

DEPARTMENT OF SOCIAL SERVICES

744 P Street, Sacramento, CA 95814



March 9, 1988

ALL COUNTY LETTER NO. 88-29

TO: ALL COUNTY WELFARE DIRECTORS

SUBJECT: DFA 285-C(10/87), FOOD STAMP SUPPLEMENTAL APPLICATION FOR SPECIAL MEDICAL DEDUCTIONS

The purpose of this letter is to notify the County Welfare Departments (CWDs) of a revision to the DFA 285-C(11/83), Supplemental Application for Food Stamps-Special Medical Deductions. Additionally, this letter transmits an advance copy of the DFA 285-C(10/87) and provides the CWDs with form-related information and revised form instructions for the eligibility worker.

OUTLINE OF MAJOR CHANGES TO THE FORM

- o The name of the form has been revised to read: Food Stamp Supplemental Application for Special Medical Deductions. Please note that the title of the English language form was inadvertently printed as "Food Stamps Supplemental Application for Special Medical Deductions." This typographical error will be corrected at next printing of the stock.
- o The narrative in the Instruction section showing the categories of individuals eligible for the deductions has been revised to incorporate the definition and verification requirements mandated by Food Stamp OBRA and Nondiscretionary #2 Regulations-RDB #1086-46.
- o Question 1 has been revised to reflect the specific type of payments received by the elderly or disabled individual.
- o The specific disqualification penalties have been incorporated in the Penalty Warning section.
- o The Certification section has been revised to incorporate a penalty of perjury statement signed by an adult household member.

IMPLEMENTATION

Although the form does not have a specific implementation date, it is recommended that CWDs implement the revision as soon as administratively possible because of the specific disqualification penalties and the penalty of perjury statement. Counties may use the attached camera ready copies of the English and Spanish versions of the form for local reproduction of the forms or may order state reproduced stock. Translations for the Chinese, Vietnamese, Cambodian, and Laotian versions of the DFA 285-C(10/87) have been mailed under separate cover by the Language Services Bureau.

ORDERING OF STATE STOCK

Orders for the DFA 285-C(10/87) should be submitted to the Department of Social Services Warehouse on the GEN 727B, County Forms Order, according to normal procedures. Stock for the DFA 285-C(10/87) and the DFA 285-C(10/87)SP is currently available in the SDSS warehouse.

FORMS INSTRUCTIONS

- o Effective with the implementation of the form, the attached forms instructions replace the instructions in the Food Stamp Handbook, Section 63-1250, DFA 285-C(11/83).
- o Vertical lines in the right hand margin identify changes or additions to the forms instructions.

If you have any questions regarding this letter, please contact Elizabeth Allred, AFDC and Food Stamp Policy Implementation Bureau at (916) 323-4954 or ATSS at 473-4954.



ROBERT A. HOREL
Deputy Director

Attachments

cc: CWDA

FOOD STAMP

SUPPLEMENTAL APPLICATION FOR SPECIAL MEDICAL DEDUCTIONS

INSTRUCTIONS

The application for special medical deductions is for any household member who is elderly or disabled. This may include anyone who is: (1) age 60 or older; (2) receiving disability payments (other than SSI/SSP) from the Veterans (VA) or Social Security (SSA) Administrations; or (3) receiving disability retirement benefits from a federal, state or local governmental agency or the Railroad Retirement Board (RRB). DO NOT list spouses or children receiving dependent only payments from SSA.

FOR COUNTY USE

CASE NAME

CASE NUMBER

①	NAME	BIRTHDATE	CHECK TYPE OF PAYMENTS RECEIVED			
			SSA	VA	OTHER GOVT. AGENCY	RRB
		/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL EXPENSES

Give the following information for ONLY the persons listed above. List expenses for which you are currently billed. Do not include past due bills. Check YES if entire bill has been or will be paid by the household. Check NO if all or part of the bills will not be paid by the household. Attach bills for each item listed.

