



CDSS

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DIRECTOR

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES

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EDMUND G. BROWN JR.
GOVERNOR

December 31, 2014

ALL COUNTY LETTER 14-106

TO: ALL COUNTY WELFARE DIRECTORS
ALL CALFRESH PROGRAM SPECIALISTS
ALL CALWORKs PROGRAM SPECIALISTS
ALL CONSORTIA REPRESENTATIVES
ALL QUALITY CONTROL COORDINATORS

SUBJECT: REVISED CALFRESH SUPPLEMENTAL FORM FOR
SPECIAL MEDICAL DEDUCTIONS

REFERENCES: ALL COUNTY LETTER 04-59, 13-75, AND 13-96; ALL
COUNTY INFORMATION NOTICE I-25-04, MANUAL OF
POLICIES AND PROCEDURES SECTIONS 63-102(e)(1)
AND 63-300.(e)(9);CALFRESH SUPPLEMENTAL FORM
FOR SPECIAL MEDICAL DEDUCTIONS (CF 31)

The purpose of this letter is to transmit revisions made to the CalFresh Supplemental Form for Special Medical Deductions (CF 31) (previously referred to as the DFA 285-C) and instructions on when to use this form. The content of this form was revised and also included in the two newly developed applications for public assistance [Application for CalFresh Benefits (CF 285) and the Application for CalFresh, Cash Aid and/or Medi-Cal/Health Care Programs (SAWS 2 PLUS)] to reduce the number of pages used during intake and recertification.

CHANGES MADE TO THE FORM

CalFresh Supplemental Form for Special Medical Deductions (Required Form) CF 31 (03/14): This form will replace the current version of the DFA 285-C upon implementation of this letter. This form is used when adding a person to an existing case and the person being added is elderly (60 or older) or disabled (disability approved by Social Security) or when an existing

REASON FOR THIS TRANSMITTAL

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

CalFresh household member turns 60 or is determined disabled mid-period (MPP Section 63-102(e)(1) and 63-300.(e)(9)).

This form was updated to change all references of Food Stamps to CalFresh and to uniformly gather the same information found in the newly implemented *Application for CalFresh Benefits* (CF 285) and the *Application for CalFresh, Cash Aid and/or Medi-Cal/Health Care Programs* (SAWS 2 PLUS). The term “application” was replaced with the term “form” as the form no longer requires a signature from the household member. This form is required and is used to gather special medical deductions that exceed the amount allowable per month. The county use section was removed to provide more writing space for the household member. The medical expense items were moved to the top of the page in bullet form and displayed as check boxes. All of the original detail requested in section 1 of the DFA 285-C was removed, with the exception of the column where the name of the elderly or disabled person is to be listed. The headings of the remaining columns on this form were changed to list the type of expense the household member is claiming, the amount of the expense, how often the expense is paid (monthly, weekly, or other), and whether the household member will be reimbursed for any of the medical expenses listed. The penalty of perjury warning along with the certification and signature block, were removed because a signature is no longer required for this form.

In addition, the household member must provide verification and attach it to this required form before any deduction can be applied to the CalFresh budget. If the applicant or recipient fails to provide the county with a completed CF 31 and/or required verification, the medical deductions will be disallowed. Examples of various types of verifications were added to the back of this form to assist the household member in identifying types of verification that can be attached.

Camera Ready Copies and Translations

For camera-ready copies in English, contact the Forms Management Unit at fmudss@dss.ca.gov. If your office has internet access you may obtain this form from the CDSS webpage at: http://www.dss.cahwnet.gov/cdssweb/FormsandPu_271.htm.

When translations are completed per MPP Section 21-115.2, including Spanish form, they are posted on our website. Copies of the translated forms can be obtained at: http://www.dss.cahwnet.gov/cdssweb/FormsandPu_274.htm.

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For questions on translated materials, please contact Language Services at (916) 651-8876. Until translations are available, recipients who have elected to receive materials in languages other than English should be sent the English version of the form or notice along with the *GEN 1365-Notice of Language Services* and a local contact.

