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APPLICATION FOR MEDI-CAL

To complete this form, use the instructions. Print clearly. Use black or blue ink only.

SECTION 1 Tell us about the person who wants Medi-Cal for themselves, their family or children in their care.

1 LAST NAME: Last Name	FIRST NAME: First Name		MIDDLE INITIAL: Middle I
2 HOME ADDRESS (NUMBER AND STREET). **DO NOT LIST A P.O. BOX** UNLESS HOMELESS: HOME ADDRESS NUMBER AND STREET DO NOT LIST A PO BO		3 APARTMENT NUMBER: APARTMENT NUMBEI	4 HOME PHONE #: (HOM) HOME PHONE PI
5 CITY/STATE: CITYSTATE 5	6 COUNTY: COUNTY 6	7 ZIP CODE: ZIP CODE 7	8 WORK PHONE #: (WOI) WORK PHONE P
9 MAILING ADDRESS (IF DIFFERENT FROM ABOVE) OR P.O. BOX: Mailing Address if different from above		10 APARTMENT NUMBER: APARTMENT NUMBEI	11 MESSAGE PHONE #: (Mess)
12 CITY: CITY 12			13 ZIP CODE: ZIP CODE 13
14A WHAT LANGUAGE/DIALECT DO YOU SPEAK BEST?: 14A WHAT LANGUAGEDIALECT DO YOU SPEAK BEST		14B WHAT LANGUAGE DO YOU READ BEST?: 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, even if they don't want coverage.

	Adult 1/Self	Adult 2	Child 1	Child 2	Child 3
15 Name: Last					
First					
Middle					
16 Relationship to person in Section 1.					
17 If address where living is not the same as listed in Section 1, put address where living:					
18 Gender:	☐ 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(s) of married minors 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
Disability expected to last:	☐ 30 Days or More ☐ 12 Months or More	☐ 30 Days or More ☐ 12 Months or More	☐ 30 Days or More ☐ 12 Months or More	☐ 30 Days or More ☐ 12 Months or More	☐ 30 Days or More ☐ 12 Months or More

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SECTION 2 Continued

	Adult 1/Self	Adult 2	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
If "Yes," under what name?					
25 Medi-Cal benefits card number (BIC), if you have it:					
26 Wants medical benefits?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
27 Do you own or are you buying 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
28 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
29 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.

30 NAME OF PERSON RECEIVING INCOME/MONEY	31 SOURCE OF INCOME/ MONEY RECEIVED (Employment, social security)	32 HOW MUCH INCOME/MONEY IS RECEIVED	33 HOW OFTEN INCOME/ MONEY RECEIVED (Monthly, bimonthly, weekly, biweekly, daily)

SECTION 5 Give information about the listed expenses/cost paid by *all* persons listed in Section 2.

TYPE OF PAYMENT YOUR FAMILY MAKES	34 NAME OF PERSON WHO PAYS	35 MONTHLY AMOUNT PAID
Child Support		
Alimony		
Other Health Insurance Premium		
Medicare Premium		

36 CHILD CARE OR DEPENDENT CARE *(List child's or dependent's name)*	37 AGE	38 NAME OF PERSON WHO PAYS	39 MONTHLY AMOUNT PAID
1.			
2.			
3.			
4.			

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SECTION 6

Skip this Section if you are only applying for children under 19 and/or pregnant women (pregnancy related services only).

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

40	Does anyone have cash or uncashed checks? If "Yes," list amount here _____ (See instructions)	☐ Yes ☐ No
41	Does anyone have a checking, savings account, or life insurance? (See instructions)	☐ Yes ☐ No
42	Is there one car or more in the household? (See instructions)	☐ Yes ☐ No
43	Does anyone have a court ordered settlement or judgement? (See instructions)	☐ Yes ☐ No
44	Does anyone have Long-Term Care insurance? (See instructions)	☐ Yes ☐ No
45	Does anyone own any items such as stocks, bonds, retirement funds, trusts, real estate, motor vehicles for a business, business accounts, promissory notes, mortgages, deeds of trust, recreational vehicles, burial trusts or funds, annuities, jewelry (not heirloom or wedding), oil or mineral rights? (See instructions)	☐ Yes ☐ No
46	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
47	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 1/Self	Adult 2	Child 1	Child 2	Child 3
48	Social Security #:					
		You may be able to receive Medi-Cal even if you do not have a Social Security Number.				
49	Place of Birth: *State or Country.*					
50	U.S. Citizen or National? If "No," write in date of entry into U.S.	☐ Yes ☐ No / / MO DAY YR	☐ Yes ☐ No / / MO DAY YR	☐ Yes ☐ No / / MO DAY YR	☐ Yes ☐ No / / MO DAY YR	☐ Yes ☐ No / / MO DAY YR
51	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: Do you intend to return home?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Do you intend to return home within six months?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
52	Has health/dental or vision coverage?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
53	Had medical expenses within the 3 months before the month you applied and want Medi-Cal for those expenses.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
54	Lawsuit pending due to accident or injury?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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SECTION 7 Continued

	Adult 1/Self	Adult 2	Child 1	Child 2	Child 3
55 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
56 Ethnicity (race): (optional)					
57 In school full time?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
58 Living away from home?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

SECTION 8 Information Release (Optional).

59 Check this box if you do not want Medi-Cal to share your child's application with the low-cost Healthy Families if your child does not qualify for no-cost Medi-Cal. ☐

60 I got help from (give name of person) _____ when I filled out this application. I agree that the local social services office may give them information about the status of this application. ***Applicant please initial*** _____

SECTION 9 Signature and Certification.

61 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 and information will be sent to you. Visit our website, www.dhcs.ca.gov

☐ Personal Care Service Program (PCSP). A program for in-home care.

☐ Access for Infants, and Mothers (AIM). A program to help pregnant women with moderate income obtain health care.

☐ Woman, Infants and Children Nutrition Program (WIC). A nutrition program for pregnant and postpartum women and children under 5.

☐ Family Planning

☐ Child Health and Disability Prevention (CHDP) program. Preventive healthcare for children and youth.

Do you want your children or youth referred to the CHDP program for follow-up? ☐ Yes ☐ No