STATEMENT OF CITIZENSHIP, ALIENAGE, AND IMMIGRATION STATUS

Print Name of Applicant (The applicant is the person who wants Medi-Cal):	Date:
Print Name of Person Acting for Applicant:	Relationship to Applicant:

SECTION A: MEDI-CAL BENEFITS TO CITIZENS AND ALIENS

Citizens and nationals of the United States who meet all eligibility requirements may receive full Medi-Cal benefits.

Aliens who meet all eligibility requirements may receive either full Medi-Cal benefits (if they are in a satisfactory immigration status) o restricted benefits limited to emergency and pregnancy-related services (if they are not in a satisfactory immigration status).

Satisfactory immigration status and full Medi-Cal benefits for aliens: Federal and state law provide that *full* Medi-Cal benefits may be received only by aliens who are in a satisfactory immigration status and who meet all eligibility requirements **including California residency**. Aliens are in a satisfactory immigration status if they are amnesty aliens with valid and current lawful temporary resident cards (I-688) o lawful permanent residents or permanently residing in the U.S. under color of law (PRUCOL). **The 16 PRUCOL categories are listed ir SECTION B, question 6 below.**

Documented aliens not in a satisfactory immigration status who meet all eligibility requirements, **including California residency**, may receive restricted benefits (limited to emergency and pregnancy-related services).

Undocumented aliens who meet all eligibility requirements, **including California residency**, may receive restricted benefits (limited to emergency and pregnancy-related services).

Citizenship/immigration status information: Every person requesting Medi-Cal is required to provide information about his/her citizenship or immigration status. Immigration status information provided as part of the Medi-Cal application is confidential and cannot be used by the INS for immigration enforcement unless you are committing fraud.

Alien status documents and verification requirements: Aliens who claim to be in a satisfactory immigration status (SIS) for Medi-Cal purposes must present INS documents that show their immigration status if they have an INS document or are eligible to obtain one. Aliens who claim to be in an SIS, but who cannot obtain an INS document or replacement receipt (for example, aliens in the last PRUCOL category indicated in SECTION B below) should submit other evidence establishing their immigration status. INS documents will be verified by the INS. Aliens who do not have these documents with them, or who have unreadable documents, may bring us receipts which show that they ve applied for replacements. Aliens will have 30 days to do this, or until their Medi-Cal application is ruled on, whichever is longer. If the ..ien is otherwise eligible, Medi-Cal will be issued during this period and while the submitted documentation is being verified by the INS. If none of the documents contains the applicant's photograph, they must show us an identity document which establishes that the applicant is the person named in the documents.

Social Security number requirement: Every person requesting Medi-Cal who has a Social Security number is asked to provide it to the county welfare department. U.S. citizens, U.S. nationals, and aliens claiming to be in a satisfactory immigration status who do not have a Social Security number must apply for one and provide it to the county welfare department. Aliens in satisfactory immigration status for Medi-Cal purposes who need help applying for a Social Security number should ask their eligibility worker for assistance. Aliens who are not in a satisfactory immigration status and who do not have a Social Security number can still get restricted Medi-Cal if they meet all eligibility requirements.

SECTION B: CITIZENSHIP/IMMIGRATION STATUS DECLARATION

1. Is the applicant a citizen or national of the United States? ☐ Yes ☐ No

   If the applicant is a citizen or a national of the United States, where was he/she born? _____ (city, state)

   IF YOU ARE A CITIZEN OR NATIONAL OF THE UNITED STATES, GO DIRECTLY TO SECTION D. IF YOU ARE AN ALIEN, PLEASE ANSWER QUESTIONS 2, 3, AND 4 BELOW (AND QUESTION 5 IF YOU CLAIM TO BE PRUCOL) THEN COMPLETE SECTIONS C AND D. **IF YOU ANSWER "NO" TO QUESTIONS 2, 3, OR 4 BECAUSE THOSE CATEGORIES DO NOT APPLY TO YOU, YOUR ANSWER IS CONFIDENTIAL. THIS INFORMATION CAN ONLY BE USED FOR MEDI-CAL PURPOSES AND CANNOT BE USED BY THE INS FOR IMMIGRATION ENFORCEMENT UNLESS YOU ARE COMMITTING FRAUD.**

2. Is the applicant an amnesty alien with a valid and current I-688? ☐ Yes ☐ No
3. Is the applicant a lawful permanent resident? ☐ Yes ☐ No
4. Is the applicant a PRUCOL alien? ☐ Yes ☐ No

IMPORTANT: All PRUCOL aliens must indicate their specific PRUCOL status in question 5.

