

DEPARTMENT OF HEALTH SERVICES

714/744 P STREET

P.O. BOX 942732

ACRAMENTO, CA 94234-7320



April 7, 1992

Letter No.: 92-28

TO: All County Welfare Directors
All County Administrative Officers
All County Medi-Cal Liaisons/Specialists

SUBJECT: MEDI-CAL STATUS REPORT

REFERENCE: Procedure Section 4H and All County Welfare Directors Letter 91-41

As many of you are already aware, the Medi-Cal Status Report (MC 176 S) was revised and streamlined by the Quarterly Status Report (QSR) Committee. The QSR Committee carefully evaluated all the factors of status reporting. It was apparent to the QSR Committee that the MC 176 S was a very useful tool.

You will find included with this letter a copy of the revised Medi-Cal Status Report and the corresponding revised procedure section "4A-Processing of Status Reports". The MC 176 S (1/92) replaces all former versions of the Medi-Cal Status Report. Former versions of the Medi-Cal Status Report includes the MC 176 SQ, MC 176 SAQ, MC 176 S and MC 176 SA. Procedure Section 4A replaces Procedure Section 4H and All County Welfare Directors Letter 91-41. The revised MC 176 S (1/92) should be implemented no later than July 1, 1992.

The Medi-Cal Status Report will be available in the warehouse April 15, 1992. The MC 176 S (1/92) denotes the English manual stock; MC 176 SA (1/92) is the English automated or pen feed form; the MC 176 S (SP) identifies the Spanish manual stock; and the MC 176 SA (SP) specifies the Spanish automated or pen feed stock. The English Medi-Cal Status Report is printed in black ink, and the Spanish Medi-Cal Status Report is printed in blue ink. The color difference makes the versions easy to distinguish.

Lastly, the Medi-Cal Eligibility Branch express their gratitude to all the QSR Committee Members, who carefully and responsibly evaluated the quarterly status reporting requirement. Specifically, **WE THANK:**

- | | |
|--------------------------|-----------------------|
| * Mr. Charles Cunningham | Kern County |
| * Ms. Emantha Moore | Los Angeles County |
| * Ms. Barbara Baranski | Orange County |
| * Ms. Stevie Leppard | San Bernardino County |

County Welfare Directors
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*	Ms. Martha Walker	San Diego County
*	Ms. Allegra Shiner	Santa Barbara County
*	Ms. Ruth Kenworthy	Ventura County

If you have questions regarding this information, please contact Sue Miller of my staff at (916) 657-3184.

Sincerely,

ORIGINAL SIGNED BY

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Enclosure

MEDI-CAL ELIGIBILITY MANUAL - PROCESURES SECTION

4A – PROCESSING OF STATUS REPORTS

BACKGROUND

Status reports must be submitted by the Medi-Cal beneficiary in accordance with California Code of Regulations, Title 22, Section 50191. The revised **Medi-Cal Status Report**, MC 176 S/MC 176 SA, dated 1/92 replaces all former versions of status reports for Medi-Cal.

USAGE

The MC 176 S/MC 176 SA (1/92) must be used to meet the quarterly status reporting requirement, and also it may be used for monthly status reporting. In counties where a single case file contains Medi-Cal, AFDC and/or Food Stamps, the Stateside Automated Welfare Systems 7, SAWS 7, may be used in place of the MC 176 S for the quarterly status report. The SAWS 7 for the designated quarterly status report month is to be used for the determination of continued Medi-Cal eligibility. SAWS pilot counties may use the SAWS 7 in place of the MC 176 S to meet the Medi-Cal quarterly status reporting requirement.

For a Medi-Cal Family Budget Unit (MFBU) that consists solely of a pregnant women, an infant up to one year of age, or a pregnant woman and an infant up to one year of age, the completion of a status report is not mandatory. If you receive a status report from a MFBU consisting solely of a pregnant woman, an infant up to one year of age, or a pregnant woman and an infant up to one year of age, you will disregard any reported income increases.

The following information will assist you in evaluating a status report.

INFORMATION EVALUATION

COMPLETED STATUS REPORTS FOR DISCONTINUANCE OF BENEFITS

The MC 176 S is considered complete if only question eight (8) is answered "NO" and the MC 176 S is signed and dated. If the Medi-Cal beneficiary fails to sign and date the status report, the status report is incomplete.

