STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY GRAY DAVIS, Governor

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October 30, 2001

MEDI-CAL ELIGIBILITY PROCEDURES MANUAL LETTER NO.: 254

TO: All Holders of the Medi-Cal Eligibility Procedures Manual

ARTICLE 4S – MAIL-IN APPLICATION PROCESS

Refer.: All County Welfare Directors Letter (ACWDL) Nos. 95-28, 95-52, 97-48, 98-06, 98-09, 98-16, 98-19, 98-39, 98-42, 99-01,99-36, 00-31, 00-31 E, 01-06, 01-17, 01-36 and EMC2 DHS No. 98104

Enclosed is the new procedure manual section for the Medi-Cal mail-in process and elimination of the face-to-face interview. This represents a compilation of instructions issued via the ACWDLs listed above. Counties are encouraged to implement use of this MC 210 revision date 8/01 as soon as administratively possible, but no later than December 1, 2001.

Welfare and Institutions Code Section 14011.15 mandates a simplified Medi-Cal application package and mail-in process for adults and families. The intent of this legislation is to provide easy access for this population to apply for and receive Medi-Cal benefits as quickly as possible.

As of July 1, 2000, state law prohibits counties from making a mandatory face-to-face interview a routine application requirement. The law also required the development and implementation of a shortened, simplified application form and procedure, and simplifies the verification requirements for earned income and pregnancy.

Some of the highlights of the procedures are:

- The Healthy Families Program (HFP) will now accept the MC 210 (rev 8/01), and appropriate Notice of Action as an application for HFP benefits.
- The MC 210 (rev 8/01) will be available in 11 threshold languages.
- The MC 13 remains part of the application documentation. However, the Department of Health Services (Department) is exploring the possibility of eliminating this requirement. As soon as a decision is made, counties will receive further instructions.

Filing Instructions:

REMOVE PAGES:	INSERT PAGES:
ARTICLE 4 Page - PTC 5	ARTICLE 4 Page – PTC 5
ARTICLE 4 TC-1 & TC-2	ARTICLE 4 TC-1 & TC-2
ARTICLE 4S Entire Article	ARTICLE 4S Pages 4S-1 through 4S-36

If you have any questions, please contact Mr. John McDaniel of my staff at (916) 657-0791.

Sincerely,

Original signed by

Shar Schroepfer, Chief
Medi-Cal Eligibility Branch

Enclosure

Article 4 - APPLICATION PROCESS

4A through 4G - THESE SECTIONS HAVE BEEN REMOVED FROM ARTICLE 4, THE INFORMATION CONTAINED IN THESE SECTIONS HAS BEEN INCORPORTED INTO ARTICLE 22, DISABILITY DETERMINATION REFERRALS, EFFECTIVE MAY 27, 1994.

4H - PROCESSING OF STATUS REPORTS

I. GUIDELINES FOR REVIEWING STATUS REPORTS FOR COMPLETNESS

II. STATUS REPORT NOTICE REQUIREMENT

4I - DILIGENT SEARCH PROCEDURES

I. REFERRAL TO PUBLIC GUARDIAN OR CONSERVATOR

II. DISABILITY DETERMINATION REFERRAL

III. DILIGENT SEARCH

IV. CASE PROCESSING

4J - PROMPTNESS REQUIREMENT

4k - PROCESSING MEDICALLY INDIGENT ADULTS (MIAs) APPLICANTS

4L - RSDI/UI/DI REPORTS

I. BACKGROUND

II. INSTRUCTIONS FOR INTERPRETING THE REPORT OF RSDI

III. INSTRUCTIONS FOR INTERPRETING THE UI/DI FORMATS ON THE REPORT OF RSDI/UI/DI

4M - VERIFICATION OF UNCONDITIONALLY AVAILABLE INCOME

4N - TIMELY REPORTING BY PUBLIC GUARDIANS/CONSERVATORS OR BENEFICIARY REPRESENTATIVES

4O - ONE MONTH EXTENDED ELIGIBILITY (EDWARDS V. MEYERS)

4P - CHILDREN HEALTH AND DISABILITY PREVENTION (CHDP) PROGRAM

I. INFORMING

II. DOCUMENTATION AND REFERRAL RESPONSIBILITIES

4S—Instructions for the MC 210 and Supplements to the MC 210

A. BACKGROUND

Welfare and Institutions Code Section 14011.15 mandates a simplified Medi-Cal application package and mail-in process for adults and families. The intent of this law is to provide easy access for this population to apply for and receive Medi-Cal benefits as quickly as possible.

The purpose of this Procedures section is to provide counties with policies and instructions, which are effective no later than December 1, 2001. These policies and procedures apply to all Medi-Cal applications.

As of July 1, 2000, state law prohibits counties from making a mandatory face-to-face interview a routine application requirement. The law also requires the development and implementation of a simplified application form and procedure, and simplifies the verification requirements for earned income and pregnancy.

B. APPLICATION FORM

1. The MC 210 (rev. 8/01) (Medi-Cal Mail-in Application) will replace the current MC 210 Statement of Facts (SOF). Counties are instructed to begin using the new MC 210 as soon as administratively possible but no later than December 1st. At that time, counties must discard their existing stock of old MC 210 SOF. However, if an old MC 210 SOF is received, the county must process the application and shall not require the applicant to fill out a new MC 210.

2. Counties shall accept either the MC 210 or the MC 321 HFP application as an application for Medi-Cal. An MC 321 received directly by the County shall be processed the same as an MC 210 application.

3. A signed MC 210 or MC 321 Healthy Families Program (HFP) is an acceptable replacement for the current Statewide Automated Welfare Systems (SAWS) 1 and now constitutes an official request for Medi-Cal benefits. The SAWS 1 can still be used but is not a mandatory form, unless otherwise specified.

4. The HFP will accept the MC 210 application as an application for Healthy Families benefits, when the counties determine a family has a share of cost (SOC) or is otherwise qualified and requests Healthy Families coverage.

5. The SAWS 2A may be used as a Medi-Cal SOF when the applicant has previously completed the form as a request for cash aid. It can be used in lieu of the MC 210 when the applicant has been found ineligible to receive cash aid (i.e. California Work Opportunity and Responsibility to Kids {CalWORKs} denial). If a SAWS 2A is used as a SOF, a signed, dated SAWS 1 must also be filed in the Medi-Cal case.

C. APPLICATION AVAILABILITY

1. Anyone may request an application to be mailed to them by calling their local county welfare department (CWD) office.

2. Applications may be picked up from the local CWD office.

3. In the near future the MC 210 application may be downloaded from the Department website (www.dhs.ca.gov) and either mailed or delivered to the local CWD office.

4. Applications may also be picked up from other sources (i.e. outstations, outreach projects etc.).

REMINDER: Should the applicant request CalWORKs or Food Stamps assistance, they must be told to apply in person. The SAWS 1 for the mail-in process only serves to protect the date of application for Medi-Cal only benefits and retroactive Medi-Cal months.

NOTE: The MC 210 (rev 8/01) will be available in eleven threshold languages. Currently the languages are English, Spanish, Vietnamese, Cambodian, Hmong, Armenian, Cantonese, Korean, Russian, Lao, and Farsi. Counties need to ensure that they have the capability to process an application in any of the aforementioned languages.

D. WHAT MUST BE SENT WITH THE APPLICATION

If the application is requested directly from the county, the following information must be provided to applicant.

1. The " New Mail-In Application and Instructions" (MC 210 [rev. 8/01]).
2. Postage paid pre-addressed return envelope.
3. Child Health Disability Prevention (CHDP) Informational Publication.
4. MC 007 "Medi-Cal General Property Limitations."
5. Medi-Cal Brochure (Pub 68).
6. MC 219 "Important Information For Persons Requesting Medi-Cal."
7. MC 13 (Statement of Citizenship) for each family member applying Medi-Cal benefits.
8. MC 003 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Brochure.

E. SUBMITTING THE APPLICATION FORM

1. Counties must not require a face-to-face interview. If counties come in contact with an applicant or Authorized Representative (AR), the county must explain his or her option to apply by mail or to go to the CWD.

2. The application can be mailed to the CWD. The CWD will stamp the date the application is received and forward the application for an eligibility determination. In the event that a county, which is not the county of residence receives an application, the county receiving the application must forward it to the correct county as soon as administratively possible (See Article 3 Medi-Cal Eligibility Procedural Manual . The receiving county shall honor the date stamp from the sending county.

3. The applicant or AR may walk the application into the local CWD or outstation site and request to leave it. The applicant may request an appointment to see an eligibility staff member in person, by phone, or through the mail. Counties must accommodate all requests by applicants for a face-to-face interview.

Exception to face-to-face elimination:

a. All applications for minor consent services must be made in person at the county Medi-Cal office or outstation sites,

b. Good cause,

c. Suspicion of fraud, or

d. To complete the application process when:

1. Questionable information appears on the application form or verifications;

2. Individual/family has no visible means of support such as in-kind income or means support not reported for the individual/family;

3. There are obvious discrepancies between information reported on an application and Income Eligibility and Verification System (IEVS) on property or income; or

4. Self-employed individual whose income and expenses do not match reported income and questionable information could not be resolved with follow-up telephone contact and/or mail.

Reminder: When the county requests a face-to-face interview for any reason, eligibility staff must document the reason(s) in the case record for post-eligibility review and audit.

F. DATE OF APPLICATION

1. If an application is mailed directly to the county, the Date of Application is the date the county receives the form.

2. If the application is picked up from the county office and the applicant has contact with a county employee, the county employee must offer the individual the SAWS 1 to complete at that time to protect the Date of Application and retroactive months.

3. If anyone calls the county office and requests that an application be mailed to them, the county employee taking the call is responsible for completing the SAWS 1 on behalf of the applicant to protect the Date of Application and retroactive months. A copy of the SAWS 1 shall be forwarded with the application at the time of mailing. It is not required that the applicant sign and return the SAWS 1.

4. The Date of Application will always be the earlier of the two dates if both an application and SAWS 1 are received separately.

G. COUNTY ACTION UPON RECEIPT OF MEDI-CAL APPLICATION

1. The county will mail the applicant a letter within five working days of the county receipt of the application, advising the applicant or AR that their application has been received and whom they can contact for information and questions. This letter will include a contact name, telephone number, and the address of the appropriate CWD office.

2. The eligibility worker shall review the application for completeness. If additional information is needed for an accurate eligibility determination, the eligibility worker shall use information/verification contained in open public assistance (PA) case records of the individual and their immediate family members and/or case records that have been closed within the last 45 days. If the necessary information cannot be obtained through available PA case records, the eligibility worker shall request this information following current policy. Current guidelines for application processing, property and income verifications have not changed.

REMINDER: An initial Medi-Cal-Only eligibility determination must not be delayed beyond 45 days, pending information/verification from a current or prior PA case record. Counties are reminded that property limits must be met sometime during the month of application and will be valid for 12 months or until there is a reported or discovered change in resources that requires an eligibility review.

NOTE: If the application received was not requested directly from the county, the county must ensure that the information listed in Section D is provided to the applicant.

H. RETROACTIVE MEDI-CAL

Anyone requesting retroactive Medi-Cal using the MC 210 or MC 321 HFP must also complete the MC 210 A (Supplement to Statement of Facts for Retroactive Coverage/Restoration). Counties must send the MC 210 A when retroactive Medi-Cal is requested.

