DEPARTMENT OF HEALTH SERVICES

*14/744 P STREET ;ACRAMENTO, CA 95814 (916) 445–1912



February 8, 1982

To: All County Welfare Directors

Letter No. 82-6

QUARTERLY SHARE OF COST (SOC)

This letter transmits the answers to the questions raised during the recent regional county training sessions. The questions and answers appear in Attachment I grouped by subject matter. If during your implementation new questions arise, please direct them to your Medi-Cal program consultant. If a sufficient number of questions of general applicability are received, another question and answer letter will be generated.

The State Printing Plant is experiencing some problems which may affect delivery of the revised Quarterly SOC forms. However, the initial supply of form MC 177S will be four part with blue carbon interleaf. Part one and two will be white paper, part three will be yellow and part four will be gold. This will only affect the initial supply and then we will return to the four part pink NCR paper. We expect all of the revised Quarterly SOC forms to be delivered to our warehouse by February 5, 1982. In order to speed up the delivery process please submit your forms request order (on the standard form) to the following address instead of the warehouse.

Department of Health Services Eligibility Branch 714 P Street, Room 1692 Sacramento, CA 95814 Attention: David Markell

If you have any questions contact your Medi-Cal program consultant.

Sincerely,

Original signed by

Madalyn M. Martinez, Chief Medi-Cal Eligibility Branch

Attachment

cc: Medi-Cal Liaisons

Medi-Cal Program Consultant

Expiration Date: July 30, 1982

A. Eligibility Questions

Intercounty Transfers (ICTs)

 Question: When does the resonsibility shift from the initiating county to the new county for multi-month share-of-cost (SOC) cases?

Answer: The shift in responsibility should coincide with the SOC period; however, the new county of responsibility shall be given a minimum of 60 days in which to prepare for acceptance of the transfer.

Example: The SOC period established by County A is June-August. On July 15, County A initiates an ICT to County B. This case would remain the responsibility of County A through November, month of eligibility, unless County B agrees to accept responsibility effective September 1.

A post hearing change will be made to Section 50137 to more clearly state this policy.

Projection of Anticipated Income

2. Question: If a person will be starting a new job during an SOC period, how is staff to project mandatory deductions?

Answer: If the Medi-Cal regulations changing earned income deductions to standard amounts have not been filed by the time quarterly SOC is implemented, these are the guidelines that should be followed:

- a. Obtain as much information from the applicant as possible (e.g., are there mandatory union dues, health insurance premimums, amounts for meals withheld, retirement withholdings, number of dependents claimed for tax purposes, etc.?) The applicant may have to contact the future employer for some of this information.
- b. Assume that State Disability Insurance (SDI) will be withheld unless you have information to the contrary. This deduction is always one percent of the gross pay.
- c. Assume that Social Security Tax (Federal Insurance Contribution Act (FICA) or Old Age Survivors and Disability Insurance (OASDI)) will be withheld unless you have information to the contrary. Effective January 1, 1982, this deduction will be 6.7 percent of the gross pay.

For federal and state income tax withholding amounts, you can obtain copies of employer tax guides from IRS and Franchise Tax Board. (Probably one per office, kept in a central location, would be sufficient.) Based upon the number of dependents claimed and whether or not the individual meets the definition of head of household, the appropriate withholding amounts can be estimated.

If you believe an approach different from above would produce equally reliable results and would be more efficient, please submit your plan to us for approval. Any approved alternative will be shared with all county departments and state quality control staff.

SOC Periods

- Some of the illustrations for determining SOC periods are included as Attachments II and III.
- 4. Question: Can the State consider simplifying the quarterly SOC concept by defining quarters as calendar quarters rather—than using the month of application as the defining point?

Answer: This option was considered, however, based upon the federal regulations and written communications from federal staff, such a definition would result in a federal compliance issue. Even given the "flexibility changes" contained in PL 97-35, the Medicaid regulations require that states have a prospective budgeting system. Additionally, we have recently received correspondence indicating that, for retroactive eligibility determinations, states must consider the income in the three months prior to application in the SOC determination.

5. Question: The MFBU consists of an ABD-MN person and an MI spouse with a quarterly SOC period of June-August. The ABD-MN person enters LTC July 2 and returns to the home September 3. What are the share of cost periods?

Answer: Based upon input from county staff after the training a policy change has been made in this area. The change is that the spouse at home will keep the originally established threemonth period when the other spouse enters/leaves LTC. (Examples have already been distributed to the Medi-Cal Liaison in your county). This same policy applies when there are children in the home.

In the example above the SOC periods would be as follows:

June-August (ABD-MN/MI June and July; MI only August).

August (ABD-MN).

September-November (ABD-MN/MI September-November)

Note the ABD-MN should not be added until October if the action is adverse. In most instances the action will not be adverse. (See Question 11).

SOC Adjustments Due to Decreases in SOC

6. Question: If a person whose ongoing SOC is now zero due to an SOC adjustment, can the amount to be adjusted be "saved" and applied the next time changes in circumstances result in an SOC?

Answer: Yes. Regulations require that for persons who elect to have an overcharge adjusted in future periods, that the adjustment take place as soon as possible. Thus, if a person goes from an SOC to a lower SOC, the adjustment must begin immediately. If the person goes from an SOC to no SOC and still elects the adjustment method, the adjustment must be made as soon as the person again has an SOC.

<u>Increase in SOC</u>

7. Question: If an SOC increases during a multi-month SOC period, can MFBU meet the lower SOC and be certified for the month(s) in the period which are prior to the effective date of the change?

Answer: Yes, provided the lower SOC is met with medical expenses incurred prior to the effective date of the increase.

Example: A family is determined eligible with a \$50 SOC for May-July. On May 28, the family reports that an increase in income will occur in June. A Notice of Action is sent indicating that due to the increase in income which will be counted effective July 1 (because of ten-day notice requirements the increase cannot be reflected for the month of June), the SOC for the May-July quarter will be \$110. A new MC 177S is included with the Notice. On June 20, the original MC 177S is brought into the office. The family met the \$50 SOC on June 17. Since technically the increase for the May-July period is not effective until July 1, the family is entitled to cards for May and June after having obligated \$50. The MC 177S should be sent to Benefits Review Unit (BRU) with only the first two eligibility boxes checked. A supplemental MC 177S should be issued for July with a \$60 supplemental SOC amount (\$110-\$50).

Adding Persons to the MFBU

8. Question: How is a case processed when the inclusion of an excluded family member will increase the multi-month SOC after the MFBU has already met the SOC and received Medi-Cal cards?

Answer: Attachment IV outlines various case situations for a family with a \$90 multi-month SOC. The excluded son, when added to the MFBU, increases the multi-month SOC by \$10 each month. The increase is immediately computed since the inclusion of an excluded family member is not an adverse action per Section 50015.

Example 1 shows the MC 176M and MC 177S when the son is excluded from the MFBU.

Example 2 shows the MC 176M and MC 177S when the MFBU has met the SOC, received Medi-Cal cards for months A and B, and the son is to be included in the MFBU for months B and C.

Note: Only the son is listed as elgibile on the MC 177S for month B since the rest of the MFBU has met the SOC and received Medi-Cal cards. Everybody is listed as eligible on the MC 177S for month C since no one has received a Medi-Cal card.

Example 3 shows the MC 176M and MC 177S when the MFBU has met the SOC, received Medi-Cal cards for months A, B, and C, and the son is to be included in the MFBU for month C only.

Example 4 shows the MC 176M and MC 177S when the MFBU has met the SOC, received Medi-Cal cards for months A, B, and C, and the son is to be included in the MFBU for month C and also receive retroactive eligibility for months A and B, and month C of the prior multi-month period for the MFBU. The MFBU has already met the SOC and received Medi-Cal cards for the prior multi-month period.

Note: The son has a one-month SOC for month C of the prior multi-month SOC period. His income for months A and B of the prior period are not to be counted because he was not a member of the MFBU, and therefore, the entire multi-month period need not be reactivated in computing his SOC.

9. Question: When a family member, not currently on Medi-Cal, returns to the home, is that person's eligibility initially determined separately?

