STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814
(916) 445-1797

August 1, 1984

To: All County Welfare Directors Letter No. 84-36

REVISED STATEMENT OF FACTS FOR MEDI-CAL (MC 210)

The purpose of this letter is to:

1. Provide you with a sample copy of the revised Statement of Facts for Medi-Cal (MC 210) together with a description of the changes.

2. Request your comments or suggestions for future revisions.

Revised MC 210

The MC 210 has been revised to reflect program changes and to provide documentation of mandated verifications. The most significant changes include the addition of a question on page one regarding dependancy for income tax purposes, revision of the property transfer question on page five, and the lien provision added to page ten.

Because of the cost of a production order, current supplies of the MC 210 must be exhausted before the new revision will be available. We anticipate that this version will be available by the end of this year.

We would appreciate your written comments and suggestions on how this form can be improved in the future.

Sincerely,

Original signed by

Caroline Cabias, Chief
Medi-Cal Eligibility Branch

Attachment

cc: MEDS Liaisons
MEDS Consultants

STATEMENT OF FACTS (MEDI-CAL)

PLEASE USE INK

INSTRUCTIONS:

Your eligibility will be decided on the information you give on this form. Be sure to read and answer every item. If you need extra space for any item, see page 9.
If you are completing this form on someone else's behalf, the terms "applicant" and "you" apply to the person you are applying for.
"Family member" means applicant, spouse, applicant's or spouse's children under 21.

1. Applicant's name (print) First Middle Last

2. Home Address Number Street City Zip Code

Mailing address (if different from above)

Home Phone Work phone Message phone Person with whom to leave message

COUNTY USE ONLY

Case name:

State No.:

App./redetermination date:

Verification of identity

Date EW

Verification of SS No.

1. Date EW
2.
3.
4.
5.
6.

Tax Record Verification

3. FAMILY MEMBERS

3A. List yourself and your spouse if he/she is in the home or Medi-Cal is being requested in his/her behalf.

Name ((First, middle, last) Social Security (SS) No.	Sex	Birthdate (Mo/Day/Yr) Birthplace	Marital Status: Single	Married	Divorced	Separated	Widowed	Living With Applicant: Yes	No	Medi-Cal Requested: Yes	No
Yourself SS No.						Date					
Your Spouse SS No.						Date					

List all your and your spouse's unmarried children under 21 (be sure to list unborn children). Also, include any children out of the home for whom you are requesting Medi-Cal or whom you claim as a deduction for income tax purposes.

Child's Name SS No.	Sex	Birthdate Place	In School: Yes	No	PARENTS: 1) Father's Name 2) Mother's Name	Parent is: (✓ if applies) Deceased	Absent	Incapacitated	Unemployed	Child Living With Applicant: Yes	No	Medi-Cal Req. for Child: Yes	No
					(1) (2)								
					(1) (2)								
					(1) (2)								
					(1) (2)								
					(1) (2)								

3C. Did you or any family member use a different name than the one listed above when each of you applied for your Social Security number(s)? Yes ☐ No ☐ If yes, list names.

3D. Are you or any family member for whom you are requesting Medi-Cal claimed as a deduction for income tax purposes by someone else? Yes ☐ No ☐

[REMEMBER: FAMILY MEMBERS INCLUDE ALL THOSE PEOPLE LISTED IN 3A AND 3B]

3E. List the names and addresses of all persons listed in 3A or 3B if they are not living in your home.

Name	Address

4. Is there anyone other than you or your immediate family members living with you, such as roommate, housemate, or relative? Yes ☐ No ☐ If yes:

Name	Relationship

5A. Are you or any family member requesting Medi-Cal living or currently staying outside California?
Yes ☐ No ☐ If yes: Date left California _____ Date expected to return _____
Reason for absence:

B. Do you or any family member have a home outside California? Yes ☐ No ☐
If yes, are you or any family member working or looking for work in California? Yes ☐ No ☐
If no, explain why you are in California.