I. COUNTY ACTION FOR INFORMATION ON THE HFP

1. If the applicant or AR indicates on the application that the CWD can send the MC 210 (if they potentially qualify) to the HFP, the CWD must forward the MC 210 to the HFP. Counties must not require a separate application.

2. The MC 210 application must be accompanied by the Med-Cal/Healthy Families Mail-In Application transmittal (MC 334) and a SOC or Federal Poverty Level program denial Notice of Action (NOA). The NOA shall:

   - Not be older than 60 days,
   - Identify those family members determined to have a SOC, or denied due to income above the federal poverty level,
   - Indicate the total number of persons in the Medi-Cal family budget unit,
   - Clearly and separately identify all income sources and deductions, and
   - Include other relevant documentation (e.g. birth certificates, Immigration and Naturalization Service documents) if available.

   If the CWD system is unable to create a detailed NOA, the CWD may send a copy of the budget (MC 176 or an automated budget) with the SOC or denial NOA Do not send Sneede allocation budgets.

The Single Point of Entry is currently unable to process Medi-Cal applications initiated by other public assistance program's statement of facts forms, such as the DFA 285 (Food Stamps) and the SAWS 2A (CalWORKs). In these situations, counties shall inform applicants or ARs of the availability of the HFP, including a telephone number to call for information, when the applicant(s) do not qualify for no-cost Medi-Cal

J. COUNTY FOLLOW-UP FOR FURTHER CASE ACTION

1. If an applicant or AR requests information and explanation of any program (e.g. CHDP, Screening, EPSDT, In-Home Support Services/Personal Care Services, etc.) or referral to any services, eligibility staff must ensure the request is met and action taken is annotated in the case record.

2. Eligibility requirements for the Medi-Cal program have not changed. Each case record must contain adequate information with supportive documentation to verify an individual's eligibility. Verification of identity, residence, alien status, income and/or property remains a part of the eligibility determination process. Applicants must provide their Social Security number(s) (SSN) as appropriate, but are not required to submit copies of their Social Security cards, unless the county is unable to verify the number provided.

K. MC 219

1. The MC 219 (11/93) form discusses the Rights and Responsibilities of an applicant/beneficiary as well as the "Citizenship/Immigration Status Information." This set of forms is now separate from the MC 210.

2. The MC 219 must be sent to the applicant. The MC 219 does not have to be returned by the applicant. The county worker shall document in the case record that the information was provided.

L. MC 210 SUPPLEMENTAL FORMS

The following are instructions to be used in determining whether a supplemental form should be given to an applicant or AR. County personnel will notice that the supplemental forms to the MC 210 are numbered MC 210 S-C, S-E, S-I, S-P, and S-W. The 'S' represents Supplement: The -C. -E. -I. etc., refers to the title of the form as detailed below. Not all of the supplemental forms listed below are mandated for use by the Department. The descriptions below will explain whether a form is mandatory. If the form is not mandatory, counties may substitute one of their own, once it has been approved by the Department.

MC 210 S-C ADDITIONAL CHILDREN

The MC 210 S-C is given to a client if he/she has indicated on the MC 210 that the family has more than three children. The information for each child should be filled in completely. If the client is requesting restricted benefits, the shaded portion for SSN should NOT be completed. This form is mandatory.

MC 210 S.E STUDENT EDUCATIONAL EXPENSES

This form is given to the client if the MC 210 indicates any family member is attending college or a similar educational institution. Information is requested on whether the client is receiving a grant, scholarship, or loan, and any student expenses or transportation costs. This form is not mandatory.

MC 210 S.I INCOME IN-KIND AND HOUSING VERIFICATION

The Income In-Kind and Housing Verification form has a two-fold purpose: First, the form should be used if the client has in-kind income, and does not agree with the chart value given by the eligibility worker. If the client does not agree, he or she may use this form as signed verification from the individual providing/sharing housing, utilities, food, or clothing that a different amount is correct. Second, the client is residing with a relative, is paying that relative rent, and has no other verification of residency. If a client is using this form solely for the purpose of verifying in-kind income, it is not a mandatory form. However, if the client wishes to use this form as verification of residency, it is mandatory. Counties

may not use any other form as verification of residency. The form may also be used as a rent receipt from a relative.

MC 210 S-P PROPERTY

This form will be used by a client if certain property questions on the MC 210 require additional information. For example, if a client has answered yes to owning, or having title to, property in another State on the MC 210, this supplemental form must be completed. The MC 210 S-P, will ask for the expenses on that property, the address of the property, value, etc. This form is mandatory when the client has answered yes to the related questions on the application.

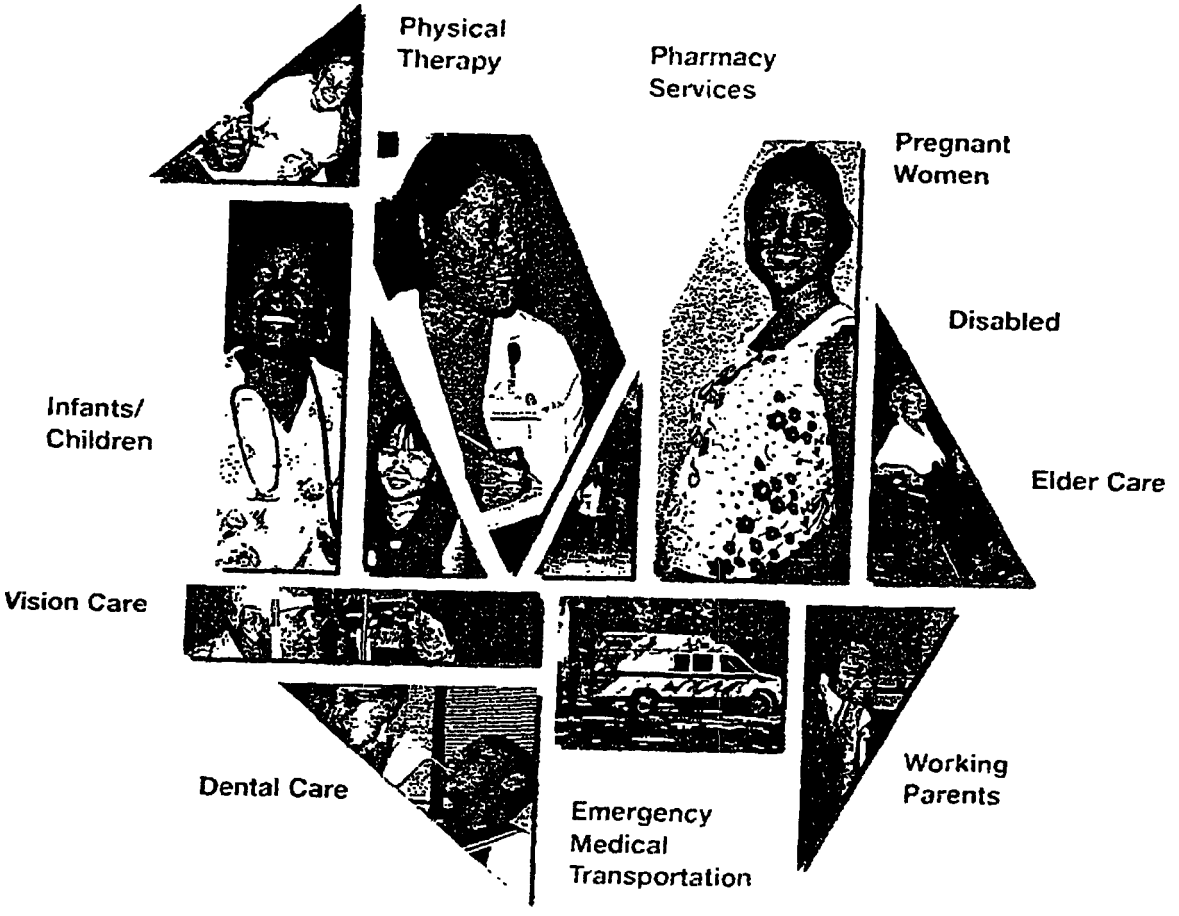
MC 210 S-W WORK HISTORY (EARNING AND EXPENSES)

This form is used if the client is applying as an unemployed parent or if certain income questions on the MC 210 require additional information, such as expenses against income. This form is not considered mandatory.

HEALTH CARE COVERAGE
FOR PEOPLE WITH LIMITED INCOME OR RESOURCES

MEDI-CAL

NEW MAIL-IN APPLICATION AND INSTRUCTIONS



For *FREE* help to apply for Medi-Cal, contact your local welfare office.

What is Medi-Cal?

- Health care coverage for qualifying persons who live in California, who have income and resources below established limits

Who can get Medi-Cal?

- Persons 65 or older
- Persons who are under 21 years of age
- Certain adults between 21 and 65 years of age, if they have minor children living with them
- Persons who are blind or disabled
- Pregnant women
- Persons receiving nursing home care
- Certain Refugees, Asylees, Cuban/Haitian Entrants

Do I have to be a U.S. citizen to get Medi-Cal?

- No, documented and undocumented aliens may be eligible for Medi-Cal. Some persons may receive pregnancy related and emergency services only; others are eligible for full Medi-Cal benefits depending on their alien status

When Medi-Cal says "a minor child," what does it mean?

- A child married or unmarried under 21 years of age living in your home or away at school

What do I do to get Medi-Cal coverage?

- Complete and send in the enclosed application
- Send copies of any required documentation (See instructions)

How can my family and I qualify for Medi-Cal coverage?

If you are in one of the groups listed in "Who can get Medi-Cal?" above:

- We look at your income and subtract some expenses you pay to decide your family's countable income for Medi-Cal
- We look at things you and your family own (bank accounts, vehicles, etc.) to see if you meet the resource limit. **Please Note:** Not all the things you or your family own are counted; your local welfare office can give you more information

If I do not fall into one of the covered groups, how can I get coverage?

- Contact your local welfare office for information about medical services in your county

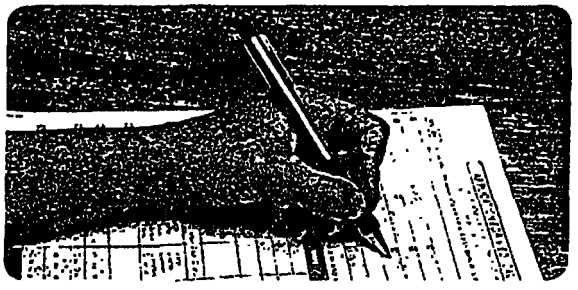
When Applying For Medi-Cal Health Coverage What Should I Do If...

I have an immediate need for health care services, such as severe illness or pregnancy.

- Take this application directly to the nearest welfare office to start the application process.

I have the application, but need help.

- Read Instructions carefully.
- Contact your local welfare office for help.
- Ask a friend or relative to help you.



My spouse or I are entering a nursing home and applying for Medi-Cal.

- Immediately contact your local welfare office for a copy of the notice regarding standards for Medi-Cal eligibility form (DHS 7077). This form will explain certain exempt resources, certain protections against spousal impoverishment, and certain circumstances under which an interest in a home may be transferred without affecting Medi-Cal eligibility.

