination and not terminate benefits even if the beneficiary fails to provide supporting documentation on expenses claimed. As long as other eligibility factors are met, the county shall certify the MFBU for another 12-month period and not allow the deduction(s) from income.

If payment for health care coverage is reported on the MC 210 RV and it was not previously reported, the county shall review information in Section 3, Other Health Insurance, for follow-up. If documentation is provided on health care insurance and premium payment, the county shall allow the deduction and continue to process the requirements for other health insurance.

Section 3. Other Health Insurance

(a) Other health care coverage information.

If the beneficiary reports other health care coverage, the county shall compare the information with the case file. If the health care coverage plan has not changed, the county shall not request the beneficiary to complete a new DHS 6155. If health care coverage is new or has changed, the county must send a new DHS 6155 to the beneficiary to complete and update the change in health care coverage on the Medi-Cal Eligibility Data System (MEDS).

If the beneficiary reports no change in health insurance being provided to a child who has an absent parent, the beneficiary is not required to complete a new medical support questionnaire or other medical support information at Annual Redetermination.

Counties shall refer to MEPM Article 15 for Other Health Care Coverage and Medicare Buy-In Coverage, and Article 23 for Medi-Cal Support Enforcement Program.

(b) Dialysis Special Treatment Programs.

If an individual is receiving Medi-Cal kidney dialysis-related services, that individual must provide the county with a copy of the SSA statement of Medicare status, or any evidence of eligibility if he/she has not provided such evidence previously. If the individual is not already receiving Medicare coverage, the county shall refer the individual to apply for Medicare coverage and provide evidence of application status.

Counties shall refer to MEPM Article 17C, Medicare Eligibility and the Medi-Cal Dialysis Special Treatment Programs.

Section 4. Living Situation

Section 4 provides information on household changes that may affect linkage, program eligibility and SOC. The County shall refer to the MEPM, Article 5, Medi-Cal Programs; Article 8, Responsible Relatives and Unit Determination; and Article 11, Maintenance Needs.

(a) Household member changes.

If the beneficiary reports that someone has moved into or out of the home, the county shall review the case file to determine whether the person is or is not an MFBU member. If the person is an MFBU member, the family's eligibility and/or benefits level may be affected by this change. If a new MFBU member is requesting Medi-Cal and being added to the case, the beneficiary must provide information on the new person, such as income, property, health insurance, and immigration status before he/she can be added to the existing case.

(b) Newborn information.

If a newborn is reported and he/she is an MFBU member, the parent, by providing the newborn's place of birth (city and country) on the MC 210 RV, has completed the requirement of declaring the newborn's citizenship and satisfactory immigration status under penalty of perjury. The parent is not required to complete an MC 13 for the newborn. In addition, a birth certificate is not required to aid the infant child.

(c) Person residing in a nursing facility or medical institution.

If an MFBU member is reported to be residing in a nursing facility or medical institution such as a board and care facility, the county shall contact the beneficiary for additional information. The county must review income and property allocation as well as put the individual in his/her own MFBU.

(d) Pregnant women in the home.

If a pregnant woman is reported living in the home, the county must determine if that individual is an MFBU member. If the pregnant woman is an MFBU member, the county shall add the unborn to the MFBU and request that she provide pregnancy verification within 60 days so that an Redetermination for full-scope benefits may be determined. If the pregnant woman is an MFBU member not currently on Medi-Cal and requests pregnancy related services only, she is allowed to self-declare that her pregnancy has been medically verified by a medical provider or a home pregnancy test if she is income eligible under the Federal Poverty Level (FPL) program. The county shall not request a verification of pregnancy in this situation. The County shall refer to MEPM, Article 4-M, Verification, for acceptable pregnancy verification.

If the pregnant woman is not an MFBU member and requests Medi-Cal, the county shall contact the beneficiary and inform the beneficiary that a Medi-Cal application will be mailed to the pregnant woman.

Any non-MFBU member living in the home requesting Medi-Cal benefits is considered a new applicant and he/she must complete an application and meet all eligibility requirements. The MC 210 RV cannot be used as an application for Medi-Cal benefits for non-MFBU members.

Section 5. Real and Personal Property

Section 5, in general, applies to all MFBU members who are receiving Medi-Cal. However, if the case contains only infants, children and pregnant women receiving Medi-Cal under the FPL programs and property information or documentation is not provided when the MC 210 RV form is returned to the county, these infants, children and pregnant women, if eligible under the FPL programs, shall have their eligibility review completed without delay. For families that provided the real and personal property information, counties shall first evaluate the family for Section 1931(b) eligibility before putting the children in the FPL programs.

If the MFBU contains adults and children from ages 19-21 who are also receiving Medi-Cal benefits, the beneficiary must provide property information for those MFBU members not eligible for the FPL percent programs. They must meet the property guidelines for Medi-Cal benefits to continue. If property information is not provided after the SB 87 three-step process, their benefits may be terminated at the Annual Redetermination.

