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- ▶ Reflects the Department's implementation of the Appellate Court ruling in the Crespin case regarding Social Security number requirement;
- ▶ Removes the shading from the Social Security number blocks;
- ▶ Moves and renumbers the applicant's/caretaker's name, home and mailing address questions;
- ▶ Provides space for the onset date of disability if an adult family member claims blind or disability status; and
- ▶ Instructs the applicant to use Question 7 to list other household members.

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- ▶ Provides space for the applicant/beneficiary to report the relationship of other household members if he or she shares housing;
- ▶ Adds question regarding the amount of rent the applicant/beneficiary pays;
- ▶ Adds question regarding the applicant/beneficiary's entry into the United States with a Visa or Border Crossing Card;
- ▶ Renumbers the employment questions;
- ▶ Provides additional space to list working MFBU members;
- ▶ Provides space for the applicant to request the specific month(s) of retroactive coverage;
- ▶ Adds question regarding the length of disability or emotional problem if an MFBU member has a disabling condition(s);
- ▶ Adds worker prompts regarding Visa, Border Crossing Card, student exemption, CA 61, DED reexamination due date, lawsuit/hearing pending, third party liability, and TCC in the county use section; and
- ▶ Provides space for the applicant to report military service connected personnel/ benefits.

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- ▶ Changes wording for the page instruction and some questions;
- ▶ Provides additional space to list personal properties such as bank accounts and motor vehicles;
- ▶ Expands question 26 to include trust, trust account(s), and LTC insurance policy;

All County Welfare Directors
All County Administrative Officers
All County Medi-Cal Program Specialists/Liaisons
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- ▶ Adds Pickle eligibility determination and State certified LTC insurance policy worker prompts in the county use section; and
- ▶ Instructs applicant to review the property related questions and provides a box for the applicant to indicate if he/she needs additional space to answer those questions.

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- ▶ Changes wording for the page instruction and subheadings;
- ▶ Adds question regarding money received from friends or relatives to include loans, gifts, and contributions; and
- ▶ Expands unearned income to include IRA, Keogh, annuity trust accounts, capital gain on investment accounts, promissory notes, deed of trust, contract of sales, gambling winnings, and inheritance.

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- ▶ Adds separate sideheading for other expenses and other health coverage;
- ▶ Adds worker prompts MC 272 and MC 273 in the county use section for Question 37;
- ▶ Renumbers and regroups questions regarding CHDP, WIC, Family Planning Services and other social services; and
- ▶ Aligns worker prompts in the county use section for questions 41 thru 44 to reference the correct questions.

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- ▶ Informs the applicant/beneficiary the requirement to provide a Social Security number if he or she claims satisfactory immigration status;
- ▶ Places all informing bullets and the ten-day reporting requirement notification above the signature lines; and
- ▶ Provides spaces for those who are assisting the applicant/beneficiary in the completion of the MC 210 and/or the face-to-face interview to sign and report his/her relationship to the applicant/beneficiary.

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MC 210 S-C ADDITIONAL CHILDREN

The MC 210 S-C Supplement to the Statement of Facts for applicants who have more than three children has also been updated. The changes:

- ▶ Advise all applicants for Medi-Cal benefits that if they have a Social Security number, they must provide it on the form;
- ▶ Remove the shading from the Social Security number (SSN) blocks; and
- ▶ Add ID in the county use section boxes.

As of September 1, 1996, counties are instructed to begin using the MC 210 (5/96) and MC 210 S-C (5/96) for all new applications and annual redeterminations. Counties must discard or recycle all previous versions of these forms. A three-month supply of the MC 210 and MC 210 S-C forms will be shipped to counties by August 1, 1996.

The MEB would like to take this opportunity to thank CWD staff for their comments/suggestions regarding the MC 210, and their participation in the revision workshops. Due to time constraints to implement the Appellate Court ruling in the Crespin case and legality of wording used, this revision could not incorporate all suggestions made by CWD staff. Suggestions such as reformatting the form and moving questions to other subheadings/pages were reviewed and noted for future MC 210 revisions.