I filled out the application and want to mail it.

- Complete the application and mail it, using the postage-paid envelope provided with the application. Include requested documentation. (See instructions)

I'm homeless or do not have a mailing address.

DO NOT MAIL THIS APPLICATION.

- Go to the nearest local welfare office to turn in this application.

I'm a minor/teenager and want confidential Minor Consent Services, for family planning, pregnancy related care, mental health, drug and alcohol abuse treatment/ counseling, sexually transmitted diseases (STD) or sexual assault.

- To maintain confidentiality, you must take this application to the local welfare office or eligibility worker site.

DO NOT MAIL IT.

I want to ask for Medi-Cal in person. I do not want to mail the application.

- Contact your local welfare office and ask for an interview to apply in person.

Remember, whether you take your application to the local welfare office or you mail it, you should *not pay* anyone to help you with this application.

www.dhs.ca.gov

For *FREE* help to apply for Medi-Cal, contact your local welfare office.

MC 210 L&M (01)
INSTRUCTIONS

INSTRUCTIONS ⇨

How to fill out the application

- **Tear out the application**
- **Read the instructions completely**
- **Fill out as much of the application as you can**
- **Include requested documentation (See instructions)**
- **If help is needed contact the local welfare office**
- **Do not delay in sending in your application**

Whose information should you put on this application?

- If you are an adult not living with a spouse, and you have no children, enter your own information.
- If you are legally married and living together, enter your and your spouse's information.
- If you are legally married but one or both of you are living in a nursing home or board and care facility, enter your and your spouse's information.
- If your children are under 21 years of age and living with you and their other parent, enter your own information, your children's and the other parent's.
- If you are under 21 years of age and not living with your parents, enter your own information.
- If you are an unmarried minor under 21 years of age living with your parent(s) and asking for Minor Consent confidential services, enter your own information.

What will happen after I send in my application?

- The local welfare office will notify you within 10 working days that they received your application. They will give you the name of someone you can contact for more information about your application.
- You will receive a packet from the county with additional program information.
- You may receive a request for additional information that the county will need in order to determine your eligibility.
- In most instances the local welfare office will determine your eligibility within 45 days and notify you in writing of that decision. An eligibility determination based on disability may take up to 90 days.
- If you are determined eligible, depending on what county you live in, you may be able to choose a health plan by completing a separate enrollment form.
- If you do not qualify for no-cost Medi-Cal and you wish to apply for the Healthy Families program, the local welfare office will forward this application to that program.

State of California - Health and Human Services Agency — Department of Health Services

APPLICATION FOR MEDI-CAL

To complete this form, use the instructions. Print clearly. Use black or blue ink only.

SECTION 1 **Tell us about the person who wants Medi-Cal for themselves, their family or children in their care.**

1 LAST NAME	FIRST NAME		MIDDLE INITIAL
2 HOME ADDRESS (NUMBER AND STREET) DO NOT LIST A P.O. BOX UNLESS HOMELESS		3 APARTMENT NUMBER	4 HOME PHONE # ( )
5 CITY/STATE	6 COUNTY	7 ZIP CODE	8 WORK PHONE # ( )
9 MAILING ADDRESS (IF DIFFERENT FROM ABOVE) OR P.O. BOX		10 APARTMENT NUMBER	11 MESSAGE PHONE # ( )
12 CITY			13 ZIP CODE
14A WHAT LANGUAGE/DIALECT DO YOU SPEAK BEST?		14B WHAT LANGUAGE DO YOU READ BEST?	

SECTION 2 **Tell us about the person listed in Section 1, his or her family and the children they care for, even if they don't want coverage.**

	Adult 1/Self	Adult 2	Child 1	Child 2	Child 3
15 Name: Last					
First					
Middle					
16 Relationship to person in Section 1.					
17 If address where living is not the same as listed in Section 1, put address where living:					
18 Gender:	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
19 Marital Status:	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
20 Name of spouse(s) of married minors in the home.					
21 Date of Birth:	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR
22 Pregnant:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Due Date:	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR
23 Has a physical, mental or emotional disability?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Disability expected to last:	☐ 30 Days or More ☐ 12 Months or More	☐ 30 Days or More ☐ 12 Months or More	☐ 30 Days or More ☐ 12 Months or More	☐ 30 Days or More ☐ 12 Months or More	☐ 30 Days or More ☐ 12 Months or More

MC 210 05/01 APPLICATION

A1

CONTINUED ⇨

SECTION 2 Continued

	Adult 1/Self	Adult 2	Child 1	Child 2	Child 3
24 Has any one ever received cash aid, SSI, Food Stamps or Medi-Cal?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If "Yes," under what name?					
25 Medi-Cal benefits BIC card number, if you have it					
26 Wants medical benefits?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
27 Do you own or are you buying a home outside California?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

SECTION 3 Answer for *all* children in Section 2.

	Child 1	Child 2	Child 3	Unborn
28	Mother's Name:	Mother's Name:	Mother's Name:	Mother's Name:
	Is Mother: ☐ Employed ☐ Disabled ☐ Unemployed ☐ Deceased ☐ Absent	Is Mother: ☐ Employed ☐ Disabled ☐ Unemployed ☐ Deceased ☐ Absent	Is Mother: ☐ Employed ☐ Disabled ☐ Unemployed ☐ Deceased ☐ Absent	Is Mother: ☐ Employed ☐ Disabled ☐ Unemployed
29	Father's Name:	Father's Name:	Father's Name:	Father's Name:
	Is Father: ☐ Employed ☐ Disabled ☐ Unemployed ☐ Deceased ☐ Absent	Is Father: ☐ Employed ☐ Disabled ☐ Unemployed ☐ Deceased ☐ Absent	Is Father: ☐ Employed ☐ Disabled ☐ Unemployed ☐ Deceased ☐ Absent	Is Father: ☐ Employed ☐ Disabled ☐ Unemployed ☐ Deceased ☐ Absent

SECTION 4 List *all* income/money received by persons listed in Section 2.

30 NAME OF PERSON RECEIVING INCOME/MONEY	31 SOURCE OF INCOME/ MONEY RECEIVED (Employment, social security)	32 HOW MUCH INCOME/MONEY IS RECEIVED	33 HOW OFTEN INCOME/ MONEY RECEIVED (Monthly, bimonthly, weekly, biweekly, daily)

SECTION 5 Give information about the listed expenses/cost paid by *all* persons listed in Section 2.

TYPE OF PAYMENT YOUR FAMILY MAKES	34 NAME OF PERSON WHO PAYS	35 MONTHLY AMOUNT PAID
Child Support		
Alimony		
Other Health Insurance Premium		
Medicare Premium		

36 CHILD CARE OR DEPENDENT CARE (For child's or dependent's name)	37 AGE	38 NAME OF PERSON WHO PAYS	39 MONTHLY AMOUNT PAID
1.			
2.			
3.			
4.			

MC 210 08/01
APPLICATION

(A2)

SECTION 6 *Skip this Section if you are **only** applying for children under 19 and/or pregnant women (pregnancy related services only).*

Otherwise answer for ***all*** persons listed in Section 2.	
40 Does anyone have cash or uncashed checks? If "Yes," list amount here_____ (See instructions)	☐ Yes ☐ No
41 Does anyone have a checking, savings account, or life insurance? (See instructions)	☐ Yes ☐ No
42 Is there one car or more in the household? (See instructions)	☐ Yes ☐ No
43 Does anyone have a court ordered settlement or judgement? (See instructions)	☐ Yes ☐ No
44 Does anyone have Long-Term Care insurance? (See instructions)	☐ Yes ☐ No
45 Does anyone own any items such as stocks, bonds, retirement funds, trusts, real estate, motor vehicles for a business, business accounts, promissory notes, mortgages, deeds of trust, recreational vehicles, burial trusts or funds, annuities, jewelry (not heirloom or wedding), oil or mineral rights? (See instructions)	☐ Yes ☐ No
46 Has anyone listed on this form transferred, sold, traded or given away any items such as those listed above in the last 30 months? (See instructions)	☐ Yes ☐ No
47 Have any items listed in this section been spent or used as security for medical costs? (See instructions)	☐ Yes ☐ No

SECTION 7 **Answer *only* for persons who want Medi-Cal.**

	Adult 1/Self	Adult 2	Child 1	Child 2	Child 3
48 Social Security #:					
	You may be able to receive Medi-Cal even if you do not have a Social Security Number.				
49 Place of Birth: *State or Country*					
50 U.S. Citizen or National? If "No," write in date of entry into U.S.	☐ Yes ☐ No / / MO DAY YR	☐ Yes ☐ No / / MO DAY YR	☐ Yes ☐ No / / MO DAY YR	☐ Yes ☐ No / / MO DAY YR	☐ Yes ☐ No / / MO DAY YR
51 Living in a Long-Term Care or Board and Care Facility?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If "Yes," name of facility:					
Do you intend to return home?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Do you intend to return home within six months?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
52 Has health/dental or vision coverage?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
53 Had medical expenses within the 3 months before the month you applied and want Medi-Cal for those expenses.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
54 Lawsuit pending due to accident or injury?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

MC 210 (9/91) APPLICATION

(A3)

CONTINUED ➥

SECTION 7 Continued	Adult 1/Self	Adult 2	Child 1	Child 2	Child 3
55 Current or past U.S. Military Service for adults, spouse or child's parents?	☐ Yes ☐ No ☐ Self ☐ Spouse ☐ Parent	☐ Yes ☐ No ☐ Self ☐ Spouse ☐ Parent	☐ Yes ☐ No ☐ Self ☐ Spouse ☐ Parent	☐ Yes ☐ No ☐ Self ☐ Spouse ☐ Parent	☐ Yes ☐ No ☐ Self ☐ Spouse ☐ Parent
56 Ethnicity (race): (optional)					
57 In school full time?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
58 Living away from home?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

SECTION 8 Information Release (Optional).

59 If family member cannot get no-cost Medi-Cal but may be able to get low-cost health care coverage, can the local welfare office send this form to the Healthy Families Program? ☐ Yes ☐ No

60 I got help from (give name of person) _____ when I filled out this application. I agree that the local welfare office may give them information about the status of this application. ***Applicant please initial*** _____ .

SECTION 9 Signature and Certification.

61 I declare under penalty of perjury under the laws of the State of California that the answers I have given in this application, and the documents given are correct and true to the best of my knowledge and belief.

I declare that I have read and understand the application instructions, the declarations, and all information printed on this application.

Signature _____ Date _____

Witness Signature *(if person signed with a mark)* _____ Date _____

Signature of person helping Applicant fill out the form _____ Telephone Number _____ Relationship to Applicant _____ Date _____

Signature of person acting for Applicant/Beneficiary _____ Telephone Number _____ Relationship to Applicant _____ Date _____

For information about any of the following programs, check the box(es) below and information will be sent to you. See the Medi-Cal brochure, "Health Care for Families with Children" or visit our website, www.dhs.ca.gov

☐ Personal Care Service Program (PCSP). A program for in-home care.

☐ Access for Infants, and Mothers (AIM). A program to help pregnant women with moderate income obtain health care.

☐ Woman, Infants and Children Nutrition Program (WIC). A nutrition program for pregnant and postpartum women and children under 5.

