SUPPLEMENTAL STATEMENT OF FACTS FOR MEDI-CAL CHILD APPLICANT ONLY — UNDER AGE 18 (MC 223C)

INSTRUCTIONS

Read ALL of the information below BEFORE you start. If you have any questions about this form, or if you need help filling it out, please call your county social services agency.

The information that you provide on this form will be used by the California Department of Social Services, Disability Determination Service Division. That agency will make the disability decision on the child's Medi-Cal application. To help process the child's case faster, fill out as much of this form as you can.

All questions on this form refer to the child - provide information about him/her, not about yourself.

- Type or print clearly
- Answer all questions fully
- Do not skip questions. If you do not know the answers do not leave it blank. Write "none," "don't know," or "does not apply".

List only one hospital/clinic or one doctor/therapist in each section of Part 5 - Medical Information. Be sure to give the following information:

- Full name of hospital/clinic and doctor/therapist
- Address
- The child's hospital/clinic number.

If the applicant is not a child under the age of 18, you must use the form that is specifically for adults (MC 223), which you can get from your county social services agency.

Information about the *Authorization for Release of Information* (MC 220)

- Please provide one Authorization for Release of Information (MC 220) for each doctor, hospital, clinic, or therapist that you have listed on this form.
- You must sign your name (not the child's name) on the "Individual Authorizing Disclosure" line of the MC 220 and check the appropriate box (Parent of minor, Guardian, or Other personal representative). Sign every MC 220—do not sign one and photocopy it.
- If you make a mistake, you must contact the county for a new release form. Do not use whiteout or make corrections on the Authorization for Release of Information (MC 220).
- If the person signing the release must sign with an "X" or a "mark", the "X" or "mark" must include the signature of a witness and state the relationship of the witness to the person releasing the information.
- Any child who has attained the age of 12 must sign his or her own Authorization for Release of Information (MC 220) if their disability is linked to services available through the Minor Consent program. The minor must sign the MC 220 and the "Minor Consent Services Only" box must be checked.

A separate MC 223C is required for each child applying for Medi-Cal based on a disability. Begin filling in the form on Page 2.

SUPPLEMENTAL STATEMENT OF FACTS FOR MEDI-CAL CHILD APPLICANT ONLY - UNDER AGE 18

County Use Only		
County Number	Aid Code	Case Number

PART 1—PERSONAL INFORMATION

A. Child's Name (first, middle, last)	**B. Social Security Number**	**C. Date of Birth**

D. Sex ☐ Male ☐ Female	**E. Height** Feet_____ Inches_____	**F. Weight in Pounds**

G. Who does the child live with?

Name	Relationship	Phone Number	☐ No Phone

Home Address (number, street)	City	State	Zip Code

H. Mailing Address (if different than home address)

Address (number, street)	City	State	Zip Code

I. Person applying for the child

Name	Relationship	Phone Number	☐ No Phone

Message Phone Number	Name of person to leave message with

J. What language/dialect does the person applying for the child speak and read best?

PART 2—THE CHILD'S ILLNESSES, INJURIES, OR MEDICAL CONDITIONS

County Use Only

A. What are the child's illnesses, injuries or medical conditions?	**When did it start? (month/year)**

County Use Only

PART 3—SOCIAL SECURITY/SSI INFORMATION

A. Has the child applied for Social Security disability or Supplemental Security Income (SSI) disability benefits in the last two years?

☐ Yes ☐ No	If Yes, please answer the following, if No, skip to Part 4.

B. Was/is the Social Security or SSI disability application:

☐ Approved Date: _____ ☐ On Appeal Date: _____	☐ Denied Date: _____ ☐ Pending Date: _____	☐ Unknown

C. Has the child's medical problem(s) worsened since the decision?

☐ Yes ☐ No	If Yes, please explain:

D. Does the child have any new medical problems since the date of the Social Security/SSI disability denial?

☐ Yes ☐ No	If Yes, what problems and when did they start?

