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

DEPARTMENT OF HEALTH SERVICES
714/744 P Street
P.O. Box 942732
Sacramento, CA 94234-7320
(916) 657-0258

October 23, 2000

Medi-Cal Eligibility Branch Information Letter No.: I00 -18

TO: All County Medi-Cal Program Specialists/Liaisons

MEDI-CAL APPLICATION FOR REVIEW AND COMMENT

The purpose of this letter is to provide you with a copy of the revised Medi-Cal Mail-In Application. This copy of the application reflects the input provided by the stakeholders' workgroup, counties, and focus group research. We are asking you to provide comments and input on the enclosed draft application.

Please provide your comments and input in writing or via E-mail to the Medi-Cal Eligibility Branch by November 8, 2000. If you need any further information, please contact Kim McCord of my staff at (916) 657-3723, or E-mail at Kmccord@dhs.ca.gov.

Sincerely,

ORIGINAL SIGNED BY

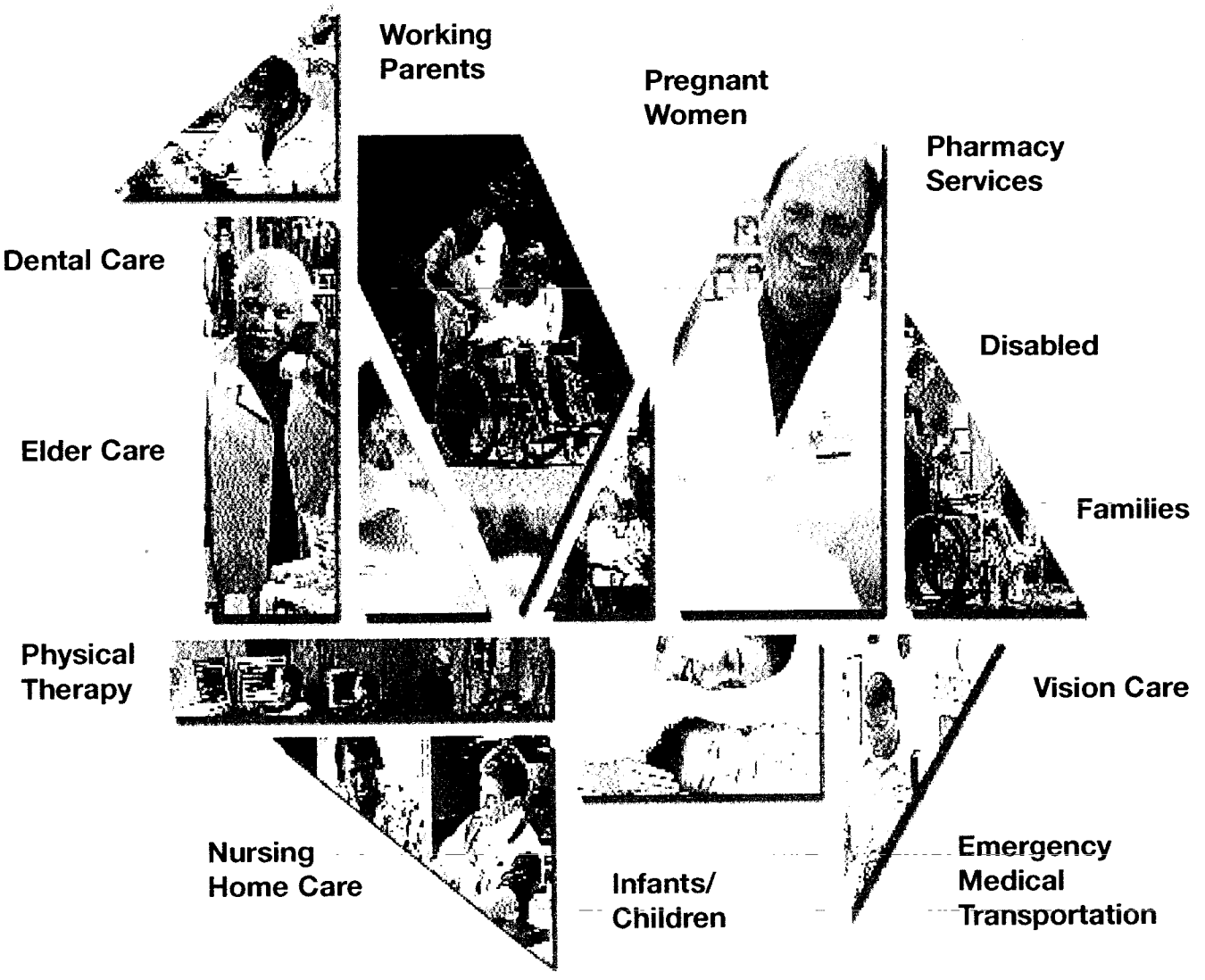
Glenda Arellano
Acting Chief
Medi-Cal Eligibility Branch