The MEB appreciates CWD staff input in improving the application forms and continues to welcome suggestions to make the MC 210 "USER FRIENDLY" for applicants and CWD staff. The MEB will, with the next revision, transmit a draft to county staff for review. All comments, suggestions, and/or questions regarding the new MC 210 may be directed to Alice Mak at (916) 654-0573 or via facsimile at (916) 657-3224.

Sincerely,

ORIGINAL SIGNED BY

FRANK S. MARTUCCI, CHIEF
Medi-Cal Eligibility Branch

Enclosures

**USE THESE INSTRUCTIONS TO HELP YOU FILL OUT
THE ATTACHED MEDI-CAL STATEMENT OF FACTS**
(Please return the completed form to your county welfare department)

1. **PRINT** all answers in ink (black ink is best).

2. Please note the following:

"Applicant" means: (a) you, if you are an adult applying for yourself and/or your family; (b) you, if you are a child applying for minor consent services; or (c) the person you are filling in this form for (including the person in long-term care).

"Caretaker" means a relative other than a parent who is applying on behalf of children under 21 years. A caretaker may ask to be included in the children's Medi-Cal case.

"Family Member" means: (a) you, even if you are a single person; (b) your spouse or other parent of the children, living with you; (c) your children under 21 years, who are living with you or are away at school; (d) your spouse's or other parent's children under 21 years, who are living with you or are away at school; (e) your unborn child.

3. If you answer **"Yes"** to any question from 23 through 39, you must give proof. *However, if you are interested in pregnancy related benefits only, or coverage for an infant (up to age one year), you may not need to bring in proof of property. Ask your eligibility worker about the Property Waiver program.*

4. If you have a problem with any question, **ask your worker for help.**

5. If you need more space to answer any question, **use Item 40.**

MC 210 (5/96) INSTRUCTION SHEET-PROPOSED

READ THIS FIRST

**USE THESE INSTRUCTIONS TO HELP YOU FILL OUT
THE ATTACHED MEDI-CAL STATEMENT OF FACTS**
(Please return the completed form to your county welfare department)

1. **PRINT** all answers in ink (black ink is best).

2. Please note the following:

"Applicant" means: (a) you, if you are an adult applying for yourself and/or your family; (b) you, if you are a child applying for minor consent services; or (c) the person you are filling in this form for (including the person in long-term care).

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3. If you answer **"Yes"** to any question from 23 through 39, you must give proof. *However, if you are interested in pregnancy related benefits only, or coverage for an infant (up to age one year), you may not need to bring in proof of property. Ask your eligibility worker about the Property Waiver program.*

4. If you have a problem with any question, **ask your worker for help.**

5. If you need more space to answer any question, **use Item 40.**

MC 210 (5/96) INSTRUCTION SHEET-PROPOSED

STATEMENT OF FACTS (MEDI-CAL)

Every applicant asking for Medi-Cal who has a Social Security number must provide it on this form.

