Additional Family Members Requesting Medi-Cal

County Use Only
Case name:
Case #
Worker #
Date:

❶ Applicant/Caretaker's Name (First, Middle, Last)		Applicant/Caretaker's Relationship to Child(ren)	Linkage
Name on Birth Certificate	Gender ❑ Male ❑ Female	Pregnant? ❑ Yes ❑ No Due date:_____ # of babies_____	SSN
Social Security No.	Date of Birth _____ Month Day Year	Medi-Cal Requested? ❑ Yes ❑ No If Yes, provide Benefits Identification Card # if you have it:	PREG
Place of Birth (City/State/Country)		U.S. Citizen or National? ❑ Yes ❑ No If No, date arrived in the U.S. _____ Month Day Year	ID
Does this person have a physical, mental, emotional or developmental disability? ❑ Yes. Date disability began: _____ ❑ No		Marital Status (check one): ❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Separated	Other

❷ Spouse/Other Parent's Name (First, Middle, Last)		Relationship to Applicant/Caretaker	Linkage
Name on Birth Certificate	Gender ❑ Male ❑ Female	Pregnant? ❑ Yes ❑ No Due date: _____ # of babies _____	SSN
Social Security No.	Date of Birth _____ Month Day Year	Medi-Cal Requested? ❑ Yes ❑ No If Yes, provide Benefits Identification Card # if you have it:	PREG
Place of Birth (City/State/Country)		U.S. Citizen or National? ❑ Yes ❑ No If No, date arrived in the U.S. _____ Month Day Year	ID
Does this person have a physical, mental, emotional or developmental disability? ❑ Yes. Date disability began:_____ ❑ No		Marital Status (check one): ❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Separated	Other

❸ Child's Name: (First, Middle, Last) or "Unborn"		Relationship to Applicant/Caretaker	Linkage
Name on Birth Certificate	Gender ❑ Male ❑ Female	Pregnant? ❑ Yes ❑ No Due date: _____ # of babies _____	SSN
Social Security No.	Date of Birth _____ Month Day Year	Medi-Cal Requested? ❑ Yes ❑ No If Yes, provide Benefits Identification Card # if you have it:	PREG
Place of Birth (City/State/Country)		U.S. Citizen or National? ❑ Yes ❑ No If No, date arrived in the U.S. _____ Month Day Year	ID
Child living in home? ❑ Yes ❑ No		Child in school? ❑ Yes ❑ No	Medical Support? ❑ Yes ❑ No ❑ CW 2.1 Q ❑ CW 2.1 ❑ Not in home, 18-21 tax dependent
Mother's Name:		Father's Name:	
Does this child have a physical, mental, emotional or developmental disability? ❑ Yes. Date disability began: _____ ❑ No		Is either parent: ❑ Deceased ❑ Absent ❑ Incapacitated ❑ Unemployed	

❹ Is anyone currently covered by health/dental insurance or Medicare? ❑ Yes ❑ No If so, who?	❑ DHCS 6155 OHC Code: _____
❺ Has anyone filed a lawsuit because of an accident or injury? ❑ Yes ❑ No	❑ DHCS 6268
❻ Do you or any family member want Medi-Cal to cover medical expenses in the last three months and wish to apply for Medi-Cal? ❑ Yes ❑ No List name(s): _____ Month(s) of coverage: _____	❑ MC 210 A Retroactive Coverage _____ _____ _____ Month 1 Month 2 Month 3
❼ Have you or any family member ever been in U.S. military service? ❑ Yes ❑ No If Yes, who? Name(s):_____ Relationship: _____	❑ CW 5

❽ The Medi-Cal program may share your information unless you check the box below:

- We 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 share it, check here ❑
- We will share your child's application with Healthy Kids or similar county program if your child does not qualify for full-scope Medi-Cal. If you **do not** want us to share it, check here ❑

❾ ***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 No.** (Optional)
			$	
			$	
			$	
			$	
			$	

❿ ***Expenses:*** List the monthly expenses for all persons listed above.

Child Day Care or Disabled Dependent Care

For (child or dependent's name):_____ Age: _____ Amount Paid: _____

How Often?_____

For (child or dependent's name):_____ Age: _____ Amount Paid: _____

How Often? _____

Court-ordered child support

Paid to: _____ Paid by: _____ Amount paid:_____

Court-ordered spousal support

Paid to: _____ Paid by: _____ Amount paid:_____

Please note that additional information about your property, income and/or resources may be required if applicable.

I certify that I have read and understand the information above. I also certify that the information I have given on this form is true and correct.

Signature_____ Date: _____