HEALTH CARE COVERAGE

FOR PEOPLE WITH LIMITED INCOME AND RESOURCES.

MEDI-CAL

NEW MAIL-IN APPLICATION AND INSTRUCTIONS



For ***FREE*** help to apply for Medi-Cal, call toll-free,
1-888-747-1222 or contact your local welfare office.

What is Medi-Cal?

- Health care coverage for California residents, with limited income and resources.

Who can get Medi-Cal?

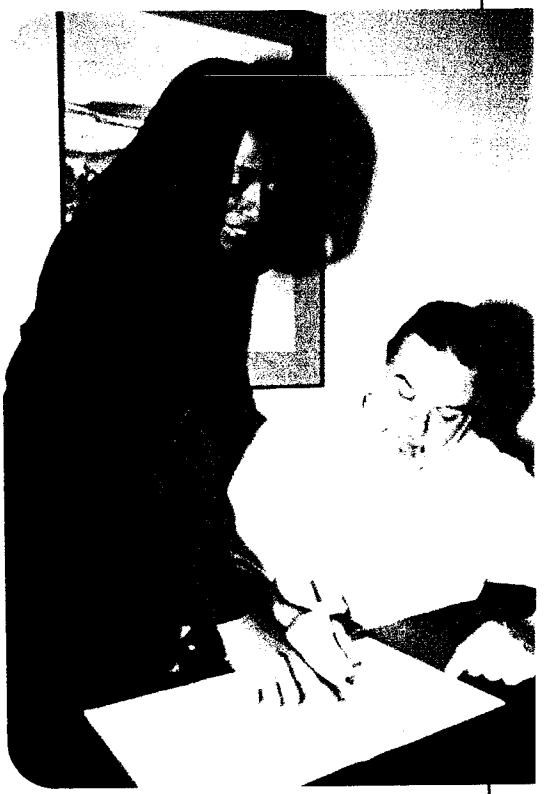
- Persons who are under 21yrs of age.
- Pregnant Woman.
- Persons over 65 years of age.
- Certain adults between 21yrs of age and 65yrs of age, if they have minor children living with then.
- Adults between 21yrs of age and 65yrs of age who are blind or disabled.
- Persons receiving Nursing home care.
- Persons with certain chronic conditions.
- Certain Refugees, Asylees, Cuban/Haitian Entrants, documented and undocumented immigrants not covered by one of the groups above.

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

- A person under 21yrs of age who is your dependent living in your home or away at school.

What do I do to get this Medi-Cal coverage?

- Complete and send in the enclosed application.
- Send copies of the proof requested, with the application now or as soon as you can.



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

- If you fall into one of the groups listed in "Who can get Medi-Cal coverage" above. Then:
- We look at your income and some expenses you pay, to decide your families countable income for Medi-Cal.
- We look at things you 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 you local welfare office for information about the county's Adult Services Medical program.

