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

July 16, 1999

TO: All County Welfare Directors
All County Administrative Officers
All County Medi-Cal Program Specialist/Liaisons
All County Public Health Directors
All County Mental Health Directors

Letter No.: 99-36

ELIMINATION OF THE FACE-TO-FACE INTERVIEW REQUIREMENT AT ANNUAL REDETERMINATION

The purpose of this letter is to inform counties that effective July 1, 1999, counties can process **ALL** Medi-Cal annual redeterminations through the mail-in process.

Also effective July 1, 1999, beneficiaries are no longer required to attend a face-to-face interview at annual redetermination. The Medi-Cal Eligibility Branch (MEB) finds sufficient support to make this administrative change after reviewing the data compiled from the Medi-Cal Redetermination Pilot Project (Pilot) conducted in fiscal year 1995-1996.

To ensure equitable program administration within each county when implementing this policy change, **each county shall have clear and concise written directives issued to all eligibility staff that the mail-in redetermination standards apply to all beneficiaries.** Although current regulations allow counties to require beneficiaries under certain categories to attend a face-to-face interview at redetermination; however, counties are to complete the entire redetermination process with beneficiaries by telephone and/or mail.

Please note: This policy change allows all beneficiaries the right to request a face-to-face interview with eligibility staff if they so desire and eligibility staff is allowed to request the beneficiary to complete a face-to-face interview before benefits are redetermined ONLY for good cause such as suspicion of fraud.

The criteria for eligibility staff to require the beneficiary to attend a face-to-face interview could be one or more of the following situations:

- Questionable information on the redetermination form or verifications provided;
- Individual/family has no visible means of support such as in-kind income or means of support is not reported for the individual and/or family;
- Obvious discrepancies between information reported on an application and Income Eligibility Verification System (IEVS) on assets or income; or

- Self-employed individual whose income and expenses do not match reported income and that questionable information could not be resolved with follow-up telephone contact and/or mail.

When a beneficiary is requested by the county to attend a face-to-face interview for any reason, eligibility staff must document the reason(s) in the case record for post-eligibility review and audit. **Eligibility requirements for the Medi-Cal program have not changed with this administrative change.** Each case record must contain adequate information with supportive documentation to verify an individual's eligibility. Verification of identify, residency, citizenship/alien status, Social Security number, income and/or resources remain a part of the eligibility determination process. Recipients of Medi-Cal benefits must comply with the requirements before benefits may be continued.

County welfare departments (CWDs), in addition to the verifications provided by the beneficiary, shall also use the electronic data exchange methods available to verify an individual's eligibility. The data exchange methods are the IEVS, Payment Verification System (PVS), and Systematic Alien Verification of Eligibility (SAVE), to confirm unearned income such as unemployment benefits/disability payments from the Employment Development Department, Social Security benefits from the Social Security Administration, earned interest on an account from a financial institution, and alien status.

I. LEGISLATIVE BACKGROUND

Federal law does not require an applicant or recipient of Medicaid to attend a face-to-face interview as a condition of receiving benefits. The only face-to-face interview requirement is found in Section 11052.5 of the Welfare and Institutions (W&I) Code for applicants for public assistance under Chapters 2 (Aid to Families with Dependent Children) and 5 (Social Services). The Medi-Cal program, adopted the face-to-face interview provision of the W&I Code and imposed the face-to-face requirement on all Medi-Cal Family Budget Units which contain at least one Aid to Families with Dependent Children (AFDC)-Medically Needy or Medically Indigent member to conform with the AFDC program requirements. As cited in W&I Code, Chapter 7 (Basic Health Care), Section 14000, the intent of legislation is that in the administration of providing health care to qualifying individuals, the Department of Health Services shall give due consideration both to the appropriate organization and to the ready accessibility

and availability of the facilities and resources to persons eligible under Chapter 7 (Basic Health Care), and to new and innovative approaches to the delivery of health care services.

II. PROGRAM ALIGNMENT

Title 22, California Code of Regulations allow the following individuals requesting benefits to be exempted from the face-to-face requirement:

- Persons who receive Medi-Cal through the Aid for Adoption of Children Program;
- Persons who have a government representative, such as a public guardian, acting on their behalf;
- Medically indigent children who are not living with a parent or relative and for whom a public agency is assuming financial responsibility in whole or in part; or
- Persons who receive Medi-Cal benefits through the Supplemental Security Income/State Supplementary Payment Program.

Recent federal legislation expanded health care coverage for low-income children ages 1-19 through Medicaid expansion and state Children Health Insurance Program (CHIP), known as the Healthy Families program in California. Eligible children for Medicaid expansion or Healthy Families are linked to the AFDC-Medically Needy and AFDC-Medically Indigent programs and their families' income is at or below 200 percent of the federal poverty level (FPL). State legislation allows families to apply for health care for these children with a common mail-in application and a simplified application process that requires no face-to-face interview. In addition, families whose income is at or below the FPL guidelines will also have their property disregarded in the children's eligibility determination.

MEB recognizes that recent federal legislation for welfare reform and CHIP has had a major impact on Medi-Cal program administration. Elimination of the face-to-face interview requirement at annual redetermination reflects MEB's commitment to work

with counties to relieve workload, prioritize caseload activities and use staff resources effectively. DHS administrative changes are also consistent with the federal and state governments' intent to remove barriers to the Medicaid program for the uninsured and working poor.

III. REDETERMINATION FORMS

Counties may use the following forms for annual redeterminations:

A. **MC 210 RV (9/96 Temp), Medi-Cal Annual Redetermination (Enclosure 1)**

The MC 210 RV form may be used for all redeterminations including those Medi-Cal Family Budget Units consist of adults receiving Medi-Cal benefits with children who are receiving Medi-Cal benefits under one of the poverty waiver programs. The MC 210 RV is a simplified Redetermination Form designed to enable families to provide adequate information to the county for continuing eligibility. The form was developed as a joint effort by the MEB, Pilot counties, and the Medi-Cal Forms Committee. The MC 210 RV was piloted by four of the five Pilot counties for annual redeterminations at the conclusion of the Pilot and the comments and feedback by eligibility staff were positive.

The MC 210 RV form (English and Spanish) is not available from the DHS warehouse at this time. However, CWDs may photocopy Enclosure 1 until it is available through the DHS warehouse. MEB will notify CWDs via E-mail when this form is available for ordering.

For incoming intercounty transfer (ICT) of cases, if the sending county provides the new county with a copy of the SAWS 1, MC 210/SAWS 2, and MC 13 along with other pertinent information for the new county to determine on-going eligibility, the MC 210 RV may provide sufficient income and property information for the new county of residence to redetermine a beneficiary or family's Medi-Cal benefits. Otherwise, the new county may request the beneficiary to provide the new county of residence with a new MC 210/SAWS 2 and other necessary documents to redetermine their eligibility.

B. **MC 321 HFP (rev. 3/99) pages A1-A3, Application for Medi-Cal for Children and Healthy Families (Enclosure 2)**

The MC 321 shall be used for children receiving Medi-Cal benefits through the simplified mail-in application process. If the adults (such as parents) and siblings (from ages 19-21) in the home are also receiving Medi-Cal benefits, county may use the MC 210 RV to complete the annual redetermination for the entire family.