If the applicant would qualify for Medi-Cal benefits as a PRUCOL alien, indicate the status category which entitles him/her to that classification:

☐ A conditional entrant admitted to the United States before April 1, 1980
☐ An alien paroled into the United States, including Cuban/Haitian entrants

- ☐ An alien subject to an Order of Supervision
- ☐ An alien granted an indefinite stay of deportation
- ☐ An alien granted an indefinite voluntary departure
- ☐ An alien on whose behalf an immediate relative petition (INS Form I-130) has been approved and who is entitled to voluntary departure
- ☐ An alien who has properly filed an application for lawful permanent resident status
- ☐ An alien granted a stay of deportation for a specified period
- ☐ An alien granted asylum
- ☐ A refugee admitted to the U.S. since April 1, 1980
- ☐ An alien granted voluntary departure who is awaiting issuance of a visa
- ☐ An alien in deferred action status
- ☐ An alien who entered and has continuously resided in the U.S. since before January 1, 1972 who would be eligible for an adjustment of status to lawful permanent resident pursuant to INA Section 249 (eligible as a Registry alien)
- ☐ An alien granted a suspension of deportation whose departure INS does not contemplate enforcing
- ☐ An alien granted withholding of deportation pursuant to INA Section 243(h)
- ☐ An alien, not in one of the above categories, who can show that: (1) INS knows he/she is in the United States; and (2) INS does not intend to deport him /her, either because of the person's status category or individual circumstances.

SECTION C: VERIFICATION OF IMMIGRATION STATUS (FOR ALIENS WHO CLAIM SATISFACTORY IMMIGRATION STATUS)

IMPORTANT: Complete this section only if you answered "YES" to question 2, question 3, or question 4 in SECTION B on the front of this form.

1. Alien Registration number and/or Alien Admission (INS Form I-94) number: _____
2. Date the applicant first entered the U.S.: _____
3. Applicant's name when he/she first entered the U.S.: _____
4. Of what country is the applicant a citizen: _____
5. Where was the applicant born: _____

SECTION D: SOCIAL SECURITY NUMBER

Does the applicant have a Social Security number (SSN)? (Aliens who are not in a satisfactory immigration status, and who do not ha SSN, can still get restricted Medi-Cal if they meet all eligibility requirements.)

- ☐ Yes, the applicant's Social Security number is: _____
- ☐ No

SECTION E:

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE ANSWERS I HAVE GIVEN ARE CORRECT AND TRUE TO THE BEST OF MY KNOWLEDGE.

Applicant Signature:	Date:
Signature of Person Acting for Applicant	Date:

FOR COUNTY USE ONLY

EW Number: _____ County: _____ Date: _____

Action taken:

- ☐ None necessary.
- ☐ SAVE primary verification performed._____Date:_____
- ☐ Document Verification Request (INS Form G-845) and copies of documentation of satisfactory immigration status sent to INS. _____Date: _____
- ☐ Full Medi-Cal benefits were granted pending verification of immigration status.
- ☐ Copies of alien status documents are in the case file.
- ☐ Person referred to INS to obtain replacement documents. _____Date: _____

COUNTY DETERMINATION OF THE APPROPRIATE LEVEL OF MEDI-CAL BENEFITS.

BASED ON THE INFORMATION PROVIDED ON THIS FORM:

- ☐ The above named applicant is a U.S. citizen or national, or an alien, who, if otherwise eligible, would receive **FULL** Medi-Cal benefits.
- ☐ The above named applicant is an alien, who, if otherwise eligible, would receive **RESTRICTED** Medi-Cal benefits.

READ THIS FIRST

USE THESE INSTRUCTIONS TO HELP YOU FILL OUT THE ATTACHED MEDI-CAL STATEMENT OF FACTS

(Please return the completed form to your county welfare department)

1. ***PRINT*** all answers in ink (black ink is best).
2. Please note the following:

   "Applicant" means: (a) you, if you are an adult applying for yourself and/or your family; (b) you, if you are a child applying for minor consent services; or (c) the person you are filling in this form for (including the person in long-term care).

   "Caretaker" means a relative other than a parent who is applying on behalf of children under 21 years. A caretaker may ask to be included in the children's Medi-Cal case.

