## SB2/Prenatal Gateway Project - Proposed Data Elements (comprehensive)

| # | Question | Purpose | Program | Alternative or Follow-up Questions | Basic A | 200% B | F/S C |
|---|---|---|---|---|---|---|---|
| 1 | Name (First, Middle, Last) | Beneficiary Info | PE | | X | X | X |
| 2 | Date of Birth (mo/day/year) | Beneficiary Info | PE | | X | X | X |
| 3 | Social Security number (optional) | File Clearance | PE | **Alternative Q:** Has anyone ever asked for or gotten aid anywhere? (y/n)<br>**Follow-up Q: If Yes**, explain: under what name, where, when, and type(s) of aid | * | * | * |
| 4 | If you have a current or past BIC card number, please enter it here | File Clearance | PE | | * | * | * |
| 5 | Home Address (Address, City, State, Zip) | Beneficiary Info | PE | **Follow-up Q:** If no permanent address, tell us where you can be reached | X | X | X |
| 6 | Mailing Address (optional if different) | Beneficiary Info | PE | | * | * | * |
| 7 | Contact Info (Telephone #s for Home, Work, Message) | Beneficiary Info | PE | | X | X | X |
| 8 | Please list all family members living in your household, their relationship to you and their date of birth. (matrix) | Beneficiary Info | PE | **Alternative Q (Short App):** How many people, including your unborn child(ren), are in your family? | X[A] | X | X |
| 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) | Beneficiary Info | PE | **Alternative Q (Short App):** How much money do you & your spouse make before taxes? (dollar amount/month)<br>**Follow-up Q if Not using Alternative Q:** IF ANY SELF-EMPLOYMENT INCOME, either flag county to ask for self-employment deductions, OR ask "How much did you spend on expenses related to your self-employment?" | X[A] | X | X |
| 10 | This application also allows you to apply for Medi-Cal. If you DO NOT want to apply for Medi-Cal coverage, please check this box. [If box is checked, applicant signs app & is done.] | Opt out of M/C app | PE Only | **Alternative Q (Med App):** 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. [If box is checked, applicant signs app & is done.] | X | X[A] | X |
| 11 | Do you have any other healthcare coverage? (y/n) | Beneficiary Info | M/C | | X | X | X |
| 12 | What language do you speak best? (optional) | Beneficiary Info | M/C | Default to English | * | * | * |
| 13 | What language do you read best? (optional) | Beneficiary Info | M/C | Default to English | * | * | * |
| 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] | Opt-in for Retroactive M/C | M/C | | * | * | * |
| 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] | Opt-out for 200% Only Pop | 200% M/C | | | X | X |
| 16 | Do you want to apply for Medi-Cal for additional members of your family? (optional) | Beneficiary Info | M/C | | * | * | * |
| 17 | Do you, your spouse, or any of your children have a physical, mental or emotional disability? (y/n) | Establish Linkage | M/C | **Follow-up Q: If Yes**:<br>a. Who has the disability? (field)<br>b. How long is it expected to last? (check box: Under 1 month, 1-12 months, over 12 months) | X | X | X |
| 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] | Opt-out for Auto AIM Referral | M/C | | X | X | X |
| 19 | I have read the MC No. XX Prenatal Gateway form on assets. (y/n) | Asset List | M/C | | | | * |
| 20 | Do you or any family member living in your home own any of the assets listed on the MC No. XX Prenatal Gateway form? (y/n) [IF ANSWER YES, ASSETS SCREENING ENDS AT No. 19] | Asset Screening if under 100% FPL | F/S M/C | | | | * |

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| 21 | How many cars, SUVs, vans, or pick-up trucks does your household own? Do not count any vehicle you live in. (number) [SEE FOLLOW-UP QUESTIONS] | Asset Screening if under 100% FPL | F/S M/C | **Follow-up Q: If NUMBER = 1 OR 2, ask:**<br>a) What is the market value of Car 1? b) How much do you owe on Car 1? **[IF N=1, ONLY A-B]**<br>c) What is the market value of Car 2? d) How much do you owe on Car 2? **[IF N=2, A-D]**<br>**IF NUMBER = 0, GO TO QUESTION #22. IF NUMBER=OVER 2, ASSET SCREENING ENDS** | | | * |
| 22 | Do you have or other household members have a checking or savings account, a money market, or a certificate of deposit? (y/n) | Asset Screening if under 100% FPL | F/S M/C | **Follow-up Q: If Yes:**<br>a) How much in total, using lowest balances in each account for the month? (dollar amount)<br>b) Is any part of that money from this month's paycheck or other income received this month? (y/n)<br>**IF b=YES, ASK:** How much? (dollar amount) | | | * |
| 23 | Do you or anyone in your family make payments for child support? (y/n) | Income Disregard | M/C | **Follow-up Q: If YES, ask**<br>a) Payor Name<br>b) Monthly Amount | | * | * |
| 24 | Do you or anyone in your family make payments for alimony? (y/n) | Income Disregard | M/C | **Follow-up Q: If YES, ask**<br>a) Payor Name<br>b) Monthly Amount | | * | * |
| 25 | Do you or anyone in your family make payments for child or dependent care? (y/n) | Income Disregard | M/C | **Follow-up Q: If YES, ask for each individual:**<br>a) Name<br>b) Age<br>c) Monthly Amount | | * | * |
| 26 | Do you or anyone in your family make payments for other health insurance premium, including Medicare? (y/n) | Income Disregard | M/C | **Follow-up Q: If YES, ask**<br>a) Payor Name<br>b) Monthly Amount | | | * |
| 27 | Signature of Applicant or Authorized Rep (Date auto populated) | Penalty Perjury | M/C, PE | | X | X | X |
| 28 | Signature of Witness to mark or interpreter (Date auto populated) | Penalty Perjury | M/C, PE | | X | X | X |
| a | Is this patient pregnant? (y/n) | Provider Info | M/C, PE | | -- | -- | -- |
| b | Estimated Due Date | Provider Info | M/C, PE | | -- | -- | -- |
| c | Is this a single or multiple pregnancy? | Provider Info | M/C, PE | | -- | -- | -- |
| | | | | **X or $X^A$ = Required Questions (not counting Provider Section):** | 12 | 13 | 13 |
| | | | | *** = Optional Questions (not counting Provider Section):** | 7 | 10 | 15 |
| | | | | **Total Questions (not counting Provider Section):** | 19 | 23 | 28 |