

DEPARTMENT OF HEALTH SERVICES

714/744 P STREET
SACRAMENTO, CA 95814

6) 445-1912



March 10, 1981

To: All County Welfare Directors
FORMS PROCESSING UNIT

Letter No. 81-10

NEW FORM AVAILABILITY

This is to notify you that form MC 262 (11/80) REDETERMINATION FOR M/C
(number) (name)RECIPIENTS is now available at the Department of Health Services

Warehouse. The form is packaged in:

- Cartons of _____
- Pads of _____
- Single sheets

Form requisitions should be sent to:

Department of Health Services Warehouse
1723 20th Street
Sacramento, CA 95814

Please allow at least 20 working days for delivery.

Sincerely,

Original signed by

Barbara V. Carr, Acting Chief
Medi-Cal Eligibility Branch

Attachment

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

REDETERMINATION FOR MEDICAL BENEFICIARIES IN LONG-TERM CARE WITHOUT A SPOUSE AND/OR CHILDREN UNDER 21

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.*

1. Name (First, Middle, Last)	Date of Birth Mo. Day Yr. / /	Social Security Number
2. Long-Term Care Facility	Marital Status	Medicare Claim Number
3. Facility Address (Number, Street, City, Zip Code)		
4. Name of Person Helping Complete Form(s)	Relationship	Telephone
5. Address of Person Helping with Form (If Information regarding beneficiary should be sent to this person)		

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,

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 Upkeep and

Utilities \$ _____ Yearly Monthly Repairs \$ _____ Yearly Monthly

COUNTY USE ONLY

State No: _____

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 a bank or savings and loan, being held for you by anyone, or being kept anywhere for you? Yes No If yes,

Location of money:	Amount
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____

10. Have you sold, transferred or given away any property (including money) since you first applied for Medi-Cal or at any time in the two years prior to that? 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			\$	\$	\$
B. Jewelry valued over \$100 (other than wedding or engagement rings or 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 life insurance policies insuring yourself or anyone else? Yes No If yes:

Insurance Company	Person Insured	Face Value	Current Cash Value
A.		\$	\$
B.		\$	\$

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 (From Registration)	Year	Purchase Price	Amount Owed	Used to Provide You With Transportation	
					Yes	No
			\$	\$		
			\$	\$		

14. Do you 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.

Social Security	\$
Railroad Retirement	\$
Veterans Benefits (including Aid and Attendance payments)	\$
Retirement or Pension	\$
Interest Income or Dividends	\$
Contributions (including those from relatives)	\$
Other (describe)	\$

15. 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

CA5 (if not already completed)

16. Do you have health or hospitalization insurance? Yes No If yes:
 insurance Company _____
 Premium you pay \$ _____ How often: Monthly Quarterly Yearly

17. 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:

18. Additional Information:

Referral Yes No

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 10 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 "MEDI-CAL RESPONSIBILITIES CHECKLIST" I RECEIVED AT THE TIME OF MY APPLICATION FOR MEDI-CAL. (A NEW "RESPONSIBILITIES CHECKLIST" WILL BE PROVIDED IF THERE IS A CHANGE IN THE PERSON ACTING ON BEHALF OF THE BENEFICIARY.)

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 ACTIONS TAKEN BY THE COUNTY WELFARE DEPARTMENT, I HAVE THE RIGHT TO A FAIR HEARING.

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

DEPARTMENT OF HEALTH SERVICES

714/744 P STREET
SACRAMENTO, CA 95814
(916) 445-1797



April 2, 1981

ERRATA NOTICE

ALL COUNTY WELFARE DIRECTORS

Letter No. 81-6

SGA DISABLED -- DEDUCTION FOR IHSS COSTS

In the first paragraph of the above mentioned letter, Section 50245(a)(2) should be changed to read Section 50223(a)(2).

ALL COUNTY WELFARE DIRECTORS

Letter No. 81-11

REVISION OF MC 210

On the second page of the above mentioned letter, number eight, Section 50816 should be changed to read Section 50186.

Medi-Cal Eligibility Branch