

Application

Please fill out all 4 pages of this form. Print clearly.
Use black or blue ink only. Mail your completed form to:

Healthy Families/Medi-Cal
P.O. Box 138005
Sacramento, CA 95813-9984



Need Help?
Call: 1-800-880-5305

Tell us about the family member filling out this form.

①	Last Name	First Name	Middle Initial	Date of Birth (mo/day/yr) () / () / ()
②	Home Address (Number and Street) Do NOT use a P.O. Box – unless homeless		Apt. #	Home Phone # () ()
③	City	County	Zip Code	Work Phone # () ()
④	Mailing Address (if different from above) or P.O. Box		Apt. #	Message or Cell Phone #
⑤	City	Zip Code	E-mail Address (Optional)	
⑥	What language do you want us to speak to you in?		⑦ What language should we write to you in?	

Tell us who you are applying for. (If more than 3 children, photocopy pages A1 and A2 to list other children.)

	Child 1	Child 2	Child 3	Pregnant Woman	Unborn Child
⑧ Name	Last First Middle				Pregnant women in Medi-Cal or AIM: do not fill out this part. <input type="checkbox"/> Check here to apply for Healthy Families for your baby before he/she is born. You must: <ul style="list-style-type: none"> • Be at least 6 months pregnant, • Send proof of pregnancy from your doctor or clinic with the application, and • Send proof of birth when the baby is born. (More information on page 5.)
⑨ Name on birth certificate (If different from name above)	Last First Middle				
⑩ Is this child living away from home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
⑪ Home address (If different from home address in ②)					
⑫ Mailing address (If different from mailing address in ④)					
⑬ Date of Birth	___/___/___ mo day yr	___/___/___ mo day yr	___/___/___ mo day yr	___/___/___ mo day yr	
⑭ Relationship to person in ①	<input type="checkbox"/> My child <input type="checkbox"/> My stepchild <input type="checkbox"/> Other: _____	<input type="checkbox"/> My child <input type="checkbox"/> My stepchild <input type="checkbox"/> Other: _____	<input type="checkbox"/> My child <input type="checkbox"/> My stepchild <input type="checkbox"/> Other: _____	Baby's Due Date: ___/___/___	
⑮ Gender	<input type="checkbox"/> Boy <input type="checkbox"/> Girl	<input type="checkbox"/> Boy <input type="checkbox"/> Girl	<input type="checkbox"/> Boy <input type="checkbox"/> Girl	Number of babies expected: _____	

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	Child 1	Child 2	Child 3	Pregnant Woman	Unborn Child
16 Ethnicity – <i>Optional</i> (For more information, see page 6.)					
17 Birthplace County: _____ State: _____ Or foreign country: _____					
18 Social Security No. (For more information, see pages 6 and 7.)	<i>This is optional if you are applying for Healthy Families or for emergency or pregnancy services.</i>				
19 U.S. Citizen or National? (More information on pages 3 and 7.) If No, date arrived in the U.S. _____/_____/_____ mo day yr	<input type="checkbox"/> Yes <input type="checkbox"/> No _____/_____/_____ mo day yr	<input type="checkbox"/> Yes <input type="checkbox"/> No _____/_____/_____ mo day yr	<input type="checkbox"/> Yes <input type="checkbox"/> No _____/_____/_____ mo day yr	<input type="checkbox"/> Yes <input type="checkbox"/> No _____/_____/_____ mo day yr	
20 Medi-Cal benefits card number (BIC), if you have it:					
21 Does this person have other health, dental or vision insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
22 Was this child covered by a health plan paid by your employer in the last 3 months? (For more information, see page 6.)	<input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, write the date it ended and check reason below.) _____/_____/_____ mo day yr Health coverage ended because: <input type="checkbox"/> Lost job <input type="checkbox"/> Job status changed <input type="checkbox"/> Moved and no insurance available <input type="checkbox"/> All employees' benefits ended <input type="checkbox"/> Death, divorce or legal separation <input type="checkbox"/> COBRA ended <input type="checkbox"/> Other _____	<input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, write the date it ended and check reason below.) _____/_____/_____ mo day yr Health coverage ended because: <input type="checkbox"/> Lost job <input type="checkbox"/> Job status changed <input type="checkbox"/> Moved and no insurance available <input type="checkbox"/> All employees' benefits ended <input type="checkbox"/> Death, divorce or legal separation <input type="checkbox"/> COBRA ended <input type="checkbox"/> Other _____	<input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, write the date it ended and check reason below.) _____/_____/_____ mo day yr Health coverage ended because: <input type="checkbox"/> Lost job <input type="checkbox"/> Job status changed <input type="checkbox"/> Moved and no insurance available <input type="checkbox"/> All employees' benefits ended <input type="checkbox"/> Death, divorce or legal separation <input type="checkbox"/> COBRA ended <input type="checkbox"/> Other _____		
23 Does this person want to apply for Medi-Cal for medical expenses in the last 3 months? (For more information, see page 6.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
24 Mother's Name: Last _____ First _____ Does this child live with the mother?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
25 Father's Name: Last _____ First _____ Does this child live with the father?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

