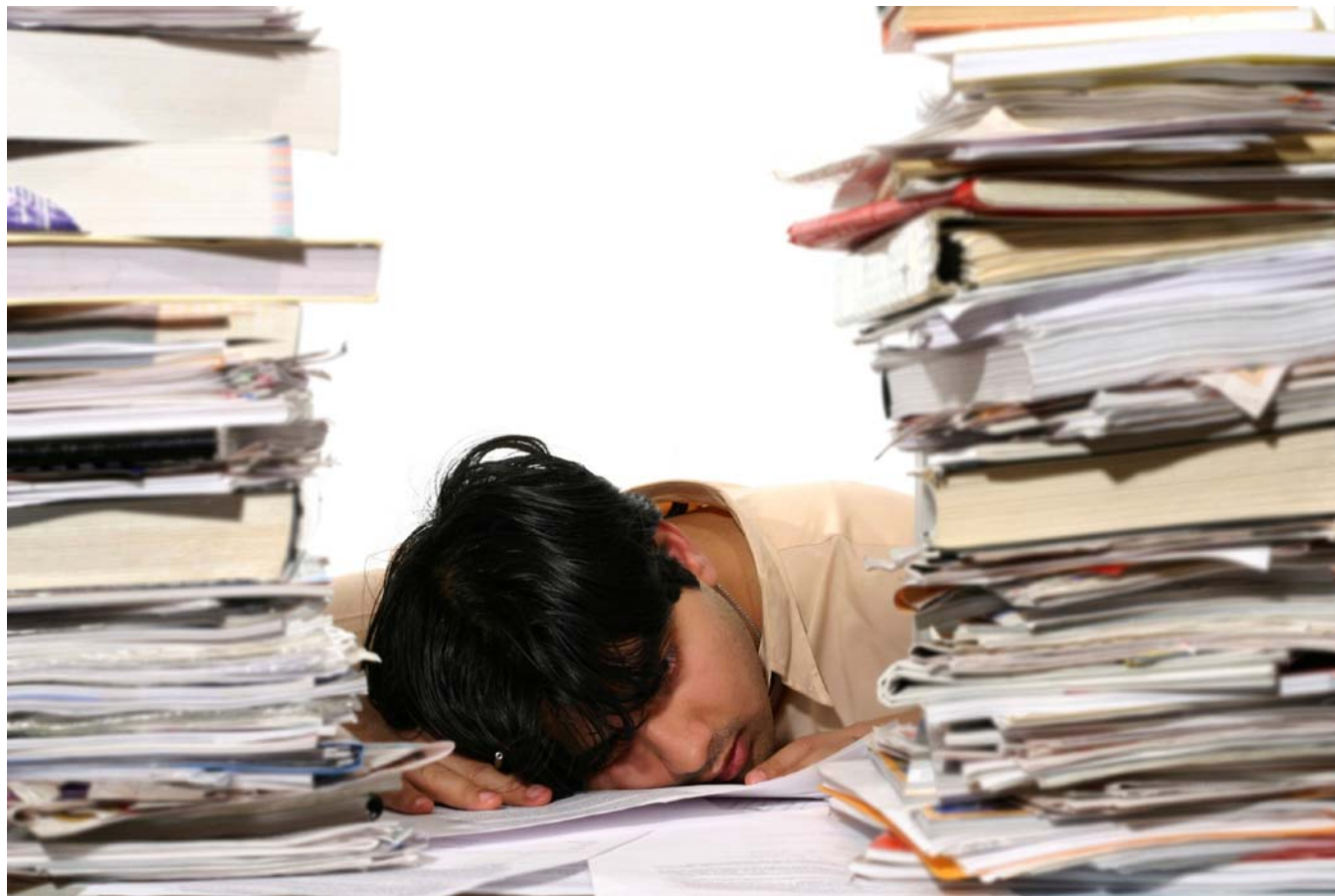


FORMS



Agenda: Application & Forms

- **MC 210 (Application)**
- **Medi-Cal Support/Good Cause**
- **MC 007 (Medi-Cal General Property Limits)**
- **DHCS 0011 (Proof of Acceptable Citizenship or Identity)**
- **MC 13 (Statement of Citizenship, Alienage, and Immigration Status)**

M C 2 1 0

State of California - Health and Human Services Agency

Department of Health Care Services

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		FIRST NAME		MIDDLE INITIAL	
2 HOME ADDRESS (NUMBER AND STREET); DO NOT LIST A P.O. BOX UNLESS HOMELESS			3 APARTMENT NUMBER	4 HOME PHONE #	
5 CITY/STATE		6 COUNTY	7 ZIP CODE	8 WORK PHONE #	
9 MAILING ADDRESS (IF DIFFERENT FROM ABOVE); OR P.O. BOX			10 APARTMENT NUMBER	11 MESSAGE PHONE #	
12 CITY			13 ZIP CODE		
14A WHAT LANGUAGE/DIALECT DO YOU SPEAK BEST?			14B 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:	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
19 Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> 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:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Disability expected to last:	<input type="checkbox"/> 90 Days or More <input type="checkbox"/> 12 Months or More	<input type="checkbox"/> 90 Days or More <input type="checkbox"/> 12 Months or More	<input type="checkbox"/> 90 Days or More <input type="checkbox"/> 12 Months or More	<input type="checkbox"/> 90 Days or More <input type="checkbox"/> 12 Months or More	<input type="checkbox"/> 90 Days or More <input type="checkbox"/> 12 Months or More