6. ARE ANY OF THE PERSONS LISTED IN 3A OR 3B ALIENS? Yes ☐ No ☐
If YES, complete:

Name of Alien	Alien Registration Number

7. Have you or any family member ever applied for or received in California or any other state:
AFDC Cash Assistance Yes ☐ No ☐ Medi-Cal Yes ☐ No ☐ Food Stamps Yes ☐ No ☐
SSI/SSP Gold Check Yes ☐ No ☐ Other Welfare Benefits Yes ☐ No ☐
If you answered yes on any item, complete the following:

Name of Person(s) Who Applied For or Received Aid	Type of Aid	Date of App. (Mo/Day/Yr)	Place of App.	Date Last Received (if no longer receiving) (Mo/Day/Yr)	Reason For Discontinuance

8. If you or any family member were *not* receiving Medi-Cal in the last three months, did you or those family members receive any medical care? Yes ☐ No ☐ If yes:

Name of Person Receiving Medical Care	Month(s) of Care	Payments Made For Care		Do You Wish Medi-Cal For Those Months	
		Yes	No	Yes	No

9A. Are you or any family member requesting Medi-Cal:
65 or over? Yes ☐ No ☐ If yes, name(s) _____
Blind? Yes ☐ No ☐ If yes, name(s) _____

B. Do you or any family member have a physical or emotional problem which makes it difficult to work or take care of your needs? Yes ☐ No ☐ If yes:

Family Member(s)	Type of Problem(s)	Beginning Date of Problem(s)

C. If the problem described in 9B was caused by an injury or accident, are you seeking compensation through an insurance settlement or lawsuit? Yes ☐ No ☐

COUNTY USE ONLY

Where required, date CA 6 signed.

- Receiving or applied for cash grant or Medi-Cal around August 1972? If yes, check for 20% SS increase eligibility.
- Four-month continuing eligibility?
- SGA disabled?
- Title II disregard?
- 30 + 1/3 earnings exemption?

Retroactive application
Retro only ☐
Retro and cont. ☐

☐ Verification of disability/blindness (list)

Date Verified _____ EW

☐ Disability referral

Date Sent

☐ Referral to Medi-Cal recovery

10. Complete the following information about your living arrangements:
- ☐ Rent a room, apartment, house, or trailer $_____ Rent
- ☐ Pay for room and board $_____ Room and board
- ☐ Work in exchange for room and board
- ☐ Receive free room
- ☐ Receive free room and board
- ☐ Live in a board and care facility
- ☐ Live in a nursing home or hospital
  Date entered _____ Date expected to return home _____
- ☐ Live in and own/buying a trailer, mobile home, boat, or motor vehicle which is *not* taxed as real property by the county.
  Description: _____
  Estimated value $_____ Amount owed $_____ Monthly payment $_____
- ☐ Live in and own/buying a home or a trailer or mobile home which is taxed as real property by the county.
  Assessed value $_____ (from tax statement) Amount owed $_____ Monthly payment $_____
  Land home is located on includes more than one parcel. Yes ☐ No ☐ If yes, complete 11.
  Land home is located on includes more than one acre. Yes ☐ No ☐ If yes, complete 11.
- ☐ Other living arrangements. Describe:

COUNTY USE ONLY
(For LTC Applicants)
Verification of exemption as "principal residence"
Date Verified EW

Verification that will return home in six months
Yes ☐ No ☐

Verification of property
Date Verified EW

11. Do you or any member of your family own real property which you do not now live in (for example, land or buildings) or a trailer or mobile home which is taxed as real property by the county and which you do not now live in? Yes ☐ No ☐ If yes:

Description: _____

Address: _____

Owner: _____ Used in part as a home? Yes ☐ No ☐

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 Repairs $_____ Yearly ☐ Monthly ☐
Utilities $_____ Yearly ☐ Monthly ☐

Verification of "good cause" for unutilized property
Date Verified EW

Verification of income and expenses (list)
Date Verified EW

12. Do you or any family member have a life estate (right to the use of) in any property? Yes ☐ No ☐
If yes, describe:

☐ Revocable
☐ Irrevocable

13. Do you or any family member own a motor vehicle (including cars, trucks, motorcycles, etc.)?
Yes ☐ No ☐ If yes, list:

Make and Model	Year	Class (From Registration)	Owner	Amount Owed	Used for Transportation: Yes	Used for Transportation: No
				$		
				$		
				$		
				$		
				$		

Verification of nonexempt vehicles
Date Verified EW

14. Do you or any family member own boats, campers (do not include trucks), motor homes, mobile homes, or trailers which are not used as a home and are not taxed as real property by the county?
Yes ☐ No ☐ If yes, list:

Description	Year	Class (If Registered)	Owner	Purchase Price	Amount Owed	Only Means of Transportation: Yes	Only Means of Transportation: No
				$	$		
				$	$		
				$	$		
				$	$		

Verification of personal property
Date Verified EW

OTE: If you think the value the Department of Motor Vehicles will give the items listed in 13–14 will be too gh, you may provide three appraisals of the actual value and the average will be used.