   "Family Member" means: (a) you, even if you are a single person; (b) your spouse or other parent of the children, living with you; (c) your children under 21 years, who are living with you or are away at school; (d) your spouse's or other parent's children under 21 years, who are living with you or are away at school; (e) your unborn child.
3. If you answer ***"Yes"*** to any question from 23 through 39, you must give proof. *However, if you are interested in pregnancy related benefits only, or coverage for an infant (up to age one year), you may not need to bring in proof of property. Ask your eligibility worker about the Property Waiver program.*
4. If you have a problem with any question, ***ask your worker for help.***
5. If you need more space to answer any question, ***use Item 40.***

MC 210 (7/96) INSTRUCTION SHEET

READ THIS FIRST

USE THESE INSTRUCTIONS TO HELP YOU FILL OUT THE ATTACHED MEDI-CAL STATEMENT OF FACTS

(Please return the completed form to your county welfare department)

1. ***PRINT*** all answers in ink (black ink is best).
2. Please note the following:

   "Applicant" means: (a) you, if you are an adult applying for yourself and/or your family; (b) you, if you are a child applying for minor consent services; or (c) the person you are filling in this form for (including the person in long-term care).

   "Caretaker" means a relative other than a parent who is applying on behalf of children under 21 years. A caretaker may ask to be included in the children's Medi-Cal case.

   "Family Member" means: (a) you, even if you are a single person; (b) your spouse or other parent of the children, living with you; (c) your children under 21 years, who are living with you or are away at school; (d) your spouse's or other parent's children under 21 years, who are living with you or are away at school; (e) your unborn child.
3. If you answer ***"Yes"*** to any question from 23 through 39, you must give proof. *However, if you are interested in pregnancy related benefits only, or coverage for an infant (up to age one year), you may not need to bring in proof of property. Ask your eligibility worker about the Property Waiver program.*
4. If you have a problem with any question, ***ask your worker for help.***
5. If you need more space to answer any question, ***use Item 40.***

MC 210 (7/96) INSTRUCTION SHEET

STATEMENT OF FACTS (MEDI-CAL)

ADULT FAMILY MEMBERS

1 Applicant or Caretaker's Name (First, Middle, Last) | Applicant/Caretaker Relationship to Children

Social Security Number | Marital Status (check one) ☐ Married ☐ Never Married ☐ Common Law ☐ Widowed ☐ Divorced ☐ Separated (Date)_____ | Sex ☐ Male ☐ Female

Birth Date | Is the Person Blind or Disabled ☐ Yes, Date of Disability: _____ ☐ No | Pregnant ☐ Yes ☐ No | Medi-Cal Requested ☐ Yes ☐ No

2 Home Address (Number and Street) | City | ZIP Code

Mailing Address (If different from above) | City | ZIP Code

(Area Code) Home Phone ( ) | (Area Code) Work Phone ( ) | (Area Code) Message Phone ( ) | Person with whom to leave Message:

3 Spouse/Other Parent (First, Middle, Last) | Relationship to Applicant

Social Security Number | Marital Status (check one) ☐ Married ☐ Never Married ☐ Common Law ☐ Widowed ☐ Divorced ☐ Separated (Date)_____ | Sex ☐ Male ☐ Female

Birth Date | Is the Person Blind or Disabled ☐ Yes, Date of Disability: _____ ☐ No | Pregnant ☐ Yes ☐ No | Medi-Cal Requested ☐ Yes ☐ No

CHILDREN

LIST CHILDREN AND UNBORN HERE ⬇ (Family members only. List Other People on Question 7)

4 Child's Name (First, Middle, Last) or "Unborn" | Relationship to Applicant

Social Security Number | In School ☐ Yes ☐ No | Sex ☐ Male ☐ Female

Birth Date or Date Unborn is Due | Is the Person Blind or Disabled ☐ Yes ☐ No | Pregnant ☐ Yes ☐ No

Father's Name | Is Either Parent (✓) ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed

Mother's Name | Child Living in Home ☐ Yes ☐ No | Medi-Cal Requested ☐ Yes ☐ No

5 Child's Name (First, Middle, Last) or "Unborn" | Relationship to Applicant

Social Security Number | In School ☐ Yes ☐ No | Sex ☐ Male ☐ Female

Birth Date or Date Unborn is Due | Is the Person Blind or Disabled ☐ Yes ☐ No | Pregnant ☐ Yes ☐ No

Father's Name | Is Either Parent (✓) ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed

Mother's Name | Child Living in Home ☐ Yes ☐ No | Medi-Cal Requested ☐ Male ☐ Female

6 Child's Name (First, Middle, Last) or "Unborn" | Relationship to Applicant

Social Security Number | In School ☐ Yes ☐ No | Sex ☐ Male ☐ Female

Birth Date or Date Unborn is Due | Is the Person Blind or Disabled ☐ Yes ☐ No | Pregnant ☐ Yes ☐ No

Father's Name | Is Either Parent (✓) ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed

Mother's Name | Child Living in Home ☐ Yes ☐ No | Medi-Cal Requested ☐ Yes ☐ No

DO YOU HAVE MORE THAN THREE CHILDREN? ☐ Yes ☐ No

IF YES, LIST NAME ONLY AND ASK YOUR WORKER FOR ADDITIONAL FORM(S): _____

COUNTY USE

Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID

Case Name: _____

Case No.: _____

Worker No.: _____

Date: _____

Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID

Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID

Medical Support ☐ YES ☐ NO

☐ CA 2.1

☐ Not in home, 18–21 & tax dep.?

Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID

Medical Support ☐ YES ☐ NO

☐ CA 2.1

☐ Not in home, 18–21 & tax dep.?

Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID

Medical Support ☐ YES ☐ NO

☐ CA 2.1

☐ Not in home, 18–21 & tax dep.?

☐ MC 210 S-C

☐ Potential Sneede

You may be asked to give proof and/or more detailed information on your residency, property/resources, income, work history before your application is approved.

	CHECK EACH ITEM "YES" OR "NO"	YES	NO	COUNTY USE
LIVING ARRANGEMENT	7 a. Is there anyone living in your home that you did not list? If Yes, list name and relationship..... Name _____ Relationship _____ Name _____ Relationship _____ b. Do you pay rent for a room, apartment, house, or trailer?..... If Yes, how much rent do your pay? _____			☐ MC 210S-I
	8 a. Is any family member living in a nursing home, hospital, or board and care home?..... Name of person _____ Name of Home/Facility _____ Date Entered _____ b. Intend to return home?.....			☐ LTC return home in six months? ☐ Excess B & C Amount: $ _____
TAX DEPENDENT	9 Are you or any family member claimed as a tax dependent by a person not living with you? ..... Name and address of person claiming the tax deduction: _____ _____			☐ Tax dependent letter sent Date: _____ ☐ CA 2.1
RESIDENCE	10 a. Do you or any family member own, lease, or maintain a home outside California? ..... b. Are you or any family member currently receiving public assistance from outside California?..... 11 a. Are you or any family member living outside California?..... b. Are you or any family member in the United States on a Visa or a Border Crossing Card?..... 12 a. Are you or any family member planning to leave California for more than 60 days?..... b. Do you and your family plan to stay permanently in California?.....			☐ Property ☐ PA ☐ Visa ☐ Border Crossing Card California Resident? ☐ Yes ☐ No
EMPLOYMENT QUESTIONS	13 Are you, your spouse, the other parent, or children in the home working? ..... List Name _____ Hours Per Week: _____ List Name _____ Hours Per Week: _____ List Name _____ Hours Per Week: _____ 14 Are the person(s) in 13 looking for work or more hours of work?..... 15 Have you, your spouse, or other parent or any children worked in the last two years?..... List Name _____ Hours Per Week: _____ List Name _____ Hours Per Week: _____ 16 Are you or any family member on strike?..... List Name(s) _____			☐ Under 100 hours ☐ Student Exemption ☐ If U-Parent MC 210 S-W ☐ UIB Referral Redetermination: Fed Eligibility determined per MC 210 dated: _____ Principal wage earner _____
RETRO	17 a. Did you or any family member have medical expenses in the last three months?..... b. Does this person wish to apply for Medi-Cal coverage for those three months?..... List Name(s): _____ Month(s) of Coverage: _____			☐ MC 210A Retroactive Coverage Mo. _____ Mo. _____ Mo. _____
DED/TPL	18 Do you or any family member have a physical or emotional problem which makes it difficult to work or take care of personal needs? ..... If yes, list name(s). _____ 19 a. Is disability or emotional problem expected to last at least a year?..... b. Is the physical or emotional problem a result of an injury or accident?.....			☐ DED Packet ☐ CA 61 ☐ SGA ☐ DED Reexamination due Date _____ ☐ Lawsuit/Hearing pending ☐ Third Party Liability
PA OR OTHER PA	20 Have you or any family member ever applied for or received assistance such as AFDC, Food Stamps, Medi-Cal, SSI/SSP, IHSS, transitional child care, or other benefits?..... List name and what kind: _____ List where last received: _____ List when last received: _____			☐ Post MC ☐ TCC
MILITARY SERVICE	21 a. Have you or any family member ever been in U.S. military service? ..... Name _____ Relationship _____ Name _____ Relationship _____ b. Receiving Service connected benefits?..... 22 a. Are you or any family member the spouse, parent, or child of a person who is/has been in U.S. military service?..... Name _____ Relationship _____ Name _____ Relationship _____ b. Receiving service connected benefits?			☐ CA 5

The county will determine whether or not the property/resources you or any family member have will count. Pleas include all property/resources (even for convenience only) owned, named, used, controlled, shared, held jointly wit or for other person(s).