If individuals answer “yes”, to questions 5(b) or 5(c) on the MC 210 RV, the county must send out the form, “Medi-Cal Property Supplement” (MC 210 PS), for the beneficiary to complete (see ACWDL, Number 03-11). *Note: Property verifications must be requested by the county only if verification has not been provided at the same time the RV form was submitted. Property must be verified at RV only when there is a change or when the value of the property is variable (e.g., financial institution accounts).*

(a) and (b). Determining ownership of property

The beneficiary is required to report any real or personal property currently held by or for any family member in the home. If he/she answers yes to questions 5(b) or 5(c), then he/she must be sent the MC 210 PS for completion. *Note: He/she must not be asked to resubmit any verification that was submitted with*

the MC 210 RV or verification of items with values that do not change. During the eligibility review process, the county shall also review any IEVS matches in the case record to determine if there are any unreported income-producing financial accounts and request additional information and/or appropriate documentation at the bottom of the MC 210 PS.

If the value of the property the beneficiary reported will affect eligibility, the county shall contact the beneficiary and explain the spend down provisions and require verification of the spend down for eligibility to continue. The county must document the disposition of any property sold or given away and the impact on the beneficiary's eligibility.

If business property is reported, the county shall refer to ACWDL No. 91-28 and 95-22 for treatment of business property.

(c) Disposition of property

If real or personal property was sold or transferred, the county shall ensure that the property was disposed of in a manner consistent with Medi-Cal policies and procedures. If real or personal property has been previously reported and no information is reported to the county on the disposition of that property, then the county shall contact the beneficiary to clarify the change.

Section 6. Immigration or Citizenship Status Change

Section 6 only applies to family members in the home who have a change in citizenship or immigration status. The beneficiary is not required to report the immigration or citizenship status of family members who are not in receipt of Medi-Cal. Counties shall refer to MEPM, Article 7, Alienage, Citizenship, and Residence.

If an immigration or citizenship status change is reported, the county shall review the case file to determine if the person with the status change is an MFBU member receiving or not receiving Medi-Cal. If the reported change is for an MFBU member who is receiving Medi-Cal, the county shall mail an MC 13 for completion by that individual or a person acting on his or her behalf. If this MFBU member claims a satisfactory immigration status on the signed MC 13, the county shall grant full-scope Medi-Cal based on the Redetermination date if the person was otherwise eligible at that time, and he or she was receiving restricted scope Medi-Cal prior to the Redetermination.

If the beneficiary completing the Redetermination form is the person whose status has changed, it is not necessary to wait for receipt of the MC 13 to grant full Medi-Cal benefits, if otherwise eligible, but a new MC 13 must be provided for the case file. A beneficiary who claims a change from a restricted scope status to a full-scope immigration status must provide evidence of their new status within 30 days of the claim or the time it takes to complete the Redetermination process, whichever is longer. The county must verify a claim of satisfactory immigration status through the Systematic Alien Verification for Entitlements (SAVE) system. Otherwise eligible individuals are eligible for full-scope Medi-Cal while their status is being verified.

If an excluded MFBU member is not receiving Medi-Cal but now wants Medi-Cal, he/she may be added to the MFBU when the county receives all appropriate information and verification on that individual. The county shall not delay the Annual Redetermination process for the MFBU pending additional verification or information on this individual. The individual shall remain an excluded MFBU member until the county has the necessary documentation to determine his/her Medi-Cal benefits.

If a non-MFBU member is reported to have a change to his/her immigration status and he/she is not receiving any type of Medi-Cal benefits, the county shall contact the beneficiary to determine if that person wants Medi-Cal. If that individual is not an MFBU member and wants Medi-Cal, the county shall mail a Medi-Cal application to the household and inform them that he/she must complete the application and eligibility determination process.

Section 7. Blindness/Disability/Incapacity

Section 7 allows the beneficiary to report any disabling condition not previously known or reported to the county. Counties shall refer to Article 22, Title 22 and MEPM Article 22, Disability Determination Referrals.

(a) Person with blindness, disability or incapacity.

If the person claiming to have a disability is not currently receiving disability-linked Medi-Cal, the county shall contact the beneficiary to clarify the condition of the person reported as having the disability. If the person considers himself/herself to be blind or disabled, the county shall send out forms necessary to initiate a referral to the State Programs Disability Adult Program Division for evaluation. The county shall not make an independent determination that the condition is not severe enough to qualify the person as blind or disabled.

If, at the time of the Annual Redetermination, the beneficiary no longer has linkage to a Medi-Cal program, such as the last child has left home, and he/she claims to be disabled, the county must continue the individual's Medi-Cal benefits during the disability evaluation process at the same benefit level that he/she was previously receiving.

If, at the time of the Annual Redetermination, a non-Medi-Cal parent in the home reports that he/she is incapacitated, the county shall contact the parent to determine if he/she wants Medi-Cal and document the results of that contact.

(b) Disabling conditions related to an injury or accident.

If the beneficiary reports a person in the home has physical, mental, or health problems as a result of an injury or accident, the county shall contact the beneficiary and follow the procedures contained in MEPM, Article 15-B, Medi-Cal Casualty Claims.

Section 8. Other Health Program Information and Referrals

Section 8 serves as a request for additional information on, or referral to, other program and services available to low-income families. With the exception of the Healthy Families (HF) program, CDHS has not issued formal or specific referral processes for the Child Health and Disability Prevention (CHDP) program; Women, Infant and Children program; or In-Home Supportive Services/Personal Care Services (IHSS/PCS) because counties have specific referral processes in place for these programs within their local offices. If the beneficiary requests information, explanation and/or referral to any of these programs and services, the county must ensure the request is met and any action taken is documented on the MC 210 RV form, county use section and in the case record.

(a) Referral to HF.