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If you need more space, make a copy of this page or attach another sheet.

Family Size List all other family members who live in the home. Include children under 21, stepparents, and the spouse of any teenager or pregnant woman who lives in the home. Do **not** list aunts, uncles, nieces, nephews, or grandparents. (For more information, see page 4.)

	Name	Gender	Date of Birth	How is this person related to the person in ①?
②6		<input type="checkbox"/> M <input type="checkbox"/> F	____/____/____ mo day yr	<input type="checkbox"/> Child <input type="checkbox"/> Boyfriend <input type="checkbox"/> Spouse <input type="checkbox"/> Stepchild <input type="checkbox"/> Girlfriend <input type="checkbox"/> Other _____
②7		<input type="checkbox"/> M <input type="checkbox"/> F	____/____/____ mo day yr	<input type="checkbox"/> Child <input type="checkbox"/> Boyfriend <input type="checkbox"/> Spouse <input type="checkbox"/> Stepchild <input type="checkbox"/> Girlfriend <input type="checkbox"/> Other _____
②8		<input type="checkbox"/> M <input type="checkbox"/> F	____/____/____ mo day yr	<input type="checkbox"/> Child <input type="checkbox"/> Boyfriend <input type="checkbox"/> Spouse <input type="checkbox"/> Stepchild <input type="checkbox"/> Girlfriend <input type="checkbox"/> Other _____

②9 Is any person in the home pregnant? Yes No
If yes, who? _____ How many babies is she expecting? _____ Due Date: ____/____/____
mo day yr

Family Income List the income of **every** person listed in this application. Include child support and spousal support received. (Use a separate line for each source of income.)

	Name of person with income (Children who are in school do not have to list their income from a job.)	Source of Income (job, social security, pension, etc.)	How often is income received? (Weekly, biweekly, monthly)	How much is the income? (total gross income)	Social Security Number (Optional)
③0				\$	
③1				\$	
③2				\$	
③3				\$	
③4				\$	

Expenses List the monthly expenses of the person in ① and the people listed above.

③5 Child Day Care or Disabled Dependent Care
For (child or dependent's name): _____ Age: _____ Amount paid: _____
For (child or dependent's name): _____ Age: _____ Amount paid: _____
For (child or dependent's name): _____ Age: _____ Amount paid: _____

③6 Court-ordered child support
Paid to: _____ Paid by: _____ Amount paid: _____
Paid to: _____ Paid by: _____ Amount paid: _____

③7 Court-ordered spousal support
Paid to: _____ Paid by: _____ Amount paid: _____

Household Information

③8 Does the person in ①, anyone listed above, or any other person in the home want Medi-Cal? . . . Yes No
If yes, who? _____ (If you answer Yes, we will contact you.)

③9 Does any person in the home have a physical, mental, emotional or developmental disability and want Medi-Cal? Yes No
If yes, who? _____ (If you answer Yes, we will contact you to see if you qualify.)

④0 Is any person applying for coverage involved in a lawsuit because of an injury or accident?
(For more information, see page 6.) Yes No

④1 Is there more than one car in the household? (Optional). Yes No

④2 Is there more than \$3,150 in household bank accounts? (Optional) Yes No

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The health care programs may share your information unless you check below:

- 43 We will send your application to Healthy Kids or a similar county program if your child does not qualify for full Medi-Cal or Healthy Families. If you do not want us to send it, check here. (For more information, see page 6.)
- 44 Medi-Cal will share your child's application with Healthy Families if your child no longer qualifies for free Medi-Cal in the future. If you do not want us to send it, check here.