Answer: The evaluation of eligibility of such persons under a multi-month SOC system is the same as under the current monthly SOC system; that is, eligibility is evaluated both in terms of the individual and in terms of the impact upon the MFBU members. If either the individual does not meet the eligibility requirements or inclusion of the individual in the MFBU renders the entire unit ineligible, the individual is not added to the MFBU during the month of return.

Example: On March 8, it is reported that the absent parent returned to the home on February 27. When combining his/her property with the property of the MFBU, the entire family becomes ineligible. In this instance, the absent parent would not be added to the MFBU for March and the remaining family members would be terminated effective March 31, providing the property is not spent down.

There are instances in which the person returning to the home can establish separate eligibility during the month of return. For example, a 20-year-old who has been living independently is hospitalized and moves back with his/her parents to recuperate on May 18, giving up his/her former apartment. For the month of May, the 20-year-old can apply on his/her own because he/she was not living with the parents for part of the month. Beginning June 1, eligibility would be established in the parents' MFBU.

Adverse Actions

10. Question: Why is the addition of a voluntarily excluded child to the MFBU treated differently from the addition of a family member with income who has returned to the home; that is, the income of the formerly excluded child is considered in the SOC computation beginning with the month in which the child is placed in the MFBU, whereas the income of a person returning to the home is considered beginning with the first of the month following issuance of a ten-day notice if there will be an increased SOC even though the person is added to the MFBU immediately?

Answer: The reason for the difference stems from the current definition of adverse action. An increase in the SOC due to the inclusion of a voluntarily excluded person is defined as not being an adverse action. We are in the process of amending the definition of adverse action so that an increase in the SOC due to the addition of any family member to the MFBU is not an adverse action. Until this nonemergency regulation revision is filed, however, a ten-day notice must be given before increasing the SOC of the MFBU when a family member returns to the home.

11. Question: How do you determine whether a change in the SOC is an adverse action when you are combining two MFBUs into one?

Example: Mr. ABD-MN is in LTC with a monthly SOC of \$474 and his MI spouse at home has a zero quarterly SOC. Mr. returns to the home and the couple will have a \$198 quarterly SOC. Is this an adverse action for the MI spouse?

Answer: If the new SOC amount is equal to or less than the two SOCs combined, then the action is not adverse and a ten-day notice is not required. Thus, in the example above, the \$198 SOC is not an adverse action.

Implementation

12. Question: When quarterly SOC is implemented, how far back in time is it applicable?

Answer: The regulations became effective November 30, 1981; therefore, the multi-month SOC concept should be applied to December 1981 and forward months for which eligibility is being determined at time of implementation.

B. Procedural Questions

1. Question: When something like the aid code changes during the quarter, where is it shown on the MC 176 and MC 177?

Answer: There is space on the back of the MC 176 to notate changes occurring during the quarter. A note clearly explaining the change and the effective date should be attached to the MC 177 before submission to BRU.

2. Question: Do you list just the beginning month of eligibility for the SOC period at the top of the MC 176 or all of the months for the SOC period?

Answer: All months of the SOC period should be listed. This was inadvertently not done on the MC 176 examples distributed during training.

3. Question: Will BRU mail the BRU generated cards to the paper counties the way GID does?

Answer: No. BRU will mail the cards to the beneficiaries. Paper counties should follow the code-a-phone procedures for reporting changes to BRU.

4. Question: Will the MC 210 income section be revised to show three months of income information?

Answer: Yes; however, until the revision occurs, the county may choose to substitute the three-month quarterly status report form when obtaining income information at time of application.

5. Question: May the county still choose to send out Medi-Cal status reports on a monthly basis?

Answer: Yes.

6. Question: Can the county send changes to BRU in writing rather than use the code-a-phone procedures if changes are known in advance of card issuance by BRU?

Answer: No. All changes must be reported to BRU via the code-a-phone.

Beginning date soc period

I.MO. OF ADD APP /EUG APRIL MAY JUNE , JULY AUG. SEPT

Who of elig.

EUG.

APRIL MAY JUNE JULL, AUG. SEPT. OCT.

3 restorations

DISC. Q. .

APP

APRIL! MAY JUNE JULY ACG. SEPT.

JUNE JULY AUG. SEP

I. ON PA.

PAPELL MAY JUNG JULY

RETED SOL

2.001 MIC LE DISC Q. APRIL! MAY JUNE JULY RESTRO SOC

PRIOR SOC PRIOR PRIOR

PRIOR SOC RETROSOC

MUST MEET PRIOR

NO COVERACE

DISC APP.

d. APRIL MAY JUNE JULY AUG

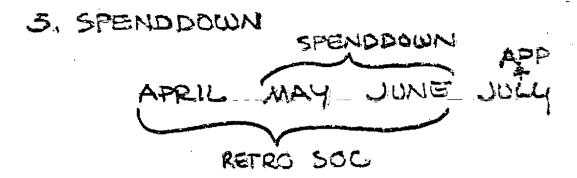
2. MI /ABD

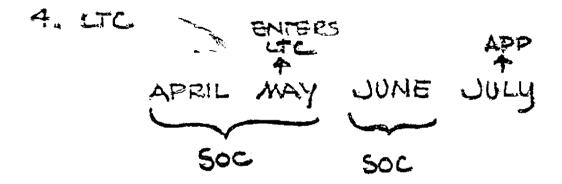
ENGUOS CEA .

WHY DUNE GUIDS ONLY ASYMI APRIL

RENTSED SOC

28C Idas and huc





DOENI 2324 ESTAGO

005 \$ वर वर्ग २०६ ELPICESN つではな हार्रेडा हार्च NET INC.

2. CHANGE NOT RPT.

119 ゆうにりゅんにゅ ゆうてくさい 9N0C コーではて

008 & GT ७२१३ ७०५ ,×3

Attehnent II-5

	я igiiku revised	AND FOR	rich
	<u>Sep</u>		

1. Applies April 15; granted April 20.

Гeb

Jan_

Mar

$$\langle \frac{A/G}{-} - - \rangle \langle - - - \rangle$$

Jul

<u>Jun</u>

2. Applies April 15, requests retro for Feb. & Mar.; granted April 20.

Apr

$$\langle - \frac{R}{R} \frac{R}{A/G} - - \rangle$$

3. Applies April 15; over property for April, but within property as of May 1; granted May 2.

<u>May</u>

$$\frac{A}{\langle G} - - \rangle \langle - - - \rangle$$

4. Applies April 15; requests retro for Mar.; over property for April, but within property for Mar. 8 May; granted May 2.

$$\langle - - \overline{R} \rangle \stackrel{A}{\longrightarrow} \langle \overline{G} - - \rangle \langle - - - \rangle$$

5. Applies April 15; granted April 20; goes LTC on Aug 13.

$$\langle \frac{A/G}{-} - \rangle \langle - \rangle \langle \frac{LTC}{-} \rangle \langle \frac{LTC}{-} \rangle \langle \frac{LTC}{-} \rangle \langle \frac{LTC}{-} \rangle$$

6. Applies April 15; requests retro for Feb. & Mar.; AFDC eligible for Jan.; granted April 20.

7. Applies April 15; granted April 20; goes LTC on May 14; comes out of LTC on Sep. 2.

$$\left\langle \left\langle \frac{A/G}{G} \right\rangle \left\langle \frac{LTC}{C} \right\rangle$$

JVN

R

ሳନዊ.