	CHECK EACH ITEM "YES" OR "NO" →	YES	NO	NAME ON ACCOUNT/ PROPERTY/RESOURCES	VALUE/ BALANCE	COUNTY USE
LIQUID RESOURCES	23 a. Savings or checking account(s)? (Banks, savings and loans, credit unions, etc.) Enter how many accounts: _____ Where: _____ Account number: _____ Where: _____ Account number: _____					☐ Current Month Income Included $ _____ $ _____
	b. IRA, KEOGH, deferred compensation, retirement account, or annuity? Enter how many accounts: _____					$ _____
	c. Cash or uncashed checks?					$ _____
	d. Stocks, bonds, certificates of deposit, money market, or mutual fund accounts?					$ _____
REAL ESTATE	24 a. A home (whether you live in it or not), other houses, ranch, land, buildings, mobile homes or life estates in or outside the U.S. or the State of California?					PR ☐ YES ☐ NO $ _____
	b. Mortgages, promissory notes, deeds of trust, or sales contracts?					$ _____
VEHICLES	25 Cars, trucks, motorcycles, trailers (any kind), off-road vehicles, recreational vehicles (RV), airplanes, boats, campers (running or not)? Enter type and number owned: _____					Pickle/MC Program: Is RV used as a home? ☐ YES ☐ NO EXEMPT ☐ YES ☐ NO $ _____
OTHER	26 a. Jewelry (not wedding/engagement or heirloom) worth more than $100?					☐ Pickle ($500) $ _____
	b. Household goods or personal items valued at more than $500 per item (i.e. musical instrument, personal computer)?					$ _____ but, jointly owned ☐ separately owned ☐
	c. Mineral rights or mining claims (oil, gas, coal, etc.)?					$ _____
	d. Burial Trusts or contracts, insurance, designated burial funds/money for cemetery plots, caskets, or other burial items?					$ _____
	e. Trust(s) or Trust Account(s)?					$ _____
	f. Life insurance? Enter how many policies owned: _____					$ _____
	g. Long Term Care insurance?					State certified LTC policy? ☐ Yes ☐ No
	h. Other assets or resources?					$ _____
BUSINESS	27 a. Business/self-employment checking/savings account or cash?					
	b. Business equipment, vehicles, tools, inventory or materials (including livestock or poultry not for personal use)?					$ _____
	c. Type of Equipment: _____					$ _____
TRANSFER	28 Has anyone closed, given away, transferred, sold or traded any money, vehicles, property or other resources like those listed above in the last 30 months? If yes, complete the following:					LTC only
	☐ Transferred ☐ Sold ☐ Traded ☐ Closed ☐ Given Away					☐ Verification ☐ List Other Trans. in # 40
LIENS	29 a. Have you borrowed money against your property to pay medical bills?					Brings property within limits? ☐ Yes ☐ No
	b. Has a lien been put on any of your property as security for medical care?					
	c. Have you used any of the items in question 23 through 26 to pay for medical expenses?					☐ MC 1054 Notice to Provider

Make and Model	Year	Class Code (Registration)	Used for Transportation Yes	Used for Transportation No	Used for Self Support Yes	Used for Self Support No

Insurance Company	Policy Number	Date Policy Issued	Benefits Paid Out

Item	Date

Review your answers on questions 23–28. If you need more space to complete your answers, check here. ☐

Obtain Verif. and enter nonexempt value _____
☐ MC 210 S-P

You must complete all items in questions 30 through 33 for all members in your family including yourself.