☐ Family Planning

☐ Child Health and Disability Program (CHDP). Preventive healthcare for children and youth. Do you want your children or youth referred to the CHDP program? ☐ Yes ☐ No

MC 210 08/01
APPLICATION

A4

INSTRUCTIONS

Please read before beginning application.

SECTION 1

Tell us about the person who wants Medi-Cal for themselves, their family or children in their care.

Questions 1-8:
Enter the name, home address and telephone numbers of the person who wants Medi-Cal or the parent/caretaker of the children who want Medi-Cal.

Questions 9-13:
Enter the phone number and mailing address (if different than home address provided in #2) of the person who wants Medi-Cal. This is the address where all information regarding the application and health benefits will be mailed.

Question 14A-B:
Enter the language you speak and/or read best.

Send proof of identity. Only one person (a parent or caretaker) in a family needs to provide an identity document. Send a **photocopy** of one of the following identity items:

- California driver license
- Identification card issued by the Department of Motor Vehicles
- U.S. citizenship or alien status documents (passport).
- School identification card
- Birth certificate
- Marriage record
- Social Security card or document containing a Social Security number.
- Divorce decree
- Work badge, building pass
- Adoption record
- Court order for name change
- Church membership or baptismal confirmation certificate

Identity proof is not needed for

- Persons in an institution
- Children in a family, if identity of one parent has been established
- Children requesting Medi-Cal for Minor Consent services
- The spouse of a person whose identity has been verified

SECTION 2

Tell us about the person listed in Section 1, his or her family and the children they care for, even if they don't want coverage.

If you are applying for more than 5 people, use a separate piece of paper or a photocopy of pages A1, A2, A3 and A4 of the application, to give us information about the additional persons.

Who counts as an adult?

- Persons 21 years of age or older
- Persons under 21 years of age who are not living in the home of their parent or caretaker relative and are not claimed as tax dependents

Who counts as children?

- All natural and adoptive children under 21 living in the home
- All natural and adoptive children between 18 and 21 years of age, away from home and claimed as tax dependents
- All stepchildren under age 21 living in the home

Question 15:
Write the last, first and middle name of each person in the house.

SECTION 2 Continued

Question 16:
How is each person related to the person in Section 1. *Example: self, wife, husband, grandparents, friend, daughter, stepchild, nephew, etc.*

Question 17:
Write the complete address, if different from the address in Section 1. *Example: child is in college and living at school.*

Question 18:
Indicate gender of each person.

Question 19:
Indicate the marital status of each person listed.

Question 20:
Write the name of the spouse of any married minors living in the home. Any income of the spouse must be listed in Section 4.

Question 21:
Write month, day and year of birth for each person.

Question 22:
Tell us if this person is pregnant. If "Yes," tell us the due date.

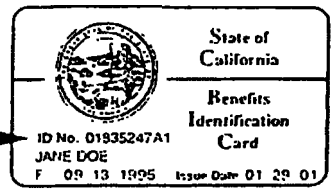
> Send proof of pregnancy from a doctor's office or a clinic within 60 days of applying to continue receiving full Medi-Cal benefits. You do not need to send verification if you only want pregnancy related services.

Question 23:
Check "Yes," if person is blind or has a physical or mental illness that is expected to last at least 30 days. If person is unable to work, check "Yes," and check the box that best describes how long the person will be unable to work if declared disabled. This will help us decide if you are eligible for Medi-Cal based on disability.

Question 24:
Tell us if anyone has ever had cash aid, SSI, Food Stamps or Medi-Cal. This will help the local welfare office check for needed information before asking you to give it. If you checked "Yes," tell us the name you received benefits under.

Question 25:
If you have ever received Medi-Cal, tell us your Medi-Cal Benefits Identification Card (BIC) number if you have it.

Your Medi-Cal Benefits Identification Card (BIC) number can be found here. →



Question 26:
Check "Yes," if you are asking for medical benefits for this person.

Question 27:
Tell us if you own or are buying a home outside California. Your answer helps us determine your residency.

> **Send proof of California residency.** You can use your proof of income as proof of residency. If your income is not from California, send other proof of residence. For example: rent receipts, utility bill or a child's school records.

SECTION 3

Answer for *all* children in Section 2.

Question 28:
Write the name of the natural or adoptive mother of each child. Check the box to tell us if the mother is employed, disabled, unemployed, deceased or absent from the home.

Question 29:
Write the name of the natural or adoptive father of each child. Check the box to tell us if the father is employed, disabled, unemployed, deceased or absent from the home.

GO TO PAGE 3 ➥

SECTION 4

List *all* income/money received by persons listed in Section 2.

Questions 30 and 31:

Use a separate line for each person who receives money. If a person receives money from two different places, use two lines.

Example: if the applicant has two jobs, use one line for each job to report her/his earnings.

Question 32:

Write the amount of money you receive each time.

Example: if you get money once a week, write the weekly amounts in the box.

If the money amount changes from time to time, put the average amount you get on a regular basis. We use pay stubs or other documents you give us to figure out the correct monthly income.

If you know your family's income will go up or down in the next few months due to overtime, promotion, raises in pay, expected increases in child support/ alimony, layoffs, furloughs, etc., explain on a separate sheet of paper.

Example: Maria's gross income from her job on this check is $1000 but her regular monthly pay is only $800. Explain on the paper that Maria's paycheck included $200 overtime pay, or a cash bonus and how long the overtime will last or how often she gets bonuses.

Question 33:

How often do you receive this money?

Example: Monthly (once a month); weekly (once-a-week); biweekly (every other week); bimonthly (twice a month); or daily (every day).

Documentation of Income

- **Send proof of income.** Send a copy of the most recent pay stub you have. If a pay stub is not available, get a signed statement from your employer. Gross monthly income and the dates received should be on the statement.

OR

- **A copy of last year's federal income tax return.**

OR

Other proof of income you may need to send:

- If a person is self-employed, send last year's federal income tax return, include Schedule C or F, or the last 3 months' profit and loss statements.
- If a person has income such as disability or retirement, send copies of award letters or bank statements showing the direct deposits.
- If anyone gets child support and/or alimony or spousal support, send copies of the checks received or statements from the District Attorney's Family Support Division for the last month.
- If anyone gets student loans or grants, send in copies of award letters or loan papers.

GO TO PAGE 4

SECTION 5

Give information about the listed expenses/costs paid by *all* persons listed in Section 2.

Tell us if you pay court-ordered **child support**, or **alimony**, or have other **health insurance** or **Medicare** premium costs.

Medi-Cal will pay your medicare premiums and deduct the cost of any other insurance premium from your countable income.

Question 34:
Write the name of the person who pays the cost.

Question 35:
Write in the total amount paid each month.

Question 36:
Write in the costs paid for child care and/or disabled dependent care.

Question 37:
List the age of the child or disabled dependent.

Question 38:
Write the name of the person who pays the cost.

Question 39:
List the total amount paid monthly for each child or disabled dependent.

Send proof of expenses (costs) listed in Section 5. Send in proof of child support or alimony costs. For childcare and dependent care, send receipts or cancelled checks.

SECTION 6

Skip this section if you are only applying for Children under 19 and/or pregnant women applying for pregnancy related services only. Otherwise answer for *all* persons listed in Section 2.

If you have questions or concerns about completing Section 6, leave it blank and contact the local welfare office for help.

The value of the home you are living in is not counted for Medi-Cal.

Question 40:
Tell us the amount of all cash you have on hand and the amount of any checks you have received but not cashed.

Question 41:
If anyone listed has a checking and/or savings account or life insurance policy, please send copies of the following documents:

- Account statements showing current balances in accounts.
- Copies of all life insurance policies.

Question 42:
If you checked "Yes," send us a copy of the vehicle registration(s) or pink slip(s) or estimate(s) of value from a qualified source, such as a dealer or mechanic.

Question 43:
If you check "Yes," send us copies of all court orders, documents and agreements.

Question 44:
If you check "Yes," send us copies of your policies, contracts and purchase agreements. If your policy is certified by the California Partnership for Long-Term Care, give us a copy of your most recent benefit statement.

GO TO PAGE 5

Questions 45-47:
If you check "Yes," you may be asked to provide additional information. You may also have to fill out a property supplement form.

SECTION 7

Answer *only* for persons who want Medi-Cal.

Question 48:
A Social Security number for each person applying for full Medi-Cal benefits is required. If you do not have a Social Security number, do not delay sending in this application. You can apply now and give us the number within the next 60 days.

Pregnancy and emergency care services may be available to persons who are unable to get a Social Security number.

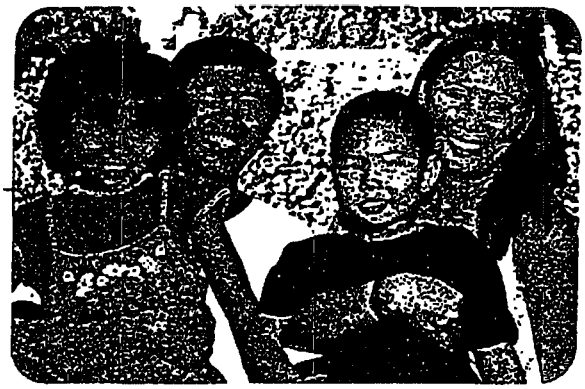
For information on how to apply for a Social Security number, call Social Security Administration toll-free, 1-800-772-1213.

Question 49:
Write the place of birth for each person. If born in the United States, write the name of the state. If born outside the U.S., write the name of the country.

Question 50:
Check "Yes" or "No," telling us if the person is a Citizen or U.S. National.

Give immigration information only for people applying for health coverage. Do not give information for people not applying. The State will use this information only for eligibility determination. Information about immigration is private and confidential.

Immigrants who meet all immigration requirements may get **full Medi-Cal benefits.** Undocumented immigrants can get pregnancy related and emergency services.



Send proof of immigration status or an INS receipt showing that you applied to replace a lost document. Many immigrants may get full Medi-Cal even if they do not have a green card or immigration document. Copy both sides and send proof now or within 30 days of application. If you do not send this proof, you may still be eligible for emergency or pregnancy related services.

Do not give immigration information about people who are not asking for Medi-Cal. Information about immigration is private and confidential.

Question 51:
Tell us if the person is in a nursing facility, residential, or board and care facility. If you check "Yes," tell us the name of the facility.

Question 52:
Check box to show if each person has other health insurance coverage.

You can get Medi-Cal and still have other health coverage. Medi-Cal may cover what your other health coverage does not.

GO TO PAGE 6 ⇨

SECTION 7 Continued

Question 53:
If you check "Yes," Medi-Cal may be able to help pay some or all of the paid or unpaid medical costs you have had in the 3 months before you applied.

Question 54:
Check "Yes," if any person has filed a lawsuit because of an accident or injury, workers compensation, or car accident.

Question 55:
Check box(es) to show if individual, spouse or parent of individual is or was in the U.S. Military. We are asking for this information to see if you can get other services or benefits.

Question 56 (Optional):
You can choose to enter the Ethnicity (race) for each person. This information is used for statistics only and has no effect on your eligibility for Medi-Cal.

Question 57:
Check box to show if person is in school. The earnings of a person under 21 years may not be counted if the person is attending school.

