EXPRESS ENROLLMENT SUPPLEMENTAL FORM FOR MEDI-CAL, HEALTHY FAMILIES and HEALTHY KIDS

Case name: ______________ Case number: ______________

Eligibility Worker: ____________ E. W. phone #: ______________

Please complete the questions below for each child requesting health coverage. Return this information with any necessary documents in the enclosed postage-paid envelope no later than ____________________________ or your child(ren)'s eligibility for Medi-Cal benefits may be discontinued or denied.

	Child 1	Child 2	Child 3	Child 4	Child 5
1. **Name of child** First, middle initial, last					
2. **Social security number**					

IMPORTANT: If your child does not have a social security number (SSN), you can apply for a SSN now and provide it to us within 60 days. Your child may be eligible to receive emergency-related Medi-Cal if he/she is unable to get a SSN.

	Child 1	Child 2	Child 3	Child 4	Child 5
3. **U.S. Citizen or national?** If NO, please check if the child has satisfactory immigration status and write the date of entry into the United States.	☐ Yes ☐ No ☐ Satisfactory immigration status ____/____/____ Date of entry	☐ Yes ☐ No ☐ Satisfactory immigration status ____/____/____ Date of entry	☐ Yes ☐ No ☐ Satisfactory immigration status ____/____/____ Date of entry	☐ Yes ☐ No ☐ Satisfactory immigration status ____/____/____ Date of entry	☐ Yes ☐ No ☐ Satisfactory immigration status ____/____/____ Date of entry

If your child is not a U.S. Citizen or national, send proof (copies) of his/her immigration status or a receipt from INS showing you have applied to replace a lost document. You may send the document now or within 30 days.

	Child 1	Child 2	Child 3	Child 4	Child 5
4. **Does this child have other health, dental, or vision insurance?**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If **YES**, please complete the enclosed "Health Insurance Questionnaire" form (DHS 6155). If the children are all covered by the same insurance plan, only one form is required per family. If the children have separate insurance plans, separate forms are required. IMPORTANT: Your child can still be eligible for Medi-Cal even if he/she has other health coverage.

	Child 1	Child 2	Child 3	Child 4	Child 5
5. **Was a child insured by an employer in the last 3 months?** If YES, check the main reason why health insurance stopped and give the date it stopped.	☐ Yes ☐ No ☐ Lost job ☐ Moved, no insurance available ☐ Employer ended benefits to all employees ☐ COBRA coverage ended ☐ Other ________ ____/____/____ Date Stopped	☐ Yes ☐ No ☐ Lost job ☐ Moved, no insurance available ☐ Employer ended benefits to all employees ☐ COBRA coverage ended ☐ Other ________ ____/____/____ Date Stopped	☐ Yes ☐ No ☐ Lost job ☐ Moved, no insurance available ☐ Employer ended benefits to all employees ☐ COBRA coverage ended ☐ Other ________ ____/____/____ Date Stopped	☐ Yes ☐ No ☐ Lost job ☐ Moved, no insurance available ☐ Employer ended benefits to all employees ☐ COBRA coverage ended ☐ Other ________ ____/____/____ Date Stopped	☐ Yes ☐ No ☐ Lost job ☐ Moved, no insurance available ☐ Employer ended benefits to all employees ☐ COBRA coverage ended ☐ Other ________ ____/____/____ Date Stopped
6. **Do you want Medi-Cal to cover any medical expenses this child had in the last 3 months?**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

7. **Is anyone else in your family interested in applying for Medi-Cal?** ☐ Yes ☐ No

Provide the following information if a box is checked.

☐ If you pay for child care services, child support, health insurance premiums, or have self-employment expenses, **send a copy** of your most recent payment/expenses. Proof of these expenses can be used to reduce the income we count for a Medi-Cal determination. A copy of your income from work, Workers Compensation, or state disability benefits may allow you an additional deduction.

☐ Other: ____

If you have any questions or need additional information, please contact your Medi-Cal Eligibility Worker listed on the top right corner of this form.

I understand and agree to the following: If my child(ren) is not eligible for no-cost full-scope Medi-Cal, this form may be shared with low-cost Healthy Families or Healthy Kids to determine if he or she is eligible for health coverage through these programs. I will be contacted for more information if my child(ren)'s application is forwarded. ☐ (check box) Do not forward my application to the Healthy Families or Healthy Kids.

Declaration and Signature

I declare under penalty of perjury under the laws of the State of California that the answers I have given in this application, the declarations made, and the documents submitted are true and correct to the best of my knowledge and belief. I declare that I have received, read, and understand the attachment titled "Important Information for Medi-Cal Applicants."

Signature of parent/guardian	Date
X	

According to California Code of Regulations, Title 22, Section 50175, **if you fail to return the required information and/or document(s) or if the information and/or documents you send do not verify your eligibility, your application for Medi-Cal shall be denied or eligibility shall be discontinued.**

EXPRESS ENROLLMENT NOTICE AND SUPPLEMENTAL FORM FOR MEDI-CAL, HEALTHY FAMILIES and HEALTHY KIDS

Notice date: ______________________________
Case number: ______________________________
Worker name: ______________________________
Worker number: ______________________________
Worker telephone number: ____________________
Office hours: ______________________________
Notice for: ______________________________

Your local county Medi-Cal office has received a copy of the School Meals application for the child(ren) listed below. On that application, you asked us to determine if your child(ren) is eligible for Medi-Cal benefits. Based on the information you provided:

(List children)

____
____
____
____
____

was found temporarily eligible for Medi-Cal benefits. If your child(ren) does not already have a California Benefits Identification Card (BIC), you will soon receive a BIC in the mail. Your child(ren) can immediately use the BIC to get medical services. This temporary eligibility will last until a Medi-Cal determination has been completed. **For us to determine if your child(ren) is eligible to continue receiving Medi-Cal, please complete and sign the enclosed form.**

(List children)

____
____
____
____
____

was NOT found temporarily eligible for Medi-Cal benefits. However, your child(ren) may be eligible for Medi-Cal once all information is reviewed. **For us to determine if your child(ren) is eligible for Medi-Cal, please complete and sign the enclosed form.**

Return the "Express Enrollment Supplemental Form for Medi-Cal, Healthy Families and Healthy Kids" in the enclosed postage-paid envelope no later than . Please be sure to attach any documents requested.

If you have any questions or need additional information, please contact your Medi-Cal worker listed on the top right corner of this notice.

According to California Code of Regulations, Title 22, Section 50175, **if you fail to return the required information and/or document(s) or if the information and/or documents you send do not verify your eligibility, your application for Medi-Cal shall be denied or eligibility shall be discontinued.**