1 Applicant or Caretaker's Name (First, Middle, Last)		Applicant/Caretaker Relationship to Children		COUNTY USE				
Social Security Number	Marital Status (check one) <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Common Law <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated (Date) _____	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID
Birth Date	Is the Person Blind or Disabled <input type="checkbox"/> Yes, Date of Disability: _____ <input type="checkbox"/> No	Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No	Medi-Cal Requested <input type="checkbox"/> Yes <input type="checkbox"/> No					
2 Home Address (Number and Street)		City		Case Name: _____				
Mailing Address (If different from above)		City		Case No.: _____				
(Area Code) Home Phone () () ()	(Area Code) Work Phone () () ()	(Area Code) Message Phone () () ()	Person with whom to leave Message:	Worker No.: _____				
3 Spouse/Other Parent (First, Middle, Last)		Relationship to Applicant		Date: _____				
Social Security Number	Marital Status (check one) <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Common Law <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated (Date) _____	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID
Birth Date	Is the Person Blind or Disabled <input type="checkbox"/> Yes, Date of Disability: _____ <input type="checkbox"/> No	Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No	Medi-Cal Requested <input type="checkbox"/> Yes <input type="checkbox"/> No					
LIST CHILDREN AND UNBORN HERE (Family members only. List Other People on Question 7)				Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID
4 Child's Name (First, Middle, Last) or "Unborn"		Relationship to Applicant						
Social Security Number	In School <input type="checkbox"/> Yes <input type="checkbox"/> No	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female						
Birth Date or Date Unborn is Due	Is the Person Blind or Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No						
Father's Name	Is Either Parent (✓) <input type="checkbox"/> Deceased <input type="checkbox"/> Incapacitated <input type="checkbox"/> Absent <input type="checkbox"/> Unemployed		Medical Support <input type="checkbox"/> YES <input type="checkbox"/> NO					
Mother's Name	Child Living in Home <input type="checkbox"/> Yes <input type="checkbox"/> No	Medi-Cal Requested <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> CA 2.1 <input type="checkbox"/> Not in home, 18-21 & tax dep.?					
5 Child's Name (First, Middle, Last) or "Unborn"		Relationship to Applicant		Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID
Social Security Number	In School <input type="checkbox"/> Yes <input type="checkbox"/> No	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female						
Birth Date or Date Unborn is Due	Is the Person Blind or Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No						
Father's Name	Is Either Parent (✓) <input type="checkbox"/> Deceased <input type="checkbox"/> Incapacitated <input type="checkbox"/> Absent <input type="checkbox"/> Unemployed		Medical Support <input type="checkbox"/> YES <input type="checkbox"/> NO					
Mother's Name	Child Living in Home <input type="checkbox"/> Yes <input type="checkbox"/> No	Medi-Cal Requested <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> CA 2.1 <input type="checkbox"/> Not in home, 18-21 & tax dep.?					
6 Child's Name (First, Middle, Last) or "Unborn"		Relationship to Applicant		Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID
Social Security Number	In School <input type="checkbox"/> Yes <input type="checkbox"/> No	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female						
Birth Date or Date Unborn is Due	Is the Person Blind or Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No						
Father's Name	Is Either Parent (✓) <input type="checkbox"/> Deceased <input type="checkbox"/> Incapacitated <input type="checkbox"/> Absent <input type="checkbox"/> Unemployed		Medical Support <input type="checkbox"/> YES <input type="checkbox"/> NO					
Mother's Name	Child Living in Home <input type="checkbox"/> Yes <input type="checkbox"/> No	Medi-Cal Requested <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> CA 2.1 <input type="checkbox"/> Not in home, 18-21 & tax dep.?					
DO YOU HAVE MORE THAN THREE CHILDREN? <input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> MC 210 S-C				
IF YES, LIST NAME ONLY AND ASK YOUR WORKER FOR ADDITIONAL FORM(S): _____				<input type="checkbox"/> Potential Sneede				

You may be asked to give proof and/or more detailed information on your residency, property/resources, income, or work history before your application is approved.