If the box is not checked indicating that the family does not want their child's information to be shared with HF and their child is determined to have a SOC at the Annual Redetermination, the county will share the child's information with the HF program. In addition, the county shall review the Medi-Cal to HF Bridging program for the SOC child as outlined in ACWDL No. 03-01. The HF program requires the following documentation:

- Medi-Cal to HF Transmittal form
- Copy of birth certificates and Bureau of Citizenship and Immigration Services Documentation (if available).
- Notice of action (NOA) showing the SOC computation
- Appropriate case information and budget if not shown on the NOA.

(b) Referral to CHDP program.

CHDP informing is required at Annual Redetermination. Each Annual Redetermination packet must contain a CHDP brochure in the language understandable to the beneficiary. If the beneficiary requests CHDP services or additional CHDP information, the county must complete a CHDP referral. Each county has developed its own CHDP referral procedures with their local CHDP program. If a CHDP referral is requested, the county shall complete the referral process and document the information in the case file.

(c) Referral to Women, Infants, and Children (WIC) program.

If information on a referral to WIC is requested, the county shall contact the beneficiary to follow-up and document the referral process in the case file.

(d) IHSS/PCS

If the beneficiary requests IHSS/PCS information, the county shall contact the beneficiary and provide the local IHSS/PCS program telephone number.

II. Obtaining Verification on information reported

When a beneficiary reports information on the MC 210 RV or MC 210 PS that requires verification, but fails to provide the documentation when the MC 210 RV is returned timely to the county, counties must follow the SB 87 three-step process to obtain them. Counties shall avoid unnecessary and repetitive requests of the beneficiary to provide verification when the county can obtain the verification through available sources such as other case records or is available through MEDS, IEVS, SAVE, etc. Exchange of important eligibility information in case records among county staff is crucial in meeting the Medi-Cal Annual Redetermination processing timeline. When a beneficiary reports information on the MC 210 RV form that requires the county to send additional form(s)

to the beneficiary to complete, the county shall document the reason in the case record. Counties shall refer to the MEPM 4M verification section and other related ACWDLs if there are questions on verification of income, alien status, pregnancy and blindness/disability.

III. Other Acceptable Forms for the Medi-Cal Annual Redetermination

There will be circumstances that counties shall accept other Statement of Facts forms such as the Statewide Automated Welfare System 2, MC 210 or the old MC 210 RV instead of the new MC 210 RV from the beneficiaries or their representatives at the Annual Redetermination. If the beneficiary or their representative mailed in any one of these Statement of Facts forms and it is complete and signed, counties shall document in the case file that the form is being accepted as the Annual Redetermination form and use the information provided on these forms to continue to process the Annual Redetermination. The beneficiaries, or their representatives, shall not be required to complete a MC 210 RV to provide the same information.

In Interim Statewide Automated Welfare System (ISAWS) counties, if a beneficiary requests a face-to-face appointment with the county to complete the MC 210 RV form, the ISAWS counties may, if the beneficiary agrees, use the "interactive" interviewing method to complete the Statement of Facts form in place of the MC 210 RV. Counties must inform the beneficiary that he/she always has the option of completing the MC 210 RV at home and mailing it back to the county.

Counties shall always allow the beneficiary the option of completing the Annual Redetermination in person. If the beneficiary requests a face-to-face appointment with his/her caseworker to complete the Annual Redetermination, the caseworker must document the request and reason in the case record.

If you have questions regarding the Annual Redetermination process or the MC 210 RV, please contact Ms. Debora Wong-Kochi at (916) 552-9490 or by email: dwongkoc@dhs.ca.gov

Original signed by

Tameron Mitchell, R.D., M.P.H., Chief
Medi-Cal Eligibility Branch

Enclosures

MEDI-CAL ANNUAL REDETERMINATION FORM

You must fill out this form and return it to the county to keep your Medi-Cal!

Case number ***(optional)***	**Social security number** ***(optional)***	
Print your name *(If you have not moved, put address label here if one is provided.)*	**Birth date** ***(optional)*** **(mm/dd/yyyy)**	
Current street address, apartment number ☐ *Check here if address is new*	**City**	**ZIP code**
Mailing Address, **if different from above**	**City**	**ZIP code**

Use ink and **PRINT** your answers. If you have any questions or need help filling out this form, call your worker at the telephone number listed on the Annual Redetermination Notice. Make sure you sign and date the form.

Use the postage paid envelope to return it. If you need more space, attach a separate sheet to this form.

Section 1. Income

(a) Do you or any family member in the home get money from a job, child support or alimony, social security, veteran benefits, unemployment or disability benefits, retirement, gifts, or interest or dividends? ☐ Yes ☐ No
If yes, complete below and list each source of income on a separate line.

Attach most recent pay stubs showing income before taxes or deductions, benefit or award letters, checks received or signed statement from employer, or last year's federal income tax return. If income is from self-employment, send a copy of your most recent tax return or profit and loss statement.

Name of Person With Income	Source of Income	Income Amount (before any deductions)	How Often Paid (weekly, monthly, twice a month)	Hours Worked (per week or month)

(b) Do you or any family member in the home get rent, utilities, food, or clothing entirely free? ☐ Yes ☐ No

If yes, who? _____ What was free? _____

(c) Was the free rent, utilities, food, or clothing received in exchange for work done? ☐ Yes ☐ No

Section 2. Expenses and Deductions

Do you or any family member in the home pay for child or adult care, health insurance or Medicare premiums, court-ordered child support or alimony, or educational expenses? ☐ Yes ☐ No
If yes, complete below and list each expense/deduction on a separate line.