Question 58:
Tell us if the person is living away from home, is away at school, or out of town working.

MC 210 (6/97)
INSTRUCTIONS

GO TO PAGE 7

SECTION 8

Information Release (Optional).

Question 59:
Check "Yes," and the local welfare office will send this application to the Healthy Families program if one or more of the family members applying do not qualify for the Medi-Cal program.

The Healthy Families Program provides comprehensive health, dental, and vision coverage. For further information call 1-800-880-5305 or visit their website at www.healthyfamilies.ca.gov

Question 60:
If you fill out this item you are telling the local welfare office it is okay to give information about your application to the person you have named.

SECTION 9

Signature and Certification.

Who can sign this application?

- The person who wants Medi-Cal, or the spouse of the person who wants Medi-Cal
- The conservator, guardian executor, or caretaker of a child who wants Medi-Cal
- Someone acting for the person who wants Medi-Cal when the person is incompetent, in a comatose condition, or suffering from amnesia and there is no spouse, conservator, guardian or executor
- Persons 14 to 21 years old if they are not living with a parent, caretaker relative, or foster parent
- Persons 14 to 21 requesting Minor Consent Services

Question 61:
State and federal laws require your signature on this application form. Your signature in this section indicates that your declarations and answers are truthful and the documents you submit are true and correct.

Medi-Cal Confidentiality Notice

The information given in this application is private and confidential under Welfare and Institutions Code 14100.2.
The information will be disclosed only in accordance with those laws.

Medi-Cal Rights, Responsibilities and Declarations

I have the right to:

- Be treated fairly and equally regardless of my race, color, religion, national origin, sex, age, or political beliefs.
- Ask for an interpreter.
- Ask for a fair hearing if I think a decision on my Medi-Cal case is unfair or wrong. I must ask for a hearing within 90 days after I get a "Notice of Action". To find out about Medi-Cal fair hearings, call toll-free, 1-800-952-5253.
- A face-to-face interview.
- Review Medi-Cal program rules and manuals.

I have the responsibility to:

- Report any changes within 10 days in the information I give on this application.
- Let local welfare office know if a family member applies for disability benefits; is in a public institution; or gets medical care for any accident or injury caused by another person.
- Cooperate if my case is reviewed.
- Apply for available income.
- Cooperate with appropriate paternity determinations and medical support enforcement efforts.
- Assignment of rights to medical support to the State of California.
- Assign rights to third party medical support to the State of California.

I understand that:

- As a condition of Medi-Cal eligibility, all rights to medical support are automatically assigned to the State of California.
- If I purposely do not give needed facts, or if I give false facts, I understand benefits may be denied or ended and repayment may be required. I may also be investigated for fraud.
- Persons I am applying for are not in jail, prison, or any other correctional facility.
- After my death, the State has the right to seek repayment from my estate for all Medi-Cal benefits I receive after age 55 unless I have a surviving spouse, minor child(ren), blind or permanently and totally disabled child(ren).
- If I am admitted to a nursing facility and I have no intention of returning to my home, the State may impose a lien against my property.

MC 210 (9/91)
IRRIGHTS

Medi-Cal Privacy Notice

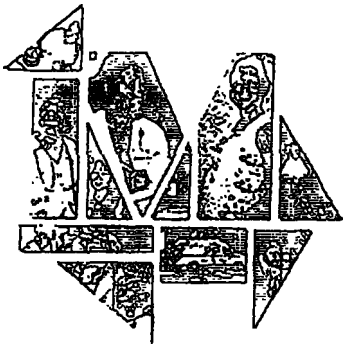
The Information Practices Act of 1977 and the Federal Privacy Act require the Department of Health Services to provide the following information: Welfare and Institutions Code Section 14011 and regulations in Title 22, CCR, require applicants for the Medi-Cal program to provide the eligibility information requested in this application.

This information may be shared with federal, state, and local agencies for purposes of verifying eligibility and for other purposes related to the administration of the Medi-Cal program, including confirmation with the INS of the immigration status of only those persons seeking full scope Medi-Cal benefits. (Federal law says the INS cannot use the information for anything else except cases of fraud.) The information will be used to process claims and make Benefits Identification Cards (BICs). Failure to provide the required information may result in denial of the application.

Information required by this form is mandatory, with the exception of ethnicity information, and any other item marked voluntary or optional. Social Security Numbers are required by Section 1137(a)(1) of the Social Security Act and by Welfare and Institutions Code Section 14011.2, unless applying for emergency or pregnancy related benefits only.

An individual has a right of access to records containing his/her personal information that are maintained by the Department of Health Services.

Contact your local welfare office to request your records.



Gray Davis
Governor, State of California

Grantland Johnson
Secretary, California Health
and Human Services Agency

Diana M. Bontà, R.N., Dr.P.H.
Director, California
Department of Health Services

9

Provided by the State of California

Flex your POWER

MC 210 08/01

English

State of California—Health and Human Services Agency

Department of Health Services

ADDITIONAL CHILDREN
(SUPPLEMENT TO THE MEDI-CAL STATEMENT OF FACTS—MC 210)

IF YOU HAVE MORE THAN THREE CHILDREN, *LIST HERE* AND GIVE THIS FORM TO YOUR WORKER.

COUNTY USE ONLY
Case name
Case number
Worker number
Date

A Child's name (first, middle, last) or "unborn"	Relationship to applicant		Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID
Social Security number	In school ☐ Yes ☐ No	Sex ☐ Male ☐ Female					
Birthdate or date unborn is due	Is the person blind or disabled ☐ Yes ☐ No	Pregnant ☐ Yes ☐ No					
Father's name	Is either parent (✓) ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed		Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18–21 and tax dep.?				
Mother's name	Child living in home ☐ Yes ☐ No	Medi-Cal requested ☐ Yes ☐ No					
B Child's name (first, middle, last) or "unborn"	Relationship to applicant		Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID
Social Security number	In school ☐ Yes ☐ No	Sex ☐ Male ☐ Female					
Birthdate or date unborn is due	Is the person blind or disabled ☐ Yes ☐ No	Pregnant ☐ Yes ☐ No					
Father's name	Is either parent (✓) ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed		Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18–21 and tax dep.?				
Mother's name	Child living in home ☐ Yes ☐ No	Medi-Cal requested ☐ Yes ☐ No					
C Child's name (first, middle, last) or "unborn"	Relationship to applicant		Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID
Social Security number	In school ☐ Yes ☐ No	Sex ☐ Male ☐ Female					
Birthdate or date unborn is due	Is the person blind or disabled ☐ Yes ☐ No	Pregnant ☐ Yes ☐ No					
Father's name	Is either parent (✓) ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed		Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18–21 and tax dep.?				
Mother's name	Child living in home ☐ Yes ☐ No	Medi-Cal requested ☐ Yes ☐ No					
D Child's name (first, middle, last) or "unborn"	Relationship to applicant		Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID
Social Security number	In school ☐ Yes ☐ No	Sex ☐ Male ☐ Female					
Birthdate or date unborn is due	Is the person blind or disabled ☐ Yes ☐ No	Pregnant ☐ Yes ☐ No					
Father's name	Is either parent (✓) ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed		Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18–21 and tax dep.?				
Mother's name	Child living in home ☐ Yes ☐ No	Medi-Cal requested ☐ Yes ☐ No					
E Child's name (first, middle, last) or "unborn"	Relationship to applicant		Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID
Social Security number	In school ☐ Yes ☐ No	Sex ☐ Male ☐ Female					
Birthdate or date unborn is due	Is the person blind or disabled ☐ Yes ☐ No	Pregnant ☐ Yes ☐ No					
Father's name	Is either parent (✓) ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed		Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18–21 and tax dep.?				
Mother's name	Child living in home ☐ Yes ☐ No	Medi-Cal requested ☐ Yes ☐ No					
F Child's name (first, middle, last) or "unborn"	Relationship to applicant		Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID
Social Security number	In school ☐ Yes ☐ No	Sex ☐ Male ☐ Female					
Birthdate or date unborn is due	Is the person blind or disabled ☐ Yes ☐ No	Pregnant ☐ Yes ☐ No					
Father's name	Is either parent (✓) ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed		Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18–21 and tax dep.?				
Mother's name	Child living in home ☐ Yes ☐ No	Medi-Cal requested ☐ Yes ☐ No					

*MC 210 S-C (4 NC/SP) (1/96)

State of California—Health and Human Services Agency — Department of Health Services

NIÑOS ADICIONALES
(SUPLEMENTO A LA DECLARACION DE DATOS DE MEDI-CAL—MC 210)

SI TIENE MAS DE TRES NIÑOS, *ANOTELOS AQUI* Y DELE ESTA FORMA A SU TRABAJADOR(A)

PARA USO DEL CONDADO
Case name _____
Case number _____
Worker number _____

			Linkage	Citizen/ Immig MC 13	SSN	Preg	ID
A Nombre del niño (nombre, inicial, apellido) o "por nacer"	Parentesco con el solicitante						
Numero del Seguro Social	¿Asiste a la escuela? ☐ Si ☐ No	Sexo ☐ Masc ☐ Fem					
Fecha de nacimiento o fecha en que se espera nazca el bebé	¿Está la persona ciega o incapacitada? ☐ Si ☐ No	¿Embarazada? ☐ Si ☐ No					
Nombre del padre	¿Está cualquiera de los padres (✓) ☐ Muerto ☐ Incapacitado ☐ Ausente ☐ Desempleado		Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18–21 and tax dep.?				
Nombre de la madre	¿Vive el niño en el hogar? ☐ Si ☐ No	¿Solicita Medi-Cal? ☐ Si ☐ No					
B Nombre del niño (nombre, inicial, apellido) o "por nacer"	Parentesco con el solicitante						
Numero del Seguro Social	¿Asiste a la escuela? ☐ Si ☐ No	Sexo ☐ Masc ☐ Fem					
Fecha de nacimiento o fecha en que se espera nazca el bebé	¿Está la persona ciega o incapacitada? ☐ Si ☐ No	¿Embarazada? ☐ Si ☐ No					
Nombre del padre	¿Está cualquiera de los padres (✓) ☐ Muerto ☐ Incapacitado ☐ Ausente ☐ Desempleado		Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18–21 and tax dep.?				
Nombre de la madre	¿Vive el niño en el hogar? ☐ Si ☐ No	¿Solicita Medi-Cal? ☐ Si ☐ No					
C Nombre del niño (nombre, inicial, apellido) o "por nacer"	Parentesco con el solicitante						
Numero del Seguro Social	¿Asiste a la escuela? ☐ Si ☐ No	Sexo ☐ Masc ☐ Fem					
Fecha de nacimiento o fecha en que se espera nazca el bebé	¿Está la persona ciega o incapacitada? ☐ Si ☐ No	¿Embarazada? ☐ Si ☐ No					
Nombre del padre	¿Está cualquiera de los padres (✓) ☐ Muerto ☐ Incapacitado ☐ Ausente ☐ Desempleado		Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18–21 and tax dep.?				
Nombre de la madre	¿Vive el niño en el hogar? ☐ Si ☐ No	¿Solicita Medi-Cal? ☐ Si ☐ No					
D Nombre del niño (nombre, inicial, apellido) o "por nacer"	Parentesco con el solicitante						
Numero del Seguro Social	¿Asiste a la escuela? ☐ Si ☐ No	Sexo ☐ Masc ☐ Fem					
Fecha de nacimiento o fecha en que se espera nazca el bebé	¿Está la persona ciega o incapacitada? ☐ Si ☐ No	¿Embarazada? ☐ Si ☐ No					
Nombre del padre	¿Está cualquiera de los padres (✓) ☐ Muerto ☐ Incapacitado ☐ Ausente ☐ Desempleado		Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18–21 and tax dep.?				
Nombre de la madre	¿Vive el niño en el hogar? ☐ Si ☐ No	¿Solicita Medi-Cal? ☐ Si ☐ No					
E Nombre del niño (nombre, inicial, apellido) o "por nacer"	Parentesco con el solicitante						
Numero del Seguro Social	¿Asiste a la escuela? ☐ Si ☐ No	Sexo ☐ Masc ☐ Fem					
Fecha de nacimiento o fecha en que se espera nazca el bebé	¿Está la persona ciega o incapacitada? ☐ Si ☐ No	¿Embarazada? ☐ Si ☐ No					
Nombre del padre	¿Está cualquiera de los padres (✓) ☐ Muerto ☐ Incapacitado ☐ Ausente ☐ Desempleado		Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18–21 and tax dep.?				
Nombre de la madre	¿Vive el niño en el hogar? ☐ Si ☐ No	¿Solicita Medi-Cal? ☐ Si ☐ No					
F Nombre del niño (nombre, inicial, apellido) o "por nacer"	Parentesco con el solicitante						
Numero del Seguro Social	¿Asiste a la escuela? ☐ Si ☐ No	Sexo ☐ Masc ☐ Fem					
Fecha de nacimiento o fecha en que se espera nazca el bebé	¿Está la persona ciega o incapacitada? ☐ Si ☐ No	¿Embarazada? ☐ Si ☐ No					
Nombre del padre	¿Está cualquiera de los padres (✓) ☐ Muerto ☐ Incapacitado ☐ Ausente ☐ Desempleado		Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18–21 and tax dep.?				
Nombre de la madre	¿Vive el niño en el hogar? ☐ Si ☐ No	¿Solicita Medi-Cal? ☐ Si ☐ No					