CHECK EACH ITEM "YES" OR "NO"		YES	NO	COUNTY USE
LIVING ARRANGEMENT	7 a. Is there anyone living in your home that you did not list? If Yes, list name and relationship. Name _____ Relationship _____ Name _____ Relationship _____			<input type="checkbox"/> MC 210S-I
	b. Do you pay rent for a room, apartment, house, or trailer? If Yes, how much rent do you pay? _____			
	8 a. Is any family member living in a nursing home, hospital, or board and care home? Name of person _____ Name of Home/Facility _____ Date Entered _____			<input type="checkbox"/> LTC return home in six months? <input type="checkbox"/> Excess B & C Amount: \$ _____
	b. Intend to return home?.....			
TAX DEPENDENT	9 Are you or any family member claimed as a tax dependent by a person not living with you? Name and address of person claiming the tax deduction: _____			<input type="checkbox"/> Tax dependent letter sent Date: _____ <input type="checkbox"/> CA 2.1
RESIDENCE	10 a. Do you or any family member own, lease, or maintain a home outside California?			<input type="checkbox"/> Property
	b. Are you or any family member currently receiving public assistance from outside California?			<input type="checkbox"/> PA
	11 a. Are you or any family member living outside California?.....			<input type="checkbox"/> Visa <input type="checkbox"/> Border Crossing Card
	b. Are you or any family member in the United States on a Visa or a Border Crossing Card?.....			California Resident? <input type="checkbox"/> Yes <input type="checkbox"/> No
EMPLOYMENT QUESTIONS	12 a. Are you or any family member planning to leave California for more than 60 days?.....			
	b. Do you and your family plan to stay permanently in California?			
	13 Are you, your spouse, the other parent, or children in the home working?			<input type="checkbox"/> Under 100 hours <input type="checkbox"/> Student Exemption <input type="checkbox"/> # U-Parent MC 210 S-W <input type="checkbox"/> UIB Referral
	14 Are the person(s) in 13 looking for work or more hours of work?.....			Redetermination: Fed Eligibility determined per MC 210 dated: _____ Principal wage earner
RETRO	15 Have you, your spouse, or other parent or any children worked in the last two years?..... List Name _____ Hours Per Week: _____ List Name _____ Hours Per Week: _____ List Name _____ Hours Per Week: _____			
	16 Are you or any family member on strike?..... List Name(s) _____			
	17 a. Did you or any family member have medical expenses in the last three months?.....			<input type="checkbox"/> MC 210A
	b. Does this person wish to apply for Medi-Cal coverage for those three months?..... List Name(s): _____ Month(s) of Coverage: _____			Retroactive Coverage Mo. _____ Mo. _____ Mo. _____
DED/TP/L	18 Do you or any family member have a physical or emotional problem which makes it difficult to work or take care of personal needs?			<input type="checkbox"/> DED Packet <input type="checkbox"/> CA 61 <input type="checkbox"/> SGA <input type="checkbox"/> DED Reexamination due Date _____
	If yes, list name(s). _____			<input type="checkbox"/> Lawsuit/Hearing pending <input type="checkbox"/> Third Party Liability
PA OR OTHER PA	19 a. Is disability or emotional problem expected to last at least a year?..... b. Is the physical or emotional problem a result of an injury or accident?.....			
MILITARY SERVICE	20 Have you or any family member ever applied for or received assistance such as AFDC, Food Stamps, Medi-Cal, SSI/SSP, IHSS, transitional child care, or other benefits?..... List name and what kind: _____ List where last received: _____ List when last received: _____			<input type="checkbox"/> Post MC <input type="checkbox"/> TCC
	21 a. Have you or any family member ever been in U.S. military service?			<input type="checkbox"/> CA 5
	Name _____ Relationship _____ Name _____ Relationship _____			
	b. Receiving Service connected benefits?.....			
	22 a. Are you or any family member the spouse, parent, or child of a person who is/has been in U.S. military service?.....			
	Name _____ Relationship _____ Name _____ Relationship _____			
	b. Receiving service connected benefits?			

The county will determine whether or not the property/resources you or any family member have will count. Please include all property/resources (even for convenience only) owned, named, used, controlled, shared, held jointly with or for other person(s).

