SB 24 Prenatal Gateway Data Elements
Option B: PE + 200%

Category	Questions
PE (Personal Information)	1. Name (First, Middle, Last) 2. Date of Birth (mo/day/year) 3. Social Security number (optional) 4. If you have a current or past BIC card number, please enter it here: 5. Home Address (Address, City, State, Zip) • If no permanent address, tell us where you can be reached 6. Mailing Address (optional if different) 7. Contact Info (Telephone #s for Home, Work, Message) 8. Please list all family members living in your household, their relationship to you and their date of birth. (matrix) 9. If you or any family member in your household received earned or unearned income, list the total amount, and where you got the money from. [Matrix; E-app auto deducts any exempt income (ie: first $50 of child support received, etc.) and $90 for earned income. If self-employed, flag for county to ask for self-employment deductions]
Opt-Out for PE Only	10. This application also allows you to apply for **continuing Medi-Cal coverage for your pregnancy**. If you DO NOT want to apply for Medi-Cal coverage, please check this box. [opt-out, If box is checked, applicant signs app & is done.]
Medi-Cal Questions	11. Do you have any other healthcare coverage? (y/n) 12. What language do you speak best? (optional) 13. What language do you read best? (optional) 14. If you have any uncovered medical expenses incurred in the three months prior to this application, please check this box [opt-in for Retroactive Medi-Cal] 16. Do you want to apply for Medi-Cal for additional members of your family? 17. Do you, your spouse, or any of your children have a physical, mental or emotional disability? (y/n) IF YES, ASK FOLLOWING: a. Who has the disability? (field) b. How long is it expected to last? (check box: Under 1 month, 1-12 months, over 12 months)
Income Disregards (Only if gross income is over 200%)	Do you or anyone in your family make payments for: 23. Child support? (y/n), If YES: How much? Payor Name? 24. Alimony? (y/n), If YES: How much? Payor Name? 25. Child Care or Dependent Care? (y/n), If YES: list each individual's Name, Age and How much?
Opt-In for Full Scope	15. Would you like to be considered for Medi-Cal's full range of health benefits, not just pregnancy-related care? (y/n) [opt-in for full-scope]
AIM Opt-Out	18. If you are found ineligible for Medi-Cal, you may still qualify for continued coverage through the Access for Infants & Mothers (AIM) program. If you DO NOT want to be automatically referred to AIM, please check this box. [opt-out]
Sign Under Penalty Perjury	27. Signature and Date of Applicant or Authorized Rep 28. Signature and Date of Witness to mark or interpreter

Required Questions: 13
Optional Questions: 10
Total Questions: 23 + 3 Provider Questions