Attach proof of expenses/deductions.

Name of Person with Expense/Deduction	Type of Expense Or Deduction	Amount of Payment	Paid to Whom	How Often Paid (weekly, monthly, twice a month)

Section 3. Other Health Insurance

(a) Did you or any family member have a change in, or get new health, dental, vision, or Medicare coverage or insurance within the last 12 months? ☐ Yes ☐ No

If yes, who has the coverage/insurance? _____

Which type of coverage/insurance? _____

(b) Is any family member living in the home receiving kidney dialysis-related services? ☐ Yes ☐ No

If yes, who? _____

Section 4. Living Situation

(a) Did anyone move into or out of your home, move in with someone else, get married, or have a baby within the last 12 months? *(Examples: newborn, child, or adult moved in or out of the home, absent parent returns home.)* ☐ Yes ☐ No

If yes, complete *below*.

Name	Relationship to you	Want Medi-Cal?	What Changed?	Date Changed
		☐ Yes ☐ No		
		☐ Yes ☐ No		

(b) If a new baby is in the home, where was the baby's place of birth? _____ / _____
City Country

(c) Did anyone in the home get inpatient care in a nursing facility or medical institution? ☐ Yes ☐ No

If yes, who? _____

(d) Is anyone in the home pregnant? ☐ Yes ☐ No

If yes, who? _____ Expected date of delivery: _____

Section 5. Real or Personal Property

(a) Indicate the total amount of cash and uncashed checks held by any family member in the home: $_____

(b) Does anyone have a checking or savings account, life insurance, long-term care insurance, motor vehicle, court-ordered settlement or judgment, stocks, bonds, retirement funds, trusts where money or property is held for the benefit of any family member in the home, real estate, motor vehicles for a business, business accounts or property, promissory notes, mortgages, deeds of trust, recreational vehicles, burial trusts or funds, annuities, jewelry (not heirloom or wedding), or oil or mineral rights? ☐ Yes ☐ No

(c) Did you or any family member in the home sell or give away any money or property in the past 12 months, or have any of the items listed in this section been spent or used as security for medical costs? ☐ Yes ☐ No

If you have answered "yes" to questions (b) or (c), you will also have to fill out a property supplement form.

Section 6. Immigration or Citizenship Status Change

Has there been a change in immigration or citizenship status for anyone in the home that has Medi-Cal or wants Medi-Cal within the last 12 months? *(If your immigration status has changed, you might qualify for full scope Medi-Cal benefits.)* ☐ Yes ☐ No

If yes, list the name(s) below and send proof of new status.

Name(s): _____

Section 7. Blindness/Disability/Incapacity

(a) Do you or any family member in the home have a physical or emotional condition that makes it difficult to work, take care of personal needs, or take care of your children? ☐ Yes ☐ No

If yes, who? _____

(b) Was the physical, mental, or health condition a result of an injury or accident? ☐ Yes ☐ No

If yes, explain? _____

_____

Section 8. Other Health Program Information and Referrals

(a) Check this box if you do **not** want your child's information shared with the low-cost Healthy Families Program if your child gets Medi-Cal with a share of cost. ☐

(b) Do you want information on the no-cost health program for children under 21 *(Child Health and Disability Prevention Program, also known as CHDP)*? ☐ Yes ☐ No

(c) Do you want information on the no-cost supplemental food program for pregnant or breastfeeding women and children under 5 *(Women, Infants, and Children Program, also known as WIC)?* ☐ Yes ☐ No

(d) Do you want information on the Personal Care Services Program, an in-home care program for aged, blind, or disabled persons (also known as In-Home Supportive Services)? ☐ Yes ☐ No

CERTIFICATION—Person completing this form must read and sign below.

- I have received and read a copy of the Important Information for Persons Requesting Medi-Cal form (MC 219).
- I am aware of, understand, and agree to meet all my responsibilities as described on the MC 219 form.
- I certify that I will report all income, property, and/or other changes that may affect Medi-Cal eligibility within ten days of the change.
- I understand that all of the statements, including benefit and income information, that I have made on this form, may be subject to investigation and verification.
- I declare, under penalty of perjury, under the laws of the State of California that all information provided on this form is true and correct.

Signature	**Date**

Daytime or Message Telephone Number	**Home Telephone Number** ☐ *Check here if new number*

Signature of Witness (if signed by a mark), Interpreter or Person Assisting

—County Use Only—

Worker Signature	**Worker Number**	**Date Annual Completed**

Referrals		**Follow-up Forms**		
☐ HF	☐ WIC	☐ DHS 6155	☐ MC 210 PS	☐ Other: _____
☐ CHDP	☐ PCSP	☐ MC 13	☐ DAPD Packet	_____

FORMULARIO ANUAL PARA VOLVER A DETERMINAR SU ELEGIBILIDAD PARA MEDI-CAL

¡Usted tiene que llenar este formulario, y devolvérselo al condado para conservar su Medi-Cal!