CHECK EACH ITEM "YES" OR "NO" →					YES	NO	NAME ON ACCOUNT/ PROPERTY/RESOURCES	VALUE/ BALANCE	COUNTY USE
LIQUID RESOURCES	23	a. Savings or checking account(s)? (Banks, savings and loans, credit unions, etc.) Enter how many accounts: _____ Where: _____ Account number: _____ Where: _____ Account number: _____							<input type="checkbox"/> Current Month Income Included \$ _____
		b. IRA, KEOGH, deferred compensation, retirement account, or annuity? Enter how many accounts: _____							\$ _____
		c. Cash or uncashed checks?							\$ _____
		d. Stocks, bonds, certificates of deposit, money market, or mutual fund accounts?							\$ _____
REAL ESTATE	24	a. A home (whether you live in it or not), other houses, ranch, land, buildings, mobile homes or life estates in or outside the U.S. or the State of California?							PR <input type="checkbox"/> YES <input type="checkbox"/> NO \$ _____
		b. Mortgages, promissory notes, deeds of trust, or sales contracts?							\$ _____
VEHICLES	25	Cars, trucks, motorcycles, trailers (any kind), off-road vehicles, recreational vehicles, airplanes, boats, campers (running or not)?							EXEMPT <input type="checkbox"/> YES <input type="checkbox"/> NO \$ _____
		Enter type and number owned: _____							
		Make and Model	Year	Class Code (Registration)	Used for Transportation Yes No	Used for Self Support Yes No			
OTHER	26	a. Jewelry (not wedding/engagement or heirloom) worth more than \$100? ..							<input type="checkbox"/> Pickle (\$500) \$ _____
		b. Household goods or personal items valued at more than \$500 per item (i.e. musical instrument, personal computer)?							\$ _____ but, jointly owned <input type="checkbox"/> separately owned <input type="checkbox"/>
		c. Mineral rights or mining claims (oil, gas, coal, etc.)?							\$ _____
		d. Burial Trusts or contracts, insurance, designated burial funds/money for cemetery plots, caskets, or other burial items?							\$ _____
		e. Trust(s) or Trust Account(s)?							\$ _____
		f. Life insurance? Enter how many policies owned: _____							\$ _____
		g. Long Term Care insurance?							\$ _____
		Insurance Company	Policy Number	Date Policy Issued	Benefits Paid Out				
h. Other assets or resources?							\$ _____		
BUSINESS	27	a. Business/self-employment checking/savings account or cash?							\$ _____
		b. Business equipment, vehicles, tools, inventory or materials (including livestock or poultry not for personal use)?							\$ _____
		c. Type of Equipment: _____							\$ _____
TRANSFER	28	Has anyone closed, given away, transferred, sold or traded any money, vehicles, property or other resources like those listed above in the last 30 months?							LTC only
		If yes, complete the following:							<input type="checkbox"/> Verification <input type="checkbox"/> List Other Trans. in # 40
		Item	Date	<input type="checkbox"/> Transferred <input type="checkbox"/> Sold					
				<input type="checkbox"/> Traded <input type="checkbox"/> Closed					
				<input type="checkbox"/> Given Away					
LIENS	29	a. Have you borrowed money against your property to pay medical bills?							Brings property within limits? <input type="checkbox"/> Yes <input type="checkbox"/> No
		b. Has a lien been put on any of your property as security for medical care?							<input type="checkbox"/> MC 1054 Notice to Provider
		c. Have you used any of the items in question 23 through 26 to pay for medical expenses?							

Review your answers on questions 23-28. If you need more space to complete your answers, check here.

Obtain Verif. and enter
nonexempt
value _____
 MC 210 S-P

You must complete all items in questions 30 through 33 for all members in your family including yourself.