MEDICAL EXPENSE ITEM	HOUSEHOLD MEMBERS WHO RECEIVED SERVICES	HOW OFTEN?	AMOUNT BILLED	PAID BY HOUSEHOLD	
				YES	NO
a. Medical or dental care provided by a certified practitioner.					
b. Hospitalization or outpatient treatment, and nursing care.					
c. Prescribed drugs.					
d. Health and hospitalization insurance policy premiums.					
e. Medicare premiums; Medi-Cal share of costs and/or spend down expenses.					
f. Dentures, hearing aids and prosthetics. Prescribed medical supplies and equipment.					
g. Seeing eye or hearing dog expenses, including the costs of dog food and veterinarian bills.					
h. Eye glasses and contact lenses, prescribed by a physician or optometrist.					
i. Cost of transportation and lodging to obtain medical treatment or services.					
j. Maintaining an attendant necessary due to age, illness or infirmity.					
k. The number and cost of meals furnished to an attendant.					
l. Other (specify)					

PENALTY WARNING

You or anyone in the household who gives wrong information on purpose can be prosecuted with penalties of a fine, jail, or both. The penalties can result in disqualification from the Program, fines up to \$10,000 or going to jail for up to 5 years. The disqualification penalties are 6 months for the first violation, 12 months for the second violation, and permanent disqualification for the third violation.

CERTIFICATION

I certify that I understand the questions on this form. I also understand that (1) the information I have given will be checked and verified by local, state, and federal personnel; (2) the household, any adult member (even if they move out), the sponsor of an alien household member or the authorized representative of residents in an eligible institution may be required to repay extra benefits the household should not have received; and (3) that I will give the county proof of my expenses or the name of a person or organization the county may contact to get the proof if I cannot get it myself.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information contained on this application is true, correct, and complete.

SIGNATURE (ADULT HOUSEHOLD MEMBER OR AUTHORIZED REPRESENTATIVE)			DATE
WITNESS, IF YOU SIGNED WITH AN X	DATE	SIGNATURE OF INTERVIEWING WORKER	DATE

ESTAMPILLAS PARA COMIDA SOLICITUD SUPLEMENTAL PARA DEDUCCIONES MÉDICAS ESPECIALES

INSTRUCCIONES

La solicitud para deducciones médicas especiales es para cualquier miembro del hogar que sea anciano o esté incapacitado. Esto puede incluir a cualquier persona que: (1) tenga 60 años o más; (2) reciba pagos de incapacidad (que no sean SSI/SSP) provenientes de las Administraciones de Veteranos (VA) o del Seguro Social (SSA); o (3) reciba beneficios de jubilación de una agencia gubernamental federal, estatal o local, o de la Directiva de Jubilaciones de los Ferrocarriles (RRB). NO ENUMERE al esposo(a) o niños que reciban pagos para dependientes-solamente de la SSA.

SÓLO PARA USO DEL CONDADO

NOMBRE DEL CASO

NÚMERO DEL CASO

①	NOMBRE	FECHA DE NACIMIENTO	MARQUE LA CLASE DE PAGOS QUE RECIBE			
			SSA	VA	OTRA AGENCIA GUBERN.	RRB
		/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

GASTOS MÉDICOS

Dé la información siguiente SOLAMENTE para las personas enumeradas arriba. Anote los gastos que le están cobrando en la actualidad. No incluya cuentas retrasadas. Marque SI, si el hogar pagó o pagará toda la cuenta. Marque NO si el hogar no pagará todas o parte de las cuentas. Adjunte los cobros para cada artículo que se enumere.

GASTO MÉDICO	MIEMBROS DEL HOGAR QUE RECIBIERON LOS SERVICIOS	¿QUÉ TAN SEGUIDO?	CANTIDAD A PAGAR	PAGADO POR EL HOGAR	
				SÍ	NO
a. Cuidado médico o dental proporcionado por un profesional autorizado.					
b. Tratamiento dentro o fuera del hospital y cuidado proporcionado por una enfermera.					
c. Medicinas recetadas.					
d. Primas de pólizas de salud y de hospitalización.					
e. Primas de Medicare: parte proporcional del costo de Medi-Cal y/o prueba de gastos.					
f. Dentaduras, audífonos y prótesis. Provisiones y equipo médico ordenados.					
g. Gastos de perro guía para ciegos o sordos, incluyendo el gasto de la comida del perro y cuentas de veterinario.					
h. Anteojos y lentes de contacto, ordenados por un doctor u optometrista.					
i. Gastos de transportación y alojamiento para obtener tratamiento o servicios médicos.					
j. Mantenimiento de un asistente necesario debido a la edad, enfermedad o debilidad.					
k. El número y costo de las comidas proporcionadas a un asistente.					
l. Otro (explique)					

