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

HEALTHY FAMILIES
MEDI-CAL FOR FAMILIES

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*					**Pregnant women in Medi-Cal or AIM: do not fill out this part.** ☐ Check here to apply for Healthy Families for your baby before he/she is born. You must: • 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.)*
First					
Middle					
⑨ Name on birth certificate *(If different from name above)* — *Last*					
First					
Middle					
⑩ Does the child live away from home because of school?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ 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	☐ My child ☐ My stepchild ☐ Other: _____	☐ My child ☐ My stepchild ☐ Other: _____	☐ My child ☐ My stepchild ☐ Other: _____	Baby's Due Date: ____/____/____	
⑮ Gender	☐ Boy ☐ Girl	☐ Boy ☐ Girl	☐ Boy ☐ Girl	Number of babies expected: _____	

Tear Here

	Child 1	Child 2	Child 3	Pregnant Woman	Unborn Child
16 Ethnicity – *Optional* *(See page 6.)*					
17 Birthplace *County:*					
State:					
***Or** foreign country:*					
18 Social Security No. *(See pages 6 and 7.)*	*This is optional if you are applying for Healthy Families or for emergency or pregnancy services.*				
19 U.S. Citizen or National? *(See pages 3 and 7.)*	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
If *No*, date arrived in the U.S.	____/____/____ mo day yr	____/____/____ mo day yr	____/____/____ mo day yr	____/____/____ 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?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Even if you have other health insurance, Medi-Cal may cover what your other insurance does not.				
22 Did this child have health insurance through someone's job in the last 3 months? *(See page 6.)*	☐ No ☐ Yes *(If yes, write the date it ended and check reason below.)* ____/____/____ mo day yr	☐ No ☐ Yes *(If yes, write the date it ended and check reason below.)* ____/____/____ mo day yr	☐ No ☐ Yes *(If yes, write the date it ended and check reason below.)* ____/____/____ mo day yr		
	Check the box to tell us why health coverage ended:				
	☐ Lost job ☐ Job status changed ☐ Moved and no insurance available ☐ All employees' benefits ended ☐ Death, divorce or legal separation ☐ COBRA ended ☐ Other_____	☐ Lost job ☐ Job status changed ☐ Moved and no insurance available ☐ All employees' benefits ended ☐ Death, divorce or legal separation ☐ COBRA ended ☐ Other_____	☐ Lost job ☐ Job status changed ☐ Moved and no insurance available ☐ All employees' benefits ended ☐ Death, divorce or legal separation ☐ COBRA ended ☐ Other_____		
23 Does this person want to apply for Medi-Cal for medical expenses in the last 3 months? *(See page 6.)*	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Medi-Cal may cover medical expenses for past 3 months.				
24 Mother's Name: *Last*					
First					
Middle					
Does this child live with the mother?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		
25 Father's Name: *Last*					
First					
Middle					
Does this child live with the father?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No

Tear Here

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		☐ M ☐ F	____/____/____ mo day yr	☐ Child ☐ Boyfriend ☐ Spouse ☐ Stepchild ☐ Girlfriend ☐ Other _____
㉗		☐ M ☐ F	____/____/____ mo day yr	☐ Child ☐ Boyfriend ☐ Spouse ☐ Stepchild ☐ Girlfriend ☐ Other _____
㉘		☐ M ☐ F	____/____/____ mo day yr	☐ Child ☐ Boyfriend ☐ Spouse ☐ Stepchild ☐ Girlfriend ☐ 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				$	

Tear Here

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 child or other 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

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.

Tear Here