MC 210 S-C (ENG/SP) (5/00)

State of California - Health and Human Services Agency — Department of Health Services, Medi-Cal Program

Property/Resources
(Supplement to the Medi-Cal Statement of Facts - MC 210)

Please fill in the following, if you answered "YES" to certain Property/Resource questions from the Statement of Facts MC 210.

(1) LIQUID RESOURCES

Fill in the following if more room was needed to list liquid resources (Checking/Savings/IRA'S, Stocks, etc.)

Type of Resource	Owner of Resource	Account Number	Name and Address	Current Value
				$
				$
				$

COUNTY USE ONLY

Case Name
Case No.
Worker No.
Date

(2) REAL ESTATE

A. If you or any family member answered "YES" to owning or buying any of the items listed under the Real Estate part of the MC 210, fill in the following. List any property in any state or country and all land you own, have title to, or share title in. ITEMS: Houses, lots, land, apartments, mobile homes taxed as real property, or other

Address or Legal Description of Property _____

_____

Name of Owner _____

Does anyone live there now? ☐ Yes ☐ No How long have they lived there? _____

Name of person living there _____ Relationship to you _____

Do you plan to return to that property to live? ☐ Yes ☐ No
(You must notify the county within ten [10] days of any change in plans for living at the property.)

Is the property currently listed for sale? ☐ Yes ☐ No

Full value of property (from tax statement) $ _____ Amount owed. $ _____

Rent collected each month from property: $ _____

Expenses on property:

- Interest $_____ Yearly/Monthly
- Insurance $_____ Yearly/Monthly
- Taxes and Assessments $_____ Yearly/Monthly
- Upkeep and Repairs $_____ Yearly/Monthly
- Utilities $_____ Yearly/Monthly

B. If you or any family member answered "YES" to the life estate property question, please fill in the address of the property below.
Address: _____

_____

_____

Do you or any family member have an income interest in a life estate? ☐ Yes ☐ No

Is the life estate (producing/earning/providing/giving) income? ☐ Yes ☐ No

Verification of Legal Cause for Normalization of Property

Verification of Income and Expenses

If you or any family member answered "YES" to owning one or more of the items in the VEHICLE section of 4. Statement of Facts, MC 210, fill in the following information about each vehicle

VEHICLES

(3) A. List all cars, trucks, motorcycles, campers or off road vehicles (even if not running) owned by you or your family. If none, write "none."

Make and Model	Year	Class (Registration)	Owner	Amount Owed	Listed for Sale?		Used for Transportation	
					Yes	No	Yes	No
				$				
				$				
				$				
				$				
				$				
				$				
				$				
				$				
				$				
				$				
				$				
				$				
				$				

B. List any boats, campers (do not include trucks), motor homes, or trailers which are not used as a home and are not taxed as real property by the county

Description	Year	Class (Registration)	Owner	Purchase Price	Listed for Sale?		Used for Transportation	
					Yes	No	Yes	No
				$				
				$				
				$				
				$				
				$				
				$				
				$				
				$				
				$				
				$				
				$				
				$				

Note: If you think the value the Department of Motor Vehicles will give the items listed in A and B will be too high, you may get three appraisals of the actual value and the average will be used

COUNTY USE ONLY

List exempt vehicle

☐ Verification of nonexempt vehicles

☐ Verification of encumbrance

☐ Verification of personal property

If you or any family member answered "YES" to owning items in the **OTHER** or **BUSINESS** section of the Statement of Facts, MC 210, please give more detailed information about those items here.

OTHER

(4) A. If you or any family member own items of jewelry valued at more than $100 each, or are applying under Pickle and your items are over $500, you must fill in the following:
(Do not include wedding, engagement rings, or heirlooms.)

Description	Listed for Sale? Yes	Listed for Sale? No	Amount Owed
			$
			$

B. If you or any family member answered "YES" to owning life insurance, you must fill in the following.

	Insurance Company	Person Insured / Policy Owned By	Face Value	Policy Number	Date Policy Issued	Current Cash Value
1.			$			$
2.			$			$
3.			$			$

C. If you or any family member answered "YES" to owning one or more of the following:

1. burial plot, vault, or crypt, is it for use of immediate family? ☐ Yes ☐ No

or 2. mineral rights or mining claims, is either listed for sale? ☐ Yes ☐ No

Please give more detailed information.

Description _____

Owned by: _____

Current Value: $ _____ Amount Owed: $ _____

Location: _____

D. If you or any family member answered "YES" to owning a burial reserve or trust, please fill in the following.

Purchase Price	Amount Owed	Purchased For Whom	Purchased From Whom
$	$		
$	$		
$	$		

BUSINESS

(5) If you or any family member answered "YES" to owning one or more of the following types of business items, equipment, vehicles, tools, inventory or materials (including livestock or poultry not for personal use) you must give more detailed information by filling in the following.

Description of Item	Estimated Value	Amount Owed
	$	$
	$	$
	$	$

COUNTY USE ONLY

Heirloom? _____
Total Nonexempt

Appraised Value $ _____

☐ Exempt

Yes No CSV

Exempt ☐ ☐ $ _____

Exempt ☐ ☐ $ _____

Exempt ☐ ☐ $ _____

Total CSV $ _____

Exempt $ _____

☐ Revocable
☐ Irrevocable
☐ Irrevocable Funeral

Current Value $ _____

MEDI-CAL U-PARENT DETERMINATION WORKSHEET
(To Be Completed By CWD Staff)

Case name: _____ Worker number: _____

Case number: _____ Date: _____

1. Determination of Principal Wage Earner (PWE)

   a. Application date OR date U-Parent deprivation began: _____
   b. To establish 24-month earnings period, check month on chart for each parent:

   Month number 1: subtract two years from line (a): _____

   Month number 24: Month/Year immediately preceding line (a): _____

Parent 1's Earnings	Current year		Year		Year	
	$	Dec.	$	Dec.	$	Dec.
	$	Nov.	$	Nov.	$	Nov.
	$	Oct.	$	Oct.	$	Oct.
	$	Sep.	$	Sep.	$	Sep.
	$	Aug.	$	Aug.	$	Aug.
	$	Jul.	$	Jul.	$	Jul.
	$	Jun.	$	Jun.	$	Jun.
	$	May	$	May	$	May
	$	Apr.	$	Apr.	$	Apr.
	$	Mar.	$	Mar.	$	Mar.
Total: $	$	Feb.	$	Feb.	$	Feb.
	$	Jan.	$	Jan.	$	Jan.

Name

Parent 2's Earnings	Current year		Year		Year	
	$	Dec.	$	Dec.	$	Dec.
	$	Nov.	$	Nov.	$	Nov.
	$	Oct.	$	Oct.	$	Oct.
	$	Sep.	$	Sep.	$	Sep.
	$	Aug.	$	Aug.	$	Aug.
	$	Jul.	$	Jul.	$	Jul.
	$	Jun	$	Jun.	$	Jun.
	$	May	$	May	$	May
	$	Apr.	$	Apr.	$	Apr.
	$	Mar.	$	Mar.	$	Mar.
Total: $	$	Feb.	$	Feb.	$	Feb.
	$	Jan	$	Jan	$	Jan

Name

The parent earning the greater amount is the PWE: _____
(Name of PWE)

2. Is the PWE working 100 hours or more a month? ☐ Yes ☐ No
   If "yes," complete the Unemployed Parent Worksheet (MC 337).

Note: **If the PWE is a recipient of Section 1931(b), he/she may exceed 100 hours with no earned income test.**

VOCATIONAL AND WORK HISTORY
(To Be Completed By Applicant/Beneficiary)

Parent Number 1 Name: _____

List your employment and training history for the last two years. Begin with your current or latest job or training.

Name of Employer or Training Program	Work or Training	When Employed	Gross Amount Monthly	Name of Employer or Training Program	Work or Training	When Employed	Gross Amount Monthly
1.	☐ Work ☐ Training	From __/__/__ To __/__/__	$	4.	☐ Work ☐ Training	From __/__/__ To __/__/__	$
2	☐ Work ☐ Training	From __/__/__ To __/__/__	$	5	☐ Work ☐ Training	From __/__/__ To __/__/__	$
3	☐ Work ☐ Training	From __/__/__ To __/__/__	$	6	☐ Work ☐ Training	From __/__/__ To __/__/__	$

Parent Number 2 Name: _____

List your employment and training history for the last two years. Begin with your current or latest job or training.

Name of Employer or Training Program	Work or Training	When Employed	Gross Amount Monthly	Name of Employer or Training Program	Work or Training	When Employed	Gross Amount Monthly
1.	☐ Work ☐ Training	From __/__/__ To __/__/__	$	4.	☐ Work ☐ Training	From __/__/__ To __/__/__	$
2	☐ Work ☐ Training	From __/__/__ To __/__/__	$	5	☐ Work ☐ Training	From __/__/__ To __/__/__	$
3	☐ Work ☐ Training	From __/__/__ To __/__/__	$	6	☐ Work ☐ Training	From __/__/__ To __/__/__	$

INCOME IN-KIND/HOUSING VERIFICATION

(SUPPLEMENT TO THE MC 210 STATEMENT OF FACTS)

WE NEED THE FOLLOWING INFORMATION TO DETERMINE THE VALUE OF THE HOUSING/RENT, UTILITIES, FOOD OR CLOTHING THAT YOU ARE RECEIVING FREE OR IN EXCHANGE FOR WORK

County Use Box

Case Name

Case No.