However, if property information or documentation is not provided at the same time, children who are eligible under the property waiver programs shall have their eligibility redetermined without delay. Other members in the Medi-Cal Family Budget Unit who must meet the property guidelines may have their benefits terminated if information/verification requested by the county is not provided within the timeframe specified in a notice of action.

The MC 321 HFP (rev. 3/99) is available in loose-leaf form. Counties may order the forms in English and Spanish through the DHS Warehouse. The loose-leaf application form is available with or without a pre-addressed postage paid envelope. Be sure to state your preference for forms with or without the envelope when ordering from the warehouse. If your loose-leaf stock has an envelope attached, please have eligibility staff remove it from the application forms before sending them to the beneficiaries to complete for the annual redetermination. The pre-addressed envelope is provided to **NEW** applicants for their return of the application forms to the Single Point of Entry Administrative vendor for income screening process for Healthy Families and/or Medi-Cal for children programs. CWDs shall provide envelopes to the beneficiaries for their return of the forms directly to their designated eligibility staff.

C. **MC 262 (5/97) Redetermination for Medi-Cal Beneficiaries--Long Term Care in Own MFBU (Enclosure 3)**

The MC 262 shall be used for beneficiaries receiving Medi-Cal under the long term care aid codes. The MC 262 was designed specifically for beneficiaries residing in long-term care facilities. The MC 262 is available from the DHS warehouse.

IV. RIGHTS AND RESPONSIBILITIES, OTHER PROGRAM INFORMING REQUIREMENTS

With each redetermination notification to the beneficiary, CWD must ensure the **MC 219---Important Information for Persons Requesting Medi-Cal, Child Health and Disability Prevention (CHDP) program brochure** and any other required program information are mailed to the beneficiary with the redetermination form to ensure the beneficiary understands his/her rights and responsibilities to these programs. If a beneficiary requests information and explanation for any program or referral to any services, eligibility staff must ensure the beneficiary's request is met and the action taken is annotated in the case record.

The MEB would like to take this opportunity to thank those program staff who participated in the Pilot for their efforts and hard work. With staff commitment and input, MEB was able to examine the effectiveness of current policies and enhance the Medi-Cal redetermination process for staff and beneficiaries. Together, we will meet the challenges ahead and make health care benefits more widely accessible to the uninsured. A brief summary of the Pilot data (Enclosure 4) is also enclosed with this letter. If you have any questions or comments regarding the redetermination process or the Pilot data, you may contact Ms. Alice Mak of my staff at (916) 654-0573.

Sincerely,

ORIGINAL SIGNED BY

ANGELINE MRVA, Chief
Medi-Cal Eligibility Branch

Enclosures

READ THIS FIRST

USE THESE INSTRUCTIONS TO HELP YOU FILL OUT THE ATTACHED MEDI-CAL ANNUAL REDETERMINATION FORM

(Please return this form to your county welfare department)

1. ***PRINT*** all answers in ink (black ink is best).
2. Please note the following:

   "Applicant" means: (a) you, if you are applying for yourself and/or your family; or (b) the person you are filling in this form for (including the person in long-term care).

   "Caretaker" means a relative other than a parent who is applying on behalf of children under 21 years. A caretaker may ask to be included in the children's Medi-Cal case.

   "Family Member" means: (a) you, even if you are a single person; (b) your spouse or other parent of the children, living with you; (c) your children under 21 years, who are living with you or are away at school; (d) your spouse's or other parent's children under 21 years, who are living with you or are away at school; (e) your unborn child.
3. If you need help or have any questions, ***ask your worker.***
4. If you need more space to answer any question, or have additional information to report, use ***question 21.***

State of California—Health and Welfare Agency

Department of Health Services

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MC 210 RV (9/96) INSTRUCTION SHEET (Temp.)

State of California—Health and Welfare Agency

Department of Health Services

MEDI-CAL ANNUAL REDETERMINATION

Do you want your Medi-Cal benefits to continue? ☐ YES ☐ NO If no, sign and date the last page of this form. If yes, you must answer all of the following questions.

ADULT FAMILY MEMBERS

1 Applicant or Caretaker's Name (First, Middle, Last) | Applicant/Caretaker Relationship to Children

Social Security Number	Marital Status (check one)	Sex
	☐ Married (Date) _____ ☐ Never married ☐ Common law ☐ Separated (Date)_____ ☐ Widowed ☐ Divorced	☐ Female ☐ Male

Is Person Working?	Is the Person Blind, Disabled or Incapacitated?	Pregnant	Medi-Cal Requested
☐ Yes ☐ No	☐ Yes, date of disability: _____ ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

2 Home Address (Number and Street) | City | ZIP Code

Mailing Address (If different from above) | City | ZIP Code

Area Code and Home Phone	Area Code and Work Phone	Area Code and Message Phone	Person With Whom to Leave Message:
( )	( )	( )	

3 Spouse/Other Parent (First, Middle, Last) | Relationship to Applicant

Social Security Number	Marital Status (check one)	Sex
	☐ Married (Date) _____ ☐ Never Married ☐ Common Law ☐ Separated (Date)_____ ☐ Widowed ☐ Divorced	☐ Female ☐ Male

Is Person Working?	Is the Person Blind, Disabled or Incapacitated?	Pregnant	Medi-Cal Requested
☐ Yes ☐ No	☐ Yes, Date of Disability: _____ ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

CHILDREN AND OTHER ADULTS IN HOUSEHOLD

4 LIST ALL CHILDREN AND OTHER ADULTS LIVING IN YOUR HOUSEHOLD:

Name	Relationship	Date of Birth	Pregnant? Yes	Pregnant? No	Student Yes	Student No	Medi-Cal Requested Yes	Medi-Cal Requested No

LIVING ARRANGEMENT/IN-KIND

5 Do you or any family member:

a. Pay for an apartment or house? Amount $ _____ ☐ Yes ☐ No

b. Get free housing, utilities, food, or clothing? ☐ Yes ☐ No

c. Work in exchange for housing, utilities, food, or clothing? ☐ Yes ☐ No

If b or c are "yes," answer all the following questions:

What was received?	Who received it?	Who provided it?

