MEDI-CAL WAIVER INFORMATION AND AUTHORIZATION

COUNTY USE ONLY	
Case name	Case number
Worker name	Worker number

Parent/Guardian: If your child was receiving Supplemental Security Income (SSI) payments while in an institution, is under 18 years of age, is now receiving Medi-Cal benefits, is now living at home, and is currently in a home- and community-based waiver program, he/she may be eligible to receive a monthly SSI personal needs payment. Please complete this portion of the form and forward to the County Waiver Person if your child is in a Medi-Cal In-Home Operations or Developmental Services Waiver. For other waivers, forward this form to the State of California, Department of Health Care Services, Medi-Cal Eligibility Division, Mail Station 4608, P.O. Box 997413, Sacramento, CA 95899-7413. After the County or State has verified that your child is in a Medi-Cal waiver, submit this form to the Social Security Administration for a determination. SSA will continue to contact the County or State each year prior to continuing the personal needs payment.

Name of child

Address (number, street)	City	State	ZIP code

Social Security number	Date of birth	Telephone ( )

Parent/Guardian

Address of parent/guardian (if different)	City	State	ZIP code

Type of waiver

I, the parent or guardian of the above child, authorize the County of _____ or the State of California to disclose to the Social Security Administration information about the above child's status in the MediCal home- and community-based waiver program.

Signature ➤	Date

COUNTY DEPARTMENT OF SOCIAL SERVICES: Please verify that the above child is currently receiving Medi-Cal benefits at home and is receiving services under the Model or DDS waiver.

I certify that the above named child is receiving Medi-Cal benefits under one of the following home- and community-based waivers:

❒ Medi-Cal In-Home Operations Waivers Nursing Facilities Waiver (Parental income and resources do not apply.)
❒ Developmental Services Waiver (Parental Income and resources do not apply.)

Signature of county authorizing person ➤

Printed name	Title	Telephone ( )

County address (number, street)	City	State	ZIP code

STATE OF CALIFORNIA, DEPARTMENT OF HEALTH CARE SERVICES: Please verify that the above child is currently receiving Medi-Cal benefits and receiving waiver services.

Signature of state authorizing person ➤

Printed name	Title	Telephone ( )

State address (number, street)	City	State	ZIP code

White: Parent copy *Yellow: County copy*