M C 2 1 0 Section 2

23	Has a physical, mental or emotional disability? Disability expected to last:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 30 Days or More <input type="checkbox"/> 12 Months or More
24	Has any one ever received cash aid, SSI, Food Stamps or Medi-Cal? If "Yes," under what name?	<input type="checkbox"/> Yes <input type="checkbox"/> No
25	Medi-Cal benefits BIC card number, if you have it:	
26	Wants medical benefits?	<input type="checkbox"/> Yes <input type="checkbox"/> No
27	Do you own or are you buying a home outside California?	<input type="checkbox"/> Yes <input type="checkbox"/> No

M C 210 Section 3

Child 1	
28	Mother's Name:
Is Mother: <input type="checkbox"/> Employed <input type="checkbox"/> Disabled <input type="checkbox"/> Unemployed <input type="checkbox"/> Deceased <input type="checkbox"/> Absent	
29	Father's Name:
Is Father: <input type="checkbox"/> Employed <input type="checkbox"/> Disabled <input type="checkbox"/> Unemployed <input type="checkbox"/> Deceased <input type="checkbox"/> Absent	

Medi-Cal Support Referrals

- Applicants must assign medical support and/or payments for medical services for children

However, there are circumstances when an applicant can claim good cause to not cooperate and still receive benefits.

Medi-Cal Support: Good Cause

- Good Cause is the right to refuse to cooperate because it is not in the best interests of the applicant and their children.
- The Medi-Cal eligibility worker and their supervisor determine if Good Cause exists.

Examples of Good Cause

- Cooperation would increase the risk of physical, sexual , or emotional harm to children.
- Cooperation would increase the risk of domestic abuse for the parent or caretaker relative.
- The applicant has other credible reasons why cooperation would not be in the interest of the child(ren).

FORMS



M C 2 1 0- Section 6

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

MC 007

PART 2: MEDI-CAL GENERAL PROPERTY LIMITATIONS FOR FAMILIES AND CHILDREN UNDER 21, AGED, BLIND, OR DISABLED INDIVIDUALS AND INDIVIDUALS IN LONG-TERM CARE

NOTE: Medi-Cal disregards property for certain pregnant women and certain children up to the age of 19. Please ask your eligibility worker. To apply, please request a mail-in application.

This information notice provides a general overview of Medi-Cal property requirements for all Medi-Cal applicants and beneficiaries. Property is defined as "real property" and "personal property." "Real property" is land, buildings, mobile homes which are taxed as real property, life estates in real property, mortgages, promissory notes, and deeds of trust. "Personal property" is any kind of liquid or nonliquid asset, i.e., cars, jewelry, stocks, bonds, financial institution accounts, boats, trucks, trailers, etc. Property that is not counted in determining your eligibility is called "exempt" or "unavailable" property. Countable property (property which is not exempt or unavailable) is included in the "property reserve." Your countable property must not exceed the property reserve limit. Any amount over the property reserve limit will make you and/or your family ineligible for Medi-Cal. To be eligible for Medi-Cal, you may reduce your property to the property reserve limit before the end of the month in which you are requesting Medi-Cal. If you are unable to reduce your property to the property limit for a month beginning with the month of application, see the "Exception: *Principe v. Beishe*" section on page 6. To be eligible for Medi-Cal, your countable property may not exceed the following property reserve limits:

Number of Persons Whose Property Is Considered	Property Limit
1	\$ 2,000
2	3,000
3	3,150
4	3,300
5	3,450
6	3,600
7	3,750
8	3,900
9	4,050
10 or more	4,200

NOTE: When there is an institutionalized spouse with a community spouse, an additional amount of countable property is allowed and jewelry is exempt regardless of its value. See page 5 for additional information.

PROPERTY EXEMPTIONS

Real Property

- **Principal residence.** Property used as a home is exempt (not counted in determining eligibility for Medi-Cal). When an applicant or beneficiary is absent from the home for any reason, including institutionalization, the home will remain exempt if the applicant or beneficiary intends to return home someday. The home also continues to be exempt if the applicant's or beneficiary's spouse or dependent relative continues to live in it. Money received from the sale of a home can be exempt for six months if the money is going to be used for the purchase of another home.
- **Other real property.** Up to \$6,000 of the equity value in nonbusiness real estate (excluding the home), mortgages, deeds of trust, or other promissory notes may be exempt. In order to receive this exemption, the property must produce an annual income of 6 percent of the net market value or current face value.
- **Real property used in a business or trade.** Real estate used in a trade or business is exempt regardless of its equity value and whether it produces income.