Worker No. Date

Part I. IN-KIND INCOME VERIFICATION

A. Applicant Authorization Section: (Sign this section if you want the county to verify IN-KIND INCOME)

Name(s):

Address:

I hereby authorize _____ county to contact _____ concerning any of the information requested below.

Applicant Signature. _____ Date. _____

B. Provider Statement Section: (Statement of person giving/sharing housing, utilities, food, clothing, etc.)

1 The person(s) named above receives from me/my family

[ ] Housing/Rent [ ] Utilities [ ] Food [ ] Clothing [ ] Cash

- This is [ ] Free [ ] In exchange for _____
- We have been providing these items since _____
- We expect to continue to provide these items until _____

2 I/We share household expenses with the person(s) named above [ ] Yes [ ] No
(If no, go to number 3.)

Our shared arrangement is: _____

3 The TOTAL cost of household items at the above address is:

Housing _____ Rent _____ Utilities _____ Food _____ Clothing _____ Cash _____

- The number of people in the household at the above address is _____

4 My relationship to the person(s) named above is: _____

I CERTIFY THAT THE INFORMATION IN THIS SECTION IS TRUE AND CORRECT:

Provider Signature _____ Date. _____

Address: _____ Phone: (___) _____

Part II. HOUSING VERIFICATION

SIGN BELOW ONLY IF YOU, THE APPLICANT, WANT TO PROVIDE INFORMATION ABOUT FREE HOUSING OR RENT PAID TO A RELATIVE AS EVIDENCE OF RESIDENCY. BEFORE YOU SIGN, YOU MUST FILL IN THE HOUSING INFORMATION REQUESTED ABOVE.

I understand that the information I provide as evidence of residency may be verified by county or state employees processing my application. I agree to cooperate with any such employee in the verification of this information. I hereby authorize any county or state employee responsible for administering the Medi-Cal program to contact _____ concerning any of the information provided above.

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE INFORMATION CONTAINED IN THIS STATEMENT IS TRUE, CORRECT, AND COMPLETE.

Applicant Signature _____ Date _____

INGRESOS – NO EN EFECTIVO/VERIFICACION DE VIVIENDA

(SUPLEMENTO A LA DECLARACION DE DATOS MC 210)

NECESITAMOS LA SIGUIENTE INFORMACION PARA DETERMINAR EL VALOR DE LA VIVIENDA/ALQUILER, SERVICIOS PUBLICOS Y MUNICIPALES, ALIMENTOS O ROPA QUE USTED RECIBE GRATIS O A CAMBIO DE TRABAJO.

Para Uso del Condado

Case Name: _____

Case No.: _____

Worker No.: _____ Date: _____

Parte I. VERIFICACION DE LOS INGRESOS NO EN EFECTIVO

A. Sección de Autorización del Cliente: (Firme esta sección si usted desea que el condado verifique los INGRESOS NO EN EFECTIVO)

Nombre(s): _____

Dirección: _____

Por medio de la presente autorizo al condado de _____ a que se comunique con _____ con relación a cualquier información que se solicita enseguida.

Firma del Solicitante: _____ Fecha _____

B. Sección para la Declaración del Proveedor: (Declaración de la persona que da/comparte la vivienda, servicios públicos y municipales, alimentos, ropa, etc.)

1. La(s) persona(s) mencionada(s) arriba recibe(n) de mi/de mi familia
   - [ ] Vivienda/Alquiler [ ] Servicios Públicos y Municipales [ ] Alimentos [ ] Ropa [ ] Dinero en efectivo
   - Esto es [ ] Gratuito [ ] A cambio de _____
   - He/hemos proporcionado estos artículos desde _____
   - Espero/esperamos continuar proporcionando estos artículos hasta _____

2. Comparto/compartimos los gastos del hogar con la(s) persona(s) mencionada(s) arriba [ ] Si [ ] No
   (Si no es así, pase al número 3.)
   Nuestro arreglo de compartir es: _____

3. El costo TOTAL de los gastos del hogar en la dirección anterior es:
   Vivienda_____ Alquiler_____ Servicios Publicos y Municipales _____ Alimentos _____
   Ropa_____ Dinero en efectivo_____
   - El número de personas en el hogar en la dirección anterior es _____

4. Mi relación/parentesco con la(s) persona(s) mencionada(s) arriba es: _____

CERTIFICO QUE LA INFORMACION QUE CONTIENE ESTA SECCION ES VERDADERA Y CORRECTA:

Firma del Proveedor _____ Fecha _____

Dirección _____ Tel ( ) _____

Parte II. VERIFICACION DE VIVIENDA

FIRME ABAJO SOLAMENTE SI USTED, EL SOLICITANTE, DESEA PROPORCIONAR INFORMACION ACERCA DE VIVIENDA GRATUITA O ALQUILER (RENTA) QUE SE LE PAGA A ALGUN PARIENTE COMO PRUEBA DE RESIDENCIA. ANTES DE FIRMAR, USTED TIENE QUE COMPLETAR LA INFORMACION SOBRE VIVIENDA QUE SE LE PIDE ARRIBA.

Entiendo que la información que yo proporcione como prueba de residencia, pudiera ser verificada por empleados del condado o del estado para tramitar mi solicitud. Estoy de acuerdo en cooperar con tal empleado en la verificación de esta información. Por medio de la presente, autorizo a los empleados del condado o del estado, que sean responsables de administrar el programa de Medi-Cal, a ponerse en contacto con _____ con relación a cualquier información que he proporcionado arriba.

DECLARO BAJO PENA DE PERJURIO, EN CONFORMIDAD CON LAS LEYES DEL ESTADO DE CALIFORNIA, QUE LA INFORMACION QUE CONTIENE ESTA DECLARACION ES VERDADERA, CORRECTA, Y COMPLETA.

Firma del Solicitante _____ Fecha _____

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF HEALTH SERVICES
MEDI-CAL PROGRAM

Student Educational Expenses

(Supplement to the Medi-Cal Statement of Facts - MC 210)

COUNTY USE ONLY

Case Name

Case No.

Worker No.

Date:

If you or any family member are in college or attending a similar educational institution, please fill in the following:

See MEM 50447 for allowable education expenses

EXEMPT:

☐ Entire amount
☐ Only expenses

VERIFICATION (Ltr.):

A	Student's name(s)		
	Name of institution(s)		
	Status of student(s)	[ ] Full time [ ] Part time [ ] Grad [ ] Undergrad	[ ] Full time [ ] Part time [ ] Grad [ ] Undergrad
B	Grants, Loans, Scholarships, Fellowships		
	Amount received	$	$
	Source(s) of grants, loans, etc.		
	How often received?		
C	Expenses Per Term		
	Is term a semester, quarter, year?		
	Tuition/fees	$	$
	Books, equipment, and supplies	$	$
	Child care necessary for school	$	$
D	Transportation to School/Child Care		
	Round trip miles per day		
	School attended how many days per week?		
	Type of transportation used (own car, borrowed car, car pool, bus, etc.)		
	Costs (per month)		
	• Amount paid by student (not own car)	$	$
	• Amount paid by riders	$	$
	• Parking, tolls, etc.	$	$
	Is public transportation (bus, train, etc.) available?	[ ] Yes [ ] No	[ ] Yes [ ] No
	• If yes, indicate cost	$	$

Transportation costs allowed (show computations):

MC 210 SF (rev)

[illegible] HEALTH AND WELFARE AGENCY

[illegible] DEPARTMENT OF HEALTH SERVICES
MEDI-CAL PROGRAM

Gastos Educativos de Estudiantes

Suplemento a la Declaración de Datos de Medi-Cal - MC 210)

PARA USO DEL CONDADO
Case Name
Case No.
Worker ID
Date

Si usted o cualquier miembro de la familia asiste a la universidad o una institución donde otorgan medio bachillerato (certificado) o una graduación educativa similar, por favor complete lo siguiente:

A	Nombre del estudiante(s)		
	Nombre de la universidad(es)	[ ] Tiempo completo [ ] Medio tiempo	[ ] Tiempo completo [ ] Medio tiempo
	Clase como estudiante(s)	[ ] Pregraduado [ ] Graduado	[ ] Pregraduado [ ] Graduado
B	Subvenciones, Premios o Becas		
	Cantidad recibida	$	$
	[illegible]		
	¿Cuándo [illegible]?		
C	Gastos por Curso		
	¿Es [illegible]?		
	Colegiaturas/cuotas	$	$
	Libros, suministros y útiles	$	$
	Cuidado de niños necesario para asistir a la escuela	$	$
D	Transporte de la Escuela/Guardería Infantil		
	Millas por viaje redondo al día		
	Días por semana que asiste a la escuela		
	Costo de transporte [illegible]		
	Costo (gasolina)		
	• Cantidad [illegible]	$	$
	• [illegible]	$	$
	• Estacionamiento [illegible]	$	$
	¿Hay [illegible]?	[ ] Sí [ ] No	[ ] Sí [ ] No
	• Costo [illegible]	$	$

Vea MEM 50447 for allowable educational expenses

EXEMPT:

[ ] Entire amount
[ ] Only expenses

VERIFICATION (Ltr)

Transportation costs allowed (show computations)

(over)

IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL (Continued)

14. Lower my share of cost by providing past unpaid medical bills (that I still owe).
15. Reduce my property reserve to within the Medi-Cal property limit by the last day of a month for which I want Medi-Cal, including the month I apply and to be told how I may spend my excess property.
16. Divide countable (nonexempt) community (MY SPOUSE's AND MY) property by written agreement into equal shares of separate property if either of us entered a long-term care (LTC) facility before September 30, 1989.
17. Keep a certain amount of countable separate and community property if I enter an LTC facility on or after January 1, 1990. My spouse and I have the right to be told the amount.
18. Have a state hearing if I am dissatisfied with an action taken (or not taken) by the county welfare department or the State Department of Health Services, except actions relating to the Health Insurance Premium Payment (HIPP) and Employer Group Health Plan (EGHP) programs. If I want a state hearing to appeal the decision, I must ask for it within **90 days** of the date the Notice of Action (NOA) was mailed to me. If I do not receive a NOA, I must request a hearing within **90 days** from the date I discover the action (or inaction) with which I am dissatisfied. The date of discovery is the date I know, or should have known, of the action. The best way to ask for a hearing is to contact the nearest county welfare department.

