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

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814

November 16, 1984

To: All County Welfare Directors Letter No. 84- 42

SURVEY -- USE OF THE MONTHLY REPORT FORM (CA-7) IN THE MEDI-CAL PROGRAM

Recently Fresno County requested the Department of Health Services to develop a common monthly report form for the Food Stamp, AFDC and Medi-Cal programs. It was suggested that we combine the Department of Social Services' CA-7 and the Medi-Cal MC 176S into one form to eliminate eligibility workers' and recipients' time spent in duplicate reporting.

In order to evaluate the feasibility of consolidating forms, we are asking for your comments in the attached questionnaire. Your participation in this survey will be very helpful to us in developing a better recipient reporting system. Please complete and return the attached questionnaire by November 30, 1984.

Please direct any questions regarding this subject to RaNae Hamby of my staff at (916) 324-4955, (ATSS) 8-454-4955.

Sincerely,

Original signed by

Doris Z. Soderberg, Chief
Medi-Cal Eligibility Branch

Attachments

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

CG417RH.1

County _____

Contact Person _____

Phone _____

Date Completed _____

REPORTING FORM QUESTIONNAIRE

1. Does your county require Medi-Cal beneficiaries to complete and return a Status Report monthly? (See Title 22, CAC, Section 50191.)

   Yes ____

   No, we require a status report each _____ (specify time period, e.g., quarter).

2. Do your Medi-Cal eligibility workers also have continuing (i.e., post-intake) caseloads in other programs? (Check one)

   Yes ____

   No, they only handle Medi-Cal ____.

   If yes, what other program(s) do EWs handle? (e.g., Non-Assistance Food Stamps (NAFS), or NAFS and AFDC, etc.):

3. If recipients were only required to fill out one form, such as a modified CA-7, for Medi-Cal, AFDC and NAFS, how would you ensure that the eligibility workers in each program receive and process the form? What problems and solutions do you envision?

4. What impact might a combined form have on error rates?

5. What impact might a combined form have on recipients?

6. What impact might a combined form have on eligibility workers?

7. What impact might a combined form have on administrative and program costs?

8. What else should we consider in evaluating this proposal?

9. Do you support this proposal?

10. Would your county be willing to work on a task force to design such a form?

(Please attach other pages as needed)

Return to:

RaNae Hamby
Medi-Cal Eligibility Banch
714 P Street, Room 1692
Sacramento, CA 95814

DI–CAL STATUS REPORT

THIS STATUS REPORT IS FOR THE MONTH OF:
AND SHOULD BE COMPLETED AFTER THE
MONTH HAS ENDED.

[ ]

ORTANT: PLEASE COMPLETE, SIGN, AND RETURN THIS FORM TO THE WELFARE DEPARTMENT IN THE ENCLOSED STAMPED ENVELOPE BY THE _____ OF THE MONTH FOLLOWING THE MONTH LISTED ABOVE. IF YOU DO NOT RETURN THIS FORM, YOUR ELIGIBILITY FOR MEDI-CAL MAY BE DISCONTINUED.

If you no longer want Medi-Cal, please complete and sign Part A. (Do not complete Part B.) Mail this form to the Welfare Department.

RT A. DISCONTINUANCE REQUEST

I no longer want Medi-Cal services and would like my Medi-Cal case discontinued as of the last day of: _____ _____.
Month Year

I understand that I may reapply for Medi-Cal at any time in the future.

_____
Signature Date

If you wish to have your Medi-Cal eligibility continue, please complete and sign Part B. This report does not change your responsibility to report any change to your eligibility worker *within 10 days of the change*. If you have any questions regarding this form or the items to be reported, contact your eligibility worker.

RT B. ELIGIBILITY STATUS INFORMATION

1. I/We received income, money or benefits ☐ Yes ☐ No

If "Yes", list all income and who received it. Income includes EARNINGS (salary, wages, tips, commissions and bonuses); UNEMPLOYMENT INSURANCE/DISABILITY INSURANCE, worker's compensation, strike benefits, training incentive (CETA); SOCIAL SECURITY/RAILROAD RETIREMENT, supplemental security income (SSI), pensions, business, farm, rental; CHILD SUPPORT, contributions (step-father, others), free housing/utilities/food/clothing; MILITARY BENEFITS, settlements, loans and grants, gifts, and any other money you receive.

ATTACH A COPY OF YOUR PAY STUBS SO THAT YOU ARE ALLOWED ALL APPROPRIATE WORK DEDUCTIONS.

Who Received Income, Money, or Benefits	Type of Income, Money or Benefits (see list above)	Amount	Dates Received	

COUNTY USE ONLY

Net nonexempt income _____

Maintenance Need _____

Share of Cost _____

BE SURE TO COMPLETE THE OTHER SIDE OF THIS FORM

2. I/We paid work, college or training program expenses. ☐ Yes ☐ No If "Yes", complete the following.

PERSON CLAIMING EXPENSE	TRANSPORTATION EXPENSES				Child Care Expenses Attach Receipt	Other Work, College, or Training Expenses	
	Method (Car, Car Pool, Bus, Etc.)	Days Using This Method This Week	Daily Cost Round Trip	Daily Miles Round Trip		(Describe)	Amo

3. I/We had a change in real or personal property during the time specified. ☐ Yes ☐ No
If "Yes", complete the following, including any item bought or sold or given away such as land, houses, automobiles, boats, etc., a any change in your checking or savings accounts, life insurance policies, etc.