PART 4—SPECIAL SOURCES AND SCHOOL INFORMATION

A. Has the child ever been tested or evaluated by any of the following agencies, or do any of these agencies have medical records or information about the child?

Regional Centers	☐ Yes	☐ No
California Children's Services	☐ Yes	☐ No
Developmental Evaluation Center	☐ Yes	☐ No
Women, Infants, and Children (WIC) Program	☐ Yes	☐ No
Mental Health Agency	☐ Yes	☐ No
Any Other Agency	☐ Yes	☐ No

☐ *(MC 220) signed*

B. If Yes to any of the above questions, complete the following information.

1. Agency Name		Agency Phone Number	
Address (number, street)	City	State	Zip Code
Counselor, Caseworker, Therapist, etc. Name		Phone Number	
Type of test or evaluation, if any (for example, vision, hearing, speech, physical, psychological)			
Date of Test or Evaluation	Child's ID Number or Claim Number		

2. Agency Name	Agency Phone Number		
Address (number, street)	City	State	Zip Code
Counselor, Caseworker, Therapist, etc. Name		Phone Number	
Type of Test or Evaluation, if any (for example, vision, hearing, speech, physical, psychological)			
Date of Test or Evaluation	Child's ID Number or Claim Number		

County Use Only

☐ *(MC 220) signed*

C. Does/did the child attend any type of preschool, day care, and/or after school program?

☐ Yes ☐ No	If Yes, please complete the following information:

Program Name		Phone Number	
Address (number, street)	City	State	Zip Code
Contact Person	Dates Attended		

☐ *(MC 220) signed*

D. Is/was the child in school?

☐ Yes ☐ No	If Yes, please complete the following information: If No, skip to Section H

1. Name of School		Phone Number	
Address (number, street)	City	State	Zip Code
Teacher's Name			
2. Name of School		Phone Number	
Address (number, street)	City	State	Zip Code
Teacher's Name			

☐ *(MC 220) signed*

☐ *(MC 220) signed*

E. Does the school make any special accommodations for the child (for example: adaptive furniture, wheelchair ramps, extra assistance, or attention)?

☐ Yes ☐ No	If Yes, what type of accommodation?

F. Is the child in a special education program?

☐ Yes ☐ No	If Yes, what type of special education program?

G. Do you have a copy of the child's Individualized Education Plan (IEP—the report in which the teacher outlines the child's problems and lists the plans for correcting them)?

☐ Yes
☐ No

If Yes, please provide a copy.

H. Does the child receive any special counseling or tutoring?

☐ Yes
☐ No

If Yes, please complete the following information (if you need more spaces, you may add pages):

Is counseling or tutoring received at school?	☐ Yes ☐ No
Is counseling or tutoring received outside of school?	☐ Yes ☐ No
If Yes, please complete the following:	

Counselor or Tutor's name			Phone Number	
Street Address (number, street)	City		State	Zip Code
Frequency of Visits	Date Therapy began	Date Therapy ended (if completed)		

I. Does/did the child receive any special therapy (physical, speech and language, occupational) or any other services for his/her illnesses or injuries? Include information about any therapy the child receives from parent, guardian, caregiver, or in school.

☐ Yes
☐ No

If Yes, please complete the following information about therapy:

1. Therapist's Name			Phone Number	
Street Address (number, street)	City		State	Zip Code
Person who prescribed/designed the therapy	Type of Therapy			
Frequency of Visits	Date Therapy began	Date Therapy ended (if completed)		

2. Therapist's Name			Phone Number	
Street Address (number, street)	City		State	Zip Code
Person who prescribed/designed the therapy	Type of Therapy			
Frequency of Visits	Date Therapy began	Date Therapy ended (if completed)		

County Use Only

☐ *(MC 220) signed*

☐ *(MC 220) signed*

☐ *(MC 220) signed*

PART 5—MEDICAL INFORMATION

County Use Only

A. Has the child been in a clinic or hospital for any illness, injury or medical condition in the last 12 months?

☐ Yes
☐ No

If No, go to Part 6. If Yes, please fully answer the following:

1. Name of Hospital/Clinic	Type of Visit(s)	Dates	
		Date in	Date out
	☐ Inpatient Stay (stayed at least overnight)		
	☐ Outpatient Visit (sent home same day)		
	☐ Emergency Room Visit		
Street Address (number, street)	City	State	Zip Code
Phone Number	Hospital/Clinic File Number		
Reason for Visits			
What treatment did the child receive?			
What doctor(s) did the child see at this hospital on a regular basis?			

