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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

March 16, 2016

TO: ALL COUNTY WELFARE DIRECTORS Letter No.: I 16-04
ALL COUNTY WELFARE ADMINISTRATIVE OFFICERS
ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIASONS
ALL COUNTY HEALTH EXECUTIVES
ALL COUNTY MENTAL HEALTH DIRECTORS

SUBJECT: Military Verification and Referral Form
(Reference: All County Welfare Directors Letters 95-29 and 05-08)

This letter provides County Welfare Departments (CWDs) with a new Military Verification and Referral (MC 05) form for the Medi-Cal program. Effective July 1, 2016, CWDs must use this new form and discontinue the use of the existing CW-5 form for Medi-Cal determinations.

Prior All County Welfare Directors Letters 95-29 and 05-08 instructed CWDs to perform military benefit verification activities using the CA-5 and its successor the CW-5. The Department of Health Care Services (DHCS) is phasing out the use of the CW-5 form for Medi-Cal determinations during Fiscal Year 2015-2016. On or before June 30, 2016, CWDs must transition to the new Military Verification and Referral Form, known as the MC 05. This is for the Medi-Cal program only and does not apply to other public assistance programs.

The new MC 05 form is available in fillable format on the DHCS website at http://www.dhcs.ca.gov/formsandpubs/forms/Pages/Index.aspx. If you have any questions regarding this letter, please contact Bianca Openiano at (916) 327-0413 or by email at bianca.openiano@dhcs.ca.gov.

Original Signed By:
Sandra Williams, Chief
Medi-Cal Eligibility Division

Enclosure

MILITARY VERIFICATION AND REFERRAL FORM

SECTION A: TO BE COMPLETED BY MEDI-CAL ELIGIBILITY WORKER

1. NAME AND ADDRESS OF MEDI-CAL ELIGIBILITY WORKER'S OFFICE:

3. CASE WORKER NAME:

4. WORKER PHONE #:

5. WORKER EMAIL:

2. NAME AND ADDRESS OF COUNTY VETERANS SERVICE OFFICE:

6. CASE NUMBER:

7. MEDI-CAL AID CODE OF VETERAN OR FAMILY MEMBER: (Required*)

VETERAN INFORMATION

8. VETERAN NAME (FIRST, MIDDLE, LAST)	**9.** DATE OF BIRTH (DOB):	**10**. SOCIAL SECURITY NUMBER (SSN):	**11.** VETERAN MARITAL STATUS (Mark only ONE):
			☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ UNKNOWN
12. VETERAN ADDRESS: (NUMBER, STREET, CITY, STATE, ZIP)	**13**. VETERAN CONTACT INFO:	**14.** VA INCOME REPORTED *(if applicable)*: $	**15**. MILITARY BACKGROUND (Dates/Branch of Service):

VETERAN'S FAMILY INFORMATION

16. NAME:	**17.** RELATIONSHIP TO VETERAN:	**18**. DATE OF BIRTH:	**19.** SOCIAL SECURITY NUMBER:	**20.** ADDRESS:

21. MEDI-CAL ELIGIBILITY WORKER REMARKS:

SECTION B: TO BE COMPLETED BY COUNTY VETERANS SERVICE OFFICE (CVSO)

1. DATE CONTACTED/VERIFIED:	**2**. VETERAN, SPOUSE, OR DEPENDENT/CHILD? *(Mark only ONE)* ☐ VETERAN ☐ SPOUSE ☐ DEPENDENT/CHILD	**3.** TYPE OF ACTION *(Mark ALL that apply)* : ☐ VA HEALTH ENROLLMENT ☐ VA MONETARY BENEFIT ☐ NOT ELIGIBLE ☐ VA BENEFIT ENHANCEMENT (even if claim is under review/in process)

4. VA HEALTH ENROLLMENT TYPE (PLEASE SPECIFY IF APPLICABLE):

5. TYPE OF VA MONETARY BENEFITS *(Mark ALL that apply)*: ☐ COMPENSATION ☐ PENSION ☐ PENSION RESTORED ☐ AWARDED INCOME ☐ SPECIAL COMPENSATION ☐ OTHER: _____	**6.** GROSS PAY: $	**7**. IF A&A/SMC/SMP IS INCLUDED: A&A: $ _____ SMC: $ _____ SMP: $ _____	**8.** IS THIS PERSON LIVING IN LONG TERM CARE (LTC)? (Mark only ONE) ☐ YES ☐ NO	**9.** IF APPLICABLE, DATE ENROLLED IN LTC:

10. CVSO REPRESENTATIVE REMARKS:

11. CVSO REPRESENTATIVE: (PRINT)	**12.** PHONE #:	**13.** DATE:

Privacy Statement: This referral is for individuals applying or receiving Medi-Cal benefits through the Department of Health Care Services (DHCS). The personal and medical information provided on it is private and confidential. DHCS or CWD will use this information to identify the applicant/recipient in order to administer our programs. This information will be shared with other state, federal, and local agencies, contractors, health plans, and programs only to enroll an applicant in a plan or program or to administer programs, and with other state and federal agencies as required by law. In most cases, an applicant has the right to see personal information about them that is in federal and state records. For the Department of Health Care Services, contact the Information Protection Unit at: P.O. Box 997413, MS 4721 Sacramento, CA 95899-7413. Phone: 1-866-866-0602 TTY: 1-877-735-2929. State and federal laws give us the right to collect and keep the information on the application: DHCS: CA Welfare and Institutions Code § 14011 and Article 3, Chapters 5 and 7, Parts 2 and 3, Division 9. This Privacy Statement is given under CA Civil Code §1798.17. DHCS's Notice of Privacy Practices can be seen at dhcs.ca.gov.