Choose your Healthy Families plans:

Write the name or code of the plans you want below. To learn more about what plans are available, see the Healthy Families Handbook or call: 1-800-880-5305. Or visit: www.healthyfamilies.ca.gov

- | | |
|---|---|
| 45 Health Plan _____
Name _____ Code _____ | 46 Doctor or Clinic _____
(Optional) _____ Name _____ Code _____ |
| 47 Dental Plan _____
Name _____ Code _____ | 48 Dentist or Clinic _____
(Optional) _____ Name _____ Code _____ |
| 49 Vision Plan _____
Name _____ Code _____ | 50 Eye Doctor or Clinic _____
(Optional) _____ Name _____ Code _____ |

Check all boxes that describe you:

- 51 Native American Indian Forestry worker Agricultural worker Working in Fishing
- If you checked any of these boxes, you may qualify for the Special Population Plan that covers your child in any California county. Look for the Plan Code for this special plan in your Healthy Families Handbook or at www.healthyfamilies.ca.gov.*

Are you (or the child applying for coverage) a Native American Indian or Alaska Native who wants free Healthy Families health care?

- 52 Yes No *If yes, see page 6.*

Healthy Families Plan Disputes

Each plan has its own rules for resolving disputes about the delivery of services and other matters. Some plans say you must use binding arbitration for disputes; others do not. Some plans say that claims for malpractice must be decided by binding arbitration; others do not. If the plan you choose requires binding arbitration, you are giving up your right to a jury trial and cannot have the dispute decided in court. To find out more about how a plan resolves disputes, you can call the plan or look in the HFP Handbook. Or go to: www.healthyfamilies.ca.gov.

Declaration and Signature (Required)

I declare under penalty of perjury under California state law that I have read this application, the answers provided, and the documents enclosed and, to the best of my knowledge, they are correct and true. I have read and understand the Notices, and I am making the Declarations on page 7.

Applicant signs here: _____ Date: _____

Witness signs here (If applicant signed with a mark): _____ Date: _____

Authorized Representative (If any): _____ Date: _____

Fill out below ONLY if a Certified Application Assistant (CAA) helped you fill out this form.

- Check this box and sign below to allow Healthy Families and Medi-Cal to speak to a representative of the Enrollment Entity (EE) listed below about the status of this Application. This permission ends when the program mails you its decision on this Application.

I certify the CAA listed below helped me complete this application. This CAA helped me for free.

Applicant Signature: _____ Date: _____

CAA# _____ EE# _____

CAA Signature: _____ Date: _____

The state will not reimburse the EE unless the CAA fills out this section completely and correctly when the application is submitted.

Healthy Families Notices

Declarations

I declare that each person I am applying for:

- Is a resident of California
- Is not in jail or in a mental hospital
- Is not eligible for Medicare Part A and Part B
- Is not eligible for any California Public Employees Retirement System Health Benefits Program(s) or is eligible for a California Public Employees Retirement Health Benefits Program, but the employer contribution for dependent(s) is less than \$10.

I also declare that:

- All individuals listed on this Application will follow the rules of participation, the utilization review process and the dispute resolution process of the plans in which the individual is enrolled.
- I have read and understand the *Healthy Families Handbook*. I understand what it says about each health, dental and vision plan and the benefits they offer.
- I am applying for all of my children eligible for Healthy Families, unless they are already enrolled, or unless I am only applying for myself.
- I give permission to Healthy Families to check my family income, health coverage, immigration status of the people I am applying for, and all other facts on this Application Form.
- I agree to notify the program within 30 days of any change of address of any person applied for who is accepted into the program and any change in the applicant's billing address.

Privacy

The law requires you provide the information requested to apply for Healthy Families. (Title 10, CCR, § 2699.6600) The personal and medical information you provide will be used only to identify you and to administer the program. This means we will share your information with the agencies and plans you want to enroll in.

Citizenship and Immigration Information

The application asks you about your citizenship and immigration status. You must answer these questions. We use your answers to administer the program and to see if you are eligible. If you are a parent or guardian and are not applying for yourself, we will not share your immigration information with other agencies, including the immigration authorities. If you do not answer the questions, we may deny your application.

Ethnicity

Unless you are applying for benefits based on your Native American ancestry, you do not have to answer the questions about ethnicity.