☐ *(MC 220) signed*

2. Name of Hospital/Clinic	Type of Visit(s)	Dates	
		Date in	Date out
	☐ Inpatient Stay (stayed at least overnight)		
	☐ Outpatient Visit (sent home same day)		
	☐ Emergency Room Visit		
Street Address (number, street)	City	State	Zip Code
Phone Number	Hospital/Clinic File Number		
Reason for Visits			
What treatment did the child receive?			
What doctor(s) did the child see at this hospital on a regular basis?			

☐ *(MC 220) signed*

If you need more space, please use Part 9—Remarks (page 9). Please remember to sign an *Authorization for Release of Information* (MC 220) for the hospital(s)/clinic(s) you listed on page 6.

County Use Only

B. Has the child been seen in the last 12 months by any doctor/therapist, not listed in Section A?

☐ *(MC 220) signed*

1. Name of Doctor or Therapist		Phone Number	
Street Address (number, street)	City	State	Zip Code
First Visit Date	Last Visit Date	Next Appointment Date	
Reason(s) for Visits			
What treatment did the child receive?			

☐ *(MC 220) signed*

2. Name of Doctor or Therapist		Phone Number	
Street Address (number, street)	City	State	Zip Code
First Visit Date	Last Visit Date	Next Appointment Date	
Reason(s) for Visits			
What treatment did the child receive?			

PART 6—MEDICATIONS

County Use Only

Does the child currently take any prescribed medication for illnesses, injuries, or medical conditions?

☐ Yes
☐ No

If Yes, tell us the following:

Prescribed Medication	Name of Doctor	Reason for Medication	Side Effects, if any

If the child has additional prescribed medications, list them in Part 9—Remarks

PART 7—TESTS

County Use Only

☐ *(MC 220) signed*

Has the child had, or will he/she have, any medical tests for illnesses, injuries, or medical conditions?

☐ Yes
☐ No

If Yes, tell us the following:

Kind of Test	When was/will the test be done? (month, year)	Where was the test done? (name of the facility)	Who sent the child for this test?
EKG (Heart Test)			
Treadmill (Exercise Test)			
Cardiac Catheterization			
Biopsy (Name of Body Part)			
Speech/Language			
Hearing Test			
Vision Test			
IQ Test			
EEG (Brain Wave Test)			
HIV Test			
Blood Test (Not HIV)			
Breathing Test			
X-Ray (Name of Body Part)			
MRI/CAT Scan (Name of Body Part)			

If the child has had other tests, list them in Part 9—Remarks

PART 8—WORK HISTORY

☐ *(MC 220) signed*

Has the child ever worked?

☐ Yes
☐ No

If Yes, complete the following:

Dates Worked

Employer Name

Street Address (number, street)	City	State	Zip Code

Phone Number

Supervisor Name

List the child's job title and briefly describe the work and any problems the child may have had doing the job.

PART 9—REMARKS

PART 10—SIGNATURE AND CERTIFICATION

I declare under penalty of perjury under the laws of the State of California that the answers I have given in this Supplemental Statement of Facts for Medi-Cal form and the documents given are correct and true to the best of my knowledge and belief.

1. Signature of person applying for the child		Relationship to the child		Date
Address (number, street)	City	State	Zip Code	Phone Number
2. Signature of witness (if appropriate)		Relationship to the person applying for the child		Date
Address (number, street)	City	State	Zip Code	Phone Number