AVISO DE SANCIÓN

Es posible que se enjuicie a usted o a cualquier miembro del hogar que intencionalmente dé información incorrecta, resultando en sanciones de una multa, encarcelamiento o ambos. Las sanciones pueden resultar en descalificación del programa, multas hasta de \$10,000 dólares o encarcelamiento hasta por 5 años. Las sanciones de descalificación son de 6 meses por la primera violación, 12 meses por la segunda violación, y descalificación permanente por la tercera violación.

CERTIFICACIÓN

Certifico que entiendo las preguntas contenidas en esta forma. También entiendo que (1) la información que he proporcionado será examinada y verificada por personal local, del estado y federal; (2) que es posible que el hogar entero, cualquier miembro adulto del mismo (aun si se mudan del hogar), el patrocinador de un miembro extranjero del hogar o el representante autorizado de personas que sean residentes de una institución elegible, tengan que reembolsar beneficios extras que el hogar no debió recibir; y (3) que le daré al condado pruebas de mis gastos o el nombre de la persona u organización con la cual el condado se puede poner en contacto para obtener las pruebas que yo no puedo conseguir.

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 solicitud es verdadera, correcta y completa.

FIRMA (MIEMBRO ADULTO DEL HOGAR O REPRESENTANTE AUTORIZADO)			FECHA
TESTIGO SI USTED FIRMÓ CON UNA X	FECHA	FIRMA DEL TRABAJADOR(A) ENTREVISTADOR	FECHA

63-1230 STATE FORMS & INSTRUCTIONS (Continued)

63-1230

DFA 285-C (10/87)

Form Instructions
(for the Eligibility Worker)

FOOD STAMPS SUPPLEMENTAL APPLICATION FOR SPECIAL MEDICAL DEDUCTIONS

Purpose:

The DFA 285-C is a supplemental food stamp application form completed by any household member(s) who is (1) age 60 or older; (2) receiving disability payments (other than SSI/SSP) from the Veterans (VA) or Social Security (SSA) Administrations; or (3) receiving disability retirement benefits from a federal, state or local governmental agency or the Railroad Retirement Board (RRB). DO NOT list spouses or children receiving dependent only payments from SSA. The application gathers information required to calculate special medical deductions for these individuals. The form is required only for those households entitled to claim excess medical expense deductions, unless they choose not to.

Preparation:

Question No.	Manual Section	Information Requested	EW Action
County-Use Section	N/A	N/A	Enter case name and case number.
1	63-102(e) 63-300.51 63-502.33	Eligible Household Members	Check that each household member named is at least 60 years of age, or will turn age 60 in the month of application, or meets one of the definitions for a disabled person. Check that any disability payment received is for the household member's own disability. Document in the county-use section if the household member has been approved for but is not yet receiving disability benefits.
2	63-102(e) 63-300.51 63-502.33 63-502.33 63-503.25 63-300.517	Medical Expenses	Determine the allowability of each item of medical expense as follows: 1. Check that each household member receiving services is an eligible household member listed in question 1. 2. Check that each amount shown is for an allowable item of expense. 3. Verify the amount of any deductible medical expenses and note the specifics of the verification in the county-use section.

63-1230 STATE FORMS & INSTRUCTIONS (Continued)

63-1230

DFA 285-C (10/87)

Question No.	Manual Section	Information Requested	EW Action
2 (Cont.)	63-502.33		4. Identify which items of expense are insured, uninsured, and which items (if any) are hospital bills, and document in the county-use section. Determine the applicable amount for each deduction.
	63-503.25		5. Determine which items of expense are recurring, one-month-only, or should be averaged over the certification period.
		Certification	Check that the application contains all required signatures.