I HAVE THE RESPONSIBILITY TO TELL MY COUNTY REPRESENTATIVE WITHIN TEN (10) DAYS WHENEVER:

1. Income received by me or any member of my family increases, decreases, starts, or stops. This includes income from Social Security Administration (SSA), loans, settlements, or any other source.
2. I plan to change or have already changed my place of residence or mailing address.
3. A person, including a newborn child, whether or not related to me or my family, moves into or out of my home.
4. An absent parent returns to the home.
5. I or a member of my family gives birth, becomes pregnant, or ends a pregnancy.
6. I, my spouse, or any member of my family enters or leaves a nursing home or an LTC facility.
7. I receive, transfer, give away, or sell real or personal property (including money) or when someone gives me or a member of my family such things as a car, house, insurance payments, etc.
8. I have any expenses that are paid for by someone other than myself
9. I or a member of my family gets a job, changes jobs, or no longer has a job.
10. I have a change in expenses related to my job or education. (For example: child care, transportation, etc.)
11. I or a member of my family becomes physically or mentally impaired so that I/he/she cannot get or keep a job (this would include a child in the family who may not be able to get a job in the future due to the impairment).
12. I or a member of my family applies for disability benefits with the SSA, Veterans Administration, or Railroad Retirement.
13. One of my children drops out of school or returns to school.
14. There is a change in the citizenship/immigration status of any family member applying for or receiving Medi-Cal.
15. Health insurance coverage for me or a member of my family changes.

I HAVE THE RESPONSIBILITY TO:

1. Complete and return a status report by the date required when requested by the county.
2. Give proof that I am a resident of California.
3. Make a declaration about my citizenship/immigration status.

IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL (Continued)

4. Provide an SSN for myself and/or for any member of my family who has an SSN and wants Medi-Cal benefits. If I am a U.S. citizen, a U.S. national, or an alien in a satisfactory immigration status, I must apply for an SSN and provide it to the county if I do not already have one. If I need to apply for an SSN, I can get help from my eligibility worker, but I must work with the SSA to clear up any questions or my Medi-Cal will be denied or stopped. (Aliens who are not in a satisfactory immigration status and do not have an SSN can get ***restricted*** Medi-Cal without applying for an SSN if they meet all the rules.)
5. Apply for any income that may be available to me or any member of my family.
6. Apply for Medicare benefits if I am blind, disabled, have End Stage Renal Disease, or am 64 years and 9 months of age or older and eligible. I am responsible for telling my providers that I have both Medi-Cal and Medicare coverage.
7. Apply for and enroll in any health insurance if that is available to me and my family at no cost. I have the responsibility to remain enrolled in the health plan when Medi-Cal approves payment of plan premiums by the State of California.
8. Report to the county department, and to the health care-provider, any health care coverage/insurance I carry or am entitled to use, including Medicare. If I willfully fail to give this fact, I may be guilty of a criminal offense, or may be billed by my provider.
9. Go to my health care plan (such as Kaiser, CHAMPUS, or a Medicare HMO) for medical care. (Medi-Cal will not pay for any services covered by the plan.)
10. Give any insurance payments I receive to the State if Medi-Cal has already paid for my care.
11. Go to a presentation, if presentations are given, and make a written choice, or answer if received by mail, about how I want to get my Medi-Cal benefits. If I do not go and make a choice, or choose by mail, my eligible family members and I may be signed up in a Medi-Cal Health Care Plan near my home.
12. Sign and date my BIC when I get it and ensure it is used only to get necessary health care for myself or eligible family members.
13. Take my BIC to my medical provider when I am sick or have an appointment. In emergencies when the BIC is not in hand, I must get the BIC to the medical provider when possible.
14. Report to the county department when I receive health care services because of an accident or injury caused by another person's action or failure to act, for which Medi-Cal has been, or may be billed.
15. Cooperate with the State or county in establishing paternity and identifying any possible medical coverage I or my family may be entitled to through an absent parent.
16. Cooperate with the State of California if my case is selected for review by the quality control review team. If I refuse to cooperate, my Medi-Cal benefits will be stopped.

I UNDERSTAND THAT:

1. Failure to give necessary facts or deliberately giving false facts can result in Medi-Cal benefits being denied or stopped. My case may also be investigated for suspected fraud.
2. The facts I give will be checked by computer with facts given by employers, banks, SSA, Franchise Tax Board, welfare, and other agencies. I will have the right to give proof to correct any facts which are found to be wrong
3. Aliens who are not in a satisfactory immigration status and do not have an SSN can get ***restricted*** Medi-Cal without applying for an SSN if they meet all the rules.
4. Immigration status data given as part of the Medi-Cal application is confidential.
5. Based on my income, I will have to pay or be billed for part of my medical expenses before I can get Medi-Cal.
6. If I do not report changes promptly, and because of this, receive Medi-Cal benefits that I am not eligible for, I may have to repay the State Department of Health Services.

IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL (Continued)

7. If I am receiving Medi-Cal based on disability and I apply for disability benefits from the SSA, and the SSA denies my disability claim, my Medi-Cal may be stopped. If I appeal my SSA denial right away, my Medi-Cal will continue until the SSA makes a final decision. If the SSA allows my claim, then my Medi-Cal benefits will continue. If the SSA does not allow my claim, then my Medi-Cal benefits will stop.
8. As a condition of Medi-Cal eligibility, all rights to medical support and/or payment for medical services for myself and any eligible persons that I have legal responsibility for, are automatically assigned to the State.
9. If medical support is court-ordered from an absent parent for my children, the insurance carrier must allow me to enroll and provide benefits to my children without the absent parent's consent.
10. If I don't apply for or keep no-cost health coverage or state-paid coverage, my Medi-Cal benefits and/or eligibility will be denied or stopped.
11. When I apply for Medi-Cal, I will be evaluated for potential eligibility under other medical assistance programs, including the HIPP and EGHP programs.
12. If I ask a Medi-Cal provider for any services not covered by my **non-Medi-Cal** health insurance plan, I must give the medical provider a written statement from my health plan saying it does not offer the Medi-Cal-covered services.
13. Medi-Cal providers cannot collect insurance copayment, coinsurance, or deductibles from me unless the payment is used to meet my Medi-Cal share of cost and/or copayment.
14. If I am admitted to a nursing facility and I have no intention of returning to my home, the State may impose a lien against my property.
15. After my death, the State has the right to seek reimbursement from my estate for all Medi-Cal benefits I received after age 55 unless I have a surviving spouse (during his or her lifetime), minor children, blind or permanently and totally disabled children, or it would create a hardship for my heirs.
16. After the death of my surviving spouse, the State has the right to claim from the part of his or her estate received from me, all Medi-Cal benefits I received after age 55 up to the amount of property my spouse received from my estate.

_____, am applying for Medi-Cal benefits from

_____ County Welfare Department (on behalf of _____).

I hereby state that I have reviewed the information on this form with the county representative and that I fully understand my **RIGHTS AND RESPONSIBILITIES** to have my eligibility determined for Medi-Cal and to maintain that eligibility.

Applicant/Representative Signature	Telephone Number	Date

Interpreter's Signature	Telephone Number	Date

I have explained to the applicant the rights, responsibilities, and other information listed on this form.

Eligibility Worker's Signature	Telephone Number	Date

MC 219 (3/99) OSP 00 36271

State of California—Health and Human Services Agency | Department of Health Services

Case Name _____ Case Number _____

SUPPLEMENT TO STATEMENT OF FACTS FOR RETROACTIVE COVERAGE/RESTORATION

My present circumstances, as listed on the Statement of Facts which I signed on _____ (Date), are true and correct statements, to the best of my knowledge, for the month(s) of _____ (For restorations, this should be the month in which the request is made) except as specified below.

Circumstances that are/were different: (If no change, write in "No change.") Documentation is needed to verify all sources of income and to support any difference in property, residence, etc.

Circumstances	Month:	Month:	Month:
Number of persons living in your home			
Income— Specify any differences in: Amount of income Kind of income Work expenses Education expenses Child care			
All Personal Property including motor vehicles, boats, bank accounts, etc. (Lowest bank account balances should be listed for each month unless they were exactly the same as the balance listed on the Statement of Facts. List differences or state "No change."	Checking: Savings:	Checking: Savings:	Checking: Savings:
Real Property (list differences only or state " No change ")			
California Resident	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Other Insurance Coverage Change	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Other (List differences only or state "No change.")			

I understand that I may not retroactively spend my property down in order to reduce its amount and thereby qualify for Medi-Cal.

I understand that I may be asked to prove my statements but that the county is required by law to keep them confidential, and that if dissatisfied, I have a right to a fair hearing. I understand that if I deliberately make false statements or withhold information, I can be prosecuted for fraud.

Signature	Date
Signature of person acting for applicant and relationship (guardian, conservator, etc.)	Date
Signature of witness (required if applicant signed by mark)	Date

The following person helped me to fill out this form:

Name and relationship to applicant	Address	Date

MC 210 A (3/99) (Formerly MC 213)

ENGLISH

IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL

PRIVACY AND CONFIDENTIALITY NOTIFICATION

Sections 14011 and 14012 of the Welfare and Institutions Code allow county welfare departments to get certain facts from you to decide if you, or the persons you represent, can get Medi-Cal benefits. You must provide these facts to get Medi-Cal benefits The information will be used:

1. By the county welfare department to establish first time and ongoing Medi-Cal eligibility.
2. By Electronic Data Systems (EDS) to process claims and make Benefits Identification Cards (BICs).
3. By the United States (U.S.) Department of Health and Human Services to make audit and quality control reviews and verify Medicare Buy-In and Social Security Numbers (SSNs).
4. To verify alien status with the U.S. Immigration and Naturalization Service (INS) only for aliens who claim to be lawfully admitted for permanent residence or Permanently Residing in the U.S Under Color of Law (PRUCOL) or Amnesty Aliens with a valid and current I-688 card. The information the INS receives can only be used to determine Medi-Cal eligibility, and cannot be used for immigration enforcement unless you are committing fraud.
5. By medical services providers and health maintenance organizations to certify eligibility.
6. To identify health insurance coverage and take recovery actions.

MEDI-CAL APPLICANT/BENEFICIARY RIGHTS, RESPONSIBILITIES, AND UNDERSTANDINGS

I HAVE THE RIGHT TO:

1. Ask for an interpreter to help me in applying for Medi-Cal if I have difficulty in speaking or understanding the English language.
2. Be treated fairly and equally regardless of my race, color, religion, national origin, sex, age, or political beliefs.
3. Apply as a disabled person if I think I am disabled.
4. Be told about the rules for retroactive Medi-Cal eligibility.
5. Apply for Medi-Cal and to be told **in writing** whether I qualify for any Medi-Cal program, even if the county representative tells me during the interview that it appears I am not eligible.
6. Review Medi-Cal program rules and regulation manuals if I want to question the basis on which my eligibility is approved or denied.
7. Have all facts that I give to the county welfare department kept in the strictest confidence and to look at those facts during regularly scheduled office hours.
8. Receive an immediate need card, **when possible and eligible**, if I have a medical emergency or I am pregnant.
9. Receive Medi-Cal, as authorized, while my satisfactory immigration status is being documented and verified, if I am otherwise eligible. **Aliens who are lawfully admitted for permanent residence or PRUCOL or Amnesty Aliens with a valid and current I-688 card are in a satisfactory immigration status.**
10. Be told about the Child Health and Disability Prevention Program and the Special Supplemental Food Program for Women, Infants, and Children, and to ask for help in receiving those services.
11. Ask for and receive information about the Family Planning Program and be told if I am eligible for those services.
12. Speak to a social worker about other public or private services or resources that I can get.
13. Be told about Medi-Cal Health Care Plans that my family and I can join to get a doctor and other medical care, and to choose the option I prefer.