MEDI-CAL CONSENT FORM

Notice Date: _____
Case Number: _____
Worker Name: _____
Worker Number: _____
Worker Telephone Number: _____
Office Hours: _____
Notice For: _____

Your child listed above may be eligible for free or low-cost health coverage through the _____; a program that provides health care for children who do not qualify for full
(Insert name of program)
Medi-Cal or Healthy Families. If you give us your consent, we will forward your child's application to this program.

If you consent to our sending your child's Medi-Cal application to the program mentioned above, they will review the information to see if your child is eligible. If you consent, you will not have to complete a new application to apply for the program mentioned above, and a program representative will contact you to let you know what additional information is needed to enroll your child.

IMPORTANT If you wish to give consent to forward your child's information, you must check the box below, sign and date this form, and return it to the county address above. You may also call your Medi-Cal worker to tell him/her that you wish to give consent.

If you do not wish to give consent, do NOT return this form. If you do not return this form, consent is NOT given. Your child's Medi-Cal application will not be sent and your child will not get health care coverage through other county programs unless you apply.

☐ **I give my consent to forward my child's Medi-Cal application form to** _____
(Insert name of program)

Sign:_____ Date:_____Phone:_____
(Return this form or call-in your response, within five days, to your worker at the address or phone number listed above)

If you have any questions or need additional information, please contact your Medi-Cal worker listed on the top right corner of this notice. Please call _____ if you want additional information
(Insert program phone number)
about _____.
(Insert name of program)