APPLICATION FOR MEDI-CAL

To complete this form, use the instructions, or call toll-free, 1-888-747-1222 for help.
Print clearly. Use black or blue ink only.

TEAR HERE

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 USE A P.O. BOX**		3 APARTMENT NUMBER	4 HOME PHONE # ( )
5 CITY	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 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.

	Adult Father/ Mother	Adult Father/ Mother	Child 1	Child 2	Child 3
15 **Name:** Last					
First					
Middle					
16 **Name on Birth Certificate:** Last					
First					
(If same as #15 above, leave blank.) Middle					
17 If address where living is not the same as listed in Section 1, put address where living:					
18 Sex:	❑ 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,including teen's spouse, living 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
Unable to work because of disability?	❑ Yes ❑ No ❑ 30 Days or More ❑ 12 Months or More	❑ Yes ❑ No ❑ 30 Days or More ❑ 12 Months or More			

TEAR HERE

SECTION 2 Continued.

	Adult Father/ Mother	Adult Father/ Mother	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
25 Medi-Cal benefits BIC card number, if you have it:					
26 Relationship to person in Section 1;					
27 Wants Medi-Cal?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
28 Do you own or are you buying or leasing 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
29 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 ❑ Deceased ❑ Absent
30 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, the spouse or parent of any child listed in Section 2.**

31 NAME OF PERSON RECEIVING THE MONEY	32 MONEY/INCOME	33 HOW MUCH MONEY/INCOME IS RECEIVED	34 HOW OFTEN MONEY RECEIVED (Monthly, bimonthly, weekly, biweekly, daily)

SECTION 5 **List expense/cost paid by *all* persons listed in section 2, the spouse or parent of any child listed in Section 2.**

35 TYPE OF PAYMENT YOUR FAMILY MAKES	36 NAME OF PERSON WHO PAYS	37 MONTHLY AMOUNT PAID
Child Support		
Alimony		
Health Insurance Premium		
Medicare Premium		

38 CHILD CARE OR DEPENDENT CARE *(List child's or dependent's name)*	39 AGE	40 NAME OF PERSON WHO PAYS	41 MONTHLY AMOUNT PAID
1.			
2.			
3.			
4.			

SECTION 6 ***If you are only applying for Children under 19 and/or pregnant women (pregnancy related services only), skip this section.***

Otherwise answer for *all* persons listed in Section 2.

42	Does anyone have cash or uncashed checks? If Yes, list amount here _____ (See instructions)	❑ Yes ❑ No
43	Does anyone have a checking, savings account, or life insurance? (See instructions)	❑ Yes ❑ No
44	Does the household have any vehicles? (See instructions)	❑ Yes ❑ No
45	Does anyone have a court ordered settlement or judgement? (See instructions)	❑ Yes ❑ No
46	Does anyone have long-term care insurance? (See instructions)	❑ Yes ❑ No
47	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
48	Does anyone own any items such as stocks, bonds, retirement funds, trusts, real estate, motor vehicles for a business, recreational vehicles, burial items or funds, annuities, oil or mineral rights? (See instructions)	❑ Yes ❑ No
49	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 Father/ Mother	Adult Father/ Mother	Child 1	Child 2	Child 3
50 Social Security #:					
	You may be able to receive Medi-Cal even if you do not have a Social Security Number.				
51 Place of Birth: *State or Country.*					
52 U.S. Citizen or U.S. National?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
53 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:					
54 Has health/dental or vision insurance?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
55 Had medical expenses within the last 3 months and want Medi-Cal for those expenses?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
56 Lawsuit pending due to accident or injury?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

SECTION 7 Continued	Adult Father/ Mother	Adult Father/ Mother	Child 1	Child 2	Child 3
57 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
58 Ethnicity (race) (optional)					
59 In school full time?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
60 Living away from home?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

SECTION 8 Information Release (Optional).

61 If your child(ren) 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

62 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.