15. DO YOU OR YOUR FAMILY HAVE ANY OF THE RESOURCES LISTED BELOW?
Check each item. If YES, explain below.

	YES	NO		YES	NO
A. Checks (at home or elsewhere)	☐	☐	I. Notes, mortgages, trust deeds, sales contracts	☐	☐
B. Cash (on hand or elsewhere)	☐	☐	J. Trust fund	☐	☐
C. Checking account	☐	☐	K. Stocks, bonds, or certificates	☐	☐
D. Savings account	☐	☐	L. Other resources which can be quickly changed into cash (specify)_____	☐	☐
E. Credit union account	☐	☐			
F. Certificates of deposit	☐	☐			
G. Treasury bills	☐	☐			
H. Money market funds	☐	☐			

Type of Resource	Owner	Current Value	Name and Address of Banks, etc.	Account Number
		$		
		$		
		$		

16. Do you or any family member have life insurance? Yes ☐ No ☐ If yes, list:

Insurance Company	1. Person Insured / 2. Policy Owned by	Face Value of Insurance	Policy Number	Date Policy Issued	Current Cash Value
A.	1. / 2.	$			$
B.	1. / 2.				
C.	1. / 2.	$			$

17. Do you or any family member own a burial reserve or trust? Yes ☐ No ☐

If yes, purchase price $_____ Amount owed $_____

$_____ $_____

For whom purchased_____

From whom purchased_____

18. Do you or any family member own a burial plot, vault, or crypt? Yes ☐ No ☐

For use of immediate family? Yes ☐ No ☐

If for use of anyone other than a member of the immediate family, complete the following:

Description_____ Owned by_____

Estimated value $_____ Amount owed $_____

Location_____

19. Do you or any family member own items of jewelry valued at more than $100 each? (Do not include wedding and engagement rings or heirlooms.) Yes ☐ No ☐ If yes, list:

Description	Estimated Value	Amount Owed
A.	$	$
B.	$	$

COUNTY USE ONLY

For A, B, C, D, and/or E income in the month included? Yes ☐ No ☐ If yes, amount:

$_____

For A, B, and/or C Income from business or self-employment included? Yes ☐ No ☐ If yes, amount:

$_____

(See 26C)

Date Verified EW

Total CSV $_____

Date Verified EW

Current value

$_____

Date Verified EW

Heirlooms?

Appraised value

$_____

20. Do you or any family member own business equipment, tools, inventory, or material (including livestock or poultry not for personal use)? Yes ☐ No ☐ If yes, list:

	Description	Estimated Value	Amount Owed
A.		$	$
		$	$
C.		$	$

21. Have you or any family member transferred, sold, or given away any property (including money) during the past two years? Yes ☐ No ☐ If yes, list:

	Description of Item	Date of Transfer, Sale, or Gift	Value	Amount Received
A.			$	$
B.			$	$

22. Do you or any family member have any of the following sources of income? Check yes or no for each item. If yes, explain below. Include loans, date loan received, and whether or not loan is repayable in "Other."