Personal Property

- **One motor vehicle.**
- **Personal property used in a trade or business.**
- **Personal effects.** This includes clothing, heirlooms, wedding and engagement rings, and other jewelry with a net value of under \$100.
- **Household items.**
- **IRAs, KEOGHs, and other work-related pension plans.** These funds are exempt if the family member whose name it is in does not want Medi-Cal. If held in the name of a person who wants Medi-Cal and payments of principal and interest are being received, the balance is considered unavailable and is not counted.
- **Irrevocable burial trusts or irrevocable prepaid burial contracts.**
- **One revocable burial fund or revocable prepaid burial contract** with a value of up to \$1,500 plus accrued interest per person.
- **Burial space items.**
- **Musical instruments.**
- **Recreation items** including TVs, VCRs, computers, guns, collections, etc.
- **Livestock, poultry, or crops.**
- **Countable property equal to the amount of benefits paid under a state-certified, long-term care insurance policy.**
- **Life insurance policies.** Each person may have life insurance policies with a combined face value of \$1,500 or less plus accrued interest and dividends.

M C 2 1 0 Section 7

49 Place of Birth: <i>State or Country.</i>	
50 U.S. Citizen or National? If "No," write in date of entry into U.S.	<input type="checkbox"/> Yes <input type="checkbox"/> No / / MO DAY YR

DHCS 0011

State of California – Health and Human Services Agency

Department of Health Care Services

Proof of Acceptable Citizenship or Identity Documents

A new law says that most Medi-Cal applicants and beneficiaries who are U.S. citizens or nationals must provide proof of citizenship and identity.

The county has received and reviewed the proof of citizenship and/or identity that you submitted for:

Applicant or Beneficiary Name: _____
First Middle Last

Date of birth: _____

Name of the citizenship document you saw: ▶	Name of the identity document you saw: ▶
<input type="checkbox"/> Approved. The citizenship document you submitted is acceptable proof of citizenship. You will not have to provide proof again for the above person.	<input type="checkbox"/> Approved. The identity document you submitted is acceptable proof of identity. You will not have to provide the proof again for the above person.
<input type="checkbox"/> Denied. The proof you submitted is not acceptable. You must submit another proof of citizenship. Attached is a list of acceptable proof of citizenship documents. <ul style="list-style-type: none">All documents must be originals or copies certified by the issuing agency. Photocopies are not acceptable.	<input type="checkbox"/> Denied. The identity document you submitted is not acceptable. You must submit another proof of identity. Attached is a list of acceptable proof of identity documents. <ul style="list-style-type: none">All documents must be originals or copies certified by the issuing agency. Photocopies are not acceptable.

- The above person has satisfied the new citizenship and identity requirements because both citizenship and identity documents were approved.
- The above person has not satisfied the new citizenship and identity requirements because one or both of the citizenship and/or identity documents were denied or not submitted.

If you have questions, please contact your county social services office at the telephone number listed below.

I declare under penalty of perjury under the laws of the State of California that the information above is true and correct.

▶ _____ Date: _____
Signature of eligibility worker

Name of eligibility worker (print): _____
First Middle Last

Telephone number: _____ County: _____

County fills out this box	
Case No: _____	Case Name: _____

FORMS



MC 13

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) or 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) or lawful permanent residents or permanently residing in the U.S. under color of law (PRUCOL). The 18 PRUCOL categories are listed in 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 (SIG) 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 SIG, 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 have 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 alien 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 6.

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 United States 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 United States since before January 1, 1972, who would be eligible for an adjustment of status to lawful permanent resident pursuant to INA Section 245 (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 questions 2, 3, or 4 in SECTION B on the front of this form.

1. Alien Registration number and/or Alien Admission number (INS Form I-94): _____
2. Date the applicant first entered the United States: _____
3. Applicant's name when he/she first entered the United States: _____
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 have an 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:		
<input type="checkbox"/> None necessary.		
<input type="checkbox"/> SAVE primary verification performed. Date: _____		
<input type="checkbox"/> Document Verification Request (INS Form G-845) and copies of documentation of satisfactory immigration status sent to INS. Date: _____		
<input type="checkbox"/> Full Medi-Cal benefits were granted pending verification of immigration status.		
<input type="checkbox"/> Copies of alien status documents are in the case file.		
<input type="checkbox"/> 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:		
<input type="checkbox"/> The above named applicant is a U.S. citizen or national, or an alien, who, if otherwise eligible, would receive FULL Medi-Cal benefits.		
<input type="checkbox"/> The above named applicant is an alien, who, if otherwise eligible, would receive RESTRICTED Medi-Cal benefits.		

M C 2 10- Section 7

52 Has health/dental or vision coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No
53 Had medical expenses within the 3 months before the month you applied and want Medi-Cal for those expenses.	<input type="checkbox"/> Yes <input type="checkbox"/> No
54 Lawsuit pending due to accident or injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No

M C 2 10- Section 8

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* _____

M C 2 1 0 - Section 9

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

Medi-Cal Health Connections

Hotline Number: 4 1 5 -8 6 3 -9 8 9 2

Monday – Friday 8 a m to 5pm

SFMedi-Cal@sfgov.org