TAX DEPENDENT

6 Are you or any family member claimed as a tax dependent by a person not living with you? ☐ Yes ☐ No

Name and address of person claiming the tax deduction: _____

RESIDENCY

7 Has anyone changed immigration/citizenship status in the last 12 months? ☐ Yes ☐ No

Who: _____ Alien number: _____

What Changed: _____ Date: _____

DED

8 Do you or any family member have a physical or emotional problem which makes it difficult to work or take care of personal needs? ☐ Yes ☐ No

Who: _____

HEALTH INSURANCE

9 Do you or any family member have health insurance? ☐ Yes ☐ No

Who is insured? _____

Did you or any family member get new health, dental, or Medicare coverage or insurance? ☐ Yes ☐ No

COUNTY USE ONLY

Case name: _____

Case Number: _____

Worker Number: _____

Date: _____

☐ MC 210 SI

☐ MC 13

☐ DED packet

☐ DED Re-exam date _____

☐ DHS 6155 form given

Linkage	FSD Referral	Sneede

EMPLOYMENT

10 Attach a copy of the three most recent wage stubs for each person who is working.

Person Number 1–Name | Gross Monthly Earnings $

Employer | Work Telephone ( ) | Date Employment Began (If New Job) ___/___/___

Address (Number and Street) | City | State | ZIP Code

Hours Worked Per Week | Hours Worked Per Month | ☐ Paid Weekly ☐ Every Two Weeks ☐ Two Times a Month ☐ Other | Income From Tips $

Person Number 2–Name | Gross Monthly Earnings $

Employer | Work Telephone ( ) | Date Employment Began (If New Job) ___/___/___

Address (Number and Street) | City | State | ZIP Code

Hours Worked Per Week | Hours Worked Per Month | ☐ Paid Weekly ☐ Every Two Weeks ☐ Two Times a Month ☐ Other | Income From Tips $

Person Number 3–Name | Gross Monthly Earnings $

Employer | Work Telephone ( ) | Date Employment Began (If New Job) ___/___/___

Address (Number and Street) | City | State | ZIP Code

Hours Worked Per Week | Hours Worked Per Month | ☐ Paid Weekly ☐ Every Two Weeks ☐ Two Times a Month ☐ Other | Income From Tips $

11 If any family member is self-employed, attach a copy of last federal tax return or profit/loss statement.
Adjusted gross income from last federal tax return: $ _____ Has income changed? ☐ Yes ☐ No

BUSINESS

12 a. Business/self employment checking/savings accounts or cash? ☐ Yes ☐ No

b. Business equipment, vehicles, tools, inventory, or materials (including livestock or poultry not for personal use):

c. Type of equipment: _____

OTHER INCOME

13 Do you, the other parent/spouse, or children living in the home receive any other income? ☐ Yes ☐ No
If yes, list the source and amount of income received each month. If income is received less often than monthly, indicate how often received. Attach proof of this income.

Source of Income	Applicant	Spouse	Child
Social Security or Railroad Retirement	$	$	$
SSI/SSP	$	$	$
Veterans Benefits (including Aid and Attendance payments)	$	$	$
Retirement or Pension	$	$	$
Interest Income or Dividends	$	$	$
Contributions (including those from relatives)	$	$	$
Child and Spousal Support	$	$	$
Unemployment	$	$	$
State Disability	$	$	$
Worker's Compensation	$	$	$
AFDC	$	$	$
Other (describe)	$	$	$

OTHER EXPENSES

14 Does anyone who works pay for care of a child or disabled adult? ☐ Yes ☐ No
If yes, please complete the following (attach receipts):

Name of Person Receiving Care	Age of Person Receiving Care	Amount of Payment	How Often Paid
Person 1			
Person 2			
Person 3			

Who do you pay for the care? _____
Name

_____
Address

15 Does anyone pay court-ordered child or spousal support? ☐ Yes ☐ No Amount $ _____

16 Is anyone receiving school grants or loans? ☐ Yes ☐ No Who? _____

COUNTY USE ONLY

- ☐ Wage Stubs
- ☐ If U-Parent, MC 210 SW
- ☐ Student exemption
- ☐ Wage Stubs
- ☐ If U-Parent, MC 210 SW
- ☐ Student exemption
- ☐ Wage Stubs
- ☐ If U-Parent, MC 210 SW
- ☐ Student exemption
- ☐ Profit/loss statement
- $ _____
- $ _____
- ☐ Verifications
- ☐ Temporary
- ☐ Permanent
- ☐ Receipts
- ☐ Court order
- ☐ Verified actual payment
- ☐ MC 210 SE

LIQUID RESOURCES

17 List all resources you, the other parent/spouse, or children living in the home have, or resources held or kept for you by anyone

a. Cash or uncashed checks: Amount $ _____

b. List all savings or checking accounts in banks, savings and loans, credit unions, IRA, KEOGH, deferred compensation, retirement accounts, annuities, stocks, bonds, certificates of deposit, money market or mutual fund accounts:

Financial Institution	Type of Account	Account Number	Value/Balance

COUNTY USE ONLY

☐ Copies of accounts

REAL AND PERSONAL PROPERTY

18 a. List real property you own in any country, state, or county (land you own, have title to, or share title in).
ITEMS: houses, land, apartments, mobile homes taxed as real property, or other. If new property, attach a copy of escrow papers and tax statement.
Address or description of property: _____

Value of new property: $ _____ Amount owed: $ _____ Monthly payment: $ _____

b. Address or description of property that you no longer own: _____
Did you sell this property? ☐ Yes ☐ No If yes: when? _____ Value of property sold $ _____
Did you give this property to someone? ☐ Yes ☐ No If yes, who did you give it to? _____
If you sold or gave away property, attach proof.

c. List all life insurance policies, burial plans, burial plots, crypts, or vaults. _____

Face value of any life insurance policies, burial plans, burial plots, crypts, or vaults: $ _____

☐ Exempt? ☐ Yes ☐ No
☐ Escrow papers
☐ Sold
☐ Given away
☐ CSV

VEHICLES

19 List all cars, trucks, campers, motor homes, motorcycles, airplanes, boats, trailers, or off-road vehicles (even if not running) owned by you or your family. Attach copies of vehicle registrations. If none, write "none."

Make and Model	VIN	Year	Owner	Amount Owed	Used for Transportation? Yes	No

☐ Exempt? ☐ Yes ☐ No
☐ Vehicle registrations
☐ Registered class

SERVICES

20 a. Do you want information for Child Health and Disability Prevention Program (CHDP) health services for children under 21? ☐ Yes ☐ No

b. Do you want information on the special supplemental program for Women, Infants, and Children (WIC) for pregnant or breastfeeding women and children under 5? ☐ Yes ☐ No

☐ CHDP brochure/referral
☐ WIC referral

ADDITIONAL INFORMATION

21 Additional information: (List any additional information for questions 1 through 20.)

_____

_____

_____

_____

CERTIFICATION

- I have read and received a copy of the Important Information for Persons Requesting Medi-Cal form (MC 219).
- I am aware of, understand, and agree to meet all my responsibilities as described on the MC 219.
- I understand that all of the statements, including benefit and income information, that I have made on this form are subject to investigation and verification.
- I understand that Section 1137 of the Social Security Act requires that I provide Social Security numbers (SSNs) for myself and/or any family members if I/we claim to be in a satisfactory immigration status. I understand that my/our SSNs will be verified and will be used in a computer match to check the income and resources I/we report with information from welfare, state employment, income tax, Social Security Administration, and other agencies. I understand that this is done to make sure that my/our family's eligibility and share-of-cost level, if any, are correct.

It is the responsibility of the applicant beneficiary and person acting for the applicant beneficiary to report to the Eligibility Worker within ten (10) days any changes that occur.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information contained in this Statement of Facts and any of its supplemental form(s) that I may be asked to complete is true and correct.