Número de caso ***(opcional)***	**Número de seguro social** ***(opcional)***	
Escriba su nombre en letra de molde *(Si no se ha mudado, coloque aquí la etiqueta con su dirección, en caso de habérsele proporcionado una.)*	**Fecha de nacimiento** ***(opcional)*** **(mm/dd/aaaa)**	
Dirección residencial actual, número de apartamento ☐ *Marque aquí si la dirección es nueva*	**Ciudad**	**Código postal**
Dirección postal, si es diferente a la de arriba	**Ciudad**	**Código postal**

Use pluma de tinta, y escriba sus respuestas en **LETRA DE MOLDE**. Si tiene alguna pregunta, o si necesita ayuda, para llenar este formulario, llame a su trabajador(a), al número de teléfono indicado en la Notificación Anual para Volver a Determinar su Elegibilidad. Asegúrese de firmar y fechar el formulario.

Use el sobre con franqueo pagado, para devolverlo. Si necesita más espacio, adjúntele a este formulario una hoja aparte.

Sección 1. Ingresos

(a) ¿Recibe usted o algún miembro de la familia, que vive en el hogar, dinero de un trabajo, del mantenimiento de los hijos o de una pensión de divorcio, del seguro social, de los beneficios para los veteranos militares, de los beneficios por desempleo o por incapacidad, de una jubilación, de regalos o de intereses o de dividendos? ☐ Sí ☐ No

Si la respuesta es sí, complete lo siguiente, y enumere cada fuente de ingresos en una línea separada.

Adjunte los talones de cheque más recientes, que muestren los ingresos antes de los impuestos o deducciones, las cartas de beneficios o de adjudicaciones, los cheques que se recibieron o una declaración firmada del empleador, o la declaración de impuestos federales sobre los ingresos del año pasado. Si los ingresos provienen de un empleo por cuenta propia, envíe una copia de su más reciente declaración de impuestos sobre los ingresos o de la declaración de ganancias y pérdidas.

Nombre de la Persona con Ingresos	Fuente de los Ingresos	Cantidad de los Ingresos (antes de cualesquier deducciones)	Frecuencia con la que se recibió pago (semanalmente, mensualmente, dos veces al mes)	Horas que Trabajó (por semana o por mes)

(b) ¿Recibe usted o algún miembro de la familia, que vive en el hogar, alquiler, servicios públicos, alimentos o ropa, de forma completamente gratuita? ☐ Sí ☐ No

Si la respuesta es sí, ¿quién? _____ ¿Qué fue gratuito? _____

(c) ¿Se recibió alquiler, servicios públicos, alimentos o ropa, a cambio de trabajo que se realizó? ☐ Sí ☐ No

Sección 2. Gastos y Deducciones

¿Paga usted o algún miembro de la familia, que vive en el hogar, por servicios de cuidado infantil o de cuidado de adultos, por seguro de salud o por primas de Medicare, por mantenimiento de los hijos o por pensiones de divorcio, ordenados por los tribunales, o por gastos educativos? ☐ Sí ☐ No

Si la respuesta es sí, complete lo siguiente, y enumere cada gasto/deducción en una línea separada.

Adjunte pruebas de los gastos/deducciones.

Nombre de la Persona con el Gasto/Deducción	Tipo de Gasto o Deducción	Cantidad del Pago	A quién se le pagó	Frecuencia con la que se recibió pago (semanalmente, mensualmente, dos veces al mes)

Sección 3. Otro Seguro Médico

(a) ¿Tuvo usted o cualquier miembro de la familia un cambio en la cobertura o seguro médico, dental, de la vista o de Medicare o recibió nueva cobertura o seguro de estos tipos, en los últimos 12 meses? ☐ Sí ☐ No

Si la respuesta es sí, ¿quién tiene la cobertura/seguro? _____

¿Qué tipo de cobertura/seguro? _____

(b) ¿Está recibiendo algún miembro de la familia, que vive en el hogar, servicios relacionados a la diálisis renal? ☐ Sí ☐ No

Si la respuesta es sí, ¿quién? _____

Sección 4. Situación de Vivienda

(a) ¿Se mudó alguien a, o de, su hogar, se mudó para vivir con otra persona, se casó, o tuvo un bebé, en los últimos 12 meses? *(Ejemplos: un recién nacido, niño(a) o adulto que se mudó a, o de, el hogar, padres ausentes que volvieron al hogar.)* ☐ Sí ☐ No

Si la respuesta es sí, complete lo *siguiente*

Nombre	Relación con usted	¿Quiere Medi-Cal?	¿Qué cambió?	Fecha del Cambio
		☐ Sí ☐ No		
		☐ Sí ☐ No		

(b) Si hay un nuevo bebé en el hogar, ¿cuál fue el lugar de nacimiento del bebé? _____ / _____
Ciudad **País**

(c) ¿Recibió alguien en el hogar atención de hospitalización en un establecimiento de atención para las personas de la tercera edad o en una institución médica? ☐ Sí ☐ No

Si la respuesta es sí, ¿quién? _____

(d) ¿Hay alguna persona embarazada en el hogar? ☐ Sí ☐ No

Si la respuesta es sí, ¿quién? _____ Fecha que se anticipa para el parto: _____

Sección 5. Bienes Raíces o Personales

(a) Indique el total de efectivo y de cheques sin cambiar, que tiene cualquier miembro de la familia en el hogar: $_____

