STATE OF CALIFORNIA–HEALTH AND WELFARE AGENCY

PETE WILSON, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P Street
P.O. Box 942732
Sacramento, CA 94234-7320
(916) 657-2941

July 12, 1996

TO: All County Welfare Directors
All County Administrative Officers
All County Medi-Cal Program Specialists/Liaisons

Letter No.: 96-37

NEW MC 4026 (REQUEST FOR ELIGIBILITY LIMITED SERVICES) ENGLISH/SPANISH VERSIONS AVAILABLE

The purpose of this All County Welfare Directors Letter (ACWDL) is to notify the counties that the revised MC 4026 is now available in the English and Spanish versions. Counties should order this form through the Department of Health Services Warehouse.

The MC 4026 is now a two-part NCR form. The eligibility worker is to give the top copy to the applicant/beneficiary and must file the second copy in the case record. A new form is required each month that the individual requests Minor Consent Limited Services, **except for outpatient mental health services**. For outpatient mental health services, an MC 4026 is required at the initial application and each time a new statement is required from the mental health professional.

Enclosed with this ACWDL are sample copies of the English and Spanish versions. The county may reproduce these copies until your order has been received or you may continue to use existing stock of the MC 4026 until it is exhausted.

If you have any questions or comments concerning the MC 4026, or Minor Consent Services, please direct them to Gary Varner of my staff at (916) 654-5321.

Sincerely,

ORIGINAL SIGNED BY

FRANK S. MARTUCCI, CHIEF
Medi-Cal Eligibility Branch

Enclosures

REQUEST FOR ELIGIBILITY LIMITED SERVICES

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

PART A.

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

Under Age 12 and Older:

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

Age 12 Years and Older:

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

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

PART B.

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

PART C. RIGHTS AND RESPONSIBILITIES

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

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

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

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

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

Signature of Applicant	Date
;nature of County Representative	Date

SOLICITUD PARA SERVICIOS LIMITADOS DE ELEGIBILIDAD

Apellido y nombre del Solicitador	FOR COUNTY USE ONLY - State Number				
	County	Aid	Serial Number	FBU	Person Number

PARTE A.

Necesito/sigo necesitando servicios relacionados con: (Ponga una cruz en una, o más, de las siguientes casillas.)

Menos de 12 Años y Más:

1. ❒ Asalto Sexual
2. ❒ Embarazo o Planificación Familiar

12 Años y Más:

3. ❒ Enfermedades Venéreas
4. ❒ Abuso de Drogas y de Alcohol
5. ❒ Servicios Ambulatorios de Salud Mental *

* Si está solicitando servicios ambulatorios de salud mental, será preciso que entregue a su trabajador(a) social una carta escrita por un profesional de la salud mental que confirma que usted cumple con los requisitos necesarios para estos servicios.

PARTE B.

Estoy solicitando asistencia médica para el mes de : _____________ / __________
Mes Año

PARTE C. DERECHOS Y RESPONSABILIDADES

Entiendo que recibiré una tarjeta Medi-Cal de papel que será vigente durante un año, empezando el día indicado en la tarjeta. Esta tarjeta sólo sirve para identificación y no prueba su elegibilidad.

2. Entiendo que sólo estoy elegible durante un mes y que cada mes que necesite servicios médicos bajo el programa de Consentimiento del Menor (Minor Consent), debo regresar al Departamento de Asistencia Pública (Welfare Department) para atestiguar de nuevo que califico para al menos uno de los servicios indicados arriba. Para que mi trabajador(a) de elegibilidad tenga suficiente tiempo para transmitir mi nueva certificación, debo acudir y llenar este formulario tan pronto como sepa que necesito ver a un doctor, o que necesito atención médica.

3. Entiendo que si pasara una de las siguientes cosas, tendría que decírselo a mi trabajador(a) de elegibilidad durante nuestra próxima entrevista para renovar mi elegibilidad.

   a. Ya no vivo en casa de mis padres/tutor.
   b. Acabo de casarme.
   c. Mis padres ya no me dan dinero o no me usan como dependiente en su declaración de impuestos.
   d. He conseguido trabajo o he dejado de trabajar.
   e. He adquirido bienes; por ejemplo cuentas bancarias, coche, acciones, bonos, fondos fiduciarios, etc.
   f. He dado a luz, o se acabó mi embarazo, por cualquier razón.

4. Entiendo que recibiré esta tarjeta y los servicios médicos que he pedido sin que se informen o comuniquen con mis padres.

Firma del Solicitador	Fecha
Firma del Representante del Condado	Fecha