Signature of Applicant		Date
Signature of Witness, Interpreter, or Person Assisting	Telephone Number ( )	Date
EW Signature		Date

LEA ESTO PRIMERO

USE ESTAS INSTRUCCIONES PARA LLENAR EL FORMULARIO DE REDETERMINACIÓN ANUAL DE MEDI-CAL ADJUNTO

(Presente el formulario en el departamento de asistencia pública de su condado)

1. ***ESCRIBA*** todas sus respuestas con tinta **en letra de imprenta** (de preferencia use tinta negra).
2. Tome en cuenta lo siguiente:

   "Solicitante" significa: (a) usted, si usted está solicitando Medi-Cal para usted mismo y/o para su familia; o (b) la persona para la cual usted está llenando este formulario (incluyendo a la persona que esté en cuidado a largo plazo).

   "Persona encargada del cuidado continuo de otro" significa un pariente que no sea el padre o la madre, y que presenta la solicitud a nombre de niños menores de 21 años. Esta persona puede solicitar que se le incluya en el caso de Medi-Cal de los niños.

   "Miembro de la familia" significa: (a) usted, incluso si Ud. es soltero; (b) su cónyuge o el padre/madre de los niños, que viva con usted; (c) los hijos menores de 21 años de edad que vivan con usted o que estén lejos en la escuela; (d) los hijos de su cónyuge o del padre o madre, menores de 21 años de edad que vivan con usted o que estén lejos en la escuela; (e) su bebé que aún no haya nacido.
3. Si necesita ayuda o tiene alguna pregunta, ***pídale ayuda a su trabajador.***
4. Si necesita más espacio para contestar alguna pregunta, o tiene que reportar información adicional, use el espacio que se proporciona en la ***casilla 21.***

State of California—Health and Welfare Agency

Department of Health Services

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MC 210 RV (Sp) (9/96) INSTRUCTION SHEET (Temp.)

State of California—Health and Welfare Agency

Department of Health Services

REDETERMINACIÓN ANUAL DE MEDI-CAL

¿Desea seguir obteniendo beneficios de Medi-Cal? ☐ SÍ ☐ NO Si no, firme y feche la última página de este formulario **Si sí, conteste todas las preguntas.**

MIEMBROS ADULTOS DE LA FAMILIA

1 Nombre del Solicitante o Tutor (Nombres, Apellido) | Parentesco/Relación con los Niños

Número de Seguro Social	Estado Civil (marque uno)	Sexo
	☐ Casado (Fecha) _____ ☐ Nunca casado ☐ Unión libre ☐ Separado (Fecha) _____ ☐ Viudo ☐ Divorciado	☐ Femen. ☐ Masc.

¿Trabaja?	¿Es ciego o está minusválido o incapacitado?	¿Embarazada?	¿Solicitó Medi-Cal?
☐ Sí ☐ No	☐ Sí, ¿Desde cuándo?: _____ ☐ No	☐ Sí ☐ No	☐ Sí ☐ No

2 Domicilio (Número y Calle) | Ciudad | Código Postal

Dirección Postal (Si es diferente a la anterior) | Ciudad | Código Postal

(Área) Teléfono particular	(Área) Teléfono del Trabajo	(Área) Teléfono para Mensajes	Persona con quien dejar Mensaje:
( )	( )	( )	

3 Cónyuge/ padre o madre del niño (Nombres, Apellido) | Parentesco con el Solicitante

Número de Seguro Social	Estado Civil (marque uno)	Sexo
	☐ Casado (Fecha) _____ ☐ Nunca casado ☐ Unión libre ☐ Separado (Fecha) _____ ☐ Viudo ☐ Divorciado	☐ Femen. ☐ Masc.

¿Trabaja?	¿Es ciego o está minusválido o incapacitado?	¿Embarazada?	¿Solicitó Medi-Cal?
☐ Sí ☐ No	☐ Sí, ¿Desde cuándo?: _____ ☐ No	☐ Sí ☐ No	☐ Sí ☐ No

NIÑOS Y OTROS ADULTOS QUE VIVAN EN CASA

4 ESCRIBA EL NOMBRE DE TODOS LOS NIÑOS Y OTROS ADULTOS QUE VIVAN EN SU CASA:

Nombre	Parentesco	Fecha de Nacimiento	¿Embarazada? Sí	¿Embarazada? No	¿Estudiante? Sí	¿Estudiante? No	¿Solicitó Medi-Cal? Sí	¿Solicitó Medi-Cal? No

ARREGLOS DE MANTENIMIENTO EN ESPECIE,

5 Usted o alguien de su familia:

a. ¿Está pagando una casa o departamento? Cantidad $ _____ ☐ Sí ☐ No

b. ¿Recibe hospedaje, servicios públicos, comida o ropa gratuitos? ☐ Sí ☐ No

c. ¿Trabaja a cambio de hospedaje, servicios públicos, comida o ropa? ☐ Sí ☐ No

Si respondió sí a las preguntas b o c, conteste a las siguientes preguntas:

¿Qué fue lo que recibió?	¿Quién lo recibió?	¿Quién se lo dio?

DEPENDIENTE PARA IMPUESTOS

6 ¿Es Ud. u otro miembro de la familia dependiente de alguien fuera del hogar para fines de impuestos? ☐ Sí ☐ No

Nombre y dirección de la persona que reclama la deducción de impuestos _____

RESIDENCIA

7 ¿Ha cambiado el estado migratorio/ciudadanía de alguno de ustedes en los últimos 12 meses? ☐ Sí ☐ No

¿De quién? _____ Número de Residente: _____

¿Cuál fue el cambio? _____ Fecha: _____

DED

8 ¿Padece Ud. o algún miembro de su familia de algún problema físico o emocional que le dificulte trabajar o cuidar de sus necesidades personales? ☐ Sí ☐ No

¿Quién? _____

SEGURO MÉDICO

9 ¿Tiene Ud. o algún miembro de la familia seguro médico? ☐ Sí ☐ No

¿Quién? _____

¿Obtuvo Ud. o alguien de la familia un seguro o cobertura médica o dental, o de Medicare nuevos? ☐ Sí ☐ No

PARA USO DEL CONDADO

Case name: _____

Case Number: _____

Worker Number: _____

Date: _____

Linkage	FSD Referral	Sneede

☐ MC 210 SI

☐ MC 13

☐ DED packet

☐ DED Re-exam date _____

☐ DHS 6155 form given

PREGUNTAS SOBRE EMPLEO

10 Adjunte copias de los tres últimos talones de pago de cada persona que esté trabajando.

Persona Número 1—Nombre | Ingreso Neto Mensual $

Empleador | Teléfono de su Trabajo ( ) | Fecha de Inicio (Si es un trabajo nuevo) ____/____/____

Dirección (Número y Calle) | Ciudad | Estado | Código Postal

Horas de Trabajo a la Semana | Horas de Trabajo al Mes | ☐ Pago semanal ☐ Pago quincenal ☐ Pago dos veces al mes ☐ Otro | Ingreso por Propinas $

Persona Número 2—Nombre | Ingreso Neto Mensual $

Empleador | Teléfono de su Trabajo ( ) | Fecha de Inicio (Si es un trabajo nuevo) ____/____/____

Dirección (Número y Calle) | Ciudad | Estado | Código Postal

Horas de Trabajo a la Semana | Horas de Trabajo al Mes | ☐ Pago semanal ☐ Pago quincenal ☐ Pago dos veces al mes ☐ Otro | Ingreso por propinas $

Persona Número 3—Nombre | Ingreso Neto Mensual $

Empleador | Teléfono de su Trabajo ( ) | Fecha de Inicio (Si es un trabajo nuevo) ____/____/____

Dirección (Número y Calle) | Ciudad | Estado | Código Postal

Horas de Trabajo a la Semana | Horas de Trabajo al mes | ☐ Pago semanal ☐ Pago quincenal ☐ Pago dos veces al mes ☐ Otro | Ingreso por propinas $

11 Si alguien de la familia trabaja por cuenta propia, adjunte copia de la última Declaración Federal de Impuestos o Declaración de Ingresos.

