APPLICANT'S SUPPLEMENTAL STATEMENT OF FACTS FOR MEDI-CAL

COUNTY USE ONLY
County Number/Aid Code/Case Number
— —

PART I—PERSONAL INFORMATION

1a. Applicant name (Last, First, MI)	1b. Social Security number		1c. Date of birth
	— —		/ /
1d. Other name(s) used (Last, First, MI)	1e. Sex ❑ Male ❑ Female	1f. Height Feet ______ Inches _____	1g. Weight Pounds _________

2a. Home address	City	State	ZIP code
2b. Mailing address (if different)	City	State	ZIP code

3. Daytime telephone number	Check if:	Best time to call
(_____) ______________________	❑ No Phone ❑ Message Phone (_____) ______________________	

4a. Do you speak English?	4b. Do you have an interpreter?	If YES, interpreter's name:	Best time to call
❑ Yes **If YES, go to Part II** ❑ No **If NO, what language(s) do you speak:** ______________________ ______________________	❑ Yes ❑ No	Interpreter's phone number: (_____) ______________________	

PART II—MEDICAL INFORMATION

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5. Have you applied for Social Security **Disability** or Supplemental Security Income (SSI) **Disability** benefits in the past two (2) years? ❑ Yes ❑ No

   If YES, please answer the following:

   a. Was/Is your Social Security or SSI Disability application:

   ❑ Approved? ❑ Denied? ❑ Pending? ❑ On Appeal? ❑ Unknown?

   b. If approved or denied, give the date of the most recent decision on your Social Security or SSI disability application: ______________________

   c. Has your medical problem(s) **worsened** since the date in 5b above? ❑ Yes ❑ No

   If YES, please explain: ______________________

   d. Do you have any **NEW** medical problem(s) since the date in 5b, above, which you did **NOT** have when your Social Security or SSI disability decision was made?

   ❑ Yes ❑ No If YES, what medical problem(s)? ______________________

6. List all medical problems (physical, mental or emotional) that keep you from working or taking care of your personal needs. (Please attach additional sheet, if necessary.)

MEDICAL PROBLEM(S)	WHEN DID IT START (Month/Year)

7. Have you received care in a **clinic** or **hospital** for your illness(es) or injury(ies) in the last 12 months? ❑ Yes ❑ No

If YES, please fully answer the following:

Name of clinic/hospital

Patient/clinic or **member number**	Clinic/hospital telephone number ( )

Name of doctor(s) seen

ADDRESS of clinic/hospital (number, street, suite)	City	State	ZIP code

Date first seen	Date last seen	Date of next appointment

Reason for the visit(s)

Did you stay in the **hospital** overnight? ❑ Yes ❑ No

If YES, date(s) entered: ____________ date(s) left: ____________

Were you seen in the **emergency** room? ❑ Yes ❑ No

If YES, date(s) seen: ____________

List ***ALL*** medicines received: ____________

List ***ALL*** treatments received and the dates the treatments were received: ____________

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8. List any additional **clinic** or **hospital** where you have been seen in the last 12 months.

Name of clinic/hospital

Patient/clinic or **member number**	Clinic/hospital telephone number ( )

Name of doctor(s) seen

ADDRESS of clinic/hospital (number, street, suite)	City	State	ZIP code

Date first seen	Date last seen	Date of next appointment

Reason for the visit(s)

Did you stay in the **hospital** overnight? ❑ Yes ❑ No

If YES, date(s) entered: ____________ date(s) left: ____________

Were you seen in the **emergency** room? ❑ Yes ❑ No

If YES, date(s) seen: ____________

List ***ALL*** medicines received: ____________

List ***ALL*** treatments received and the dates the treatments were received: ____________

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If you have been seen at additional clinics or hospitals in the last 12 months, complete page 8.

9. Have you been seen by any doctor **outside of the clinic(s) or hospital(s) you have already listed** in the last 12 months? ❑ Yes ❑ No

If NO, go to number 10. If YES, please fully answer the following, if more than one doctor was seen please complete page 8 for all additional information:

Name of doctor(s)

Patient/clinic or **member number** | Doctor's telephone number ( )

Address of doctor (number, street, suite) | City | State | ZIP code

Date first seen | Date last seen | Date of next appointment

Reason for the visit(s)

List ***ALL*** medicines received: ____________________

List ***ALL*** treatments received and the dates the treatments were received: ____________________

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10. Please list below if you have had any of the following tests in the last 12 months. Be sure to check yes or no next to each test. (**IF ADDRESS OF DOCTOR, CLINIC, OR HOSPITAL WAS GIVEN ALREADY, LIST <u>ONLY</u> THE NAME AND DATE.**)