	CHECK EACH ITEM "YES" OR "NO" → Do you or any family member get, expect to get, or has anyone applied for:	YES	NO	WHOSE INCOME	AMOUNT BEFORE TAXES	WHEN PAID/HOW OFTEN	COUNTY USE
EARNED INCOME	**30** a. Money from a job (including occasional work)?..						☐ MC 210 S-W
	If yes, how many people in your home work?____						☐ Daily
	List Name _____						☐ Weekly (4.33)
	List Name _____						☐ Bi-Weekly (2.167)
	b. Expect a change in your job?.....						☐ Monthly
	(Hours or money) If yes, explain:						☐ Twice Monthly
	_____						☐ Actual
	_____						☐ Other:
							☐ Student Exemption
SELF EMPLOYED	**31** Self-employed income (includes businesses, baby sitting, out-of-home sales, swap meets, arts, crafts and income from crops or other farm income)?.....						☐ Tax Statement ☐ Profit/Loss
	If yes, how many people are self-employed? _____						
UNEARNED INCOME	**32** Social Security Benefits (Self).....						Use copy of award letter or check or other verification.
	Social Security Benefits (Others).....						
	Social Security Benefits (Others).....						$ _____
	Cash aid such as: SSI, AFDC, GR/GA or any other...						$ _____
	Child/Spousal Support or Alimony.....						$ _____
	Money From Friends or Relatives (include loans gifts, and contributions).....						☐ Occasional $ _____
	Railroad Retirement.....						$ _____
	Veteran's Benefits/Military Allotments.....						$ _____
	Worker's Compensation.....						$ _____
	Unemployment Benefits (Self).....						$ _____
	Unemployment Benefits (Others).....						$ _____
	Disability or Sick Benefits.....						$ _____
	Pensions, Retirement, IRA, Keogh, Annuity, or Trust...						$ _____
	Interest Income or Dividends.....						$ _____
	Income From Rent, Mortgages, Promissory Notes, Deed of Trust, or Contract of Sales (including room and/or meal).....						$ _____
	Scholarships, Loans, or Grants.....						$ _____
	Income From Training Program.....						$ _____
	Name of Program: _____						☐ MC 210 S-E
	Any Other Unearned Income (Include gambling/ lottery/bingo winnings, lump sum payments, inheritance).....						$ _____ ☐ Inheritance, Insurance, etc.
IN-KIND	**33** Receive Rent/Housing, Food?..... If yes, check boxes:				Value		☐ Chart Value
	FREE / WORK FOR						☐ Actual Value
	Housing ☐ ☐				$ _____		☐ MC 210 S-I
	Utilities ☐ ☐				$ _____		
	Food ☐ ☐				$ _____		
	Clothing ☐ ☐				$ _____		

CHECK EACH ITEM "YES" OR "NO" →	YES	NO	WHO PAYS	MONTHLY AMOUNT	COUNTY USE
OTHER EXPENSES					
34 Does the self-employed person have business expenses?					☐ MC 210 S-W ☐ Verification
35 Does anyone in your home pay child/spousal support, alimony or make other payments (medical, dental, etc.) for someone who does not live in the home?					☐ Court Order ☐ Actual Payment $ _____
36 Does anyone in your home pay someone to care for a child, a disabled or elderly adult so that a household member can work, attend training or school or look for work? List person(s) cared for: _____					☐ Dependent Care Receipts ☐ MFBU Member
37 Is anyone in your home a working disabled person who has medical expenses necessary to keep the job, such as wheelchair?					☐ Receipts ☐ MC 272 ☐ MC 273 $ _____ ☐ QDWI
38 Is anyone paying college or educational costs?					☐ MC 210 S-E
OTHER HEALTH COVERAGE					
39 a. Is anyone currently covered by health/dental insurance or Medicare? List name(s) _____ List name of insurance _____					☐ QMB ☐ Card ☐ SLMB ☐ DHS 6155 ☐ HIPP ☐ EGHP
b. Is health/dental insurance available through employment?					OHC CODE: _____ $ _____
c. Do you or any family member have a high cost medical condition?					☐ SSA Referral
d. Have your health/dental insurance stopped in the last 60 days?					
ADDITIONAL INFORMATION					
40 Additional Information: (List any additional information for questions 1 through 39.) _____ _____ _____ _____					

YOUR ANSWERS TO THE FOLLOWING QUESTIONS WILL NOT AFFECT YOUR ELIGIBILITY FOR MEDI-CAL	YES	NO	COUNTY USE
SERVICES			
41 Regular check-ups to help protect your family's health are available upon request through the Child Health and Disability Prevention Program (CHDP) for eligible members of your family under age 21.			☐ CHDP Brochure and Explanation Given ☐ CHDP Referral Date _____
a. Do you want more information about CHDP Services?			
b. Do you want CHDP medical or dental services?			
42 Pregnant women may get help finding a doctor and transportation to see the doctor.			☐ Pregnant ☐ Parent or Guardian of child under 5.
a. Do you want to talk to someone about this help?			
b. Have you given birth within the last three months?			☐ Breastfeeding ☐ Postpartum
c. Are you breast feeding a child?			☐ WIC Referral Date _____
If you answered "YES" to either b or c, you may be eligible for services provided by the Special Supplemental Food Program for Women, Infants and Children (WIC).			
43 Do you want information about Family Planning Services?			☐ Family Planning Information Given
44 Do you want to talk to a social worker about other services which may be available to you?			☐ Social Services Referral
If "YES," briefly describe:			

CERTIFICATION

- I have read and received a copy of the Important Information for Persons Requesting Medi-Cal form (MC 219).
- I am aware of, understand, and agree to meet all my responsibilities as described on the MC 219.
- I understand that all of the statements, including benefit and income information, that I have made on this form are subject to investigation and verification.
- I understand that Section 1137 of the Social Security Act requires that I provide Social Security numbers (SSNs) for myself and/or any family members if I/we claim to be in a satisfactory immigration status. I understand that my/our SSNs will be verified and will be used in a computer match to check the income and resources I/we report with information from welfare, state employment, income tax, Social Security Administration, and other agencies. I understand that this is done to make sure that my/our family's eligibility and share-of-cost level, if any, are correct.

