Additional Family Members Requesting Medi-Cal

County Use Only
Case name:
Case #
Worker #
Date:

❶

Applicant/Caretaker's Name (First, Middle, Last)		Applicant/Caretaker's Relationship to Child(ren)	
Name on Birth Certificate	Gender ❑ Male ❑ Female	Pregnant? ❑ Yes ❑ No Due date:_________________ # of babies_____	Linkage
Social Security No.	Date of Birth Month Day Year	Medi-Cal Requested? ❑ Yes ❑ No If Yes, provide Benefits Identification Card # if you have it:	SSN
Place of Birth (City/State/Country)		U.S. Citizen or National? ❑ Yes ❑ No If No, date arrived in the U.S. Month Day Year	PREG
Does this person have a physical, mental, emotional or developmental disability? ❑ Yes. Date disability began:______________ ❑ No		Marital Status (check one): ❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Separated	ID Other

❷

Spouse/Other Parent's Name (First, Middle, Last)		Relationship to Applicant/Caretaker	Linkage
Name on Birth Certificate	Gender ❑ Male ❑ Female	Pregnant? ❑ Yes ❑ No Due date: ___________________ # of babies ______	SSN
Social Security No.	Date of Birth Month Day Year	Medi-Cal Requested? ❑ Yes ❑ No If Yes, provide Benefits Identification Card # if you have it:	PREG
Place of Birth (City/State/Country)		U.S. Citizen or National? ❑ Yes ❑ No If No, date arrived in the U.S. Month Day Year	ID
Does this person have a physical, mental, emotional or developmental disability? ❑ Yes. Date disability began:____________ ❑ No		Marital Status (check one): ❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Separated	Other

❸

Child's Name: (First, Middle, Last) or "Unborn"		Relationship to Applicant/Caretaker	Linkage
Name on Birth Certificate	Gender ❑ Male ❑ Female	Pregnant? ❑ Yes ❑ No Due date: ___________________ # of babies ______	SSN
Social Security No.	Date of Birth Month Day Year	Medi-Cal Requested? ❑ Yes ❑ No If Yes, provide Benefits Identification Card # if you have it:	PREG
Place of Birth (City/State/Country)		U.S. Citizen or National? ❑ Yes ❑ No If No, date arrived in the U.S. Month Day Year	ID
Child living in home? ❑ Yes ❑ No		Child in school? ❑ Yes ❑ No	
Mother's Name:		Father's Name:	Medical Support? ❑ Yes ❑ No ❑ CW 2.1 Q ❑ CW 2.1 ❑ Not in home, 18-21 tax dependent
Does this child have a physical, mental, emotional or developmental disability? ❑ Yes. Date disability began: ___________ ❑ No		Is either parent: ❑ Deceased ❑ Absent ❑ Incapacitated ❑ Unemployed	

❹ Is anyone currently covered by health/dental insurance or Medicare? ❑ Yes ❑ No If so, who?	❑ DHCS 6155 OHC Code: ___________
❺ Has anyone filed a lawsuit because of an accident or injury? ❑ Yes ❑ No	❑ DHCS 6268
❻ Do you or any family member want Medi-Cal to cover medical expenses in the last three months and wish to apply for Medi-Cal? ❑ Yes ❑ No List name(s): ______________________________________ Month(s) of coverage: ______	❑ MC 210 A Retroactive Coverage ______ Month 1 ______ Month 2 ______ Month 3
❼ Have you or any family member ever been in U.S. military service? ❑ Yes ❑ No If Yes, who? Name(s):____ Relationship: ____	❑ CW 5

❽ The Medi-Cal program may share your information unless you check the box below:

- We will share your child's application with Healthy Families if your child no longer qualifies for free Medi-Cal in the future. If you **do not** want us to share it, check here ❑
- We will share your child's application with Healthy Kids or similar county program if your child does not qualify for full-scope Medi-Cal. If you **do not** want us to share it, check here ❑

❾ ***Family Income:*** List the income of **every** person listed in this application. Include child support and spousal support received. (Use a separate line for each source of income.)

Name of person with Income (Children who are in school do not have to list their income from a job.)	**Source of Income** (Job, social security, pension, etc.)	**How often is income received?** (Weekly, biweekly, monthly)	**How much is the income?** (Total gross income)	**Social Security No.** (Optional)
			$	
			$	
			$	
			$	
			$	

❿ ***Expenses:*** List the monthly expenses for all persons listed above.

Child Day Care or Disabled Dependent Care

For (child or dependent's name):____ Age: ______ Amount Paid: _____________

How Often?______________

For (child or dependent's name):____ Age: _______ Amount Paid: ____________

How Often? _____________

Court-ordered child support

Paid to: _________________________________ Paid by: __________________________________ Amount paid:_____________

Court-ordered spousal support

Paid to: _________________________________ Paid by: __________________________________ Amount paid:_____________

Please note that additional information about your property, income and/or resources may be required if applicable.

I certify that I have read and understand the information above. I also certify that the information I have given on this form is true and correct.

Signature____ Date: ________________