63 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, call toll-free, 1-888-747-1222, see the Medi-Cal brochure, "Health Care for Families with Children" or visit our website, www.dhs.ca.gov

❑ Access for Infants and Mothers Health Care Plan (AIM)

❑ Woman, Infants and Children Nutrition Program (WIC) ❑ Family Planning

❑ Child Health and Disability Program (CHDP) referral wanted ❑ Yes ❑ No

How to fill out the application

Whose information should you put on this application?

- Your own if you are an adult or considered an adult, you are not living with a spouse, and you have no children.
- Yours and your spouse's if you are legally married and living together.
- Yours and your spouse's if you are legally married but one or both of you is living in a nursing home.
- Your own, your children's if they are under 21 years of age, and the information about the other parent of those children if they are living in the home.
- Your own if you are a minor under 21 years of age living with your parent(s) and asking for Minor Consent confidential services.
- Your own if you are under 21 years of age and not living with your parents.

Fill out as much of the application as you can. The instructions should help you with your questions, if they don't call the Toll Free Line* 1-888-747-1222 *or contact the local welfare office for help. Do not delay sending in your application because you are unsure how to answer some of the questions. The local welfare office will contact you if they need clarification or additional information.

What will happen after I send in my application?

- The local welfare office will notify you in writing or by phone, that they received your application, and whom you can contact for information about your application.
- You will receive a packet from the county with additional information.
- You may receive additional forms in the mail that will need to completed and returned to the local welfare office.
- The local welfare office should determine your eligibility within 45 days and notify you in writing of that decision.
- When determined eligible depending on what county you live in you may have to choose a health coverage plan by completing a health plan enrollment form.

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

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

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

I filled out the application and want to mail it.

- Complete the application and mail it, using the self addressed postage paid envelope included with the application.

I have the application, but need help.

- Call toll-free, 1-888-747-1222 for help.
- Contact your local welfare office for help.
- Ask a friend or relative to help you.

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.

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 example family planning, pregnancy related care, mental health, drug and alcohol abuse treatment/counseling

- You must take this application to the local welfare office.

DO NOT MAIL IT.

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.

For *FREE* help to apply for Medi-Cal, call toll-free, *1-888-747-1222* or contact your local welfare office.

INSTRUCTIONS ➥

INSTRUCTIONS

SECTION 1

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

Question 1:
Enter the name of the person who wants Medi-Cal, or the parent/ caretaker of the children who want Medi-Cal.

Questions 2-8:
Enter the address and telephone numbers of the person who wants 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. Medi-Cal information is available in several languages.

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's 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

Send identity proof is not needed for

- Persons in an institution
- Children in a family, if identity of one parent has been made
- 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.

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 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 at school and claimed as a tax dependent
- All stepchildren under age 21 living in the home

Who counts as an adult?

- Person 21 years of age or older
- Person under 21 years of age who is not living in the home of their parent or caretaker relative and is not claimed as a tax dependent by the parent or caretaker
- Persons between 14 and 21 years of age living with their parent(s) applying for Minor Consent services

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

GO TO PAGE 2

SECTION 2 Continued

Question 16:
Tell us this person's name as it appears on the birth certificate if different than in Question 15.

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 sex of each person.

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

Question 20:
Write the name of the spouse living in the home including the spouses of married minors. Any income of the spouse must be listed in Section 6.

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

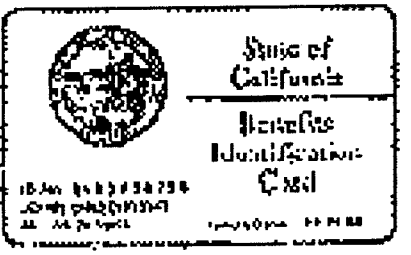
Question 22:
Tell us if this person is pregnant. If "Yes", tell us the due date.

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.

Question 24:
Tell us if any one has ever had cash aid, SSI, Food Stamps or Medi-Cal? This will help county social services check for needed information before asking you to give it.