Social Security Numbers

You do not have to provide your Social Security Number if you do not want to.

Access to Your Records

You have the right to access records maintained by the Managed Risk Medical Insurance Board that contain your personal information. To do so, contact:

Managed Risk Medical Insurance Board
Attn: HIPAA Coordinator
P.O. Box 2769
Sacramento, CA 95812-2769
(916) 324-4695

Medi-Cal Notices

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.

I have the responsibility to:

- Send in a status report when the county asks me to.
- Report any changes in the information I gave on this Application Form within 10 days.
- Let the county 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.

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.

I further declare that:

- I understand that as a condition of Medi-Cal eligibility, all rights to medical support and third party payments are automatically assigned to the State of California.
- If I am not eligible for this Medi-Cal Program, I understand I may qualify for other programs and have the right to apply for them.
- 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.

Confidentiality

The information you give on this Application Form is private and confidential. It will only be disclosed if required by law. (*Welfare and Institutions Code Sections 10850 and 14100.2*)

Privacy

The law requires Medi-Cal applicants answer all questions on this application not marked optional. (*Welfare & Institutions Code, § 14011 and Title 22, CCR regulations*) The personal and medical information you provide will be used only to identify you and to administer the program. This means we will share your information with federal, state, and local agencies.

Citizenship and Immigration Information

If you are applying for benefits, you must answer the questions about citizenship and immigration status. If you are a parent or guardian and are not applying for yourself, you do not have to provide your immigration information. If you are applying for full-scope Medi-Cal, we will confirm your immigration status with Immigration (USCIS) only to see if you are eligible. We will not share your immigration information with Immigration or other agencies for any other reason. Your application will be incomplete if you do not answer these questions for persons applying and we may deny your application.

Social Security Numbers

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

Access to Your Records

You have the right to access records maintained by the Department of Health Care Services that contain your personal information. To do so, contact your county health and human services or social services office.

1 Fill out the 4-page application.

If you do not understand a question, or do not have any of the documents, call: **1-800-880-5305**. Or, look for the information you need on pages 3–7.

2 Send us copies of income and expense documents.

(You may be able to use other documents not listed here.)

One document for each person living in the home who has a job:

- A recent pay stub (from less than 45 days ago), **or**
- A signed, dated statement from your employer showing your gross income and how often you are paid, **or**
- Last year's federal income tax return.

One document for each person living in the home who is self-employed:

- Last year's federal income tax form with Schedules C, C-EZ, or F, **or**
- A signed, itemized profit and loss statement for the last 3 months. For a sample profit and loss statement, go to: www.healthyfamilies.ca.gov, then click on *Download Forms and Documents*.

If you have income from Disability, Pensions, Retirement, Social Security, Veteran's Benefits, Workers' Compensation, or Unemployment, send a copy of:

- The award letter, check, **or** bank statement showing direct deposit for the most recent payment.

If you receive or pay child support or spousal support, send a copy of:

- The court order, paycheck stub showing support deduction, receipts, or the monthly support check, **or**
- A statement from the Department of Child Support Services or the person who pays support that lists: the amount of monthly support, who the support is for, who pays for it, and who receives it.

If you pay for child day care or disabled dependent care, send a copy of:

- A cancelled check **or** receipt, **or** a signed statement from your child day care provider showing how much you pay each month.

3 Send citizenship or immigration documents for each person applying.

(Send this now or as soon as you can.)

Citizens or Nationals: Send a copy of the birth certificate, passport, certificate of U.S. citizenship or naturalization or other proof of citizenship for each person applying. We may ask you for more information later.

Non-citizens: Send proof of immigration status. Make copies of front and back sides of documents. Or send a receipt from Immigration (USCIS) showing that you have applied to replace a lost document. *Even if the person applying does not have immigration papers, you can still apply for Medi-Cal.*

4 Send one document per household that proves California residency.

(You may be able to use other documents not listed here.)

- A pay stub that shows your address in California, **or**
- California Driver's license or ID card from DMV, **or**
- Rent receipt or utility bill, **or**
- Proof of your child's enrollment in school.

5 Sign and Mail the Application *(The application is on pages A1-A4.)*

Mail your application and copies of the documents in the attached envelope. No stamps needed!

Mail it to: **Healthy Families/Medi-Cal, P.O. Box 138005, Sacramento, CA 95813-9984**