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

DEPARTMENT OF HEALTH SERVICES
714/744 P Street
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(916) 657-2941

November 2, 2001

TO: All County Welfare Directors
All County Administrative Officers
All County Medi-Cal Program Specialists/Liaisons
All County MEDS Coordinators
All County Health Executives
All County Mental Health Directors

Letter No.: 01-60

TRANSMIT CAMERA-READY COPIES OF THE MC 250A APPLICATION AND REDETERMINATION FORM

The purpose of this letter is to transmit camera-ready copies of the MC 250A application and redetermination form.

This form is only to be used for former foster care youth who turned 18 while they were in foster care and who are under 21. Youth who apply for Medi-Cal some time after they have left foster care or who have experienced a break in aid may use this form as an application for Medi-Cal. This form may also be used for annual redeterminations.

If you have any questions regarding this form, please contact Ms. Erin Lynch at (916) 654-5769 or Ms. Janeen Jimenez at (916) 657-1248.

Sincerely,

ORIGINAL SIGNED BY

Shar Schroepfer, Chief
Medi-Cal Eligibility Branch

Enclosure

COUNTY USE ONLY
Case name:
Case number:
Date of discontinuance:

APPLICATION AND STATEMENT OF FACTS FOR AN INDIVIDUAL WHO IS OVER 18 AND UNDER 21 AND WHO WAS IN FOSTER CARE PLACEMENT ON HIS OR HER 18TH BIRTHDAY

☐ New application ☐ Redetermination ☐ Request for retroactive coverage for ____ months
(Eligibility cannot be established prior to 10/1/00)

Name	Date of birth (mm/dd/yy)	☐ Male ☐ Female	
Social Security Number	Have you applied for SSI/SSP? ☐ Yes. Date of application _____ ☐ No		
Address	City	State	Zip
Mailing address (if different)	City	State	Zip

Do you have other medical insurance (through work or parents)?

☐ Yes ☐ No Name of Insurance company: Policy #:

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

Signature _____ Date _____

Instructions

If you are completing this application it is because you were in foster care when you turned 18. The Foster Care Independence Act of 1999 allows you to receive Medi-Cal benefits at no share of cost until you reach the age of 21. Under this Act, you are not required to show proof of income or resources (such as a car) in order to be eligible for Medi-Cal. You only have to have been in the care of a foster care family or agency when you turned 18.

Once you have completed this form, you will have to mail it to or drop it off at your local county social services department. Check your phone book for the nearest office.

If you move, you will still be eligible for Medi-Cal, but you will have to notify your county eligibility worker of your address change. If you move out of the county that you lived in when you applied, the county worker will have to change the information on your case so that you can continue to get medical coverage without difficulty. If you have any changes in your living arrangements, such as moving back in with your parents or getting married, or if you are pregnant, notify your eligibility worker immediately to report the change. These changes, however, will not affect your eligibility for this program.

If you move out-of-state, you may still be eligible for medical benefits in your new state, but you will have to apply for these benefits in the new state of residence.