APR

IM DF 1

eT takk

This

Alte

€ 4

0 ~~

k k m i #

عد مربيعة

Dec_

<u>Jan</u>	Feb	Mar	$\underline{\mathtt{Apr}}$	May	<u>Jun</u>	Jul	Aug	Sep	Oct	Nov	Dec

Applies April 15; requests retro for Jan., Teb. & Mar.; went into LTC on Feb. 14; granted April 20.

$$\left\langle \frac{R}{R} \right\rangle \left\langle \frac{R}{R} \right\rangle \left\langle \frac{A/G}{A} \right\rangle \left\langle \frac{LTC}{C} \right\rangle$$

for Jan., Feb., | Mar. Soc quarter

9. Requests discontinuance on January 10 (effective February 1); reapplies March 10; granted March 17.

Jan, Feb, & Mar, Soc quarter

Requests discontinuance on Jan. 10 (effective Feb. 1); reapplies May 14; requests ratro for Mar. & Apr.; granted May 21. |

$$\langle\langle - | - | \frac{R}{\rangle} \rangle \langle \frac{R}{\rangle} \langle \frac{A/G}{\rangle} \rangle$$

for Jan., Feb. & mar. Soc quarter

Requests discontinuance on Jan. 10, (effective Feb. 1); reapplies June 21; requests metro for Mar., Apr. & May; granted June 28.

$$\left\langle \left\langle -\frac{1}{1} \frac{X}{X} \frac{R}{R} \right\rangle \left\langle \frac{R}{R} \frac{R}{R} \right\rangle \left\langle \frac{M_G}{R} \frac{R}{R} \frac{R}{R}$$

ABD couple applies Jan 20; granted Feb. 7 for Jan.; one enters LTC on Feb. 10.

13. MI + ABD couple applies Jan. 20; granted Feb. 7 for Jan.; ABD enters LTC on Feb. 10.

NAT LE8 may ΰu. OCT) S.C.

HARE OF COST	DETERMIN	VATION -	MFBUs WH	סא כם אטו	TINCLUDE	LTC PERS	ons H	Hachn	ient I	<u> </u>	44
lase Name		EXAn					Ĭ	County	District	County Use	7
☐ New Application	on 🗆 Red	eterminatio	n 🗆 Char	nge 🗆 Reti	roactive Eliq	3. 🗆 Corr	ection	Mo. As	r-May-	Junyr. &	₹- 3 .
State !	Number .					3irtt	date	Sex	1) Social Seco	urity No. and	-
Ca. Aid 7 Digit S	erial No. MF	Pars. BU No.	Name -	- First, Middle	, Last	Ma, D	ay Yr.	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	or Railroad Re	ance Claim No itirement No.	Coverage
7 850123	456 0	OI L	arry	Larre	nce	91	4 38		.5.12-3		У
9 85 0123	ı	od m	lary	Larrer	nce	62	ু স্থ	+	312-98		У
9830123	456 0	10 5	Tanet.	Larrer	100	<u>5</u> 1.	4 69	F (2)		45678	· Y1
1 Exclud	ed!	<u> </u> <u></u> <u></u> <u></u> <u></u> <u></u>	ohn b	rarreno	٠٤	7 7	1 63	m (2)		8-7654	· Y
						.]		(2)		• • • • • • • • •	<u> </u>
			· · · · · · · · · · · · · · · · · · ·		·_ /			(2)		• • • • • • • •	<u> </u>
			- N	- 			·	(2)	•••••		•
Income of MFBU (except PA or oth		ilying as ABC	plus income (of spouse or pa	t4U\$		il, inco	me of MFB apr PA or o	IU members oc	et listed in I.	
A NONEXEMPT U		COME		•					UNEARNED I	NCOME	
	Man	th 1	Mon	ith 2	Mon	th 3			Month	1 Month 2	Month 3
	ASD-MN	Spouse or Parent	ABO-MN	Spouse of Parent	ABD-MN	Spouse or Parent	1. So	cial Securit	Υ	- 	-
1.Social Security 2.Net Income	<u> </u>					<u> </u>		t Income			
from Property		1						ner-Itemiz			1
3. Other-Itemize		<u> </u>									
4.							4.				
5. Total (3dd 1 thru 41											<u> </u>
6. Deductions		1						stal unearna	rd		
7. Remainder (5 minus 6)	a.	D.	a.	D.	4.	D.	{a	dd 1 mru 4 ductions	1	i i	!
8, Combined un-		* * *	-								
(add 7s and 7b)						August Transport	,	ned incom	Į.		
9. Any Income deduction	-s20		-\$20	30 A. 200	-\$20		l	minus 6)	* -0	- +	->
10.Countable un- earned income (8 minus 9)					·	-	EL NO	ONEXEMP	T EARNED IN	COME	
B. NONEXEMPT E	ARNED INCO	ME		-					Month	1 Month Z	Month 3
	Mon	nth 1	Mor	nth 2 b.	Mon	i di 3		come_	1900	<u> </u>	>
	ABO-MN	Spouse or Parent	ABD-MN	Spouse or Parent	ABD-MN	Spouse or Parent	,	CG in last 4 os, enter SI			
11.Gross Earned Income							96. 1/	3 remainde	٠ :		(4
12. Deductions 13. Remainder) } 3.	b.,	a.	a.	- B	j 0.	10. M	andah	°7 200		M
(11 minus 12) 14.Combined	-	100000000000000000000000000000000000000	<u> </u>		1	10 feet 20 jobs	11. 6	iorle.			
earned Income (add 13a & 13b)						*	٧	<u>clated</u>	75		
15.565 earned Inc.		(; N				Superior Control	ė,	ජය 9, 10, &		5	<u> </u>
deduction plus \$ unused \$20						*****		ountable ead come	med 62	5	 ->
15. Remainder (14 minus 15)	Ī					2000	C. TO	OTAL COU	NTABLE INC	OME	
17:Countable earned Income									.Month	1 Month 2	Mc 1
(divide 16 by 2)	A DI E IVAS					200	وا	ibtotal dd 7 and 13		5	+->
C. TOTAL COUNT.		ith 1	Mar	nth 2	Mor	ith 3		mony	₩ <u>}</u>	}	}
18. Total countable Income							l n	otal countai	120	5	
(add 10 and 17)] (1	4 minus 15	<u>، اره ۷</u>		1

AND THE RESERVE OF THE PARTY OF		· OHELMINA	1 111-12	Care Mamé:	
	Month 1	Month 2	Month 3		
Countable Income from 1 18					
2. Countable Income from II 16	625		>		.•
3.inc. allocated from LTC/3&C person to family members at home (176W, Part IV)	-			- • .	****
4. Combined countable Income (add 1, 2, and 3)	625			•	
ALLOCATIONS AND DEDUCTION	ıs				
5. Allocation to excluded children (176W, Part I)	→		1900		
6. Special deduction (176W, Part II)	-0-	gen at the			
7, Income to determine PA Eligibility	-0-	2			
8. Health Insurance	12.50			•	-
9.					
10.				,	
11. Total allocations/deductions (add 5 through 10)	12.50		>		
12. Total net nonexampt Income (4 minus 11)	612.50		>	SHARE OF COST	
13. Total net nonexempt Income rounded	613	613	613	13a. Total of Mos 1, 2, and 3	1839
14. Maintenance need	583	<i>583</i>	583	14a, Total of Mos. 1, 2, and 3	1749
				15. Share of cost (13a, minus 14a,)	90
		•		16, Underpayment adjustment	
				17. Adjusted Share of Cost (15 minus 16)	
IV. EXEMPT INCOME					