(b) ¿Tiene alguien una cuenta corriente o de ahorros, seguro de vida, seguro de atención a largo plazo, vehículo motorizado, convenio de arreglo o fallo ordenado por los tribunales, acciones, bonos, fondos de jubilación, fideicomisos, donde se mantiene el dinero o los bienes de cualquier miembro de la familia, que vive en el hogar, bienes raíces, vehículos motorizados para fines comerciales, cuentas o propiedades comerciales, pagarés, hipotecas, escrituras de fideicomiso, vehículos para recreación, escrituras o fondos para entierro, anualidades, joyas (que no sean reliquias familiares ni de matrimonio), o derechos petroleros o minerales? ☐ Sí ☐ No

(c) ¿Vendió o regaló usted o algún miembro de la familia, que vive en el hogar, algún dinero o bienes, en los últimos 12 meses, o se ha gastado o utilizado algún artículo enumerado en esta Sección, como garantía, para cubrir gastos médicos? ☐ Sí ☐ No

Si usted contestó "sí" a las preguntas (b) o (c), también tendrá que llenar un formulario suplementario de bienes.

Sección 6. Cambio en la Situación de Inmigración o de Ciudadanía

¿Ha habido algún cambio en la situación de inmigración o de ciudadanía para alguien en el hogar, que tiene Medi-Cal o que quiere Medi-Cal, en los últimos 12 meses? (*Si su situación de inmigración ha cambiado, es posible que tenga derecho a recibir los beneficios completos de Medi-Cal.)* ☐ Sí ☐ No

Si la respuesta es sí, enumere el/los nombre(s) a continuación y envíe pruebas de la nueva situación.

Nombre(s): _____

Sección 7. Ceguera/Impedimento/Incapacidad

(a) ¿Tiene usted o algún miembro de la familia, que vive en el hogar, una condición física o emocional, que le haga difícil trabajar, atender a sus necesidades personales, o cuidar a sus niños? ☐ Sí ☐ No

Si la respuesta es sí, ¿quién? _____

(b) ¿Fue la condición física, mental o de salud el resultado de una lesión o accidente? ☐ Sí ☐ No

Si la respuesta es sí, explique: _____

_____

Sección 8. Otra Información sobre Programas de Salud y Envíos a Servicios

(a) Si su hijo recibe Medi-Cal con parte del costo y **no** desea que la información de su hijo se comparta con el programa *Healthy Families* de bajo costo, ponga una **X** en esta casilla. ☐

(b) ¿Quiere información acerca del programa de salud sin costo alguno, para niños menores de 21 años [*el Programa de Salud para los Niños y Prevención de Incapacidad, también conocido por las siglas CHDP (*Child Health and Disability Prevention Program*)]*? ☐ Sí ☐ No

(c) ¿Quiere información acerca del programa de alimentos suplementarios, sin costo alguno, para mujeres embarazadas o que están amamantando y para niños menores de 5 años [*el Programa para Mujeres, Bebés y Niños, también conocido por las siglas WIC* (Women, Infants, and Children Program)]*?* ☐ Sí ☐ No

(d) ¿Quiere información acerca del Programa de Servicios de Atención Personal (*Personal Care Services Program*), un programa de atención a domicilio, para personas ancianas, ciegas o incapacitadas [también conocido como Servicios Auxiliares a Domicilio (*In-Home Supportive Services*)]? ☐ Sí ☐ No

CERTIFICACIÓN—La persona que completa este formulario tiene que leer y firmar lo siguiente.

- He recibido y leído una copia del formulario de Información Importante para las Personas que Solicitan Medi-Cal (MC 219).
- Estoy consciente de, entiendo y estoy de acuerdo en cumplir con todas mis responsabilidades, según se describen en el formulario MC 219.
- Certifico que reportaré todos los ingresos, bienes u otros cambios, que podrían afectar mi elegibilidad para recibir Medi-Cal, en un plazo de diez días, a partir del cambio.
- Entiendo que todas las declaraciones, incluyendo la información acerca de los beneficios y de los ingresos, que he hecho en este formulario, podrían estar sujetas a investigación y verificación.
- Declaro, bajo pena de perjurio, según las leyes del Estado de California, que toda la información proporcionada en este formulario es verdadera y correcta.

Firma	**Fecha**

Número de Teléfono durante el Día o para Dejar Mensajes	**Número de Teléfono en el Hogar** ☐ *Marque aquí si es un número nuevo*

Firma del/de la Testigo (si se firma con una marca), del/de la Intérprete o de la Persona Auxiliar

—Solamente para Uso del Condado—

Worker Signature	**Worker Number**	**Date Annual Completed**

Referrals		**Follow-up Forms**		
☐ HF	☐ WIC	☐ DHS 6155	☐ MC 210 PS	☐ Other: _____
☐ CHDP	☐ PCSP	☐ MC 13	☐ DAPD Packet	_____

REDETERMINATION FOR MEDI-CAL BENEFICIARIES (LONG-TERM CARE IN OWN MFBU)

INSTRUCTIONS: Your continuing eligibility will be decided on the information you give on this form. If you are completing this form on someone else's behalf, the term "you" applies to that person. ***ALL QUESTIONS MUST BE ANSWERED.***

1. Name (first, middle, last) | Date of birth (month, day, year) | Social security number

2. Long-term care facility name | Marital status | Medicare claim number
   Facility address (number, street) | City | ZIP code

3. Name of spouse | Social security number | Telephone ( )
   Address of spouse (number, street) | City | State | ZIP code