TEST PERFORMED	YES	NO	NAME AND ADDRESS OF OFFICE, CLINIC, OR HOSPITAL WHERE TEST WAS COMPLETED	DATE (MO/YR)	COUNTY USE ONLY
Electrocardiogram (EKG)			Name Address (number, street, suite) City State ZIP Code		MC 220 Signed ❑
Treadmill (exercise heart test)			Name Address (number, street, suite) City State ZIP Code		MC 220 Signed ❑
Chest X-ray			Name Address (number, street, suite) City State ZIP Code		MC 220 Signed ❑
Breathing Test (PFT)			Name Address (number, street, suite) City State ZIP Code		MC 220 Signed ❑
Blood Tests			Name Address (number, street, suite) City State ZIP Code		MC 220 Signed ❑
Other (Specify)			Name Address (number, street, suite) City State ZIP Code		MC 220 Signed ❑

11. Have you had any other medical treatment or testing in the past 12 months? ❑ Yes ❑ No

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If NO, go to number 12.
If YES, complete page 8.

12. Is there anyone else (a friend, relative, social worker, rehab counselor, attorney, physical therapist, etc.) we may contact for information regarding your illness or injury and how it limits your daily activities or keeps you from working? ❑ Yes ❑ No

If YES, please list below:

Name	
Address (number, street, suite)	
Telephone number ( )	Relationship to you

Name	
Address (number, street, suite)	
Telephone number ( )	Relationship to you

Name	
Address (number, street, suite)	
Telephone number ( )	Relationship to you

13. You may be asked to go to additional medical examinations to help evaluate your medical problem(s). (These examinations are free to you.)

Are you willing to go to additional medical examinations if needed? ❑ Yes ❑ No

PART III—SOCIAL AND EDUCATIONAL INFORMATION

14. Describe your daily activities and tell us how much your condition limits your activities.

____

____

____

15. Describe your educational background.

a. Check the highest grade you finished in school:

❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 ❑ 11

❑ 12 or ❑ GED (same as finishing 12th grade) ❑ 12+

b. When finished? Month/year: ______________________

c. Did you take special education classes? ❑ Yes ❑ No

16. Have you done any type of work for more than 30 days during the last 15 years? (This includes work done in another country.)

❑ Yes ❑ No

If NO, skip Part IV, go to Part V, page 7, for your signature.

If YES, answer Part IV, page 5, beginning with number 17.

PART IV—WORK HISTORY

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17. Describe all of the jobs you have done for at least 30 days during the **last 15 years**. Start with your most recent job. (If you had more than two jobs, ask your county worker for additional pages.)

a.

Job title	Type of business		
Dates worked (month/year) From: ________________ To: ________________	Hours per week	Rate of pay	Per hour/wk/mo

DESCRIPTION OF THE JOB (This is what I did and how I did it.)

____

____

____

These are the tools, machines, and equipment I used:

____

____

I took this long to learn the job: ______________ day(s) or ______________ month(s).

I wrote, completed reports, or performed similar duties: ❑ Yes ❑ No

I had supervisory responsibilities: ❑ Yes ❑ No

PHYSICAL ACTIVITY **Circle One**

I walked this many hours in an average workday: 0 1 2 3 4 5 6 7 8

I stood this many hours in an average workday: 0 1 2 3 4 5 6 7 8

I sat this many hours in an average workday: 0 1 2 3 4 5 6 7 8

I climbed this much in an average workday:

❑ Never ❑ Occasionally ❑ Frequently ❑ Constantly

I bent over this much in an average workday:

❑ Never ❑ Occasionally ❑ Frequently ❑ Constantly

Heaviest weight I lifted: ❑ 10 lbs ❑ 20 lbs ❑ 50 lbs ❑ Over 100 lbs

I often lifted/carried up to: ❑ 10 lbs ❑ 20 lbs ❑ 50 lbs ❑ Over 100 lbs

Did you have any of your current medical problem(s) when you performed this job? ❑ Yes ❑ No

If NO, and you have had NO other jobs go to Part V, page 7, for your signature. If NO, but you have had other jobs, go to 17b, next page. If YES, please complete the following information.