v	=>=	4 3J A	TION	~=	~11.4		WITHI			
Υ.	2.WL	$-\infty$	HUN	U۲	CHA	NGES	WILMI	N 201	CPER	100

Eligibility Worker Signature

Worker Numbe

Computation Date

County Use

	E,	Χ'n	m	PL	F	_	1_	_		H	ucr	MEN	ل <i>ل</i> ٦	L	د	
State of Californis—Health and Welfare Agency Medi-Cal Program		,		, ,		•		_						Dep	DIST	COUNTY
RECORD OF HEALTH CARE COSTS - SHARE OF COS	π															Sanoma
READ INSTRUCTIONS ON BACK BEFORE COMPLETI	NG								ai exp			ow.	l	Share of		Page
				1		Manti	A	. N	Aonts	9	Mon	th C			that you bilgate is	
					,		Ο.			-		-		<u> </u>	<u> </u>	
					AN MO	<u>Pr</u>		$-\frac{m}{Mo.}$	lay.	<u> </u>		<u> 82</u>	s	<u>40</u>		NO (Yes/
										<u> </u>						
							-									
Name .				,		,										
Address .																
City/State/Zip																
County							-									
49								•								
Medical expenses of family members listed below may be	used to	meet S	hare (of Cas												
State Number Nam	e Las	t, Firs	t			igible In BIC	ļ	Birtho			Otner Cav.	Socia	l Securi	ty Na.	н	C or RR No.
85 0123 456 0 01 Larrence	La	rty			र्रो	XIX	q	14	<u>, yr</u> 38	M	Y	512	34.5	5678	<u> </u>	
85 0123456 0 02 Larrence	<u>, m</u>	مم			$\langle \cdot \rangle$	XX	७।	20		_	γ	512		7654		
83 0123456 0 10 Larrence Excluded Larrence	·	oh	<u> </u>		\times	<u>~ ~</u>	5	7	<u> 63</u>		y	527	<u>34</u>	<i>5</i> 678 7654		
	') 									T						
		~ 								+	ļ —				<u> </u>	***************************************
Occlaration of Provider: Each service listed below has payment or will seek payment from the datient for it that amount. I also understand and agree that I may This is the amount shown in the "Billed Medi-Car" cold I understand that If I bill insurance or any other third barry. I am aware that financial information on this form may	seek pa mn, and party	int sno lyment is the for the	wn in t from t diffe t servi	the frence ice ren	detr petv detr	ed Pat l-Cal p veen t ad, 1 d	ilent" Pogra he "T Janno	colui m foi otai i t list	mn and rithe o Bill!" as on thi	that osts o no am s form	I will f my s ount ' s the a	not acce ervice in Billed P mount o	et paya excess atient", of the ch	nent from of the ad narge pai	m the Me mount bil id by the	di-Cal position in led to the position the p
PROVIDER NAME Provider No.	Date	of Ser	vice		3 1 10					F	roc. C	ode/	Total 8	iii B	lited tient	Billed Meoi-
PATIENT NAME	Mo.	Uay	1 6.	-							Presc.	10.	5	s		\$
PATIENT NAME												-				
PROVIDER SIGNATURE (See Declaration Above)		! ! !								1		Į				
PROVIDER NAME Provider No.	Ţ									1	·					
PATIENT NAME										1						······································
PROVIDER SIGNATURE (See Declaration Above)		()											•		-	
PROVIDER NAME Provider No.				-						+				- 		
PATIENT NAME				<u> </u>												
FAIRENT NAME											•			-		
PROVIDER SIGNATURE (See Declaration Above)																
PROVIDER NAME Provider No.	1			 						+						
PATIENT NAME	1		} 												-	
PROVIDER SIGNATURE (See Deciaration Above)			 -	-						-			 –			
TATELYSE COUNTY	<u> </u>) hav		the in	157711	ction	on t	ne sa	ck of	nis to	m. I	agree to	assume.	full leca	i respons	ibility for th
MO. Day Yr. Reviewed By: Trans. R	epiace	-ām ot	ints in	\$16 d- 85	OVE	in th	BII	led P	atlent'	colu	mn.					
Date of		X				. 6			, <u></u>	10.75	÷					
Cartification					<u> </u>	IGNA	TUR	E OF	APPL	CAN	[-	DATE	-60 1_3634 T

	J				•••	و پیاد است						Alleate	na dian	+	· <u>·</u> ····•	
	RE (LE WHI	CH DO NOT	INCLUDE	LTC PERS	ONS	The same of	y Oterric		ounty Use	
	Vew	Apolicatio						ge 🖸 Retr	nactive Elic	2 Corr				_	of this Budge	-
			Number				- C- C-131	de muiten	OBCTIAG CIT		date	Mo.			<u> </u>	<u> </u>
			 · · · · · · · · · · · · · · · · ·	l	Pers		Name	- First, Middle,	l set	Mo, D			(2) Heal	ciel Security th Insurance	Claim Na.	Other
Ca.	<u>: Ald</u> 	7 Digit Se	enal No.	W-R	U No.	! 				1	-	1	or Rail	Iroad Retire	ment Na.	Coverso
	-			<u> </u>	+	<u> </u>							(Z) (I)			
				<u> </u>								<u> </u>	(2)		• • • • • •	
								····				1 1	(1)		• • • • • • •	
9	83	0123	456	0	11)	2	ohn 1	arrenc	<u>e</u>	77	63	s m	(1) . 5.7 (2)	श.नहः.	162. 4. .	ļУ
													(1) (2)			
						1							(2)			
					Ī							1	(1)		• • • • • •	
				appi	ying as	ASD ;	pius income o	f spouse or pa	rint			ncome of M	FSU med	mbers nat lä	ated in I.	<u> </u>
_		t PA or oth XEMPT UI		D INC	OME				~ ~~~~~~~			EXCHOLPA C		A)	24.45	
				Mont			Mon	th Z	Mon	dı 3		CHEXEM	ONEA		· · · · · · · · · · · · · · · · · · ·	36
			A .		b. Spous	or	4.	b. Spouse or	L	Spouse or	-	Social Secu		Month 1	Month 2	Month:
1.3	Social	Security	ABO-M	IN	Pare	nt	ABD-MN	Parent	ABD-MN	Parent						
	Vet In	came				1					2,	Net Incom from proof	rty			
						<u>-</u>				 	3.	Other-Ite:	nize			
3.	Other-	-Itemize	<u> </u>	\dashv	-,							•	<u>'</u>			·
4.	Tatal] 			4.					
		thry 4)	<u> </u>									, , , , , , , , , , , , , , , , , , , 	ļ			· ·
	Remai		a.		ò.		a. ,	5.	£,	1 5.	5.	Total unea (neome	_			
	(5 mir		-		· · · · · · · · · · · · · · · · · · ·		4.]	4,		6.	ladd 1 thro Deduction				
_	•	ined un- Lincome			(1) (2) (3)	(1000) (1000)	•									
-		a and 7b)	1		423	Carrier 1		* * * * * * * * * * * * * * * * * * * *		Egydd draedd	7.	Countable earned inco		-		-
	deduc	tion	-520				-250		- \$ 20			(5 minus 6				
	earnec	able un-			92 23						B.	NONEXE	MPT EAF	NED INCO	ME	
	(8 mir	XEMPT E	ABNED	NCO) u E	- 1				- 30 M W 30				Month 1	Month 2	Month
-		XCIBE I E	ARITED !	Mont		·	Mor	ith 2	Mor	 1ជា 3	8.	Gross earn	ed		1100	
			E,		b. Spou:		ē.	b. Spouse or	I.	b. Spouse or	9a.	Income If CG in la			100000	51
11	Con	Earned	ABO-A	IN !	Pare		ABO-MN	Parent	ABO-MN	Parent	95.	mas, enter			*200	
_	Incor	ė						-		*				77		# 15 m
	Deduc		1.		ò.		à.	b.	a.,	<u> </u> a.	10.	mande	lon	1977 1977 1972 1972	250	5
-	(11 m Comb	inus 12) ined	1	<u> l</u>	<u></u>	+98.as					11.	سماد ۵	2-0.4	V		1000
	esme	income			1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1						 			<u> </u>	106	
		erned Inc.	<u> </u>			are reel	<u> </u>	100 T 1400		******	12	Total dedu (add 9, 10		1	356	
	deduc S	tion plus unused								* 74	13.	Countable	eamed			
	\$20 Rema	indet	[-	1	Income		<u> </u>	744	<u> </u>
	(14 m	inus 15)	<u>[</u>		Ş					And the second s	1 -	TOTAL C	OUNTAE	BLE INCOM	<u></u>	<u> </u>
		income										C., 5		Month 1	Month 2	Mc
	<u>. </u>	• 16 by 2)	ARIFIN	COM		·			ł	1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1	<u> </u>	Subtotal ladd 7 and			744	
_				Mant			Mo	nth 2	Mo	nth 3	15,	Child supp alimony	αrt/			
	Total Incom	countable									16.	Total cou-	120(4		744	
		0 and 171									1	(14 minus	15)		744	

