REQUEST FOR ELIGIBILITY LIMITED SERVICES

Name of applicant (last, first)	FOR COUNTY USE ONLY–State Number				
	County	Aid	Serial Number	FBU	Person Number

PART A.

I need/continue to need services related to: (Please check one or more of the following.)

Under Age 12 and Older:

1. ❒ Sexual Assault
2. ❒ Pregnancy or Family Planning

Age 12 Years and Older:

3. ❒ Sexually Transmitted Diseases
4. ❒ Drug or Alcohol Abuse
5. ❒ Outpatient Mental Health*

* If requesting outpatient mental health services, a statement from a mental health professional confirming that you meet the requirements for those services must be presented to your eligibility worker.

PART B.

I am requesting medical assistance for the month of: _____/_____
Month Year

PART C. RIGHTS AND RESPONSIBILITIES

1. I understand that I will receive a paper Medi-Cal ID card that is good for one year from the issue date on the card. This card is for identification only and does not verify eligibility.

2. I understand that my eligibility is good for one month, and each month I need Minor Consent medical services, I must come back into the welfare department to recertify my eligibility to at least one of the above services. To allow time for my eligibility worker to process my recertification, I must come in and complete this form as soon as I know I need to see a doctor or need medical care.

3. I understand that if any of the following happens, I must tell my eligibility worker at my next interview when I recertify my eligibility:

   a. I move out of my parent's/guardian's house.
   b. I get married.
   c. My parent(s) stop supporting me or declaring me as a dependent for tax purposes.
   d. I get a job or quit working.
   e. My income, such as earnings, increases, decreases, or stops.
   f. I get some property; i.e., bank accounts, automobiles, stocks, bonds, trust funds, etc.
   g. I give birth or my pregnancy ends for any reason.

4. I understand that I will receive this card and the medical services I have requested without my parents being contacted.

Signature of Applicant		Date
Signature of County Representative	**Worker number**	**Date**