STATE OF CALIFORNIA–HEALTH AND WELFARE AGENCY
PETE WILSON, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P Street
P.O. Box 942732
Sacramento, CA 94234-7320
(916) 657-2941

April 3, 1997

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

Letter No.: 97-13

QUARTERLY STATUS REPORT (QSR) MC 176

This letter updates the Department of Health Services' (DHS) policy for the Quarterly Status Report (QSR) MC 176 (SA) used by beneficiaries to report changes affecting their program eligibility.

1. DHS will continue to:

   a. maintain manual copies of the MC176 (SA) at the state level;

   b. publish and distribute changes to the form MC 176 (SA); and

   c. provide state language for approved substitutions (SAWS 7).

2. Consortia/Counties will decide to what degree they automate changes to MC 176 (SA) or approved substitutions. Counties are responsible for the timely and accurate implementation of these changes

3. Counties have the flexibility to:

   a. choose the form format to use within their automated welfare systems;

   b. add as appropriate, their own language to QSRs to adapt to special circumstances (provided they obtain approval for such language from DHS); and

   c. consult on an as needed basis with DHS staff for direction/clarification on individual QSR issues/state language.

4. If counties choose not to automate the form MC 176 (QSR) or not to use a substitute, they will:

   a. notify DHS, Medi-Cal Eligibility Branch, they will not automate the QSR requirement or change within 90 days of its release; and

   b. use manual QSRs in order to remain in compliance with state requirements.

DHS is currently in process of reviewing Article 4H in the Medi-Cal Eligibility Procedures Manual. Revisions to these requirements are anticipated. Counties and Consortia will receive timely updates and informations on these changes as they become available.

This policy applies to all Consortia/Counties. If there are questions about the QSR and specific Medi-Cal requirements, please contact Kveta Simon of my staff at (916) 657-2767.

Sincerely,

ORIGINAL SIGNED BY

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Enclosure

:TATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF HEALTH SERVICES

MEDI-CAL STATUS REPORT

THIS REPORT IS FOR THE MONTH OF

OTICE:

- **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

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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.*

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?

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 / EMPLOYER/SOURCE	TOTAL HOURS WORKED IN REPORT MONTH:		MO DAY YR	MO DAY YR	MO DAY YR	MO DAY YR	MO DAY YR
		DATE PAID:	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
		GROSS AMOUNT:	$	$	$	$	$
NAME / EMPLOYER/SOURCE	TOTAL HOURS WORKED IN REPORT MONTH:		MO DAY YR	MO DAY YR	MO DAY YR	MO DAY YR	MO DAY YR
		DATE PAID:	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
		GROSS AMOUNT:	$	$	$	$	$
NAME / EMPLOYER/SOURCE	TOTAL HOURS WORKED IN REPORT MONTH:		MO DAY YR	MO DAY YR	MO DAY YR	MO DAY YR	MO DAY YR
		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 / SOURCE		MO DAY YR	MO DAY YR	MO DAY YR	MO DAY YR	MO DAY YR
	DATE:	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
	AMOUNT	$	$	$	$	$
NAME / SOURCE		MO DAY YR	MO DAY YR	MO DAY YR	MO DAY YR	MO DAY YR
	DATE:	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
	AMOUNT	$	$	$	$	$
NAME / SOURCE		MO DAY YR	MO DAY YR	MO DAY YR	MO DAY YR	MO DAY YR
	DATE:	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
	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 MEDI-CAL BENEFITS TO CONTINUE? ☐ YES ☐ NO

IF YOU CHECK NO, YOUR MEDI-CAL 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