		12 HELLINGTH CALL	114 50	Case Name:	
	, Month 1	Month 2	Month 3		
1. Countable Income from 1 18					
2 Countable Income from II 16		744	>		_
3, Inc. allocated from LTC/B&C person to family members at home 1176W, Part (V)			-	-	بالما
4. Combined countable Income (add 1, 2, and 3)		744	>		
ALLOCATIONS AND DEDUCTION	i\$				
5. Allocation to excluded children (176W, Part I)					
6. Special deduction (176W, Part II)					
7.1ncome to determine PA Eligibility			5.0.7		
3. Health Insurance		12,50			-
9,	20 Table 2	12.5 0			
10,		222		·	
11. Total allocations/deductions (add 5 through 10)		12.50	>		•
12. Total net nonexempt Income (4 minus 11)		731.50		SHARE OF COST	
13. Total net nonexempt income rounded	613	732	732	13a. Total of Mos 1, 2, and 3	2077
14, Maintenance need	583	692	692	14s. Total of Mos. 1, 2, and 3	196
				15.Share of cost (134. minus 14a.)	110
				16, Underpayment adjustment	
,				17. Adjusted Share of Cost (15 minus 16)	

IV. EXEMPT INCOME

V. EXPLANATION OF CHANGES WITHIN SOC PERIOD

5/12/82 mother reguested that son John be included in the MFBU for May and angoing. John was previously excluded

Eligibility Worker Signature	Worker Number	Computation Date	Caunty Use
ا مير			
Signal Control of the		1	

State of California—Health	and Welfare Agency
Medi-Cal Program	

EXAMPLE

Month A

_	
Departmen	t of Health Sen
CO DIST	COUNTY U

HTTEREMENTERS ILL

Departmen	t of Health Sty
CO DIST	COUNTY U

CORD OF HEALTH	ぐんロピ ぐつぐてぐ	一 マレックに へん たつぐて

READ INSTRUCTIONS ON BACK BEFORE COMPLETING

Only Medical expenses in the following months may be listed below. Month B

Month C

The amount that you must pay or obligate is:

Re.

May 82 Jun 82

2000

Name

Address

City/State/Zip

County Code 49

Medical expenses of family members listed below may be used to meet Share of Cost Eligible State Number Birthdate Sex Cov. Name — Last, First 음ci Social Security No. HIC or RR No. Aid 7 Digit Serial No. FBU Pers. Mo. Day Yr. 38 m Y 512 34 5678 01 Larrence 85 0123456 0 Larry Y 512 98 7654 02 39 F 85 0123456 0 10 69 F Y 522 34 5678 83/0123456 0 63 m 521 98 7654 <u>83 0123456 0</u> John

Declaration of Provider: Each service listed below has been provided to the person listed on the date specified. I, the undersigned provider, hereby declare the apparent or will seek payment from the patient for the amount shown in the "Billed Patient" column and that I will not accept payment from the Medi-Cal progratinate amount. I also understand and agree that I may seek payment from the Medi-Cal program for the costs of my service in excess of the amount billed to the paths the amount shown in the "Billed Medi-Cal" column, and is the difference petween the "Total Billi" and amount "Billed Patient".

I understand that If I bill insurance or any other third party for the service rendered, I cannot list on this form the amount of the charge paid by the insurance or third party.

I am aware that financial information on this form may be subject to scrutliny by the internal Revenue Service and/or State Franchise Tax Board.

PROVIDER NAME	Provider No.		of Service Day Yr.	SERVICE	Proc. Code/ Presc. No.	Total Bill	Billed Patient S	Billed Med
PATIENT NAME								
PROVIDER SIGNATURE (S	e Declaration Above)							
PROVIDER NAME	Provider No.		[·			
PATIENT NAME							<u>-</u>	
PROVIDER SIGNATURE (S	es Declaration Above)							
PROVIDER NAME	Provider No.							
PATIENT NAME								
PROVIDER SIGNATURE (S	ee Declaration Above))					
PROVIDER NAME	Provider Na.							
PATIENT NAME								
PROVIDER SIGNATURE (S	en Declaration Above)							
STATE USE	ONLY		I have rea	the instructions on the	back of this form. I agree	to assume full	legal respo	nsibility for t
Mo. Day Yr. Reviewed B		apiaca	-amounts	Isted above in the "Billed	Patient" column.			
Date of	[[· ~	SIGNATURE			ĎÁ.	

بجمعي		*******		1144		r 1 1 1 2								******	M(40 M(1) P)
SHAR	EC	F COST					IFBUs WHI	CH DO NOT	INCLUDE	LTC PERS	ONS	Attachmen			ع. ر
Casa N	4me		2	X١	AY	1P	LE	3				County Distric	:t	County Use	1 1
	· · ·											Effective Eligi	bility Date	for this Budge	
<u> </u>	•w /			Rede	termir	nation	M. Chan	ge 🗌 Retr	oactive Elig	L Corre	ection	Mo. Ju	NE	Yr. 8	<u>2</u>
 -		State A	lumber I		Pers.					Birch	idat e		ocial Securit	y No. and te Claim No.	Other
<u></u>	Aid	7 Digit Se	rial No.	MEB	U No.		Name -	- First, Middle	, Last	Mo. D	ay Yr.		iroad Retin		Coveraç
					1			· · · · · · · · · · · · · · · · · · ·				(2)			<u> </u>
												(1)			
												(1)			
9 8	32	0123	456	0	11	-	John	Larren		7 7	63		યા.98	65.4	V
1	ررر	0100	(30	Ŭ			- O N V	HUITER			<u> </u>	(1)			
					+-					_		(2)			
					+		· · · · · · · · · · · · · · · · · · ·					(2)			<u> </u>
		4 MCBII				480		of spouse or pa		1		ome of MFSU me			•
(R2	K CAP	t PA or oth	er PAl			A80 (pics income i	or aboutar or br				end of MrsQ me exot PA or other i		erred in t.	
A. NO	BMC	XEMPT UN		D INC			Mon	th 2	Mon	ф3	A. NO	NEXEMPT UNEA	ARNED INC	SME	
		İ			Ь.			Ь.		b.			Month 1	Month Z	Month 3
			ABD-M	N	Spous enec		ABD-MN	Spouse or Parent	ABD-MN	Spouse or Parent	1. \$0	ocial Security	_		
		Security										et Income	}		
		roperty								<u> </u>		om property ther-Itemize	<u> </u>		
3,C	ther-	-Itemize													
4.				1							4.			1	
\$. To (a)		rhau 4))	-									•		ļ !
		tions									5. T	otal uneamed		l	
		nder us 6)	a,		ō.		a.	۵.	ā.	5.	(a	icome idd 1 thru 4)		,	
8. Cc	om bi	ned un-		-			-			- American	9.0	eductions	ļ]
		income a end 75)			120.					The second of th	7. C	ountable un-	<u> </u>		<u> </u>
	מע לי מעני	ncome tion	-\$20		1,4.49		-\$20		-\$20		}	smed income 5 minus 6)			
10.Cc	unt	abie un-		·	18. 18.					The contract				1	<u> </u>
		i income ius 9)			: \$2						B. N	ONEXEMPT EA	HAED INC	JME	ī .
B. N	ONE	XEMPT EA	RNEDI	NCO	MÉ				,		1		Month 1	Month Z	Month :
-				Mont	.ft 1	,	Mor	ith 2	Mor	tth 3	10	ross earned roome			1100
			2 A80-M	ın	Spous		ABO-MN	Spouss or Parent	ABD-MN	Spouse or Parent		CG in last 4 los, enter \$30			
	carr	Samed									9b. 1	/3 remainder	- 100 m		
12.0											10	, <u>,</u>		4 1	
13.A		nder inus 12)	3.		Þ.		1.	b.	ă.	۵.	M	audatory	Signal Si		250
14. Ca	_	ined Lincome			ان ان						^{11.} ω	ork Rel	W.120		ſΘ
(a	<u>od 1</u>	3 & 135)			13						12 T	otal deduct.			25
		imed Inc., tion plus			4	7.					} -	odd 9, 10, & 11) Sountable earned		1	35
\$ \$:	20	unused						- 1 3		\$1.77 <u>2.</u>	9 .	ncome			74
16.9		incer inus 15)			3				1	200 au	C. 1	DTAL COUNTA	BLE INCO	4E	
17, Ç	C4.72	able						**************************************			7		.Month 1	Month 2	Мо
		1 income 16 by 2)					1	7.00 apr	<u> </u>		g 14. S	uptotal add 7 and 131	1		1742
C. To	OTA	L COUNT							· · ·		15. 0	hild support/	-		1 1
18.7	otal	countable	<u> </u>	Moa	th 1		Mo:	nth 2	I Mo	n th 3	 	fimony otal countable	1 -		1
in	icor:								}		4	ncome 14 minus 15)			744
HARLE TOPIC		(9/\$1)			من مبر. حاك								· · · · · · · · · · · · · · · · · · ·	<u>-</u>	