Ingreso Neto de la última Declaración Federal de Impuestos después de cualquier ajuste $_____ ¿Cambió su ingreso? ☐ Sí ☐ No

NEGOCIOS

12 a. ¿Efectivo o cuenta de cheques/ ahorros del negocio o de la persona que trabaja por cuenta propia? ☐ Sí ☐ No

b. Equipo comercial, vehículos, herramientas, inventario, o material (incluyendo ganado o aves que no sean para uso personal):

_____

c. Tipo de equipo: _____

OTROS INGRESOS

13 ¿Usted, el padre/madre, su cónyuge, o los niños que viven en casa tienen algún otro ingreso? ☐ Sí ☐ No

Si sí, nombre la fuente de ingreso y la cantidad mensual. Si dicho ingreso no se recibe mensualmente, indique con que frecuencia se recibe. Adjunte prueba de dicho ingreso.

Fuente de Ingreso	Solicitante	Cónyuge	Hijo
Jubilación de Ferrocarril o Seguro Social	$	$	$
SSI/SSP	$	$	$
Beneficios para Veteranos (incluya pagos de Asistencia y Cuidados	$	$	$
Jubilación o Pensión	$	$	$
Ingresos por cobro de Intereses o Dividendos	$	$	$
Contribuciones (incluyendo las de sus parientes)	$	$	$
Mantenimiento de hijos o pensión alimenticia	$	$	$
Beneficios por desempleo	$	$	$
Beneficios por Incapacidad proporcionados por el Estado	$	$	$
Compensación por lesiones de trabajo	$	$	$
AFDC	$	$	$
Otro (describa)	$	$	$

OTROS GASTOS

14 ¿Paga alguna de las personas que trabaja gastos de cuidado de un menor o adulto incapacitado? ☐ Sí ☐ No

Si sí, conteste lo siguiente (adjunte recibos):

Nombre de la Persona que Recibe Cuidado	Edad de la Persona que Recibe Cuidado	Cantidad del Pago	Frecuencia del Pago
Persona 1			
Persona 2			
Persona 3			

¿A quién le paga por este servicio? _____
Nombre

_____
Dirección

15 ¿Paga algún miembro de la familia mantenimiento de hijos o pensión alimenticia por orden de la corte? ☐ Sí ☐ No Cantidad $_____

16 ¿Recibe alguien de la familia becas o préstamos escolares? ☐ Sí ☐ No ¿Quién? _____

PARA USO DEL CONDADO

- ☐ Wage Stubs
- ☐ If U-Parent, MC 210 SW
- ☐ Student exemption
- ☐ Wage Stubs
- ☐ If U-Parent, MC 210 SW
- ☐ Student exemption
- ☐ Wage Stubs
- ☐ If U-Parent, MC 210 SW
- ☐ Student exemption
- ☐ Profit/loss statement

$_____

$_____

- ☐ Verifications
- ☐ Temporary
- ☐ Permanent

- ☐ Receipts

- ☐ Court order
- ☐ Verified actual payment

- ☐ MC 210 SE

RECURSOS EN EFECTIVO

17 Anote todas sus posesiones, las del padre/madre, conyuge o niños en casa , incluyendo las suyas que estén a nombre de otro.

a. Dinero en efectivo o cheques sin cobrar Cantidad $ _____

b. Anote todas las cuentas corrientes o ahorros en el banco, cuentas de ahorros y prestamos, uniones de crédito, IRA, KEOGH,compensación diferida, cuentas de jubilación, anualidades, acciones, bonos, certificados de depósito, cuentas a plazo fijo o fondos mutualistas

Institución Financiera	Tipo de Cuenta	Número de Cuenta	Valor/Saldo

PARA USO DEL CONDADO

☐ Copies of accounts

BIENES RAÍCES Y PROPIEDAD PERSONAL

18 a. Anote todos los bienes raices que posea en cualquier pais, estado, o condado (terrenos que posea, o comparta título de propiedad) ARTÍCULOS: casas, terrenos, departamentos, casas móviles consideradas como bienes raices para fines de impuestos, u otro. Si la propiedad es nueva, adjunte copia de escrituras de fideicomiso y declaración de impuestos.

Dirección o descripción de la propiedad: _____

Valor de la nueva propiedad: $_____ Cantidad que debe: $_____ Pago mensual: $ _____

b. Dirección o descripción de la propiedad que ya no le pertenece: _____

¿Vendió esta propiedad? ☐ Si ☐ No Si sí.: ¿Cuándo? _____ Valor de dicha propiedad $ _____

¿Regaló esta propiedad a alguien? ☐ Si ☐ No Si sí: ¿A quién? _____

Si vendió o regaló la propiedad, adjunte documentos que lo prueben.

c. Anote todos los seguro de vida, fideicomiso para entierro, lotes de cementerio, ataudes o criptas : _____

Valor nominal de sus seguros de vida, fideicomisos de entierro, lotes de cementerio, ataudes o criptas: $_____

☐ Exempt? ☐ Yes ☐ No

☐ Escrow papers

☐ Sold

☐ Given away

☐ CSV

VEHÍCULOS

19 Anote todos los automóviles, camiones, cámpers, remolques, motocicletas, aviones, botes, trailers, vehículos todo terreno(aun si no funcionan) que le pertenezcan a Ud. o su familia. Adjunte copias de los registros de los vehículos. Si no tiene ninguno, escriba "none"

Fabricante y Modelo	Número de Serie	Año	Propietario	Cantidad que todavía debe	¿Se emplea para Transporte? Sí	No

☐ Exempt? ☐ Yes ☐ No

☐ Vehicle registrations

☐ Registered class

SERVICIOS

20 a. ¿Desea información sobre los servicios de salud del Programa de Salud y Prevención de Incapacidad para Niños y Adolescentes (CHDP) disponibles para menores de 21 años? ☐ Si ☐ No

b. ¿Desea información sobre el programa especial de ayuda suplementaria para Mujeres, Bebés y Niños (WIC) para mujeres embarazadas o que estén amamantando y para niños menores de 5 años? ☐ Si ☐ No

☐ CHDP brochure/referral

☐ WIC referral

INFORMACIÓN ADICIONAL

21 Información Adicional: (Anote cualquier información adicional a las preguntas 1 a la 20.)

_____

_____

_____

_____

CERTIFICACIÓN

- He leído y recibido un ejemplar del formulario Información Importante para Solicitantes de Medi-Cal (MC 219).
- Estoy informado, entiendo y estoy de acuerdo en cumplir con todas las responsabilidades descritas en el formulario MC 219.
- Entiendo que toda la información que he proporcionado, incluyendo la referente a ingresos y beneficios, está sujeta a investigación y verificación.
- Entiendo que la Sección 1137 del Acta del Seguro Social requiere que proporcione mi Número de Seguro Social (SSN) así como el de mis familiares, si yo (nosotros) declaro(amos) tener un estado migratorio satisfactorio. Entiendo que mi SSN y el de mis familiares serán verificados y utilizados para comparar por medio de una computadora los ingresos y recursos declarados con información del departamento de asistencia pública, de empleo del estado, de impuestos, de la Administración del Seguro Social y otras agencias. Entiendo que esto se lleva a cabo a fin de verificar mi (nuestra) elegibilidad y la parte del costo, si la hay, y que sean correctas.