It is the responsibility of the applicant/beneficiary and person acting for the applicant/beneficiary to report to the Eligibility Worker within ten (10) days any changes that occur.

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 Statement of Facts and any of its supplemental form(s) that I may be asked to complete is true and correct.

Signature of Applicant/Beneficiary			Date
Signature of Witness (If Applicant Signed With a Mark)	Telephone Number	Relationship to Applicant/Beneficiary	Date
Signature of Person Helping Applicant Fill Out the Form	Telephone Number	Relationship to Applicant/Beneficiary	Date
Signature of Interpreter	Telephone Number	Relationship to Applicant/Beneficiary	Date
Signature of Person Acting for Applicant/Beneficiary		Relationship to Applicant/Beneficiary	Date
Address of Person Acting for Applicant/Beneficiary			Telephone Number of Person Acting for Applicant/Beneficiary

COUNTY USE ONLY

Supplemental Forms Issued	Client Initial	Date
EW Signature	Worker Number	Date

IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL

PRIVACY AND CONFIDENTIALITY NOTIFICATION

Sections 14011 and 14012 of the Welfare and Institutions Code allow county welfare departments to get certain facts from you to decide if you, or the persons you represent, can get Medi-Cal benefits. You must provide these facts to get Medi-Cal benefits. The information will be used:

1. By the county welfare department to establish first time and ongoing Medi-Cal eligibility.
2. By Electronic Data Systems (EDS) to process claims and make Benefits Identification Cards (BICs).
3. By the United States (U.S.) Department of Health and Human Services to make audit and quality control reviews and verify Medicare Buy-In and Social Security Numbers (SSNs).
4. To verify alien status with the U.S. Immigration and Naturalization Service (INS) only for aliens who claim to be lawfully admitted for permanent residence or Permanently Residing in the U.S. Under Color of Law (PRUCOL) or Amnesty Aliens with a valid and current I-688 card. The information the INS receives can only be used to determine Medi-Cal eligibility, and cannot be used for immigration enforcement unless you are committing fraud.
5. By medical services providers and health maintenance organizations to certify eligibility.
6. To identify health insurance coverage and take recovery actions.

MEDI-CAL APPLICANT/BENEFICIARY RIGHTS, RESPONSIBILITIES, AND UNDERSTANDINGS

I HAVE THE RIGHT TO:

1. Ask for an interpreter to help me in applying for Medi-Cal if I have difficulty in speaking or understanding the English language.
2. Be treated fairly and equally regardless of my race, color, religion, national origin, sex, age, or political beliefs.
3. Apply as a disabled person if I think I am disabled.
4. Be told about the rules for retroactive Medi-Cal eligibility.
5. Apply for Medi-Cal and to be told **in writing** whether I qualify for any Medi-Cal program, even if the county representative tells me during the interview that it appears I am not eligible.
6. Review Medi-Cal program rules and regulation manuals if I want to question the basis on which my eligibility is approved or denied.
7. Have all facts that I give to the county welfare department kept in the strictest confidence and to look at those facts during regularly scheduled office hours.
8. Receive an immediate need card, **when possible and eligible**, if I have a medical emergency or I am pregnant.
9. Receive Medi-Cal, as authorized, while my satisfactory immigration status is being documented and verified, if I am otherwise eligible. **Aliens who are lawfully admitted for permanent residence or PRUCOL or Amnesty Aliens with a valid and current I-688 card are in a satisfactory immigration status.**
10. Be told about the Child Health and Disability Prevention Program and the Special Supplemental Food Program for Women, Infants, and Children, and to ask for help in receiving those services.
11. Ask for and receive information about the Family Planning Program and be told if I am eligible for those services.
12. Speak to a social worker about other public or private services or resources that I can get.
13. Be told about Medi-Cal Health Care Plans that my family and I can join to get a doctor and other medical care, and to choose the option I prefer.

IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL (Continued)

14. Lower my share of cost by providing past unpaid medical bills (that I still owe).
15. Reduce my property reserve to within the Medi-Cal property limit by the last day of a month for which I want Medi-Cal, including the month I apply and to be told how I may spend my excess property.
16. Divide countable (nonexempt) community (MY SPOUSE's AND MY) property by written agreement into equal shares of separate property if ether of us entered a long-term care (LTC) facility before September 30, 1989.
17. Keep a certain amount of countable separate and community property if I enter an LTC facility on or after January 1, 1990. My spouse and I have the right to be told the amount.
18. Have a state hearing if I am dissatisfied with an action taken (or not taken) by the county welfare department or the State Department of Health Services, except actions relating to the Health Insurance Premium Payment (HIPP) and Employer Group Health Plan (EGHP) programs. If I want a state hearing to appeal the decision, I must ask for it within **90 days** of the date the Notice of Action (NOA) was mailed to me. If I do not receive a NOA, I must request a hearing within **90 days** from the date I discover the action (or inaction) with which I am dissatisfied. The date of discovery is the date I know, or should have known, of the action. The best way to ask for a hearing is to contact the nearest county welfare department.