	•	Hamman L	14-	Case Name:	
	Month 1	Month 2	Month 3		
1. Countable Income from £ 18					
2.Countable income from II 16			744		
3, Inc., allocated from LTC/S&C person to family members at home (176W, Part IV)				-	•
4. Combined countable Income (add 1, 2, and 3)			744		
ALLOCATIONS AND DEDUCTIONS	1				
5. Allocation to excluded children (176W, Part I)			(1		
6. Special deduction (176W, Part II)		i i i			
7. Income to determine PA Eligibility	lievier.				
& Health Insurance		- autorities	12.50	•	•
9.	omitwo 2000	in the second			
10.					
11. Total allocations/deductions (add 5 through 10)			12.50		
12. Total net nonexempt Income (4 minus 11)	·	•	731.50	SHARE OF COST	· · · · · · · · · · · · · · · · · · ·
13. Total net nonexempt Income rounded	613	613	732	13a. Total of Mos 1, 2, and 3	1958
14, Main tenance need	583	583	692	14a. Total of Mos. 1, 2, and 3	1858
				15. Share of cost (13a, minus 14a.)	100
				16. Underpayment adjustment	
				17. Adjusted Share of Cost (15 minus 16)	· · · · · · · · · · · · · · · · · · ·

V. EXPLANATION OF CHANGES WITHIN SOC PERIOD

6/14/82 mother phoned and requested medi-Cal for John effective 6/1/82. John was previously excluded due to income.

Eligibility Worker Signature | Worker Number | Computation Date | County Use

Attachment 111-4.

State of California-Health and Welfare Agency Medi-Cal Program

EXAMPLE

Department of Health St.

COUNTY U Sonoma

RECORD	OF HEAL	тн саяб	COSTS -	SHARE	OF COST
					

READ INSTRUCTIONS ON BACK SEFORE COMPLETING

Page Only Medical expenses in the Share of Cost following months may be listed below. The amount that you must pay or obligate is: Retru 2 Month C Month A <u>90</u> (Yes/N

Name Address		
County Code		<u> </u>

			Casta	Other		Ł	h date	80	pie	ligit≨ Int	=	- Last Steer		bi a mara		7	umoe	te N	5ta	
is. HIC or RR No	Social Security No.			Code		ABC Mo. Day Yr.		ÍΑ	Name — Last, First		rvame.	Pers.	FBU	No.	<u>serla</u>	Digit S	Ale			
181	456781	34.	51Z	Y	m	88	4 3	9				Larry		Larrence,	01	0	56	4	いてる	35
	8 7654				F	39	८०	6				mary	· -	Larrence	02	0	56	43	123	35
78	34 5678	-34	522	Y	F	ا و	4	5				Janet		Larrence.	10	0	56	340	223	33
54	18 7654	198	521	Υ	m	3	7 (7	X		i			Larrence,	((0)/Z.3	
						}			1		- 1									
	j]]				Π					i					
_		· · · · · · · · ·																		

Declaration of Provider: Each service listed below has been provided to the person listed on the date specified. I, the undersigned provider, nereby declare that i. et payment or will seek bayment from the patient for the amount shown in the "Billed Patient" column and that I will not accept payment from the Medi-Cai program that amount. I also understand and agree that I may seek payment from the Medi-Cai program for the costs of my service in excess of the amount billed to the paths is the amount shown in the "Billed Medi-Cai" column, and is the difference between the "Total Bill" and amount "Billed Patient".

I understand that If I bill insurance or any other third party for the service rendered, I cannot list on this form the amount of the charge paid by the insurance or third party.

tiam aware that financial information on this form may be subject to scrutiny by the Internal Revenue Service and/or State Franchise Tax Board.

PROVIDER NAME	Provider No.		of Se Day		SERVICE	Proc. Code/ Presc. No.	Total Bill	Billed Patient \$	Billed Me
PATIENT NAME			1		-				
PROVIDER SIGNATURE (see Declaration Above)		 	! 					
PROVIDER NAME	Provider No.		!	i I					<u> </u>
PATIENT NAME			: }	 					
PROVIDER SIGNATURE (See Declaration Above)		! } 	<u>L. </u>				L	
PROVIDER NAME	Provider No.	<u> </u>	 	1					
PATIENT NAME			ļ——- ļ	 					
PROVIDER SIGNATURE (See Declaration Above)		! !	! !					
PROVIDER NAME	Provider No.		 	<u>; </u>					
PATIENT NAME			 						
PROVIDER SIGNATURE (see Declaration Above)			1					
STATE US	E ONLY		inav	re read	the instructions on the b	ack of this form. I agree	o assume ful	l legal respo	nsibility for
Mo. Day Yr. Reviewed 8	y: Trans_ R	eptace	-100	unts iis •	ted apove in the "Billed	Patient" column.			
ate of	1 1				SIGNATUREO			ÖΑ	

SHARE OF COST	DETERMI	MOITAN	 4 — M	FBUs WHI	тои са нэ	INCLUDE	LTC PERS	ONS	Attachme	nt III	· (b	4
Case Name	£χ				4				County Distric	2 0	ounty Use	-
· · · · · · · · · · · · · · · · · · ·						 			Effective Eligi	bility Date fo	r this Budge	18
☐ New Applicatio	n 🗆 Rec	letermin	ation	₩ Chan	ge 🖾 Retr	oactive Elig	. D Corre	ection	Ma. Apr - N			
State A	lumber	10					Birth	idate		ocial Security		
Co. Aid 7 Digit Se	erial No. MF	BU No.		Name -	First, Middle	, Last	Mo. D	ay Yr.	or Ra	Iroad Retire		Coverag
	-			<u></u>					(1)	• • • • • • •		·
									(1)			
	İ								(1)			
15 02 515 71	100			- 1	~~ ~~				(1) 52	1:98:7	65H	1
19 83 012 34	156 0	11		John	harre	<u>ace</u>	177	63	M (2)			<u> </u>
				,					(2)			
			-						(2)			·
	1								(2)	• • • • • • • •		
L. Income of MFBU (except PA or oth		plying as	ABO p	ius income o	of spouse or pa	rent - '.' /			ome of MFSU me seat PA or other i		rted in I.	
A. NONEXEMPT UN		NCOME			: -			A, NO	NEXEMPT UNE	ARNED INC	OME .	
	mor	b.		Mon	ъ. ъ.	Mon	B			Month 1	Month 2	Month 3
	ABD-MN	Spouse		ABO-MN	Spouse or Parent	ABD-MN	Spouse or Parent	t. So	ocial Security			
1.Social Security		ļ							et Income			
2. Net Income from Property									om property ther—(temiza	<u> </u>		••
3, Other—I temize									•		-	
4.												
5. Total								4,		ļ		
6. Deductions	<u>'</u>	1	- 		1			5 T	otal uneamed			
7. Remainder	<u> </u>	b.		a.	b.	ā.	5.	ţc	come cd 1 thru 4)			
(5 minus 6) 8. Combined un-	1	<u> </u> 		_	1		<u> </u> - ⊕ 500000		eductions			
earned income					*			7.0			-	
(add 7a and 7b) 9. Any Income	<u> </u>	996			La mar				med income			
deduction 10.Countable un-	-520	~~~ **		-250	1.00 (-\$20		(5	minus 6)			
earned Income (8 minus 9)		i Ti	- 3					B. N	ONEXEMPT EAR	RNED INCO	ME	
B. NONEXEMPT EA	ARNED INC)ME	**********		700000			}		Month T	Month 2	Month 3
•	Mod	nth 1		Mon	idi 2	Mon			ross tarned	1100		-
	ā.	Spouse		£	Spouse or	<u>k</u>	b. Spoum or	9a_ 1f	CG in last 4 los, enter S30	****	- 38	
11.Grass Earned	ABO-MN	Parer	nt	ABD-MN	Parent	ABO-MN	Parent		/3 remainder	***		
Income 12 Deductions		1					<u> </u>			1 250	+2% 46%	2008 1000 1000
13. Remainder	1.	D.		1.	ъ.	a. ,	ъ.	10. M	andertory	250		() Fair
(11 minus 12) 14.Combined	<u> </u>	- 3			1	1	1	11.,	ork Rel	100		=======================================
earned income (add 13a & 13b)		**						12 T	otal deduct.	1060 1		<u> </u>
15.565 earned Inc.								4	dd 9, 10, & 11)	356		->
deduction plus unused				•				3	ountable earned .	744		->
\$20 16. Remainder		**** ****	26.00				****	1	OTAL COUNTA			
(14 minus 15) 17;Countable	<u> </u>				Same and the same		***************************************	, - '	OTAL COOKTA	T	T	Mar
earned Income (divide 16 by 2)	1						- 15 - 15 - 15 - 15 - 15 - 15 - 15 - 15	14. S	ubtotal	Month 1	Month 2	Mor
C. TOTAL COUNT	ABLE INCO	AE	Sec. Sec. 3		್ಷ ಪ್ರಾಥಕ್ಷಿಗಳು	<u> </u>	80.77	4 (;	add 7 and 13) hild support/	744	}	
	Мо	nth 1		Mor	ith 2	Mon	th 3	a	imony		[
18. Total countable income	}							1.	otal countable	74.4		<u></u>
(add 10 and 17) MC 176M (9/\$1)					<u> </u>			(14 minus 15)	14 1-1	1	(<