		CHECK EACH ITEM "YES" OR "NO" →		WHOSE INCOME	AMOUNT BEFORE TAXES	WHEN PAID/HOW OFTEN	COUNTY USE																																			
Do you or any family member get, expect to get, or has anyone applied for:		YES	NO																																							
EARNED INCOME	30 a. Money from a job (including occasional work)? If yes, how many people in your home work? _____ List Name _____ List Name _____ b. Expect a change in your job? (Hours or money) If yes, explain: _____ _____						<input type="checkbox"/> MC 210 S-W <input type="checkbox"/> Daily <input type="checkbox"/> Weekly (4.33) <input type="checkbox"/> Bi-Weekly (2.167) <input type="checkbox"/> Monthly <input type="checkbox"/> Twice Monthly <input type="checkbox"/> Actual <input type="checkbox"/> Other: <input type="checkbox"/> Student Exemption																																			
	31 Self-employed income (includes businesses, baby sitting, out-of-home sales, swap meets, arts, crafts and income from crops or other farm income)? If yes, how many people are self-employed? _____						<input type="checkbox"/> Tax Statement <input type="checkbox"/> Profit/Loss																																			
UNEARNED INCOME	32 Social Security Benefits (Self) Social Security Benefits (Others)..... Social Security Benefits (Others)..... Cash aid such as: SSI, AFDC, GR/GA or any other ... Child/Spousal Support or Alimony Money From Friends or Relatives (include loans gifts, and contributions) Railroad Retirement..... Veteran's Benefits/Military Allotments Worker's Compensation Unemployment Benefits (Self)..... Unemployment Benefits (Others) Disability or Sick Benefits Pensions, Retirement, IRA, Keogh, or Annuity Trust.... Interest Income, Dividends, or Capital Gain..... Income From Rent, Mortgages, Promissory Notes, Deed of Trust, or Contract of Sales (including room and/or meal)..... Scholarships, Loans, or Grants Income From Training Program..... Name of Program: _____ Any Other Uneamed Income (include gambling/ lottery/bingo winnings, lump sum payments, inheritance)						Use copy of award letter or check or other verification. \$ _____ \$ _____ \$ _____ <input type="checkbox"/> Occasional \$ _____ \$ _____ \$ _____ \$ _____ \$ _____ \$ _____ \$ _____ \$ _____ \$ _____ \$ _____ <input type="checkbox"/> MC 210 S-E \$ _____ <input type="checkbox"/> Inheritance, Insurance, etc.																																			
	33 Receive Rent/Housing, Food?..... If yes, check boxes: <table style="width: 100%; border: none;"> <tr> <td></td> <td style="text-align: center;">FREE</td> <td style="text-align: center;">WORK FOR</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Housing</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> <td></td> <td style="text-align: right;">Value</td> <td></td> </tr> <tr> <td>Utilities</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> <td></td> <td style="text-align: right;">\$ _____</td> <td></td> </tr> <tr> <td>Food</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> <td></td> <td style="text-align: right;">\$ _____</td> <td></td> </tr> <tr> <td>Clothing</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> <td></td> <td style="text-align: right;">\$ _____</td> <td></td> </tr> </table>		FREE	WORK FOR					Housing	<input type="checkbox"/>	<input type="checkbox"/>			Value		Utilities	<input type="checkbox"/>	<input type="checkbox"/>			\$ _____		Food	<input type="checkbox"/>	<input type="checkbox"/>			\$ _____		Clothing	<input type="checkbox"/>	<input type="checkbox"/>			\$ _____							<input type="checkbox"/> Chart Value <input type="checkbox"/> Actual Value <input type="checkbox"/> MC 210 S-I
		FREE	WORK FOR																																							
	Housing	<input type="checkbox"/>	<input type="checkbox"/>			Value																																				
	Utilities	<input type="checkbox"/>	<input type="checkbox"/>			\$ _____																																				
	Food	<input type="checkbox"/>	<input type="checkbox"/>			\$ _____																																				
	Clothing	<input type="checkbox"/>	<input type="checkbox"/>			\$ _____																																				