I HAVE THE RESPONSIBILITY TO TELL MY COUNTY REPRESENTATIVE WITHIN TEN (10) DAYS WHENEVER:

1. Income received by me or any member of my family increases, decreases, starts, or stops. This includes income from Social Security Administration (SSA), loans, settlements, or any other source.
2. I plan to change or have already changed my place of residence or mailing address.
3. A person, including a newborn child, whether or not related to me or my family, moves into or out of my home.
4. An absent parent returns to the home.
5. I or a member of my family gives birth, becomes pregnant, or ends a pregnancy.
6. I, my spouse, or any member of my family enters or leaves a nursing home or an LTC facility.
7. I receive, transfer, give away, or sell real or personal property (including money) or when someone gives me or a member of my family such things as a car, house, insurance payments, etc.
8. I have any expenses that are paid for by someone other than myself.
9. I or a member of my family gets a job, changes jobs, or no longer has a job.
10. I have a change in expenses related to my job or education. (For example: child care, transportation, etc.)
11. I or a member of my family becomes physically or mentally impaired so that I/he/she cannot get or keep a job (this would include a child in the family who may not be able to get a job in the future due to the impairment).
12. I or a member of my family applies for disability benefits with the SSA, Veterans Administration, or Railroad Retirement.
13. One of my children drops out of school or returns to school.
14. There is a change in the citizenship/immigration status of any family member applying for or receiving Medi-Cal.
15. Health insurance coverage for me or a member of my family changes.

I HAVE THE RESPONSIBILITY TO:

1. Complete and return a status report by the date required when requested by the county.
2. Give proof that I am a resident of California.
3. Make a declaration about my citizenship/immigration status.

IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL (Continued)

7. If I am receiving Medi-Cal based on disability and I apply for disability benefits from the SSA, and the SSA den ...ly disability claim, my Medi-Cal may be stopped. If I appeal my SSA denial right away, my Medi-Cal will continue until the SSA makes a final decision. If the SSA allows my claim, then my Medi-Cal benefits will continue. If the SSA does not allow my claim, then my Medi-Cal benefits will stop.
8. As a condition of Medi-Cal eligibility, all rights to medical support and/or payment for medical services for myself and any eligible persons that I have legal responsibility for, are automatically assigned to the State.
9. If medical support is court-ordered from an absent parent for my children, the insurance carrier must allow me to enroll and provide benefits to my children without the absent parent's consent.
10. If I don't apply for or keep no-cost health coverage or state-paid coverage, my Medi-Cal benefits and/or eligibility will be denied or stopped.
11. When I apply for Medi-Cal, I will be evaluated for potential eligibility under other medical assistance programs, including the HIPP and EGHP programs.
12. If I ask a Medi-Cal provider for any services not covered by my **non-Medi-Cal** health insurance plan, I must give the medical provider a written statement from my health plan saying it does not offer the Medi-Cal-covered services.
13. Medi-Cal providers cannot collect insurance copayment, coinsurance, or deductibles from me unless the payment is used to meet my Medi-Cal share of cost and/or copayment.
14. If I am admitted to a nursing facility and I have no intention of returning to my home, the State may impose a lien against my property.
15. After my death, the State has the right to seek reimbursement from my estate for all Medi-Cal benefits I received after age 55 unless I have a surviving spouse (during his or her lifetime), minor children, blind or permanently and totally disabled children, or it would create a hardship for my heirs.
16. After the death of my surviving spouse, the State has the right to claim from the part of his or her estate received from me, all Medi-Cal benefits I received after age 55 up to the amount of property my spouse received from my estate.

I, _____, am applying for Medi-Cal benefits from _____ County Welfare Department (on behalf of _____).

I hereby state that I have reviewed the information on this form with the county representative and that I fully understand my **RIGHTS AND RESPONSIBILITIES** to have my eligibility determined for Medi-Cal and to maintain that eligibility.

Applicant/Representative Signature	Telephone Number	Date
Interpreter's Signature	Telephone Number	Date

I have explained to the applicant the rights, responsibilities, and other information listed on this form.

Eligibility Worker's Signature	Telephone Number	Date