Es responsabilidad del solicitante/beneficiario y de la persona que representa al solicitante/beneficiario reportar al Trabajador de Elegibilidad cualquier cambio en un plazo de diez (10) días a partir de la fecha en que ocurra.

Declaro bajo pena de perjurio, en conformidad con las leyes de los Estados Unidos de América y del Estado de California, que la información contenida en esta Declaración de Datos y cualquiera de los formularios suplemetarios que me pudieran pedir que complete es verídica y correcta.

Firma del Solicitante		Fecha
Firma del Testigo, Intérprete o de la persona que ayudó al solicitante a llenar el formulario	Número de Teléfono ( )	Fecha
Firma del Trabajador de Elegibilidad (EW)		Fecha

ENCLOSURE 2

MEDI-CAL FOR CHILDREN

APPLICATION

Please use the instructions to complete this application.
Print clearly. Use black or blue ink only.

HEALTH

SECTION 1: Tell us about the person applying for the child, the pregnant woman or the 18 year old applying for self.

1 LAST NAME	FIRST NAME	MIDDLE INITIAL	2 BIRTHDATE MO / DATE / YR	
3 HOME ADDRESS (NUMBER AND STREET). DO NOT USE A P.O. BOX		4 APARTMENT NUMBER	5 HOME PHONE # ( )	
6 CITY	7 COUNTY	8 ZIP CODE	9 WORK PHONE # ( )	
10 MAILING ADDRESS (IF DIFFERENT FROM ABOVE) OR P.O. BOX		11 APARTMENT NUMBER	12 MESSAGE PHONE # ( )	
13 CITY		14 ZIP CODE	15 WHAT LANGUAGE DO YOU SPEAK BEST?	

16 We will enroll the child or pregnant woman in the program they qualify for. If you do not want to be enrolled in one of these programs, check the box(es) below.

I DO NOT WANT:
- ❑ **Healthy Families**: Do not send birth certificates. Do not complete the Healthy Families Page.
- ❑ **Medi-Cal**: Do not send proof of income deductions, or if working out of state, proof of California residency.
- ❑ Access for Infants and Mothers (**AIM**).

SECTION 2: Tell us about the children under 19 and/or the pregnant woman who want health coverage.

	Child 1	Child 2	Child 3	Child 4	Pregnant Woman or 18 year old applying for self
17 Name: Last					
First					
Middle					
18 Name on Birth Certificate: Last *(If same as #17 above, leave blank.)*					
First					
Middle					
19 If the child's address is not the same as in Section 1, Question 3, give complete address:					
20 Relationship to person in Section 1:					
21 Sex:	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female
22 Date of Birth:	/ / MO DATE YR	/ / MO DATE YR	/ / MO DATE YR	/ / MO DATE YR	/ / MO DATE YR
23 Place of Birth: County or State or Country, if outside the U.S.					
24 Ethnic Code: *(See #24 instructions)*					
25 U.S. Citizen or National? If "no", please write date of entry into U.S.	❑ Yes ❑ No / / MO DATE YR	❑ Yes ❑ No / / MO DATE YR	❑ Yes ❑ No / / MO DATE YR	❑ Yes ❑ No / / MO DATE YR	❑ Yes ❑ No / / MO DATE YR
26 Social Security #:					

Social Security Numbers are not required for Healthy Families or for persons who want emergency or pregnancy related services only.

SECTION 2: Continued

	Child 1	Child 2	Child 3	Child 4	Pregnant Woman or 18 year old applying for self
27 Mother's Name: Last					
First					
Does the mother live in the home?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
28 Father's Name: Last					
First					
Does the father live in the home?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
29 Name of teen's spouse or pregnant woman's husband: *(If living in the home)*					
30 Does any person(s) being applied for have **no-cost Medi-Cal**? If "yes", give date coverage ends/ended.	❑ Yes ❑ No / / MO DATE YR	❑ Yes ❑ No / / MO DATE YR	❑ Yes ❑ No / / MO DATE YR	❑ Yes ❑ No / / MO DATE YR	❑ Yes ❑ No / / MO DATE YR
31 Does the pregnant woman and/or children have other health, dental or vision insurance?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
32 Were any of the children insured by an employer in the last 90 days? If "yes", check the main reason why health insurance stopped and give the date it stopped.	❑ Yes ❑ No ❑ Lost job ❑ Moved and no insurance available ❑ Employer ended benefits to all employees ❑ COBRA coverage ended ❑ Other / / MO DATE YR	❑ Yes ❑ No ❑ Lost job ❑ Moved and no insurance available ❑ Employer ended benefits to all employees ❑ COBRA coverage ended ❑ Other / / MO DATE YR	❑ Yes ❑ No ❑ Lost job ❑ Moved and no insurance available ❑ Employer ended benefits to all employees ❑ COBRA coverage ended ❑ Other / / MO DATE YR	❑ Yes ❑ No ❑ Lost job ❑ Moved and no insurance available ❑ Employer ended benefits to all employees ❑ COBRA coverage ended ❑ Other / / MO DATE YR	❑ Yes ❑ No ❑ Lost job ❑ Moved and no insurance available ❑ Employer ended benefits to all employees ❑ COBRA coverage ended ❑ Other / / MO DATE YR

SECTION 3: Family members living in the home. Family size is taken into consideration when determining which program your children are eligible for.

33 List any other children living in the home under age 21 who are not listed in Section 2. Give their relationship to the person in Section 1, Question 1.

LAST NAME, FIRST NAME	RELATIONSHIP	LAST NAME, FIRST NAME	RELATIONSHIP
LAST NAME, FIRST NAME	RELATIONSHIP	LAST NAME, FIRST NAME	RELATIONSHIP

34 Are any family members who are living in the home pregnant? ❑ Yes ❑ No

If yes, who: ______________________ Date Due: ______________

35 List any stepparent living in the home not already listed: ______________________
LAST NAME, FIRST NAME

36 Do any of the people listed in this Section, or any of the parents listed in Section 2, want **Medi-Cal**? ❑ Yes ❑ No

SECTION 4: List the gross income (before taxes) of all persons listed in Section 2, Questions 17, 27, 28, 29 and Section 3 who live in the home. If self-employed or using federal income tax return to prove income, only complete Questions 37, 38 and 40 in this section.