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

Your Medi-Cal Benefits Identification number can be found here. →



Question 26:
How is each person related to the person in Section 1. ***Example: self, wife, husband, grandparents, friend, daughter, stepchild, nephew, etc.***

Question 27:
Check "Yes", if you are asking for benefits for this person.

Question 28:
Tell us if you own or are leasing a home outside California. Your answer helps us determine if you are a California resident.

- Send **proof of California residency.** You can use your proof of income as proof of residency, too. 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 29:
Write the name of the mother of each child. If the mother is the same for all children, write her name for child 1, and write "same" for the other children. Check the box to tell us if the mother is employed, disabled, unemployed, deceased or absent.

Question 30:
Write the name of the father of each child. If the father is the same for all children, write his name for child 1, write "same" for the other children. Check the box to tell us if the father is employed, disabled, unemployed, deceased or absent.

GO TO PAGE 3 ➥

SECTION 4

List all income/money received by persons listed in Section 2, and the spouse or parent of any child listed in Section 2.

Questions 31 and 32:

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.*

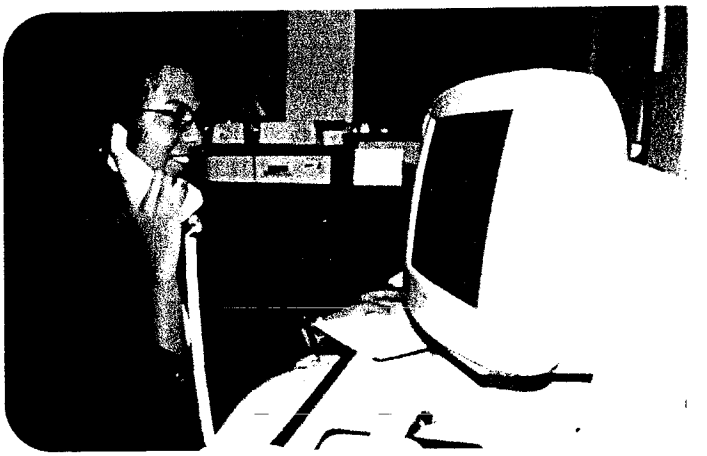
Question 33:

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 a pay stub or other document 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 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.



- **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.**

If using last year's federal income tax return, add all income amounts reported. Do not deduct losses.

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 the last 3 months' profit and loss statements.
- If a person has money 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 4 Continued

Question 34:

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).***

SECTION 5

List expenses/costs paid by *all* persons listed in Section 2, and the spouse or parent of any child listed in Section 2.

Question 34:

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

Question 36:

Write the name of the person who pays the cost.

Question 37:

Write in the total amount paid each month.

Question 38:

We consider costs paid for child care and/or disabled dependent care under some circumstances.

Question 39:

List the age of the child or disabled dependent.

Question 40:

Write the name of the person who pays the cost.

Question 41:

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

If you are only applying for Children under 19 and/or pregnant women (pregnancy related services only), skip this section. 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 used to determine eligibility for Medi-Cal

Question 42:

Tell us the amount of all cash you have on hand and the amount of any uncashed checks, you have received but not cashed.

Question 43:

If anyone listed has a checking 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 44:

If you Check "Yes", if you have a vehicle, even if that vehicle does not run. Send us a copy of vehicle registration, pink slip, purchase document or one estimate of value from a qualified source, such as a dealer or mechanic.

Question 45:

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

Question 46:

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.

Question 47:
If you check "Yes", you may be asked to provide additional information.

Questions 48-49:
If "Yes" checked for Question 48 or 49, you will have to fill out a property supplement form. Ask the local welfare office to send you the form.

SECTION 7

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

Question 50:
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 related 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 51:
Write 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 52:
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 income and 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 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 information about people who are not asking for Medi-Cal. The State will use this information only for eligibility determination. Information about immigration is private and confidential.

Question 53:
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 54:
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.

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SECTION 7 Continued

Question 55:
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 apply.

