

DEPARTMENT OF SOCIAL SERVICES

744 P Street, Sacramento, CA 95814



August 5, 1997

ALL COUNTY INFORMATION NOTICE I-47-97

TO: ALL COUNTY WELFARE DIRECTORS

REASON FOR THIS TRANSMITTAL

- State Law Change
 Federal Law or Regulation
 Change
 Court Order
 Clarification Requested by
 One or More Counties
 Initiated by CDSS

SUBJECT: CHANGES TO CA 61, MEDICAL REPORT, USED FOR MEDI-CAL, FOOD STAMPS AND AID TO FAMILIES WITH DEPENDENT CHILDREN

This letter transmits the CA 61 (6/97), Medical Report. The form is revised to add a question regarding whether the patient's physical/mental incapacity prevents or substantially reduces his/her ability to provide necessary care for the child(ren) in the home. See Attachment A for information regarding instructions, implementation, stock, obtaining camera-ready copies and translations. See Attachment B for a detailed outline of the changes to the form.

If you have questions or need further information, please contact the following staff regarding the specific program areas:

- The CA 61 or this letter: Donna Morgan at (916) 654-5709 or CALNET 464-5709;
- Food Stamp Program: Melissa Buchanan at (916) 654-8467 or CALNET 464-8467;
- Asian/Spanish translations: Shirley LuKung at (916) 654-1277 or CALNET 464-1277.

Sincerely,

BRUCE WAGSTAFF
Deputy Director
Welfare Programs Division

Attachments

c: CWDA

Attachment A

INSTRUCTIONS and IMPLEMENTATION

The CA 61 (6/97) replaces the CA 61 (8/96) Medical Report for Aid to Families with Dependent Children (AFDC) and the DFA 440 for Food Stamps. The CA 61 will be a joint-use form for Food Stamps, Medi-Cal and AFDC. It is formatted to allow for bilingual translation of Section I which is completed by the client. It is recommended that counties begin using the revised CA 61 as soon as administratively feasible.

STOCK

The CA 61 is designated as a required form, substitutes are permitted with prior approval of California Department of Social Services (CDSS). The CA 61 may be ordered from the CDSS warehouse according to the forms ordering procedures in the County Forms Catalog upon receipt of the Notice of Change Form (Gen 127) which is issued when stock is available.

CAMERA-READY COPIES AND TRANSLATIONS

Camera-ready copies of the English and Spanish versions of the CA 61 (Bi) may be obtained by calling the Forms Management Bureau at (916) 657-1907 or CALNET 437-1907. Camera-ready copies of the Asian language (Chinese, Cambodian and Vietnamese) versions, will be mailed to the county contact person as soon as they have been translated. If counties do not receive the translation, they may call the Language Services Bureau (LSB) at (916) 464-1282 or CALNET 464-1282. To order more than one form, counties may FAX their requests to LSB (916) 657-3429 or CALNET 473-3429.

Attachment B

REVISIONS TO THE MEDICAL REPORT, CA 61 (6/97)

Section I is enlarged to permit more space for the Spanish translation. The narrative in the header for Section I is changed from "PATIENT/APPLICANT/RECIPIENT" to "PATIENT/CLIENT." A subset item is added to provide ages of the children in the home.

The title of both Section II and III is changed to "PHYSICIAN OR LICENSED/CERTIFIED PSYCHOLOGIST."

Section II is reformatted but contains similar language to the previous version.

Section III, question 1, is expanded to "Does the patient have a physical or mental incapacity that prevents or substantially reduces his/her ability to engage in work, training, and/or provide necessary care for his/her child(ren)?" Check boxes and narrative are added that state if "YES" is checked, then indicate if full-time or part-time.

Question 4 is revised to add check boxes and narrative to indicate if expected to release patient for full-time or part-time work.

Question 7 is added asking, "Does patient's physical/mental condition prevent or substantially reduce his/her ability to provide necessary care for the child(ren) in the home?"

The narrative in the signature line of Section IV is revised to add "... OR PERSON AUTHORIZED TO COMPLETE FORM" to "SIGNATURE OF PHYSICIAN, LICENSED/CERTIFIED PSYCHOLOGIST." The second line is revised to add "PRINTED NAME AND TITLE" to "SPECIALITY."

MEDICAL REPORT

COUNTY USE ONLY

CASE NAME:

CASE NUMBER:

WORKER NAME:

WORKER NUMBER:

SECTION I: PATIENT/CLIENT INFORMATION AND MEDICAL RELEASE

NAME OF PATIENT/CLIENT (LAST, FIRST, MIDDLE)

BIRTHDATE

SOCIAL SECURITY NUMBER

SEX (CIRCLE)

AGES OF CHILDREN IN HOME

-

-

-

-

M

F

I authorize _____

(NAME OF LICENSED PHYSICIAN OR CERTIFIED PSYCHOLOGIST)

of _____

(NAME OF CLINIC OR MEDICAL GROUP)

to release my medical information on this form to the County Welfare Department and the California Department of Rehabilitation. This authorization is valid for one year from the date signed and I may ask for a copy of this authorization.

PATIENT/CLIENT SIGNATURE

DATE

SECTION II: PHYSICIAN OR LICENSED/CERTIFIED PSYCHOLOGIST INSTRUCTIONS

- The County Welfare Department needs your information to determine if the above-named person has a physical or mental incapacity that prevents or substantially reduces the patient's ability to engage in full time work, training, and/or provide necessary care for his/her child(ren).

Please complete the rest of this form. Explain if you need additional lab work or other exam(s) before you can determine the duration of incapacity. If you need more space, use another sheet of paper and attach it to this form.

PLEASE GIVE THIS FORM TO THE PATIENT OR RETURN IT AND/OR OTHER VERIFICATION WITHIN 5 WORKING DAYS TO:

(COUNTY STAMP)

SECTION III: PHYSICIAN OR LICENSED/CERTIFIED PSYCHOLOGIST STATEMENT

- Does the patient have a physical or mental incapacity that prevents or substantially reduces his/her ability to engage in work, training, and/or provide necessary care for his/her child(ren)? YES NO
If "YES" (✓) Full-time Part-time
(If "YES", complete Items 2 - 8 and Physician/Psychologist Certification. If "NO", sign and date in Certification Section.)
- List DIAGNOSIS and PROGNOSIS for this patient:

- ONSET DATE: _____
(MONTH, DAY, YEAR)
- EXPECTED DURATION:
 Temporary, expect to release patient for
 Full-time Part-time work on _____
(MONTH, DAY, YEAR)
 Permanent
- DATE OF NEXT SCHEDULED APPOINTMENT _____ NONE
(MONTH, DAY, YEAR)
- Does patient's condition require someone to be in the home to care for him/her? YES NO
If YES, describe care needed (related to diagnosis):

- Does patient's physical/mental condition prevent or substantially reduce his/her ability to provide necessary care for the child(ren) in the home? YES NO
- Describe the patient's limitations caused by this physical/mental condition:

SECTION IV: PHYSICIAN OR PSYCHOLOGIST CERTIFICATION

- I understand that the statements I have made on this form are subject to verification and investigation for welfare fraud.
- I declare under penalty of perjury under the laws of the United States and the State of California that the information contained in this report is true, correct, and complete.

SIGNATURE OF PHYSICIAN, LICENSED CERTIFIED PSYCHOLOGIST OR PERSON AUTHORIZED TO COMPLETE FORM

DATE

PRINTED NAME AND TITLE/SPECIALTY

PHONE NUMBER

STREET ADDRESS

(MAILING ADDRESS, IF DIFFERENT)

CITY

STATE

ZIP CODE