CHECK EACH ITEM "YES" OR "NO" →		YES	NO	WHO PAYS	MONTHLY AMOUNT	COUNTY USE
OTHER EXPENSES	34 Does the self-employed person have business expenses?					<input type="checkbox"/> MC 210 S-W <input type="checkbox"/> Verification
	35 Does anyone in your home pay child/spousal support, alimony or make other payments (medical, dental, etc.) for someone who does not live in the home?					<input type="checkbox"/> Court Order <input type="checkbox"/> Actual Payment \$ _____
	36 Does anyone in your home pay someone to care for a child, a disabled or elderly adult so that a household member can work, attend training or school or look for work? List person(s) cared for:					<input type="checkbox"/> Dependent Care Receipts <input type="checkbox"/> MFBU Member
	37 Is anyone in your home a working disabled person who has medical expenses necessary to keep the job, such as wheelchair?					<input type="checkbox"/> Receipts <input type="checkbox"/> MC 272 <input type="checkbox"/> MC 273 \$ _____ <input type="checkbox"/> QDWI
	38 Is anyone paying college or educational costs?					<input type="checkbox"/> MC 210 S-E
OTHER HEALTH COVERAGE	39 a. Is anyone currently covered by health/dental insurance or Medicare? List name(s) _____ List name of insurance _____					<input type="checkbox"/> QMB <input type="checkbox"/> Card <input type="checkbox"/> SLMB <input type="checkbox"/> DHS 6155 <input type="checkbox"/> HIPP <input type="checkbox"/> EGHP OHC CODE: _____ \$ _____
	b. Is health/dental insurance available through employment?					<input type="checkbox"/> SSA Referral
	c. Do you or any family member have a high cost medical condition?					
	d. Have your health/dental insurance stopped in the last 60 days?					
	40 Additional Information: (List any additional information for questions 1 through 39.) _____ _____ _____					
SERVICES	YOUR ANSWERS TO THE FOLLOWING QUESTIONS WILL NOT AFFECT YOUR ELIGIBILITY FOR MEDI-CAL		YES	NO	COUNTY USE	
	41 Regular check-ups to help protect your family's health are available upon request through the Child Health and Disability Prevention Program (CHDP) for eligible members of your family under age 21. a. Do you want more information about CHDP Services? b. Do you want CHDP medical or dental services?					<input type="checkbox"/> CHDP Brochure and Explanation Given <input type="checkbox"/> CHDP Referral
	42 Pregnant women may get help finding a doctor and transportation to see the doctor. a. Do you want to talk to someone about this help? b. Have you given birth within the last three months? c. Are you breast feeding a child? If you answered "YES" to either b or c, you may be eligible for services provided by the Special Supplemental Food Program for Women, Infants and Children (WIC).					<input type="checkbox"/> Pregnant <input type="checkbox"/> Parent or Guardian of child under 5. <input type="checkbox"/> WIC referral <input type="checkbox"/> Breastfeeding <input type="checkbox"/> Postpartum
	43 Do you want information about Family Planning Services?					<input type="checkbox"/> Family Planning Information Given
	44 Do you want to talk to a social worker about other services which may be available to you? If "YES," briefly describe: _____ _____					<input type="checkbox"/> Social Services Referral

CERTIFICATION

- I have read and received a copy of the Important Information for Persons Requesting Medi-Cal form (MC 219).
- I am aware of, understand, and agree to meet all my responsibilities as described on the MC 219.
- I understand that all of the statements, including benefit and income information, that I have made on this form are subject to investigation and verification.
- I understand that Section 1137 of the Social Security Act requires that I provide Social Security numbers (SSNs) for myself and/or any family members if I/we claim to be in a satisfactory immigration status. I understand that my/our SSNs will be verified and will be used in a computer match to check the income and resources I/we report with information from welfare, state employment, income tax, Social Security Administration, and other agencies. I understand that this is done to make sure that my/our family's eligibility and share-of-cost level, if any, are correct.

It is the responsibility of the applicant/beneficiary and person acting for the applicant/beneficiary to report to the Eligibility Worker within ten (10) days any changes that occur.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information contained in this Statement of Facts and any of its supplemental form(s) that I may be asked to complete is true and correct.