INCOMPLETE STATUS REPORTS FOR CONTINUING BENEFICIARIES

If the Medi-Cal beneficiary fails to sign and date the status report, the status report is incomplete.

MEDI-CAL ELIGIBILITY MANUAL - PROCECURES SECTION

The status report is incomplete when the following applies to the specified question.

QUESTION

- | | |
|-----|---|
| 1A. | The question is not answered and information is not reported.
The question is answered "yes", but the information is not reported. |
| 1B. | The question is not answered and information is not reported.
The question is answered "yes", but the information is not reported. |
| 2. | The question is not answered; information is not reported; and verification is not provided.
The question is answered "yes" Information is reported, but verification is not provided. |
| 3. | The question is not answered; information is not reported; and verification is not provided.
The question is answered "yes", but information is not reported.
The question is answered "yes" Information is reported, but verification is not provided. |
| 5. | The question is not answered, and the information is not reported.
The question is answered "yes", but the information is not reported. |
| 6. | The question is not answered. |
| 7. | The question is not answered. |

Questions four and eight are never considered to be incomplete.

NOTICE REQUIREMENTS

You will send a Discontinuance of Benefits, MC 239 I when the following situations occur.

1. Status report is not received prior to the last date a change may be effected, and also a "reasonable effort" per Section 50175 by the eligibility worker to contact the beneficiary by telephone or written notice produced no further information.
2. Status report is received, but it is incomplete. In addition, a "reasonable effort" per Section 50175 by the eligibility worker to contact the beneficiary by telephone or written notice produced no further information.

The appropriate statement must be written or checked on the MC 239 I. The missing information needed to complete the received status report must be stated. If a completed status report is received on or before the effective date of the discontinuance, the beneficiary has met the status reporting requirement, and a discontinuance must be rescinded.

Unless the beneficiary signs the Voluntary Request For Withdrawal of Application Or Discontinuance of Eligibility or Waiver of Ten Day Advance Notice of Action, MC 215, there must be a timely (10-day) notice of action before adverse changes can be effective.

MEDI-CAL STATUS REPORT**THIS REPORT IS FOR THE MONTH OF****NOTICE:**

- YOU MUST COMPLETE AND SIGN THE OTHER SIDE OF THIS REPORT.
- YOU MUST RETURN THIS REPORT TO THE WELFARE DEPARTMENT IN THE ENCLOSED RETURN ENVELOPE BY THE 5TH OF THE MONTH **FOLLOWING THE MONTH SHOWN ABOVE**.
- IF YOU DO NOT RETURN THIS FORM, YOUR ELIGIBILITY FOR MEDI-CAL MAY BE DISCONTINUED.
- REMEMBER, YOU STILL MUST REPORT ALL CHANGES TO YOUR ELIGIBILITY WORKER WITHIN TEN (10) DAYS.

CLIENT

COUNTY

NEED HELP? CALL YOUR WORKER:

TELEPHONE:

SPECIAL INSTRUCTIONS:

1. YOU MUST COMPLETE EVERY SECTION ON THE OTHER SIDE OF THIS PAGE, UNLESS YOU NO LONGER NEED MEDI-CAL.
2. IF YOU NO LONGER NEED MEDI-CAL, COMPLETE ONLY QUESTION 8 ON THE OTHER SIDE OF THIS FORM, SIGN AND DATE IT.
3. THE INFORMATION YOU PUT ON THIS REPORT MUST COVER THE ENTIRE REPORT MONTH.
4. IF YOU NEED MORE SPACE TO REPORT INFORMATION, YOU MUST ATTACH A SHEET OF PAPER WITH THE ADDITIONAL INFORMATION.
5. YOU MUST SIGN AND DATE THIS REPORT.
6. IF YOU RECEIVED MONEY, YOU MUST ATTACH PROOF OF ALL INCOME TYPES AND AMOUNTS.

