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
   Utilities $ _____ ❒ Yearly ❒ Monthly Upkeep and repairs $ _____ ❒ 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 a trust or agreement where money or property is being held for your benefit 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

❒ DHCS 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

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)			$	$	$
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.		$	$

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
			$	$
			$	$

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.)		$	$

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

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

❒ Verification

$_____

❒ Exempt

$_____

$_____

$_____

$_____

Verification of CSV on file?

$_____

Copy of annuity on file?

❒ Yes ❒ No

State certified LTC policy?

❒ Yes ❒ No

Amount paid out $_____

DHCS 6155 completed

❒ Yes ❒ No

Exempt ❒ Yes ❒ No

$_____

Use copy of award letter or check or other verification

$_____

$_____

$_____

$_____

$_____

$_____

$_____

$_____

$_____

$_____

CA5 (if not already completed)

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:

Name of insurance company

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

DHCS 6155 completed?
❒ Yes ❒ No
OHC Code _____

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

If yes, explain the services you wish to discuss:

Service Referral ❒ Yes ❒ No

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

PRIVACY STATEMENT

- **Medi-Cal Confidentiality Notice:** The information given in this application is private and confidential under Welfare and Institutions Code, Section 14100.2. This information will be disclosed only in accordance with those laws.
- **Medi-Cal Privacy Notice:** This information may be shared with federal, state, and local agencies for purposes of verifying eligibility and for other purposes related to the administration of the Medi-Cal program, including confirmation with the INS of the immigration status of only those persons seeking full scope Medi-Cal benefits. (Federal law says the INS cannot use the information for anything else except cases of fraud.)
- **Information required by this form is mandatory**, with the exception of ethnicity information, and any other item marked voluntary or optional.