ITEM	WHAT HAPPENED	DATE	CURRENT VALUE	MONEY RECEIVED	MONEY OWED	OWNER

4. I/We had changes affecting the people in our family or household during the time specified. ☐ Yes ☐ No. If "Ye complete the following, including information on someone who moved into or out of your home; entered or left a hospital; beca pregnant; gave birth or otherwise ended pregnancy; entered or left school; recovered from a major illness; became disabled or d began, changed or terminated employment.

PERSON	WHAT HAPPENED	DATE	RELATIONSHIP	DATE OF BIRTH	INCOME	PROPERTY

5. I/We now have Medicare Coverage ☐ Yes ☐ No Medicare Number _____ Part A ☐ Yes ☐
Part B ☐ Yes ☐

I/We have Health Insurance coverage privately or through our employer. ☐ Yes ☐ No
If "Yes", complete the following:

PERSONS INSURED	INSURANCE COMPANY	GROUP/PRIVATE	PREMIUM PAID		EFFECTIVE DATE
			AMOUNT	WHEN	

6. Do you expect changes in any of the above or do you have any other information affecting Medi-Cal eligibility to report?
☐ Yes ☐ No
If "Yes", please provide that information in the space provided below.

I DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING IS TRUE AND CORRECT.

SIGNATURE OR MARK	DATE SIGNED	COMPLETE IF ADDRESS HAS CHANGED STREET AND NUMBER
SIGNATURE OF SPOUSE/PARENT IN HOME	TELEPHONE	CITY AND ZIP CODE
SIGNATURE OF WITNESS, INTERPRETER OR PERSON COMPLETING FORM FOR BENEFICIARY	TELEPHONE	COMPLETE IF HOME ADDRESS IS DIFFERENT THAN MAILING ADDRESS/STREET & NUMBER

71122-449 2,000 [illegible] 189

MONTHLY ELIGIBILITY REPORT

For Cash Aid and Food Stamps

THIS REPORT IS FOR THE MONTH OF:

Complete, sign, date and return this form AFTER the last day of:

- You must complete this report and return it by the **5th** of the month. If this report is not received by the 11th of the month or is incomplete, your Cash Aid, Cash-based Medi-Cal and/or Food Stamps may be delayed, decreased or discontinued.
- If you do not **ATTACH** proof of reported income, your benefits may be discontinued. If you do not **ATTACH** proof of expenses, your benefits may be decreased or discontinued.
- **Call your worker if you need help completing the form.** Attach a separate sheet of paper if needed.

Worker: Phone:

NOTE: If you or your family no longer want Cash Aid, Medi-Cal or Food Stamps check this box ☐, state the reason and type(s) of assistance no longer wanted, complete the signature block and return the form by the due date.

Reason and Type(s) of assistance:

If you receive cash aid or food stamps, answer (1) through (9). Answer for everyone in your household if you receive food stamps. If you do not receive food stamps, answer for everyone receiving cash aid, the aided children's parents, stepparents, and your spouse if in your home.

(1) **Did anyone receive income, money, or benefits in the month,** such as: earnings, training payments, earned income tax credit, strike benefits, social security, railroad retirement, unemployment/disability insurance, interest, worker's compensation, SSI/SSP (gold checks), child/spousal support, loans, grants, tax refund, cash, gifts, free housing/utilities, etc.? ☐ YES ☐ NO

If **YES**, complete section below. **ATTACH PAYSTUBS** or other proof of earnings each month. **ATTACH PROOF** for any other income only when it starts and when it changes. If anyone is self-employed, list business expenses on a separate sheet of paper and **ATTACH PROOF** of income and expenses each month. **(If you receive cash aid and you fail to report or ATTACH PROOF of earned income by the 11th of the month, the standard work expense, dependent care, and when eligible for it, the $30 and 1/3 disregard will not be allowed.)**

Who Received Income, Money or Benefits?	Source (If Earnings, List Name of Employer)	Enter below dollar amounts and actual dates received. If earnings, enter gross amount before deductions.					If Earnings: Number of Days Worked in Month	If Earnings: Number of Hours Worked in Month
Name		Amount $ / Date	Amount $ / Date	Amount $ / Date	Amount $ / Date	Amount $ / Date		
Name		Amount $ / Date	Amount $ / Date	Amount $ / Date	Amount $ / Date	Amount $ / Date		
Name		Amount $ / Date	Amount $ / Date	Amount $ / Date	Amount $ / Date	Amount $ / Date		

(2) **Did anyone pay for the care of a child or disabled adult so that someone in the home could go to work, training or look for a job?** ☐ YES ☐ NO

If **YES**, complete below and **ATTACH** a receipt for each person receiving care.