37 NAME OF PERSON WITH INCOME	38 SOURCE OF INCOME?	39 HOW OFTEN RECEIVED?	40 HOW MUCH GROSS INCOME?	41 SOCIAL SECURITY # *(Optional)*
1.				
2.				
3.				
4.				

SECTION 5: Deductions from Family Income. The answers in this section will help determine what amounts may be deducted from your family's gross monthly income.

42 TYPE OF PAYMENT YOUR FAMILY MAKES	43 NAME OF PERSON WHO PAYS	44 MONTHLY AMOUNT PAID
Child Support		
Alimony		

45 CHILD CARE OR DEPENDENT CARE *(List child's name)*	46 AGE	47 MONTHLY AMOUNT PAID
1.		
2.		
3.		
4.		

SECTION 6: Other Coverage.

48 Has anyone filed a lawsuit because of an accident or injury on behalf of the pregnant woman and/or child applying for benefits? ❑ Yes ❑ No

49 Does the pregnant woman and/or child want to apply for **Medi-Cal** coverage for any unpaid medical expenses in the last 3 months? ❑ Yes ❑ No

If "yes", list month(s): _____

SECTION 7: Voluntary Information. Not required. Your answers will not affect your eligibility but they will help the state to get additional federal money to pay for health care programs.

50 Is there more than one car in the children's household? ❑ Yes ❑ No

51 Is there more than $3,150 cash in bank accounts in the children's household? ❑ Yes ❑ No

SECTION 8: Signature and Certification.

52 I declare under penalty of perjury under the laws of the State of California that the answers I have given in this application, the declarations made, and the documents submitted are true and correct to the best of my knowledge and belief. I declare that I have read and understand the application instructions, the declarations, and all information printed on this application.

Signature _____ Date _____

Witness Signature _____ Date _____
(If person signed with a mark)

Authorized Representative *(If any)* _____ Date _____

SECTION 9: Reimbursement for Application Assistance. For Certified Application Assistant use only.

53 I certify I had help completing this form from the Certified Application Assistant listed below. This CAA help was FREE of charge. The state will not issue a reimbursement to the EE unless Section 9 is completely and correctly filled out at the time this application is submitted.

Applicant Signature _____ Date _____

CAA Signature _____ CAA# _____ EE# _____ Date _____

REDETERMINATION FOR MEDI-CAL BENEFICIARIES (LONG-TERM CARE IN OWN MFBU)

INSTRUCTIONS: Your continuing eligibility will be decided on the information you give on this form. If you are completing this form on someone else's behalf, the term "you" applies to that person. ***ALL QUESTIONS MUST BE ANSWERED.***

1. Name (first, middle, last) | Date of birth (month, day, year) | Social Security number*

2. Long-term care facility name | Marital status | Medicare claim number
   Facility address (number, street) | City | ZIP code

3. Name of spouse | Social Security number | Telephone ( )
   Address of spouse (number, street) | City | State | ZIP code

4. Name of person helping complete form | Relationship | Telephone ( )

5. Address of person helping with form (if information regarding beneficiary should be sent to this person)
   Number, street | City | State | ZIP code

6. Do you own any real property, have an interest in real property, or own a trailer or mobile home taxed as real property? ☐ Yes ☐ No
   If yes:
   a. Is this property your former home? ☐ Yes ☐ No
      If yes, do you intend to return to that property to live in the future? ☐ Yes ☐ No
      (If this intent changes, you must notify the county within 10 days.)
      If you do not intend to return to that property, does anyone else live there now? ☐ Yes ☐ No
      If yes, enter name: _____ Relation to you: _____
      Basis of dependency (financial, medical, etc.) _____
      How long have they lived there? _____
   b. Is this property currently listed for sale? ☐ Yes ☐ No
      Description of property: _____
      Address of property: _____
      Owner(s): _____
      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

7. Do you have a life estate in any property? ☐ Yes ☐ No
   If yes, describe: _____

8. Do you own a note, mortgage, or deed of trust? ☐ Yes ☐ No
   If yes: Appraised value $ _____ Monthly payment: $ _____ Interest rate: _____%

9. Do you have any checks or money on hand in banks, savings and loans, or credit unions, etc. (checking or savings accounts), or a patient trust account, or being held for you by anyone, or being kept anywhere for you? ☐ Yes ☐ No
   If yes:
   a. On hand?
      Location | Amount | Account number
   b. In bank or savings?
      Location | Amount | Account number
      Location | Amount | Account number
   c. Held or kept for you by anyone?
      Location | Amount | Account number

COUNTY USE ONLY

PR ☐ Yes ☐ No

☐ DHS 7014

Utilized ☐ Yes ☐ No

$ _____

Current month income included ☐ Yes ☐ No

$ _____

$ _____

$ _____

$ _____

10. Have you sold, transferred, or given away any property (including money) at any time in the past year?... ☐ Yes ☐ No ☐ Verification

If yes:

Description	Date of Transfer, Sale, or Gift	Value	Amount Received
		$	$
		$	$
		$	$

11. Do you own any of the following items of property? Check yes or no. If yes, provide the other information requested.

	Yes	No	Purchase Price	Current Value	Amount Owed	
a. Stocks or bonds, certificates of deposit, money market, or mutual fund account			$	$	$	$
b. Jewelry valued over $100 (other than wedding or engagement heirlooms)			$	$	$	☐ Exempt
c. Burial reserve or trust			$	$	$	$
d. Burial plot, vault, or crypt			$	$	$	$
e. Business equipment, tools, inventory, or material			$	$	$	$
f. Other			$	$	$	$

12. Do you own any annuities or life insurance policies or long-term care insurance policies for yourself or anyone else? ☐ Yes ☐ No

If yes:

Company	Name of Insured or Annuitant	Face Value	Current Cash Value
a.		$	$
b.		$	$
c.		$	$

Verification of CSV on file? $_____
Copy of annuity on file? ☐ Yes ☐ No
State certified LTC policy? ☐ Yes ☐ No
Amount paid out $_____
DHS 6155 completed ☐ Yes ☐ No

13. Do you own a motor vehicle (car, truck, etc.); or a boat, camper, or motor home; or mobile home or trailer not taxed as real property? ☐ Yes ☐ No

If yes:

Description	Class Code (From Registration)	Year	Purchase Price	Amount Owed
			$	$
			$	$

Exempt ☐ Yes ☐ No

14. Do you or your spouse receive any income? ☐ Yes ☐ No

If yes, list the source and amount of income received each month. If income is received less often than monthly, indicate how often received. Attach verification of this income.