4. Name of person helping complete form | Relationship | Telephone ( )

5. Address of person helping with form (if information regarding beneficiary should be sent to this person)
   Number, street | City | State | ZIP code

6. Do you own any real property, have an interest in real property, or own a trailer or mobile home taxed as real property? ..... ❒ Yes ❒ No
   If yes:
   a. Is this property your former home? ..... ❒ Yes ❒ No
      If yes, do you intend to return to that property to live in the future? ..... ❒ Yes ❒ No
      (If this intent changes, you must notify the county within 10 days.)
      If you do not intend to return to that property, does anyone else live there now? ..... ❒ Yes ❒ No
      If yes, enter name:_____Relation to you: _____
      Basis of dependency (financial, medical, etc.) _____
      How long have they lived there? _____
   b. Is this property currently listed for sale? ..... ❒ Yes ❒ No
      Description of property: _____
      Address of property: _____
      Owner(s):_____
      Full value (from tax statement): $_____ Amount owed: $ _____
      Rent collected each month: $_____ Expenses on property: $ _____
      Interest $ _____ ❒ Yearly ❒ Monthly Insurance $ _____ ❒ Yearly ❒ Monthly
      Taxes and assessments $ _____ ❒ Yearly ❒ Monthly
      Utilities $ _____ ❒ Yearly ❒ Monthly Upkeep and repairs $ _____ ❒ Yearly ❒ Monthly

7. Do you have a life estate in any property? ..... ❒ Yes ❒ No
   If yes, describe:_____

8. Do you own a note, mortgage, or deed of trust? ..... ❒ Yes ❒ No
   If yes: Appraised value $ _____ Monthly payment: $ _____ Interest rate:_____%

9. Do you have any checks or money on hand in banks, savings and loans, or credit unions, etc. (checking or savings accounts), or a patient trust account, or a trust or agreement where money or property is being held for your benefit or being held for you by anyone, or being kept anywhere for you? ..... ❒ Yes ❒ No
   If yes:
   a. On hand? _____ (Location / Amount / Account number)
   b. In bank or savings? _____ (Location / Amount / Account number)
      _____ (Location / Amount / Account number)
   c. Held or kept for you by anyone? _____ (Location / Amount / Account number)

COUNTY USE ONLY

PR ❒ Yes ❒ No

❒ DHS 7014

Utilized ❒ Yes ❒ No

$_____

Current month income included ❒ Yes ❒ No

$_____

$_____

$_____

$_____

10. Have you sold, transferred, or given away any property (including money) at any time in the past year? ❒ Yes ❒ No

If yes:

Description	Date of Transfer, Sale, or Gift	Value	Amount Received
		$	$
		$	$
		$	$

11. Do you own any of the following items of property? Check yes or no. If yes, provide the other information requested.

	Yes	No	Purchase Price	Current Value	Amount Owed
a. Stocks or bonds, certificates of deposit, money market, or mutual fund account			$	$	$
b. Jewelry valued over $100 (other than wedding or engagement heirlooms)			$	$	$
c. Burial reserve or trust			$	$	$
d. Burial plot, vault, or crypt			$	$	$
e. Business equipment, tools, inventory, or material			$	$	$
f. Other			$	$	$

12. Do you own any annuities or life insurance policies or long-term care insurance policies for yourself or anyone else? ❒ Yes ❒ No

If yes:

Company	Name of Insured or Annuitant	Face Value	Current Cash Value
a.		$	$
b.		$	$
c.		$	$

13. Do you own a motor vehicle (car, truck, etc.); or a boat, camper, or motor home; or mobile home or trailer not taxed as real property? ❒ Yes ❒ No

If yes:

Description	Class Code (From Registration)	Year	Purchase Price	Amount Owed
			$	$
			$	$

14. Do you or your spouse receive any income? ❒ Yes ❒ No

If yes, list the source and amount of income received each month. If income is received less often than monthly, indicate how often received. Attach verification of this income.

	When Paid/How Often	Applicant	Spouse
Social Security (green check)		$	$
SSI/SSP		$	$
Railroad retirement		$	$
Veterans benefits (including Aid and Attendance payments)		$	$
Retirement or pension		$	$
Annuities		$	$
Interest income or dividends		$	$
Contributions (including those from relatives)		$	$
Earnings (gross)		$	$
Other (include lump sum payments, inheritance, etc.)		$	$

15. a. Have you or any family member ever been in U.S. military service? ❒ Yes ❒ No

b. Are you or any family member the spouse, parent, or child of a person who has been in U.S. military service? ❒ Yes ❒ No

16. Have you applied for or do you think you are eligible for any payments you are not now receiving? ❒ Yes ❒ No

If yes:

Kind of Payment	Date Applied For	Date Expected

❒ Verification

$_____

❒ Exempt

$_____

$_____

$_____

$_____

Verification of CSV on file?

$_____

Copy of annuity on file?

❒ Yes ❒ No

State certified LTC policy?