	Month 1	Month 2	Month 3		
1. Countable Income from 1 18	γ			,	
2. Countable Income from II 16	744		>		
3.inc. allocated from LTC/B&C person to family members at home (176W, Part IV)				_	
4. Combined countable Income [add 1, 2, and 3]	744		>		
ALLOCATIONS AND DEDUCTION	vs	*.···			
S. Allocation to excluded children (176W, Part I)		233	\$200		
6. Special deduction (176W, Part II)		and the second s			
7. Income to determine PA Eligibility					
8, Health Insurance	12.50			•	-
9,	100 July 100		13 au (17 12 1		
0,	ALCONOMIC CONTROL OF THE PROPERTY OF THE PROPE				
1. Total allocations/deductions (add 5 through 10)	12.50		>		
2. Total net nonexempt Income (4 minus 11)	731.50		>	SHARE OF COST	
3. Total net nonexempt Income rounded	732	732	732	13a. Total of Mos 1, 2, and 3	219
4.Maintenance need	692	692	692	14a. Total of Mos. 1, 2, and 3	20
				,15. Share of cost (13a. minus 14a.)	12
	•			16. Underpayment adjustment	
				17. Adjusted Share of Cost (15 minus 16)	

V. EXPLANATION OF CHANGES WITHIN SOC PERIOD

C/14/82.P/c Mrs. Larrence requested medi-Gol for John and retro eligibility back to march 82. John was previously excluded for a income.

Eligibility Worker Signature	Worker Number	Computation Oate	County Use
ر م			

State	q t	California -He:	alth and	Welfare	Agency
استخد	~~) O			

tate of California—Health and Welfane Agency	WALS A	Department of I	Health Sun
Medi-Cai Program IECORD OF HEALTH CARE COSTS - SHARE OF COST			ONONW
LEAD INSTRUCTIONS ON BACK BEFORE COMPLETING	month 2 months	Share of Gost The amount that you hust day or obligate is:	Page Re.
7	Apr 82 may 82 Jun 82 Mo. Yr. Mo. yr. Mo. Yr.	. 30 <u>e</u>	Yes Ver/r
	, 		

Name Address City/State/Zip

County Code

	State Numb			sted below may be used to meet Share of	Eligible	Birthdate		Other		
Aid	7 Digit Serial No	FBU	Pers.	Name — Last, First	AI B C			Cov.	Social Security No.	HIC or RR No
85	0123456	0	01	Larrence, Larry		9 1438	m	У	512 34 5678	
85	0123456	0	02	Larience, mary		6 2039	IF	Y	5129876541	
83	0123456	Jo	10	Larrence, Jamest		5 14 69	LF	У	522 34 5678	
83	0123456	ه ا	11	Larrence, John	XXX	7763	m	Y	521 987634	
		<u> </u>]							
		<u> </u>			1111	·	!	<u> </u>		
		1					1	1)	

Declaration of Provider: Each service listed below has been provided to the person listed on the date specified. I, the undersigned provider, hereby declare to payment or will seek payment from the patient for the amount shown in the "Billed Patient" column and that I will not accept payment from the Medi-Cal program for the costs of my service in excess of the amount billed to the pithis is the amount shown in the "Billed Medi-Cal" column, and is the difference between the "Total Billi" and amount "Billed Patient".

I understand that if I bill insurance or any other third party for the service rendered, I cannot list on this form the amount of the charge paid by the insurance or third party.

I am aware that financial information on this form may be subject to scrutiny by the internal Revenue Service and/or State Franchise Tax Board.

PROVIDER NAME	Providet Na.		of Se Day		SERVICE	Proc. Cods/ Presc. No.	Total Bill	Billed Patient S	Billed Med
PATIENT NAME	-1·		i I	1	, <u>, , , , , , , , , , , , , , , , , , </u>				
PROVIDER SIGNATURE (56ª Dec	aration Above)		 	<u> </u>					
PROVIDER NAME	Provider No.		, 	 					i
PATIENT NAME			 -	 [
PROVIDER SIGNATURE (See Dec	laration Above)		<u> </u>						
PROVIDER NAME	Provider No.		; 	1					
PATIENT NAME			 	 			 	<u> </u>	
PROVIDER SIGNATURE (See Dec	aration Above)	<u> </u>	1 1 1	1					
PROVIDER NAME	Provider No.		j	 					
PATIENT NAME		<u> </u>	1	 					
PROVIDER SIGNATURE (SAC Dec	laration Above)	-	1	1		-			
STATE USE ONL		<u> </u>	l ha	ve read	the instructions on the back of	t this form. Lagree	to assume fui	i legal respo	nsibility to
Ma. Day Yr. Reviewed By:	Trans. A	apiaca	amo	iunts IIs F	ted above in the "Billed Patien	L. coinwer			
Date of	} }		7		SIGNATURE OF APP	LICANT		AC	ΤE