CWDs shall ensure that effective bilingual services are provided. This requirement may be met through utilization of paid interpreters, qualified bilingual employees, and qualified employees of other agencies or community resources. These services shall be provided free of charge to the applicant/recipient.

In the event that CDSS does not provide translations of a form, it is the county's responsibility to provide the translation if an applicant or recipient requests it. More information regarding translations can be found in MPP Section 21-115.

This ACL and other CDSS Letters and Notices are available on the internet at: <http://www.dss.cahwnet.gov/lettersnotices/default.htm>.

If you have any question regarding this ACL, please contact the CalFresh Policy Bureau at (916) 654-1896.

Sincerely,

“Original Document Signed By:”

TODD R. BLAND
Deputy Director
Welfare to Work Division

Attachment

CALFRESH SUPPLEMENTAL FORM FOR SPECIAL MEDICAL DEDUCTIONS

Case Name: _____ Case Number: _____

This form is for special medical deductions for any CalFresh household member who is elderly or disabled. See the other side of this page for what we mean when we say "elderly or disabled."

Are you, or anyone you buy and prepare food with, an elderly (60 or older) or disabled person that has any out-of-pocket medical expenses? Yes No

If **yes**, please check all the boxes of the types of medical expenses that apply from these examples listed below (there may be others not listed here). List expenses you expect to have during the certification period. Please complete the section below and attach bills, receipts, or proof of expenses.

NOTE: Don't list spouses or children receiving dependent payments from Social Security Administration (SSA) Veteran's Administration (VA), etc. Allowable medical expenses are:

- | | | |
|-----------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Medical or dental care | <input type="checkbox"/> Hospitalization or outpatient treatment/nursing care | <input type="checkbox"/> Prescribed medication |
| <input type="checkbox"/> Prescribed over the counter medications | <input type="checkbox"/> Health and hospitalization insurance policy premiums | <input type="checkbox"/> Medicare premiums (Medi-Cal share of costs, etc.) |
| <input type="checkbox"/> Dentures, hearing aids and prosthetics | <input type="checkbox"/> Prescribed medical supplies and equipment | <input type="checkbox"/> Service animals (i.e. seeing eye or hearing dog) expenses (food and vet bills, etc.) |
| <input type="checkbox"/> Prescribed eye glasses contact lenses | <input type="checkbox"/> Cost of transportation (mileage or fee) treatment or services | <input type="checkbox"/> Cost of lodging to obtain medical and to obtain medical treatment or services |
| <input type="checkbox"/> Maintaining an attendant necessary due to age, illness, or infirmity | <input type="checkbox"/> The number and cost of meals furnished to an attendant | <input type="checkbox"/> Other (specify) |

Name of elderly or disabled person	What type of expense? (prescriptions, dentures, # of meals for attendant, etc.)	Amount of expense?	How often paid? (monthly, weekly, other)	Will the household be reimbursed for any medical expenses? (By Medi-Cal, insurance, etc.)
		\$		If yes, by who: How much \$
		\$		If yes, by who: How much \$
		\$		If yes, by who: How much \$
		\$		If yes, by who: How much \$
		\$		If yes, by who: How much \$

The supplemental form for special medical deductions is for any CalFresh household member who is elderly or disabled.

When we say “elderly” we mean anyone who is age 60 or older.

When we say “disabled” we mean anyone who is getting:

- 1) Disability payments from the Social Security Administration (SSA) (other than Supplementary Security Income/State Supplementary Program (SSI/SSP)) or the Veterans Administration (VA); OR
- 2) Disability retirement benefits from a federal, state or local governmental agency or the Railroad Retirement Board; OR
- 3) Medi-Cal services because of a disability; OR
- 4) Interim assistance/emergency general relief while waiting to get SSI/SSP because of a disability **approved** by the Social Security Administration.

Examples of Verifications:

- Medical bills or receipts
- Medical transportation bills or receipts
- Health or dental insurance policies or premiums
- Medicare card (*for Medi-Cal only*)
- Doctor statement or disability finding by an agency (SSA/SDI/VA, etc.)
- Medical verification form (CW61)