Question 56:
Check "Yes", if any person has filed a lawsuit because of an accident or injury, workman's compensation, car accident.

Question 57:
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.

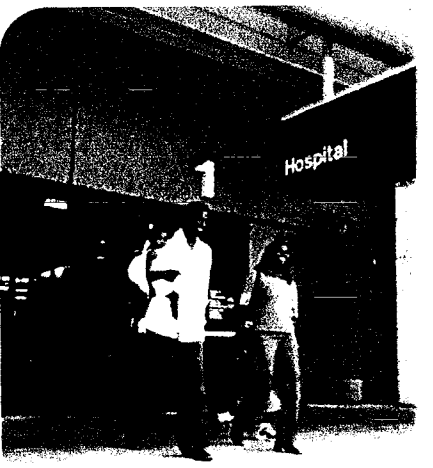
Question 58 (Optional):
You can choose to enter the Ethnicity (race) for each person. This information is used for statistics only and has no affect on your eligibility for Medi-Cal.

Question 59:
Check box to show if person is in school. The earnings of a person under 21 years are not counted if the person is attending school.

Question 60:
Tell us if the person is living away from home, is away at school, or out of town working.

SECTION 8

Information Release (Optional).



Question 61:
Check "Yes", if you want the local welfare office to send this form to the Healthy Families Program.

Question 62:
If you fill out this item you are telling the local welfare office it is okay to give information about your application to the persons 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 63:
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.

GO TO PAGE 7

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 county social services 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 paternity determinations and medical support enforcement efforts.
- Assignment of rights to medical support to the state.
- Assign rights to third party medical support to the state.

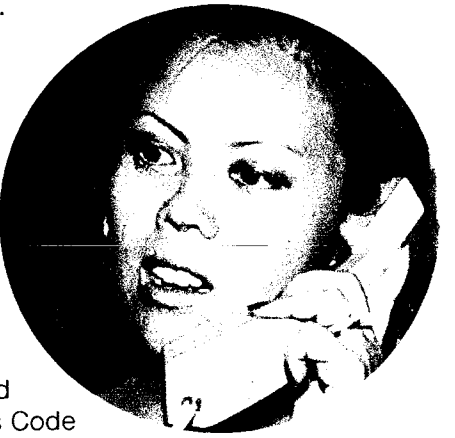
I understand that:

- 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.

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 office to request your records.

For help in your language...

Please call toll-free, 1-888-747-1222

For English information, Press 1.....	**1** English
Si desea información en español, oprima el 2.....	**2** Spanish
Muốn được giúp đỡ bằng tiếng Việt, xin gọi số trên và Bấm số 3.....	**3** Vietnamese
សម្រាប់ពត៌មានបន្ថែមជាភាសាខ្មែរ, សូមទូរស័ព្ទទៅលេខខាងលើហើយចុចលេខ 4.....	**4** Cambodian
Yog koj xav paub xov ntxiv hais ua lus Hmoob, thov koj hu tus xov tooj teev los saum toj no, tom qab ntawd, koj mam nias tus nabnpawb 5....	**5** Hmong
Հայերենով տեղեկություն ստանալու համար խնդրում ենք հեռաձայնեք վերը նշված համարով եւ սեղմեք 6.....	**6** Armenian
如需粵語資訊，請按 7.....	**7** Cantonese
한국어로 된 정보를 원하시면, 위에 나온 번호로 전화하신 다음 (8)을 누르십시오.....	**8** Korean
Для получения информации на русском языке звоните, пожалуйста, по вышеуказанному телефону и нажмите кнопку 9.....	**9** Russian
برای کسب اطلاعات به زبان فارسی با شماره فوق الذکر تماس بگیرید و شماره 0 را فشار دهید.....	**0** Farsi

Grantland Johnson
Secretary, California Health and Human Services Agency

Gray Davis
Governor, State of California

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

Provided by the State of California

MC 345 10/13/00

English