STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY PETE WILSON, *Governor*

DEPARTMENT OF HEALTH SERVICES
1/744 P STREET
. BOX 942732
SACRAMENTO, CA 94234-7320

(916) 657-2941

April 26, 1995

TO: All County Administrators
All County Welfare Directors
All County Medi-Cal Program Specialists/Liaisons

Letter No.: 95-29

VETERANS' BENEFITS VERIFICATION AND REFERRAL FORM

Veterans' Benefits Verification and Referral form (CA5) is used by county eligibility workers to request information from the County Veterans Service Offices (CVSO) regarding a Medi-Cal applicant who has indicated that he/she is a veteran, a veteran's spouse/widow, or the dependent child or parent of a veteran. The CVSO determines whether the applicant is receiving disability, death, or other benefits through the U.S. Department of Veterans' Affairs.

This letter is to encourage accuracy and thoroughness in completing the CA5 form (enclosed). The CVSOs indicate they are receiving incomplete forms which delay processing or require that the forms be returned to the welfare department for additional information. The Social Security number of the Medi-Cal applicant must be included on the CA5 form. In many cases, the Medi-Cal applicant may be the spouse/widow or dependent child or parent of the veteran. In these situations, it is essential to provide the Social Security number of both the veteran and the Medi-Cal applicant.

Complete information is also necessary in order for the CVSO to document its Medi-Cal related activities which are reimbursed by the State Department of Health Services. Incomplete information results in a loss of funding for your county veterans' office. When entering an aid code on the CA5 form, you must use a valid aid code. The CVSO cannot be reimbursed for applicants listed with temporary aid codes such as 99 or XX. If necessary, county staff may enter the case's anticipated aid code even though eligibility has not yet been established.

Any questions regarding this letter may be directed to Ms. Chari Hug of the Health Insurance Section at (916) 327-0492.

Sincerely,

ORIGINAL SIGNED BY

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Enclosure

STATE OF CALIFORNIA — HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

VETERANS' BENEFITS VERIFICATION AND REFERRAL

Instructions on Reverse

Original and three copies: *County Veterans Service Office*

One copy: *Case File*

NOTE: DO NOT *COMPLETE THIS FORM UNLESS ONE OF THE FOLLOWING IS KNOWN: VETERAN'S SOCIAL SECURITY NO.* AND *DATE OF BIRTH, MILITARY SERIAL NO., OR VETERANS ADMINISTRATION (V.A.) CLAIM NO.*

Social Security Number (SSN) — You must provide the veteran's SSN, if known, to assist in the evidence gathering process and to explore potential benefits. The furnishing of the SSN of family members is a condition of eligibility required by Section 402(a)(25) (AFDC) and Section 1137(a)(Medi-Cal) of the Social Security Act. Failure to cooperate may result in denial or discontinuance of aid as required by MPP Sections 40-157 and 44-103 (AFDC) and Title 22, CAC Section 50168 (Medi-Cal).

Enter Name and Address of County Veterans Service Office

ELIGIBILITY WORKER (PLEASE PRINT)	
Mary A. Worker	
WORKER NUMBER: Z123	TELEPHONE NUMBER: 732-1234
CASE NAME: VETERAN, John Q.	
CASE NUMBER: 34-18-0370000	APPLICANT/RECIPIENT PHONE NO: 732-6811

[X] Please verify any VA benefits being received by veteran/dependant including Aid and Attendance (A and A), if applicable.

[X] Please determine veteran's/dependent's eligibility for veterans' benefits (see below if requesting A and A).

I

1 VETERAN'S NAME (LAST, FIRST, MIDDLE)	BIRTHDATE	BIRTHPLACE	LIVING?
VETERAN, John Q.	02-27-1925	Sacramento, CA	[X] YES [ ] NO

FOR FG/U ONLY IN HOME?	VETERAN'S ADDRESS (NUMBER, STREET, CITY, STATE, ZIP CODE)	DATE OF DEATH	PLACE OF DEATH
[X] YES [ ] NO	1819 K Street - Sacramento, CA 95814	N/A	N/A

V.A. CLAIM NO.	SOCIAL SECURITY NUMBER	MILITARY SERIAL NUMBER	DATE ENTERED SERVICE	DATE DISCHARGED	BRANCH OF SERVICE
(Indicate, if known)	542-00-0000	39 000 123	04-13-42	08-16-46	Army

	2 NAME OF CLAIMANT	RELATIONSHIP	BIRTHDATE	SOCIAL SECURITY NUMBER	ADDRESS
2	Jane C. Veteran	spouse	01-26-1926	540-12-1234	(Same as veterans)
3					
4					

REQUEST FOR AID AND ATTENDANCE DETERMINATION FOR MEDI-CAL (MA) ONLY CASES

[X] VETERAN [ ] WIDOW [ ] PARENT

MEDI-CAL I.D. NUMBER: 34-18-0370000-000

SHARE OF COST: $ 225.00

EFFECTIVE DATE: 01-01-95

VETERAN'S MONTHLY GROSS INCOME	SSA	CIVIL SERVICE	OTHER	WIDOW'S/PARENT'S MONTHLY GROSS INCOME	SSA	CIVIL SERVICE	OTHER
	$ 626.00	$ 0	$ 220.00		$ 262.00	$ 0	$ 0

LIVING IN: [ ] NURSING FACILITY [X] INDEPENDENT LIVING SITUATION

NAME AND ADDRESS OF NURSING FACILITY

AUTHORIZATION FOR RELEASE OF INFORMATION

III *I hereby authorize the welfare department to release the above information to the County Veterans Service Office and the Veteran's Administration for purposes of identifying or obtaining benefits available to the persons identified above. I also authorize the County Veterans Service Officer and Veteran's Administration to release their findings (to be noted below).*

SIGNATURE (OR MARK) OF VETERAN/DEPENDENT/FC REP.	DATE	SIGNATURE OF WITNESS TO MARK	DATE

IV —TO BE COMPLETED BY COUNTY VETERANS SERVICE OFFICE—

	1-Veteran	2-Claimant	3-Claimant	4-Claimant
Monthly Benefit	$	$	$	$
Beginning Date (Month/Day/Year)				
Ending Date (Month/Day/Year)				
Lump Sum Payment Past 6 Months	$	$	$	$

If Monthly Benefit is being paid, please check:

- [ ] Compensation
- [ ] Pension
- [ ] Other (see Remarks section)
- [ ] Includes A and A benefits of $ _____

Eligibility Status: (Please check)

- [ ] No Basic Eligibility
- [ ] Claim Initiated
- [ ] Claim Being Reviewed
- [ ] Claim Denied

Remarks:

Enter Name and Address of County Welfare Department

FROM:

VETERANS SERVICE REPRESENTATIVE (PRINT)	
TELEPHONE NO.	DATE