Who Received Care?	Cost of Care	Who Received Care?	Cost of Care
	$		$
	$		$

		YES	NO
(3)	**Did anyone move into your home (including a new born), move out, get married, or die?**	☐	☐
(4)	**Did anyone become disabled or recover from a disability?**	☐	☐
(5)	**Did anyone start, refuse, lose, quit or change a job/training, or go on strike?**	☐	☐
(6)	**Did anyone start, stop or change school or college?**	☐	☐
(7)	**Did anyone receive, buy, sell or give away any property such as a house, land, motor vehicle, camper, boat, etc.?**	☐	☐

If **YES**, to any of the changes, give name of person, date of change and explain the change. If property change, give value of item.

COUNTY USE ONLY E.W. INITIALS DATE:

(8) **Did anyone have a checking, savings or credit union account open at the end of the month?** ☐ YES ☐ N
If **YES**, complete below.

☐ Credit Union ☐ Checking ☐ Savings	Balance On Last Day of Report Month	Whose Account?	☐ Credit Union ☐ Checking ☐ Savings	Balance On Last Day of Report Month	Whose Account?

(9) **Did you move, or do you have a new mailing address or phone number?** ☐ YES ☐ N
If **YES**, complete below.

Home Address (Number, Street Name, Avenue Blvd. Etc.)	Apt. No.	City	State	Zip Code	Phone No.

Mailing Address (If Different Than Home Address)	City	State	Zip Code

If you receive food stamps, answer (10) through (13) for everyone in your household. If you do not receive food stamps, go to (14) through (17).

(10) **Did the household have housing costs?** ☐ YES ☐ N
If **YES**, enter amount billed.
ATTACH bills only if you moved or the cost changed.

Rent or Mortgage	Property Taxes or Insurance (if not in mortgage)
$	$

(11) **Did the household have utility costs?** ☐ YES ☐ N
If **YES**, and you moved or claim actual utility costs, complete below and **ATTACH BILLS.**

Gas/Fuel	Electricity	Telephone	Utility Installation	Garbage/Trash	Water	Sewage	Other (Specify)
$	$	$	$	$	$	$	$

(12) **Did the household share housing or utilities or did anyone help pay these costs?** ☐ YES ☐ N
If **YES**, list each item, amount paid, who paid and **ATTACH PROOF.**

(13) **Did anyone who is disabled or age 60 or older have any medical expenses in the month?** ☐ YES ☐ N
If **YES**, complete below and **ATTACH BILLS** for each expense.

Who Had the Expense?	Type of Expense	Amount	Who Had the Expense?	Type of Expense	Amount
		$			$

If you receive cash aid, answer (14) through (17) for everyone receiving cash aid, the aided children's parents, stepparents, and your spouse if in the home. If you do not receive cash aid, go to (17).

(14) **Did you or anyone in your family who received income pay any court ordered support in the month?** ☐ YES ☐ N
If **YES**, enter the amount paid and **ATTACH RECEIPTS:** $

(15) **Did anyone start, stop or change health or hospitalization insurance coverage such as Prudential, Blue Cross, Champus, etc.?** ☐ YES ☐ N
If **YES**, give name of person, date and explain change.

(16) **Did anyone become pregnant, have a baby or terminate a pregnancy?** ☐ YES ☐ N
If **YES**, give name of person, date and explain change.

If you receive cash aid or food stamps, answer (17). Answer for everyone in the household if you receive food stamps. If you do not receive food stamps, answer for everyone receiving cash aid, the aided children's parents, stepparents, and your spouse if in the home.

(17) **Does anyone in the home have other information to report for this month or next month,** such as: recent or expected changes in income, place of employment, number of working hours or days per week, place of residence, property, persons in the household, etc? ☐ YES ☐ N
If **YES**, explain the change, if it is expected to be temporary or permanent and indicate the date of the change.

CERTIFICATION

- *I understand that failing to report information or misrepresentation of facts for Cash Aid programs, Food Stamps or Cash-based Medi-Cal can result in le prosecution with penalties of a fine, imprisonment or both. In the Food Stamp Program the penalties can result in permanent disqualification from the Program, fi up to $10,000 or imprisonment for up to 5 years.*
- *I understand that I must contact my worker to report any unexpected changes which affect my eligibility for or the amount of my Cash Aid within 5 days of the occurre or if I have any doubt about needing to report any changes.*
- *I understand that reported information may result in a decrease or discontinuance of benefits.*
- *I understand I have the right to request a state hearing on any proposed action by the county welfare department.*
- *I declare that the information contained in this report is true and correct and is complete for the entire report month.*

YOU MUST SIGN AND DATE THIS REPORT AFTER THE LAST DAY OF THE REPORT MONTH OR IT WILL BE CONSIDERED INCOMPLETE
For Cash Aid programs, you and your aided spouse (or the other parent of aided children) living in the home must sign the form. For the Food Stamp Program, the head of household, a household member or the household's authorized representative must sign the form.

Signature of Cash Aid Parent or Caretaker Relative and/or Food Stamp Household Member ▶	Date Signed
Signature of Cash Aided Spouse or Other Parent of Cash Aided Children ▶	Date Signed
Signature of Witness to Mark, Interpreter, or Other Person Completing Form ▶	Date Signed