Signature of Applicant/Beneficiary			Date
Signature of Witness (If Applicant Signed With a Mark)	Telephone Number	Relationship to Applicant/Beneficiary	Date
Signature of Person Helping Applicant Fill Out the Form	Telephone Number	Relationship to Applicant/Beneficiary	Date
Signature of Interpreter	Telephone Number	Relationship to Applicant/Beneficiary	Date
Signature of Person Acting for Applicant/Beneficiary		Relationship to Applicant/Beneficiary	Date
Address of Person Acting for Applicant/Beneficiary			Telephone Number of Person Acting for Applicant/Beneficiary

COUNTY USE ONLY

Supplemental Forms Issued	Client Initial	Date
EW Signature	Worker Number	Date

5-9-96

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.

Every applicant asking for Medi-Cal who has a Social Security number must provide it on this form.

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 <input type="checkbox"/> Yes <input type="checkbox"/> No	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female					
Birthdate or date unborn is due	Is the person blind or disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No					
Father's name	Is either parent (✓) <input type="checkbox"/> Deceased <input type="checkbox"/> Incapacitated <input type="checkbox"/> Absent <input type="checkbox"/> Unemployed		Medical Support <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> CA 2.1				
Mother's name	Child living in home <input type="checkbox"/> Yes <input type="checkbox"/> No	Medi-Cal requested <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Not in home, 18-21 and tax dep.?				

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 <input type="checkbox"/> Yes <input type="checkbox"/> No	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female					
Birthdate or date unborn is due	Is the person blind or disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No					
Father's name	Is either parent (✓) <input type="checkbox"/> Deceased <input type="checkbox"/> Incapacitated <input type="checkbox"/> Absent <input type="checkbox"/> Unemployed		Medical Support <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> CA 2.1				
Mother's name	Child living in home <input type="checkbox"/> Yes <input type="checkbox"/> No	Medi-Cal requested <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Not in home, 18-21 and tax dep.?				

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 <input type="checkbox"/> Yes <input type="checkbox"/> No	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female					
Birthdate or date unborn is due	Is the person blind or disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No					
Father's name	Is either parent (✓) <input type="checkbox"/> Deceased <input type="checkbox"/> Incapacitated <input type="checkbox"/> Absent <input type="checkbox"/> Unemployed		Medical Support <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> CA 2.1				
Mother's name	Child living in home <input type="checkbox"/> Yes <input type="checkbox"/> No	Medi-Cal requested <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Not in home, 18-21 and tax dep.?				

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 <input type="checkbox"/> Yes <input type="checkbox"/> No	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female					
Birthdate or date unborn is due	Is the person blind or disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No					
Father's name	Is either parent (✓) <input type="checkbox"/> Deceased <input type="checkbox"/> Incapacitated <input type="checkbox"/> Absent <input type="checkbox"/> Unemployed		Medical Support <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> CA 2.1				
Mother's name	Child living in home <input type="checkbox"/> Yes <input type="checkbox"/> No	Medi-Cal requested <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Not in home, 18-21 and tax dep.?				

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 <input type="checkbox"/> Yes <input type="checkbox"/> No	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female					
Birthdate or date unborn is due	Is the person blind or disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No					
Father's name	Is either parent (✓) <input type="checkbox"/> Deceased <input type="checkbox"/> Incapacitated <input type="checkbox"/> Absent <input type="checkbox"/> Unemployed		Medical Support <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> CA 2.1				
Mother's name	Child living in home <input type="checkbox"/> Yes <input type="checkbox"/> No	Medi-Cal requested <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Not in home, 18-21 and tax dep.?				

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 <input type="checkbox"/> Yes <input type="checkbox"/> No	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female					
Birthdate or date unborn is due	Is the person blind or disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No					
Father's name	Is either parent (✓) <input type="checkbox"/> Deceased <input type="checkbox"/> Incapacitated <input type="checkbox"/> Absent <input type="checkbox"/> Unemployed		Medical Support <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> CA 2.1				
Mother's name	Child living in home <input type="checkbox"/> Yes <input type="checkbox"/> No	Medi-Cal requested <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Not in home, 18-21 and tax dep.?				

5-9-96

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)

Cada solicitante pidiendo por Medi-Cal que tiene un número de Seguro Social debe facilitarlo en este formulario.

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

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