HELPFUL HINTS:**INCOME EXAMPLES:**

- * **FREE HOUSING, UTILITIES, FOOD OR CLOTHING.**
- * **EARNINGS FROM A JOB INCLUDES SALARY, HOURLY WAGES, TIPS, COMMISSIONS AND ON THE JOB INCENTIVES SUCH AS JTPA (JOB TRAINING PARTNERSHIP ACT).**
REMEMBER, GROSS INCOME IS WHAT YOU EARNED BEFORE ANY DEDUCTIONS WERE TAKEN OUT OF YOUR CHECK.
- * **GOVERNMENT BENEFITS INCLUDES SOCIAL SECURITY, WORKERS COMPENSATION PAYMENTS, VETERANS PENSIONS, RAILROAD RETIREMENT, UNEMPLOYMENT INSURANCE, SSI, OTHER RETIREMENT, DISABILITY PAYMENTS OR INCOME TAX REFUNDS.**
- * **OTHER MONEY IS CHILD SUPPORT, ALIMONY, SELF-EMPLOYMENT, INTEREST INCOME, LOANS, GRANTS, SETTLEMENT BENEFITS, RENTAL INCOME, GIFTS, CONTRIBUTIONS, LOTTERY WINNINGS, ETC.**

IF YOU HAVE RECEIVED THESE OR ANY OTHER TYPES OF INCOME, YOU MUST REPORT IT ON THE OTHER SIDE OF THIS FORM.

OTHER CHANGES TO REPORT:

- * **PREGNANCY, BIRTH OF BABY, SCHOOL, HOUSING, LAND, CARS, BOATS, BANK ACCOUNTS, DISABILITY, MARRIAGE, DIVORCE, SEPARATION, IMMIGRATION STATUS, ETC.**
- * **FAMILY MEMBER USUALLY MEANS APPLICANT, SPOUSE, APPLICANT'S OR SPOUSE'S UNMARRIED CHILDREN UNDER AGE 21.**

CALIFORNIA LAW (WELFARE AND INSTITUTIONS CODE, SECTION 14014) STATES THAT IF YOU FAIL TO REPORT CHANGES IN INCOME, PROPERTY OR FAMILY STATUS WITHOUT GOOD CAUSE AND SUCH FAILURE CAUSES MORE THAN \$400.00 TO BE WRONGLY EXPENDED FOR MEDICAL SERVICES, YOU HAVE COMMITTED A FELONY.

YOU MUST COMPLETE THE OTHER SIDE OF THIS REPORT

NOTICE: YOU MUST ATTACH PROOF OF ALL INCOME TYPES AND AMOUNTS. EXAMPLES OF PROOF ARE: PAYCHECK STUBS FOR EARNED INCOME. PROOF OF UNEARNED INCOME MAY BE AWARD LETTERS, COURT ORDERS OR SIGNED STATEMENTS FROM PERSONS OR ORGANIZATIONS WHO ISSUED THE INCOME. COPIES OF CHECKS MAY BE USED. A LIST OF INCOME AND EXPENSES MAY BE USED AS PROOF OF SELF-EMPLOYMENT.

- 1 A. DID YOU OR ANY FAMILY MEMBER RECEIVE FREE HOUSING, UTILITIES, FOOD OR CLOTHING IN THE REPORT MONTH? ☐ YES ☐ NO
 B. DID YOU OR ANY FAMILY MEMBER WORK FOR HOUSING, UTILITIES, FOOD OR CLOTHING IN THE REPORT MONTH? ☐ YES ☐ NO
 IF YES TO 1A AND/OR 1B, YOU MUST ANSWER THE THREE QUESTIONS ON THE NEXT LINE.

WHAT WAS RECEIVED?	WHO RECEIVED IT?	WHO PROVIDED IT?
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- 2 DID YOU OR ANY FAMILY MEMBER WORK DURING THE REPORT MONTH? ☐ YES ☐ NO
 IF YES, YOU MUST COMPLETE THE ITEMS BELOW AND ATTACH ALL PAY STUBS FOR THE REPORT MONTH.
 GROSS AMOUNT IS WHAT WAS EARNED BEFORE DEDUCTIONS WERE TAKEN OUT OF THE CHECK.

