

APPLICANT'S SUPPLEMENTAL STATEMENT OF FACTS FOR MEDI-CAL

<i>COUNTY USE ONLY</i>	
County Number/Aid Code/Case Number	
—	—

PART I—PERSONAL INFORMATION

1a. Applicant name (Last, First, MI)		1b. Social Security number		1c. Date of birth	
		— —		/ /	
1d. Other name(s) used (Last, First, MI)		1e. Sex	1f. Height	1g. Weight	
		<input type="checkbox"/> Male	Feet _____	Pounds _____	
		<input type="checkbox"/> Female	Inches _____		
2a. Home address		City		State	
2b. Mailing address (if different)		City		State	
3. Daytime telephone number		Check if:		Best time to call	
(____) _____		<input type="checkbox"/> No Phone			
		<input type="checkbox"/> Message Phone (____) _____			
4a. Do you speak English?		4b. Do you have an interpreter?	If YES, interpreter's name:		Best time to call
<input type="checkbox"/> Yes If YES, go to Part II		<input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/> No If NO, what language(s) do you speak:		Interpreter's phone number:			
_____		(____) _____			

PART II—MEDICAL INFORMATION

COUNTY USE ONLY

5. Have you applied for Social Security **Disability** or Supplemental Security Income (SSI) **Disability** benefits in the past two (2) years? Yes No

If YES, please answer the following:

a. Was/Is your Social Security or SSI Disability application:

Approved? Denied? Pending? On Appeal? Unknown?

b. If approved or denied, give the date of the most recent decision on your Social Security or SSI disability application: _____

c. Has your medical problem(s) **worsened** since the date in 5b above? Yes No

If YES, please explain: _____

d. Do you have any **NEW** medical problem(s) since the date in 5b, above, which you did **NOT** have when your Social Security or SSI disability decision was made?

Yes No If YES, what medical problem(s)? _____

6. List all medical problems (physical, mental or emotional) that keep you from working or taking care of your personal needs. (Please attach additional sheet, if necessary.)

MEDICAL PROBLEM(S)	WHEN DID IT START (Month/Year)

7. Have you received care in a **clinic** or **hospital** for your illness(es) or injury(ies) in the last 12 months? Yes No

If YES, please fully answer the following:

Name of clinic/hospital			
Patient/clinic or member number		Clinic/hospital telephone number ()	
Name of doctor(s) seen			
ADDRESS of clinic/hospital (number, street, suite)		City	State ZIP code
Date first seen	Date last seen	Date of next appointment	
Reason for the visit(s)			

MC 220 Signed

Did you stay in the **hospital** overnight? Yes No

If YES, date(s) entered: _____ date(s) left: _____

Were you seen in the **emergency** room? Yes No

If YES, date(s) seen: _____

List **ALL** medicines received: _____

List **ALL** treatments received and the dates the treatments were received: _____

8. List any additional **clinic** or **hospital** where you have been seen in the last 12 months.

Name of clinic/hospital			
Patient/clinic or member number		Clinic/hospital telephone number ()	
Name of doctor(s) seen			
ADDRESS of clinic/hospital (number, street, suite)		City	State ZIP code
Date first seen	Date last seen	Date of next appointment	
Reason for the visit(s)			

MC 220 Signed

Did you stay in the **hospital** overnight? Yes No

If YES, date(s) entered: _____ date(s) left: _____

Were you seen in the **emergency** room? Yes No

If YES, date(s) seen: _____

List **ALL** medicines received: _____

List **ALL** treatments received and the dates the treatments were received: _____

*If you have been seen at additional clinics or hospitals
in the last 12 months, complete page 8.*

9. Have you been seen by any doctor **outside of the clinic(s) or hospital(s) you have already listed** in the last 12 months? Yes No

COUNTY USE ONLY

If NO, go to number 10. If YES, please fully answer the following, if more than one doctor was seen please complete page 8 for all additional information:

Name of doctor(s)			
Patient/clinic or member number		Doctor's telephone number ()	
Address of doctor (number, street, suite)		City	State ZIP code
Date first seen	Date last seen	Date of next appointment	
Reason for the visit(s)			

MC 220 Signed

List **ALL** medicines received: _____

List **ALL** treatments received and the dates the treatments were received: _____

10. Please list below if you have had any of the following tests in the last 12 months. Be sure to check yes or no next to each test. (IF ADDRESS OF DOCTOR, CLINIC, OR HOSPITAL WAS GIVEN ALREADY, LIST ONLY THE NAME AND DATE.)

TEST PERFORMED			NAME AND ADDRESS OF OFFICE, CLINIC, OR HOSPITAL WHERE TEST WAS COMPLETED	DATE (MO/YR)
	YES	NO		
Electrocardiogram (EKG)	<input type="checkbox"/>	<input type="checkbox"/>	Name	
			Address (number, street, suite)	
			City State ZIP Code	
Treadmill (exercise heart test)	<input type="checkbox"/>	<input type="checkbox"/>	Name	
			Address (number, street, suite)	
			City State ZIP Code	
Chest X-ray	<input type="checkbox"/>	<input type="checkbox"/>	Name	
			Address (number, street, suite)	
			City State ZIP Code	
Breathing Test (PFT)	<input type="checkbox"/>	<input type="checkbox"/>	Name	
			Address (number, street, suite)	
			City State ZIP Code	
Blood Tests	<input type="checkbox"/>	<input type="checkbox"/>	Name	
			Address (number, street, suite)	
			City State ZIP Code	
Other (Specify)	<input type="checkbox"/>	<input type="checkbox"/>	Name	
			Address (number, street, suite)	
			City State ZIP Code	

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11. Have you had any other medical treatment or testing in the past 12 months? Yes No

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If NO, go to number 12.