A. TYPE OF INCOME

	Yes	No
Cash grant (welfare), e.g., SSI/SSP (gold check), AFDC, GR, or GA	☐	☐
Social Security: i.e., Retirement, Survivors, Disability	☐	☐
Railroad Retirement	☐	☐
Nonmilitary retirement or pension	☐	☐
Unemployment Insurance Benefits (UIB)	☐	☐
Disability insurance: check one: ☐ state ☐ private	☐	☐
Workers' Compensation	☐	☐
Veteran's benefits including GI Bill	☐	☐
Military retirement	☐	☐
Military allotment	☐	☐
Child support	☐	☐
Alimony	☐	☐
Payment from roomers	☐	☐
Monetary gifts/contributions	☐	☐
Interest income and dividends	☐	☐
Other (itemize)	☐	☐

B. Name of Person Receiving Income	Type of Income	Date Received (or Expected)	Amount	How Often? (Weekly, Monthly)

C. Do you receive or expect to receive a cost-of-living increase to this income one or more times a year? Yes ☐ No ☐ If yes, give date of last and next cost-of-living increase.
Last _____ Next _____

23. Do you or any family member receive any of the following items free or in exchange for work you do?

		Who receives:	From whom:
A. Rent or housing	Yes ☐ No ☐		
B. Food	Yes ☐ No ☐		
C. Utilities	Yes ☐ No ☐		
D. Clothing	Yes ☐ No ☐		

24. Do you or any family member pay child support or alimony under a court order or based on an agreement with the district attorney? Yes ☐ No ☐ If yes, complete the following:

Amount Paid	By Whom	To Whom

COUNTY USE ONLY

Disposition of proceeds:

Note: Refer to transfer of property regs. in Title 22.

Type of cash grant:

Verification (list):

Date Verified EW

Verification (list):

Date Verified EW

Yes ☐ No ☐ If yes, complete the following:

A. 1. Working member's name			
2. Employer's name			
3. Address of employer			
4. Days of work per week	Days	Days	Days
5. Hours of work per week	Hrs.	Hrs.	Hrs.
6. How often paid (every week, twice a month, every two weeks, etc.)			
7. Day of the week you are paid			
8. Gross (total) earnings per pay period (before deductions) (include tips). If self-employed, write self-employed here and complete No. 26.	$	$	$
9. Occupation			

B. 1. Do you pay child care necessary for work? Yes ☐ No ☐ $_____ monthly amount

2. Do you pay for the care of an incapacitated adult living in your home in order to be able to work? Yes ☐ No ☐ $_____ monthly amount Name _____ Relationship _____

C. Anticipated Income. If your income varies from month to month, show your actual gross income for the current month in Month 1 and your estimated gross income for the following two months in Month 2 and Month 3.

Name and Occupation	Month 1	Month 2	Month 3
	$	$	$
	$	$	$
	$	$	$

Additional Information. Explain reasons for entries in C. Also, state any facts concerning your employment which may affect future months (for example, temporary employment).

26. Are you or any family member self-employed? Yes ☐ No ☐ If yes, complete the following. If no, proceed to question 27.

A. Name of business _____

Type of business _____

Location _____

A. Adjusted Gross Income From Last Tax Statement	Has Income Changed Since Last Tax Statement: Yes	No	If No Tax Statement or Change in Income: Estimated Yearly Gross Profit	Estimated Yearly Business Expenses
$			$	$

B. Cash on Hand for Business	Money in Checking Accounts for Business	Average Monthly Cash Expenditures for Business
$	$	$

COMPLETE ONLY IF THE FAMILY INCLUDES CHILDREN UNDER 21.

Is a parent living in the home unemployed or working less than 100 hours per month? If yes, **COMPLETE THE FOLLOWING FOR THE CHILD(REN)'S PARENT(S) WHO IS/ARE LIVING IN THE HOME:**

COUNTY USE ONLY

Verification (list)

☐ Wage stubs

☐ Tips

Verification of dependent care

Date Verified _____ EW _____

Verification
☐ Tax return
☐ Business records

Date Verified _____ EW _____

Net profit from self-employment:

$

27A: If Unemployed, Last Day Worked

Month / Day / Year	Working Less Than 100 Hours: Yes	No	In School Or Training: Yes	No	Actively Seeking Full-Time Employment: Yes	No	Date Began Seeking Employment: Month / Day / Year
/ /							/ /

B. **FIRST PARENT** (name _____). List employment and training history for the past five years. Begin with this person's last job or training.

	Name of Employer or Training Program	Work or Training ✓ Check	When Employed From / / mo dy yr To / /	Amount Paid		Name of Employer or Training Program	Work or Training ✓ Check	When Employed From / / mo dy yr To / /	Amount Paid	
1.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	7.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	
2.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	8.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	
3.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	9.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	
4.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	10.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	
5.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	11.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	
6.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	12.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	

C. **SECOND PARENT OR OTHER SPOUSE** for whom aid is requested (name _____). List employment and training history for the past five years. Begin with this person's last job or training.