NAME	TOTAL HOURS WORKED IN REPORT MONTH:	MO	DAY	YR	MO	DAY	YR	MO	DAY	YR	MO	DAY	YR	MO	DAY	YR
EMPLOYER/SOURCE		DATE PAID:														
		GROSS AMOUNT: \$			\$			\$			\$			\$		

NAME	TOTAL HOURS WORKED IN REPORT MONTH:	MO	DAY	YR	MO	DAY	YR	MO	DAY	YR	MO	DAY	YR	MO	DAY	YR
EMPLOYER/SOURCE		DATE PAID:														
		GROSS AMOUNT: \$			\$			\$			\$			\$		

NAME	TOTAL HOURS WORKED IN REPORT MONTH:	MO	DAY	YR	MO	DAY	YR	MO	DAY	YR	MO	DAY	YR	MO	DAY	YR
EMPLOYER/SOURCE		DATE PAID:														
		GROSS AMOUNT: \$			\$			\$			\$			\$		

- 3 DID YOU OR ANY FAMILY MEMBER RECEIVE MONEY OR BENEFITS FROM OTHER SOURCES? ☐ YES ☐ NO
 (EXAMPLES ARE ON THE OTHER SIDE.)
 IF YES, YOU MUST COMPLETE THE ITEMS BELOW AND ATTACH PROOF OF ALL CHANGES.

NAME	DATE:	MO	DAY	YR	MO	DAY	YR	MO	DAY	YR	MO	DAY	YR	MO	DAY	YR
SOURCE	AMOUNT	\$			\$			\$			\$			\$		

NAME	DATE:	MO	DAY	YR	MO	DAY	YR	MO	DAY	YR	MO	DAY	YR	MO	DAY	YR
SOURCE	AMOUNT	\$			\$			\$			\$			\$		

NAME	DATE:	MO	DAY	YR	MO	DAY	YR	MO	DAY	YR	MO	DAY	YR	MO	DAY	YR
SOURCE	AMOUNT	\$			\$			\$			\$			\$		

- 4 DID YOU OR ANY FAMILY MEMBER PAY FOR CHILD OR DEPENDENT CARE IN THE REPORT MONTH? ☐ YES ☐ NO
 IF YES, YOU MUST ATTACH RECEIPTS TO RECEIVE A DEDUCTION.

- 5 DID ANYONE MOVE INTO OR OUT OF YOUR HOME, OR DID YOU MOVE IN WITH SOMEONE ELSE? ☐ YES ☐ NO
 INCLUDE: NEWBORNS; ANYONE WHO ENTERED OR LEFT A HOSPITAL, NURSING HOME, REHABILITATION CENTER; OR ANYONE WHO DIED.
 IF YES, YOU MUST STATE DATE OF CHANGE AND WHAT HAPPENED.

NAME	RELATIONSHIP TO YOU	WHAT CHANGED	DATE CHANGED

NAME	RELATIONSHIP TO YOU	WHAT CHANGED	DATE CHANGED

- 6 DID YOU OR ANY FAMILY MEMBER HAVE A CHANGE OR GET NEW HEALTH, DENTAL OR MEDICARE COVERAGE OR INSURANCE? ☐ YES ☐ NO

- 7 DO YOU OR ANY FAMILY MEMBER HAVE ANY OTHER CHANGES TO REPORT? ☐ YES ☐ NO
 (EXAMPLES ARE ON THE OTHER SIDE.) IF YES, EXPLAIN ON A SEPARATE SHEET OF PAPER.

- 8 DO YOU WANT YOUR MEDICAL BENEFITS TO CONTINUE? ☐ YES ☐ NO
 IF YOU CHECK NO, YOUR MEDICAL CASE WILL BE DISCONTINUED.

I CERTIFY THAT I WILL REPORT ALL INCOME, PROPERTY AND/OR OTHER CHANGES IN TEN (10) DAYS.
 I DECLARE UNDER PENALTY OF PERJURY THAT ALL INFORMATION PROVIDED IS TRUE AND CORRECT.

SIGNATURE	DATE	TELEPHONE NUMBER
		()

STREET ADDRESS	CITY	ZIP CODE

SIGNATURE OF WITNESS, INTERPRETER OR PERSON ASSISTING	TELEPHONE NUMBER	DATE
	()	

COUNTY USE