MILITARY VERIFICATION AND REFERRAL FORM INSTRUCTIONS

USE THE MILITARY VERIFICATION AND REFERRAL FORM:

1. To verify monetary amounts of veterans' benefits and VA health enrollment for new applicants, current Medi-Cal recipients, and during Medi-Cal redeterminations.
2. To refer applicants or recipients to the County Veterans Service Office (CVSO).
3. To obtain or enhance veteran benefits when the information on the Statement of Facts indicate a military background.

* Do not complete this form if the service person is still on active duty.

INSTRUCTIONS FOR COMPLETION OF THE MEDI-CAL MILITARY REFERRAL FORM:

SECTION A: TO BE COMPLETED BY MEDI-CAL ELIGIBILITY WORKER

# 1	Enter name and address of Medi-Cal Eligibility worker's office the form will be returned to.
# 2	Enter name and address of County Veterans Service Office (CVSO) the form will be sent to.
# 3-5	Enter case worker (person filling out the form) contact information on # 3 – 5.
# 6	Enter Medi-Cal case number of applicant/recipient (if applicable)
# 7	Enter valid Medi-Cal Aid Code. (Required) * If necessary, county staff may enter the case's anticipated aid code even though eligibility has not yet been established. When the aid code is determined, county staff will update the aid code (if different from the anticipated aid code) and inform CVSO of the updated aid code.
# 8-13	Enter all known personal information of Veteran. *Required: Date of Birth (DOB), and Social Security Number (SSN).*
# 14	Enter the VA income reported by the applicant/recipient (if applicable). Verify and evaluate income when MC 05 is returned.
# 15	Enter Veteran's Military Background. This may include but not limited to Dates of Service/Branch of Service etc.
# 16-20	Enter all family member information if someone other than the veteran is applying for benefits. (E.g. Spouse or dependent/child of veteran.) Note: A dependent is defined as a veteran whose parent(s)/ or family member who are dependent upon him/her for financial support may be paid additional benefits from the VA based on specific eligibility requirements.
# 21	Enter any additional notes/remarks that the CVSO may need to know regarding the Medi-Cal applicant/recipient's case that may help determine VA and Medi-Cal eligibility.

SECTION B: TO BE COMPLETED BY COUNTY VETERANS SERVICE OFFICE (CVSO)

# 1-2	Enter date you attempted to contact or verify the beneficiary and confirm whether they are the veteran, spouse, or dependent/child. * Military dependents are the spouse(s), children, and possibly other familial relationship categories of a sponsoring military member (such as dependent parent of a veteran) for purposes of pay as well as special benefits, privileges and rights.
# 3	Select VA benefit type the applicant is receiving and/or eligible to receive. Mark all that apply.
# 4	Enter VA Health Information. Specify if applicable. This may include the VA Health System, CHAMPVA, TRICARE, or any other military health coverage.
# 5	Select the type of monetary benefit the veteran is already receiving and/or entitled to receive (Mark all that apply if applicable).
# 6	Enter gross pay the veteran is reported to be receiving.
# 7	Enter amount of Aid and Attendance (A&A)/ Special Monthly Compensation (SMC)/ Special Monthly Pension (SMP) if applicable. (A&A/SMC/SMP is required in order for the Medi-Cal worker to properly treat income.)
# 8 - 9	If the veteran is in Long Term Care (LTC), enter all known LTC information (if applicable)
# 10	If applicable, enter any additional information/comments/remarks that may be necessary for the Medi-Cal worker to know for eligibility determination.
#11- 13	Enter all CVSO contact information and date.

DISTRIBUTION AND FILING OF THE MEDI-CAL MILITARY VERIFICATION AND REFERRAL FORM:

1. The Medi-Cal eligibility worker will fill out Section A of the MC 05 form if a Medi-Cal applicant/beneficiary or anyone in the household indicates they have a military background.
2. The Medi-Cal eligibility worker will keep one copy of the MC 05 for their records and submit the original copy to the CVSO. The copy for the case file is to be retained until the original is completed and returned by CVSO.
3. The CVSO will utilize any VA resources and/or contact the veteran and confirm VA benefits eligibility (if any) and complete Section B of the MC 05 Form. This may include VA compensation, Health, and enhancement of current benefits.
4. The CVSO will make a copy of the completed MC 05 form and keep it for case file records. The CVSO will then return the original MC 05 form to the Medi-Cal eligibility worker.
5. The Medi-Cal eligibility worker will review the MC 05 form to complete/determine Medi-Cal eligibility. Any incomes reported should be evaluated and have the Share of Cost (SOC) adjusted, if applicable. If the applicant/recipient is in receipt/eligible for VA Health, the applicant must accept any unconditionally available income for which they appear eligible followed by § 50186 of Title 22 of the California Code of Regulations. For existing Medi-Cal recipients, The Medi-Cal eligibility worker will send the recipient an MC 215 for voluntary discontinuance.