	Name of Employer or Training Program	Work or Training ✓ Check	When Employed From / / mo dy yr To / /	Amount Paid		Name of Employer or Training Program	Work or Training ✓ Check	When Employed From / / mo dy yr To / /	Amount Paid	
1.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	7.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	
2.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	8.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	
3.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	9.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	
4.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	10.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	
5.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	11.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	
6.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	12.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	

C. **HAS EITHER PERSON LISTED IN 27A OR B RECEIVED UNEMPLOYMENT INSURANCE BENEFITS (UIB) WITHIN THE LAST 12 MONTHS?** Yes ☐ No ☐ If YES, complete:

Name of Person	Dates Received

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First Parent's Earnings

YR.	QUARTER Jan-Mar	Apr-Jun	Jul-Sept	Oct-Dec
	EARNINGS			
	$			
	$			
	$			

Total Earnings $_____

YR.	QUARTER Jan-Mar		Apr-Jun		Jul-Sept		Oct-Dec	
	$50	Trng.	$50	Trng.	$50	Trng.	$50	Trng.

☐ Quarters _____

Second Parent's Earnings

YR.	QUARTER Jan-Mar	Apr-Jun	Jul-Sept	Oct-Dec
	EARNINGS			
	$			
	$			
	$			

Total Earnings $_____

Primary Wage Earner ☐ 1st ☐ 2nd Parent

YR.	QUARTER Jan-Mar		Apr-Jun		Jul-Sept		Oct-Dec	
	$50	Trng.	$50	Trng.	$50	Trng.	$50	Trng.

☐ Quarters _____

UIB:
☐ Eligible ☐ Referral
☐ Eligible ☐ Referral

28. Have either of the child(ren)'s parents living in the home quit or refused a job or training within the last 30 days? If yes, complete below. Yes ☐ No ☐

Parent's Name	Amount of last paycheck	Last day of job/training mo. / day / yr.	Hours of work/training in last 30 days
	$	/ /	

Name and Address of Employer/Training Program

Reason for Leaving or Refusal
☐ Quit ☐ Layoff ☐ Refusal
☐ Fired ☐ Other (list reason):

COUNTY USE ONLY
☐ Employer statements
☐ Determination of "good cause" required

B. Are you or anyone in your family participating in a labor strike? Yes ☐ No ☐ If yes, complete:

☐ Striker(s)

Who	Date Person Went on Strike

29. Are you or any family member in college or attending a similar educational institution? Yes ☐ No ☐
If yes, complete the following: Full-Time ☐ Part-Time ☐

	Student:	Student:	Student:
A. 1. Name of institution			
2. Status of student	Grad ☐ Undergrad ☐	Grad ☐ Undergrad ☐	Grad ☐ Undergrad ☐
B. Grants, loans, scholarships, fellowships			
1. Amount received	$	$	$
2. Source(s) of grants, loans, etc.			
3. How often received			
C. Expenses Per Term			
1. Is term a semester, quarter, year			
2. Tuition/fees	$	$	$
3. Books, equipment, and supplies	$	$	$
4. Child care necessary for school	$	$	$
5. Transportation to school—child care			
a. Round trip miles per day			
b. School attended how many days per week			
c. Type of transportation used (own car, someone else's car, car pool, bus, etc.)			
d. Costs (per month) • Amount paid by student (if doesn't use own car)	$	$	$
• Amount paid by riders	$	$	$
e. Parking, tolls, etc.			
f. Is public transportation (bus, train, etc.) available	Yes ☐ No ☐ Cost $	Yes ☐ No ☐ Cost $	Yes ☐ No ☐ Cost $

Verification (list):

Date Verified EW

Exempt:
☐ Entire amount
☐ Only expenses

Transportation costs allowed: (show computation)

J. Do you or any family member have Medicare coverage? Yes ☐ No ☐ If yes, list:

Person Covered	Medicare Claim Number	Monthly Premium	
		Deduction From Check	Paid by You
		Yes ☐ No ☐	Yes ☐ No ☐
		Yes ☐ No ☐	Yes ☐ No ☐
		Yes ☐ No ☐	Yes ☐ No ☐

