MEDI-CAL TO HEALTHY FAMILIES TRANSMITTAL

Healthy Families
P.O. Box 138005
Sacramento, CA 95813-9984

County name

County representative

Telephone number

Date referred

Case name (last) (first)

Case number

Applicant name (last) (first)

Language
Spoken: _____ Written:

Applicant phone number

One or more individuals *(check all applicable boxes)*:

- ☐ Changed mind about not wanting Healthy Families
- ☐ Were determined ineligible for Medi-Cal (see comments)
- ☐ Were determined to have a share-of-cost (see below)

Type of application *(check all applicable boxes)*:

- ☐ Food stamps only application
- ☐ School lunch application
- ☐ Redetermination (RV)

HF Requested		M/C FBU		LIST ALL HOUSEHOLD MEMBERS		CIN Number	Social Security Number	Sex		Date of Birth	Relationship to Applicant	Individual Gross Income	Type of Income (UIB, SDI)	Share-of-Cost Amount
Yes	No	Yes	No	Last Name	First Name			Male	Female					

ENCLOSURES: the following documents are enclosed with the application (check all applicable boxes).

Mandatory:
- ☐ Medi-Cal NOA(s) and Medi-Cal Budgets (if not on NOA)
- ☐ Copy of appropriate application

If available:
- ☐ Birth certificate
- ☐ Immigration
- ☐ Residency
- ☐ Other _____

Comments: Explain why county is forwarding the application. If a member of the household is on CalWORKS, SSI, or Foster Care, please indicate person(s) and type(s) of assistance.