		and Photograph		•	-000		:	e electricismos de la composición de la composición de la composición de la composición de la composición de l	. ಫ್ರೂಫಿಕಾರಿ ಕಾ. ಮಿ ಇ.ವ ಭಿ ಕ	అయ్యకారాయితోంది. ఇంగర తా	······································	1 Hook and L	· - 77 - 1		مانشستان مانشستان موجی مو
	RE		المجيد المراجع المراجع			_			INCLUDE	LTC PERS	ONS I	Hackment		<i>2.</i>	713
				$\mathbf{\Sigma}_{i}$	XA	m	PLE	4	1.2					Ounty Use	
= i	Vew	Applicati	on 🗆 R	ledet	ermin	ation	Chan	ge Kar	oactive Elig	L 🗆 Corr	ection	Ma. Ma		Yr. 8	- *
		State	Number				<u>-</u> -		 	Bird	ida te		cial Security		، ن <i>ک</i>
		7.50		4551	Pers		Name -	- First, Middle,	Last	1	ay Yr.	(2) Hea	ith Insurance	e Claim No.	Othe
<u> </u>	Aio	Orgit S	erial No. A	MER	No.							(1)	iroad Retire	ment Na.	Covers
		<u> </u>	-		-+			·		1	·	(2)	<u> </u>		
	<u> </u>	<u> </u>										(2)			<u>}</u>
_		 			1	_		1	<u> </u>			(2)	zi - 98	<u>- तरहा</u>	
9	183	0123	उनटह	0	111	<u> </u>	ohn_	Larre	ace_	77	<u>63</u>	1(2)	~17.78		LY.
	1	1								· .		(2)	* * * * * * * * *		
_									•		·	(2)	· · · · · · · ·		
	1	1.								1 .		(2)	• • • • • • •		
		of MFBL		z ΦÞłγ	ing es.	A80 ;	olus income i	of spouse or pa	rent		II. inc	ome of MFSU me	mbers not la	rred in I.	
Ä., (HONE	XEMPT L	NEARNED		·			•		:		MEXEMPT UNE		OME	
			- M	lonth	1 2-	-	Mon	th 2	Mon	1 5			Month 1	Month 2	Month
			ABD-MA	1 -	Paren	,	ABD-MN	Spouse or Parent	ABD-MN	Spouse or	1. 5	ocial Security	<u> </u>		
		Security		1							2. *	let income	[•	· · · · · · · · · · · · · · · · · · ·
		ncome Property										rom property Stitet—Itemize	<u> </u>		
3.	Öther	Itemize		1											
4.							-				4.				
5.	Total		İ								•			,	
		thou 41 ctions		1							5. 7	otal uneamed	<u> </u>		-
	nema Aema		2.		٤.	. <u> </u>	à.	b.	4.	<u> </u>	{	ncome add 1 mnu 41	ļ		
		nus 6) sined un-	<u> </u>		J. (1886)	**************************************		<u>l</u>	_		6. (Deductions			
	ame	d income 7a and 75)			:: :::::::::::::::::::::::::::::::::::						, ,	Countable un-		· .	<u> </u>
9.	Any I	ncome	-520				_\$ 2 0		-\$20			arned income			
10.		table um	-320				-320	(-320		}	5 minus 6)	<u> </u>		<u> </u>
		d Income nus 91							•	12.	B. !	NONEXEMPT EA	RNED INCO	ME ·	<u> </u>
3.	нои	EXEMPT E	ARNED IN	ICOM	E						<u> </u>		Month 1	Month 2	Month
			<u>N</u>	Aonth	1 5.		Mor	th 2	Mor	125 3 b.	!	aroca samed acome			1103
			ABD-MI		Spous Parer		ABD-MN	Spou⊯ or Parent	ABD-MN	Spoure or Parent		1 CG in last 4 mos, enter \$30	Serve Constitution of the		
	Gross	Samed ne							,		9t.	1/3 remainder	*(0-)	1	1103
12.	Dedu	ctions	i				* • ,				10.		1 2		25
	_	inder inus 121	a.		b		4.	D	4. .	1 0 .		landatory		•	254
	Comb	oined d Income					_			2	11.0	Dork Rel			10
		13 & 135	<u> </u>		<u> </u>						-1	Total deduct			
		amed inc.								2.5	}	(add 9, 10, å 11) Countable earned		<u> </u>	35
	\$ \$20	unused		-	170						2	Income		<u> </u>	74
٤.	Rema	inder inus 151			***	200				A Comment	- -	TOTAL COUNTA	BLE INCOM	IE	
7.	Coun				97.e						1		.Month 1	Month Z	Month
	(divio	# 16 by2}	1		<u> </u>						-	Supratal (add 7 and 13)		1	74
-	TOTA	AL COUNT	ABLE INC				,		<u> </u>		15.	Child support/		İ	
Ē.	Total	countable	1	donth	1 1		Mo	nth 2	Mo	n zh 3	16.	alimony Total countable	<u> </u>		1
	incon	ne 18	1				}					Income	}	}	71

·	Month 1	Month 2	Month 3	Altochment III	14
1. Countable Income from 1 18		1			
2.Countable Income from 11 16			744		
3.tnc, allocated from LTC/3&C person to family members at home (175W, Part IV)				_	e de la companya de l
4. Combined countable Income (add 1, 2, and 3)			744	•	-
ALLOCATIONS AND DEDUCTIONS					
5. Allocation to excluded children (175W, Part I)		2015	35.	•	•
6. Special deduction (176W, Part II)				•	•
7, Income to determine PA Eligibility			######################################	•	
3, Health Insurance			12.50	•	•
9.		13-30			
10.		£2-8		• .	
11. Total allocations/deductions ladd 5 through 10)					
12. Total net nonexempt Income [4 minus 11]			731.50	SHARE OF COST	
13. Total net nonexempt Income rounded	613	613	733	13a. Total of Mos 1, 2, and 3	195
14, Main tenance need	583	<i>5</i> 83	692	14a. Total of Mos. 1, 2, and 3	185
				15. Share of cost [13a, minus 14a,	
	•			16. Underpayment adjustment	
				17. Adjusted Share of Cost (15 minus 16)	
IV.EXEMPT INCOME					

V. EXPLANATION OF CHANGES WITHIN SOC PERIOD

See explusation on prior budget.

Eligibility Worker Signature Computation Data County Use

Date of

Attachment 111

Aedi-Cai Program			CO DIST	COUNTY
RECORD OF HEALTH CARE COSTS - SHARE OF COST				Sonom
READ INSTRUCTIONS ON BACK SEFORE COMPLETING	Only Medical expertage following months may		Share of Cost] -
	Month A Month	B Month C	The amount that must pay or obligat	
		Mar 82	1000	Yes
	Mo. Yr. Mo.	yr. Ma. Yr.		(Yes/

		٦	<u> </u>
lame			
address			
lity/State/Zip			1
County		1	1

State Number			North Bines	į E	Eligible Birthdate			te		Other Cov.		* 1		
Ald	7 Digit Serial No.	FBU	Pers.	Name — Last, First		BIC	Ma.	Day	Yr.		Code	Social Security No.		HIC or RR No
35	0123456	0	01	Larrence, Larry			9	14	38	m	7	512	34 <i>5</i> 678	
85	0123456	0	07	Larrence, marry		i	5	20	39	ĪF	N	512	48 76541	
	0123456		10	Larrence, Jamet			5	14	69	ΙĒ	N	522	34 5678	
83	0123456	0	11	Larrence, John		X	7	_7_	63	m	M	521	98 7654	
]]								
						Ţ				Ī				

Declaration of Provider: Each service listed below has been provided to the person listed on the date specified. I, the undersigned provider, hereby declare that I repayment or will seek payment from the patient for the amount shown in the "Bitled Patient" column and that I will not accept payment from the Medi-Cal program that amount. I also understand and agree that I may seek payment from the Medi-Cal program for the dosts of my service in excess of the amount blilled to the paths is the amount shown in the "Bitled Medi-Cal" column, and is the difference between the "Total Bill" and amount "Billed Patient".

I understand that If I bill insurance or any other third party for the service rendered, I cannot list on this form the amount of the charge paid by the insurance or third party.

PROVIDER NAME	Provider No.		of Ser		SERVICE		Proc. Code/ Presc. No.	Total Bill	Silied Patient	Billed Med
								5	\$	\$
PATIENT NAME										
PROVIDER SIGNATURE (544 Deci	eration Apove)	<u></u>		i						
PROVIDER NAME	Provider No.						,			
PATIENT NAME			i 					<u> </u>	<u> </u>	<u> </u>
PROVIDER SIGNATURE (See Dec	laration Above)									
PROVIDER NAME	Provider No.									1
PATIENT NAME					-					
PROVIDER SIGNATURE (See Dec	aration Above)		<u></u>				<u> </u>		·	
PROVIDER NAME	Pravider No.	<u> </u>						<u>[</u>		!
			i	[[
PATIENT NAME		[
PROVIDER SIGNATURE (See Dec	aration Above)		i I	 						
STATE USE ONL	······································	ــــــــــــــــــــــــــــــــــــــ	Ihav	e read	the instructions on	the back of thi	s form. agree	o assume full	legal respo	nsibility for
Mo. Day Yr. Reviewed By:	Trans. A	001200	-amoi	ınts ils	ted above in the "B	llied Patient" c	otumn.			
	ļ [~							

SIGNATURE OF APPLICANT