Name of medical problem(s): ____

Did your employer make special arrangements (such as extra breaks, special equipment, change in job duties, etc.) so you could continue to work? ❑ Yes ❑ No

If YES, describe the special arrangements made: ________________________________

Did you have to stop working because of your medical problem(s)? ❑ Yes ❑ No

If YES, when? Month ______________________ Day ________ Year ________

Have you done **any** other work for more than 30 days during the **last 15 years?** ❑ Yes ❑ No

If NO, go to Part V, page 7 for your signature. If YES, continue on 17b, next page.

17. b.

Job title	Type of business		
Dates worked (month/year) From: ______ To: ______	Hours per week	Rate of pay	Per hour/wk/mo

COUNTY USE ONLY

DESCRIPTION OF THE JOB (This is what I did and how I did it.)

These are the tools, machines, and equipment I used:

I took this long to learn the job: ______ day(s) or ______ month(s).

I wrote, completed reports, or performed similar duties: ❑ Yes ❑ No

I had supervisory responsibilities: ❑ Yes ❑ No

PHYSICAL ACTIVITY **Circle One**

I walked this many hours in an average workday: 0 1 2 3 4 5 6 7 8

I stood this many hours in an average workday: 0 1 2 3 4 5 6 7 8

I sat this many hours in an average workday: 0 1 2 3 4 5 6 7 8

I climbed this much in an average workday:

❑ Never ❑ Occasionally ❑ Frequently ❑ Constantly

I bent over this much in an average workday:

❑ Never ❑ Occasionally ❑ Frequently ❑ Constantly

Heaviest weight I lifted: ❑ 10 lbs ❑ 20 lbs ❑ 50 lbs ❑ Over 100 lbs

I often lifted/carried up to: ❑ 10 lbs ❑ 20 lbs ❑ 50 lbs ❑ Over 100 lbs

Did you have any of your current medical problem(s) when you performed this job? ❑ Yes ❑ No

If NO, and you have had NO other jobs go to Part V, page 7, for your signature. If NO, but you have had other jobs, ask your county worker for additional pages. If YES, please complete the following information.

Name of medical problem(s): ______

Did your employer make special arrangements (such as extra breaks, special equipment, change in job duties, etc.) so you could continue to work? ❑ Yes ❑ No

If YES, describe the special arrangements made: ______

Did you have to stop working because of your medical problem(s)? ❑ Yes ❑ No

If YES, when? Month ______ Day ______ Year ______

Have you done **any** other work for more than 30 days during the **last 15 years?** ❑ Yes ❑ No

If NO, go to Part V, page 7 for your signature. If YES, ask your county worker for additional pages to complete.

PART V—SIGNATURE AND CERTIFICATION

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information contained in this Supplemental Statement of Facts is true and correct.

Signature of Applicant	Date
Signature of Witness (If applicant signed with a mark)	Date
Signature of person helping applicant fill out the form	Date

You will need to sign an authorization for release of information for each clinic, hospital, and testing facility that you list and for each doctor you saw outside of a clinic or hospital. Your county worker will provide you with additional forms which you will need to sign.

Continued answer(s) to question(s) number 8 on page 2, number 9 on page 3, and number 10 on page 3. If you need more room, please ask your county worker for additional pages to complete.

COUNTY USE ONLY

List any additional **clinic** or **hospital** where you have been seen in the last 12 months:

Name of clinic/hospital

Patient/clinic or **member number**

Clinic/hospital telephone number ( )

Name of doctor(s) seen

ADDRESS of clinic/hospital (number, street, suite) City State ZIP code

Date first seen | Date last seen | Date of next appointment

Reason for the visit(s)

Did you stay in the **hospital** overnight? ❑ Yes ❑ No

If YES, date(s) entered: ____________ date(s) left: ____________

Were you seen in the **emergency** room? ❑ Yes ❑ No

If YES, date(s) seen: ____________

List *ALL* medicines received: ____________

List *ALL* treatments received and the dates the treatments were received: ____________

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List any additional doctor you saw **outside of the clinic(s) or hospital(s)** you have already listed:

Name of doctor(s)

Patient/clinic or **member number**

Doctor's telephone number ( )

Name of doctor(s) seen

ADDRESS of doctor (number, street, suite) City State ZIP code

Date first seen | Date last seen | Date of next appointment

Reason for the visit(s)

List *ALL* medicines received: ____________

List *ALL* treatments received and the dates the treatments were received: ____________

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List any additional tests you have had in the last 12 months:

TEST PERFORMED	NAME AND ADDRESS OF OFFICE, CLINIC, OR HOSPITAL WHERE TEST(S) WAS COMPLETED.	DATE (MO/YR)
	Name Address (number, street, suite) City State ZIP code	
	Name Address (number, street, suite) City State ZIP code	

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