Date Verified EW

31. Do you or any family member have health or hospitalization insurance, including insurance paid by an employer or absent parent? This information will not affect your eligibility for Medi-Cal.
Yes ☐ No ☐ If yes, complete the following:

Coverage (Check)	Person(s) Insured	Monthly Premium Paid
☐ CHAMPUS/CHAMPVA		$
☐ Veterans Administration coverage (50% or above disability rating)		$
☐ Kaiser		$
☐ Ross-Loos (INA)		$
☐ Blue Shield		$
☐ Blue Cross		$
☐ Other		$

32. Have you or any family member made a down payment for medical care you will receive in the future?
Yes ☐ No ☐ If yes,

Amount of Down Payment	To Whom Made	Medical Care to be Received
$		

33A. 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 ☐

34. Have you or any family member applied for or do you or any family member think you are eligible for any payment/s you are not now receiving? Yes ☐ No ☐ If yes, complete the following:

Kind of Payment	Person Possibly Eligible	Date of Application Month/Day/Year	Date Expected Month/Day/Year
Social Security			
Disability payments			
Veteran's payments			
Unemployment Benefits			
Workers' Compensation			
Medicare			
Pending suit or insurance settlement for accident or injury			
Other: Describe			

35. Services (these questions do not affect your eligibility for Medi-Cal)

A. Are you interested in physical examinations for any family member under 21 through the Child Health Disability Prevention Program? Yes ☐ No ☐

B. Are you interested in information on the Family Planning Program? Yes ☐ No ☐

C. Are you interested in talking to a social services worker about other services which may be available to you? Yes ☐ No ☐ If yes, explain:

36. Additional information. Please give the item number in the column to the left.

COUNTY USE ONLY

Date HRB 2 completed _____

☐ Other health coverage code entered

Verification (list)

_____ _____
Date Verified EW

Payment used to bring property within property limits Yes ☐ No ☐

If yes:
☐ Notice to provider

CA 5 ☐

CA 5 ☐

_____ _____
Date Verified EW

Medi-Cal recovery referral

Date _____

_____
Date of accident/injury

Medi-Cal recovery referral

Date _____

☐ CHDP brochure given

_____
Date

☐ CHDP referral

☐ Social services referral

BE SURE YOU HAVE READ EVERY ITEM AND ANSWERED ALL THE QUESTIONS. READ THE FOLLOWING CAREFULLY BEFORE SIGNING.

- 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 in the number of persons in the household or of any change of address or of any change in other health insurance coverage; and I agree to meet all other responsibilities explained in the "Medi-Cal Responsibilities Checklist" I have received.
- I understand that I must report immediately the death of a member of my household or the person on whose behalf I am acting.
- I understand that the information I put on this form will be verified and that I must cooperate fully in any investigation required for quality control.
- I understand that Section 700.1 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 65 from the estate of a Medi-Cal beneficiary if there is no surviving spouse, minor children, or blind or totally disabled children.
- I understand that any information gathered is confidential and not open to inspection other than for purposes directly connected with the administration of the Medi-Cal program.
- I understand that if I am dissatisfied with actions taken by the county welfare department, I have the right to a state hearing.
- I understand that in accordance with Section 14006(b) of the Welfare and Institutions Code, the State may record a lien against my property as reimbursement for the cost of medical care.

IF YOU DO NOT UNDERSTAND THESE STATEMENTS OR IF YOU HAVE ANY QUESTIONS, ASK YOUR COUNTY WORKER TO EXPLAIN.

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 MEDI-CAL CARD AND/OR I CAN BE PROSECUTED FOR FRAUD.

I DECLARE UNDER PENALTY OF PERJURY THAT THE ANSWERS I HAVE GIVEN ARE CORRECT AND TRUE TO THE BEST OF MY KNOWLEDGE.

Signature of Applicant		Date
Signature of Person Acting for Applicant	Relationship	Date
Signature of Witness (If Applicant Signed With Mark)		Date
Signature of Person Helping Applicant Complete Form	Address	Date
COUNTY USE ONLY	EW Signature	
	Date	