❒ Yes ❒ No

Amount paid out $_____

DHS 6155 completed

❒ Yes ❒ No

Exempt ❒ Yes ❒ No

$_____

Use copy of award letter or check or other verification

$_____

$_____

$_____

$_____

$_____

$_____

$_____

$_____

$_____

$_____

CA5 (if not already completed)

17. Do you have Medicare coverage? ❒ Yes ❒ No

If yes:

Name	Medicare claim number	Monthly premium
		Deduction from check? ❒ Yes ❒ No Paid by you? ❒ Yes ❒ No

_____
Date verified

18. Do you have health or hospitalization insurance? ❒ Yes ❒ No

If yes:

Name of insurance company

Premium you pay	How often?		
$	❒ Monthly	❒ Quarterly	❒ Yearly

DHS 6155 completed?
❒ Yes ❒ No
OHC Code _____

19. Would you like to speak to a social worker about services available to you? ❒ Yes ❒ No

If yes, explain the services you wish to discuss:

Service Referral ❒ Yes ❒ No

20. Additional information

BE SURE YOU HAVE READ EVERY ITEM AND ANSWERED ALL THE QUESTIONS.

READ THE FOLLOWING CAREFULLY BEFORE SIGNING.

I declare under penalty of perjury that the answers I have given are correct and true to the best of my knowledge.

I agree to tell the county welfare department within ten days if there are any changes in my (or the person's on whose behalf I am acting) income, possessions, or expenses, or a change in my living situation. I agree to meet all the other responsibilities explained in the "Important Information for Persons Requesting Medi-Cal" (MC 219) I received at the time of my application for Medi-Cal. (A new "Important Information for Persons Requesting Medi-Cal" (MC 219) will be provided if there is a change in the person acting on behalf of the beneficiary.)

I understand that Section 1137 of the Social Security Act requires that I provide my Social Security number (SSN). My SSN will be verified and will be used in a computer match to check the income and resources I report with information from welfare, state employment, income tax, Social Security Administration, and other agencies.

I understand that Sections 215, 9202, and 9203 of the Probate Code and Section 14009.5 of the Welfare and Institutions Code provide for the recovery of all Medi-Cal benefits received after age 55 from the estate of a Medi-Cal beneficiary if there is no surviving spouse, minor children, or blind or totally disabled children, or it would create a hardship for my heirs. After the death of my surviving spouse, the State has the right to claim from the part of his/her estate received from me, all Medi-Cal benefits I received after age 55 up to the amount of property my spouse received from my estate.

I understand that I may be asked to prove my statements, but that the county is required by law to keep them confidential.

I understand that if I am dissatisfied with any action or inaction taken by the county welfare department, I have the right to a state hearing which I may request from the county welfare department within 90 days after the action or inaction with which I am dissatisfied.

I realize that if I deliberately make false statements or withhold information, I (or the person on whose behalf I am acting) may lose my (or his/her) Medi-Cal card and/or be prosecuted for fraud.

Signature of beneficiary	Date
Signature of person acting for beneficiary	Date
Signature of witness (if beneficiary signed with mark)	Date
E.W. signature	Date

PRIVACY STATEMENT

- **Medi-Cal Confidentiality Notice:** The information given in this application is private and confidential under Welfare and Institutions Code, Section 14100.2. This information will be disclosed only in accordance with those laws.
- **Medi-Cal Privacy Notice:** This information may be shared with federal, state, and local agencies for purposes of verifying eligibility and for other purposes related to the administration of the Medi-Cal program, including confirmation with the INS of the immigration status of only those persons seeking full scope Medi-Cal benefits. (Federal law says the INS cannot use the information for anything else except cases of fraud.)
- **Information required by this form is mandatory**, with the exception of ethnicity information, and any other item marked voluntary or optional.

APPLICATION AND STATEMENT OF FACTS FOR AN INDIVIDUAL WHO IS OVER 18 AND UNDER 21 AND WHO WAS IN FOSTER CARE PLACEMENT ON HIS OR HER 18TH BIRTHDAY

❒ New application

❒ Redetermination

❒ Request for retroactive coverage for ____ months
(Eligibility cannot be established prior to 10/01/00.)

COUNTY USE ONLY

Case name:_____

Case number: _____

Date of discontinuance:_____

Name	Date of birth (mm/dd/yy)	Gender ❒ Male ❒ Female
Telephone number ( )	Social security number	

Address (number, street)	City	State	ZIP code
Mailing address (if different) (number, street, P.O. Box)	City	State	ZIP code

Do you have other medical insurance (through work or parents)? ❒ Yes ❒ No

If yes, name of insurance company	Policy number

I declare under penalty of perjury under the laws of the State of California that the answers I have given in this application are true and correct to the best of my knowledge and belief.

Signature	Date

Instructions

If you are completing this application it is because you were in foster care when you turned 18. The Foster Care Independence Act of 1999 allows you to receive Medi-Cal benefits at no share-of-cost until you reach the age of 21. Under this act, you are not required to show proof of income or resources (such as a car) in order to be eligible for Medi-Cal. You only have to have been in the care of a foster care family or agency when you turned 18.

Once you have completed this form, you will have to mail it to or drop it off at your local county social services department. Check your phone book for the nearest office.

If you move, you will still be eligible for Medi-Cal, but you will have to notify your county eligibility worker of your address change. If you move out of the county that you lived in when you applied, the county worker will have to change the information on your case so that you can continue to get medical coverage without difficulty. If you have any changes in your living arrangements, such as moving back in with your parents or getting married, or if you are pregnant, notify your eligibility worker immediately to report the change. These changes, however, will not affect your eligibility for this program.

If you move out of state, you may still be eligible for medical benefits in your new state, but you will have to apply for these benefits in the new state of residence.