	When Paid/How Often	Applicant	Spouse	
Social Security (green check)		$	$	$
SSI/SSP		$	$	$
Railroad retirement		$	$	$
Veterans benefits (including Aid and Attendance payments)		$	$	$
Retirement or pension		$	$	$
Annuities		$	$	$
Interest income or dividends		$	$	$
Contributions (including those from relatives)		$	$	$
Earnings (gross)		$	$	$
Other (include lump sum payments, inheritance, etc.)		$	$	$

$_____
Use copy of award letter or check or other verification

15. a. 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

CA5 (if not already completed)

16. Have you applied for or do you think you are eligible for any payments you are not now receiving? ☐ Yes ☐ No

If yes:

Kind of Payment	Date Applied For	Date Expected

17. Do you have Medicare coverage? ☐ Yes ☐ No

If yes:

Name	Medicare claim number	Monthly premium
		Deduction from check? ☐ Yes ☐ No Paid by you? ☐ Yes ☐ No

Date verified

18. Do you have health or hospitalization insurance? ☐ Yes ☐ No

If yes:

DHS 6155 completed? ☐ Yes ☐ No

Name of insurance company

OHC Code

Premium you pay	How often?		
$	☐ Monthly	☐ Quarterly	☐ Yearly

19. Would you like to speak to a social worker about services available to you? ☐ Yes ☐ No

Service Referral ☐ Yes ☐ No

If yes, explain the services you wish to discuss:

20. Additional information

BE SURE YOU HAVE READ EVERY ITEM AND ANSWERED ALL THE QUESTIONS.

READ THE FOLLOWING CAREFULLY BEFORE SIGNING.

I declare under penalty of perjury that the answers I have given are correct and true to the best of my knowledge.

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 a change in my living situation. I agree to meet all the other responsibilities explained in the "Important Information for Persons Requesting Medi-Cal" (MC 219) I received at the time of my application for Medi-Cal. (A new "Important Information for Persons Requesting Medi-Cal" (MC 219) will be provided if there is a change in the person acting on behalf of the beneficiary.)

I understand that Section 1137 of the Social Security Act requires that I provide my Social Security number (SSN). My SSN will be verified and will be used in a computer match to check the income and resources I report with information from welfare, state employment, income tax, Social Security Administration, and other agencies.

I understand that Sections 215, 9202, and 9203 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 55 from the estate of a Medi-Cal beneficiary if there is no surviving spouse, minor children, or blind or totally disabled children, or it would create a hardship for my heirs. After the death of my surviving spouse, the State has the right to claim from the part of his/her estate received from me, all Medi-Cal benefits I received after age 55 up to the amount of property my spouse received from my estate.

I understand that I may be asked to prove my statements, but that the county is required by law to keep them confidential.

I understand that if I am dissatisfied with any action or inaction taken by the county welfare department, I have the right to a state hearing which I may request from the county welfare department within 90 days after the action or inaction with which I am dissatisfied.

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 (or his/her) Medi-Cal card and/or be prosecuted for fraud.

Signature of beneficiary	Date
Signature of person acting for beneficiary	Date
Signature of witness (if beneficiary signed with mark)	Date
E.W. signature	Date

Enclosure 4

PILOT SUMMARY

In fiscal year 1995-1996, the Medi-Cal Eligibility Branch (MEB) conducted a five-county (Orange, San Diego, Contra Costa, Sonoma, and Stanislaus) Medi-Cal Redetermination Pilot (Pilot) study for a six-month period comparing the effectiveness of a mail-in approach to eligibility redetermination with the face-to-face method required under Title 22, California Code of Regulations, Section 50189(d).

In each county, the pilot (mail-in) approach was compared to the control (face-to-face) approach. Three key study variables were reviewed: (1) the time required to conduct the redetermination; (2) the change in share of cost (SOC); and (3) the difference in cases discontinued as a result of the redetermination requirement. Data was collected from a total of 16,615 cases. Total cases in the control group equals 6,465 and the pilot group equals 10,150.

In addition, the Medi-Cal Eligibility Branch conducted on-site case review in the five counties and collected additional data on 10 percent of SOC and 20 percent of the discontinued cases from the pilot study. The purpose of the on-site case review was to determine if there were significant changes (1) in the SOC amount before and after redetermination; and (2) the number of reapplications within the six-month period following case discontinuance.

FINDINGS

1. Length of Time to Complete a Redetermination

   The tasks associated with the redetermination process are: mailing packages, reviewing the forms, contacting the beneficiaries on the telephone, and conducting the face-to-face interviews.

   - The control group average was 50.4 minutes per case, including 2.2 minutes for telephone contacts; and
   - The pilot group was 45.4 minutes per case, including 4.0 minutes for telephone contacts.

   The data shows there are time savings with the mail-in process even with a longer time spent on telephone contacts.

2. **Change in SOC**

   The SOC data is used to determine if information received at redetermination has any impact on budget recomputation. The data collected shows:

- 5,700 cases had a SOC during the Pilot: control group equals 2,163 (38 percent) and pilot group equals 3,537 (62 percent);

- the control group: 69 percent had a SOC before and after redetermination, 17 percent did not have a SOC before but gained a SOC after, and 14 percent had a SOC before then lost the SOC after;

- the pilot group: 74 percent had SOC before and after, 13 percent had no SOC before but gained a SOC after, and 13 percent had a SOC but lost the SOC after the redetermination.

The SOC data from the survey forms shows 1.06 percent more cases in the control group gained a SOC and the pilot group had .49 percent more cases lost a SOC. The data does not show the actual gains or losses because the survey form was not designed to capture the actual gains or losses. When the Med.-Cal Eligibility Branch conducted the on-site case review, the SOC data collected demonstrates using the mail-in process did not result in lower SOC for the beneficiaries in the pilot group. The on-site case review SOC data shows:

- A greater number of cases had an increase in the SOC after redetermination and the pilot group had higher ratio of SOC increases than the control group;

- The difference in SOC increases between the two groups is only 2 percent (40 percent control versus 42 percent pilot);

- Some income cases with children were eligible for benefits under one of the federal poverty level programs or Sneede v. Kizer budgeting; and

- The beneficiaries had already reported the increase in earned/unearned income on their Quarterly Status Report in the same month of the redetermination and that rebudgeting was already in progress.

3. **Discontinued Cases**

There were more discontinuances among the pilot cases. The differences between the two groups are not significant but the reasons for the discontinuance were different.

- Pilot discontinuance 11.3 percent (1, 151 cases) versus 9.2 percent (595) for control cases;
- Percentage difference between the two groups, 2.1 percent;

- Highest discontinuance, 8.2 percent (892) in the pilot group are in the "failure to cooperate" category; and

- Highest discontinuances, 5.1 percent (332) for the control group are in the "no show" category.

The survey form did not ask for specifics in the "failure to cooperate" category. The conditions or specific time frame for beneficiaries cooperation for restoration of benefits are unknown. Very few beneficiaries, 1.6 percent become ineligible due to information received at redetermination.

The on-site case review data shows:

- most cases discontinued for failure to cooperate were for incomplete or non-return of the redetermination forms; and

- no particular pattern of reapplication when beneficiaries were discontinued for failure to cooperate with the requirements of annual redetermination.

CONCLUSIONS

The pilot study data suggest that a mail-in approach to eligibility determination can be implemented without adverse effects on county administration of cases or the beneficiaries. Face-to-face interview can become an option when implemented with Department of Health Services directives and established standards. To protect the integrity of the Medi-Cal program and ensure that the face-to-face interview requirement is imposed on the applicants or beneficiaries correctly, the Department, with the counties' cooperation, could identify the standards and fraud indicators to assess cases that would require a follow-up interview.