

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 social services 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.



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.

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 social services 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.

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 a USCIS 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.



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.

SECTION 8

Information Release (Optional).

Question 59:

If a child does not qualify for the Medi-Cal program, the local social services office will send this application to the Healthy Families program. If you do not want your application to be sent to Healthy Families, check this box.

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 social services 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 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 the notice of action is mailed to me. 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 in the information I give on this application within 10 days.
- Let the local social services 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.
- Assign 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.
- 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.

I declare that each person I am applying for:

- Lives in California.
- Is not getting public assistance from outside California.
- Is not in jail, prison or any other correctional facility.

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 if required by law.

Medi-Cal Privacy Notice

The Information Practices Act of 1977 and the Federal Privacy Act require the Department of Health Care 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 USCIS of the immigration status of only those persons seeking full scope Medi-Cal benefits. (Federal law says the USCIS 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

Unless you are applying for emergency or pregnancy-related benefits only, you must provide your Social Security Number. (Welfare and Institutions Code section 14011.2 and Social Security Act section 1137(a)(1)).

Access to Records

You have the right to access records maintained by the Department of Health Care Services that contain your personal information.

Contact your local social services office to request your records.