If YES, complete page 8.

12. Is there anyone else (a friend, relative, social worker, rehab counselor, attorney, physical therapist, etc.) we may contact for information regarding your illness or injury and how it limits your daily activities or keeps you from working? Yes No

If YES, please list below:

Name

Address (number, street, suite)

Telephone number
()

Relationship to you

Name

Address (number, street, suite)

Telephone number
()

Relationship to you

Name

Address (number, street, suite)

Telephone number
()

Relationship to you

13. You may be asked to go to additional medical examinations to help evaluate your medical problem(s). (These examinations are free to you.)

Are you willing to go to additional medical examinations if needed? Yes No

PART III—SOCIAL AND EDUCATIONAL INFORMATION

14. Describe your daily activities and tell us how much your condition limits your activities.

15. Describe your educational background.

a. Check the highest grade you finished in school:

1 2 3 4 5 6 7 8 9 10 11

12 or GED (same as finishing 12th grade) 12+

b. When finished? Month/year: _____

c. Did you take special education classes? Yes No

16. Have you done any type of work for more than 30 days during the last 15 years? (This includes work done in another country.)

Yes No

If NO, skip Part IV, go to Part V, page 7, for your signature.

If YES, answer Part IV, page 5, beginning with number 17.

PART IV—WORK HISTORY

COUNTY USE ONLY

17. Describe all of the jobs you have done for at least 30 days during the **last 15 years**. Start with your most recent job. (If you had more than two jobs, ask your county worker for additional pages.)

a. Job title	Type of business		
Dates worked (month/year) From: _____ To: _____	Hours per week	Rate of pay	Per hour/wk/mo

DESCRIPTION OF THE JOB (This is what I did and how I did it.)

These are the tools, machines, and equipment I used:

I took this long to learn the job: _____ day(s) or _____ month(s).

I wrote, completed reports, or performed similar duties: Yes No

I had supervisory responsibilities: Yes No

PHYSICAL ACTIVITY

Circle One

I walked this many hours in an average workday: 0 1 2 3 4 5 6 7 8

I stood this many hours in an average workday: 0 1 2 3 4 5 6 7 8

I sat this many hours in an average workday: 0 1 2 3 4 5 6 7 8

I climbed this much in an average workday:

Never Occasionally Frequently Constantly

I bent over this much in an average workday:

Never Occasionally Frequently Constantly

Heaviest weight I lifted:

10 lbs 20 lbs 50 lbs Over 100 lbs

I often lifted/carried up to:

10 lbs 20 lbs 50 lbs Over 100 lbs

Did you have any of your current medical problem(s) when you performed this job? Yes No

If NO, and you have had NO other jobs go to Part V, page 7, for your signature. If NO, but you have had other jobs, go to 17b, next page. If YES, please complete the following information.

Name of medical problem(s): _____

Did your employer make special arrangements (such as extra breaks, special equipment, change in job duties, etc.) so you could continue to work? Yes No

If YES, describe the special arrangements made: _____

Did you have to stop working because of your medical problem(s)? Yes No

If YES, when? Month _____ Day _____ Year _____

Have you done **any** other work for more than 30 days during the **last 15 years**? Yes No

If NO, go to Part V, page 7 for your signature. If YES, continue on 17b, next page.

17. b. Job title	Type of business		
Dates worked (month/year) From: _____ To: _____	Hours per week	Rate of pay	Per hour/wk/mo

COUNTY USE ONLY

DESCRIPTION OF THE JOB (This is what I did and how I did it.)

These are the tools, machines, and equipment I used:

I took this long to learn the job: _____ day(s) or _____ month(s).
 I wrote, completed reports, or performed similar duties: Yes No
 I had supervisory responsibilities: Yes No

PHYSICAL ACTIVITY

Circle One

I walked this many hours in an average workday: (0) (1) (2) (3) (4) (5) (6) (7) (8)
 I stood this many hours in an average workday: (0) (1) (2) (3) (4) (5) (6) (7) (8)
 I sat this many hours in an average workday: (0) (1) (2) (3) (4) (5) (6) (7) (8)

I climbed this much in an average workday:
 Never Occasionally Frequently Constantly

I bent over this much in an average workday:
 Never Occasionally Frequently Constantly

Heaviest weight I lifted: 10 lbs 20 lbs 50 lbs Over 100 lbs
 I often lifted/carried up to: 10 lbs 20 lbs 50 lbs Over 100 lbs

Did you have any of your current medical problem(s) when you performed this job? Yes No

If NO, and you have had NO other jobs go to Part V, page 7, for your signature. If NO, but you have had other jobs, ask your county worker for additional pages. If YES, please complete the following information.

Name of medical problem(s): _____

Did your employer make special arrangements (such as extra breaks, special equipment, change in job duties, etc.) so you could continue to work? Yes No

If YES, describe the special arrangements made: _____

Did you have to stop working because of your medical problem(s)? Yes No

If YES, when? Month _____ Day _____ Year _____

Have you done **any** other work for more than 30 days during the **last 15 years**? Yes No

If NO, go to Part V, page 7 for your signature. If YES, ask your county worker for additional pages to complete.

PART V—SIGNATURE AND CERTIFICATION

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information contained in this Supplemental Statement of Facts is true and correct.

Signature of Applicant ▶	Date
Signature of Witness (If applicant signed with a mark) ▶	Date
Signature of person helping applicant fill out the form ▶	Date

You will need to sign an authorization for release of information for each clinic, hospital, and testing facility that you list and for each doctor you saw outside of a clinic or hospital. Your county worker will provide you with additional forms which you will need to sign.

