HEALTHY FAMILIES

MEDI-CAL FOR FAMILIES

Free and Low-Cost Health Care
for Children and Pregnant Women

A healthier tomorrow starts today!

Free and low-cost health care, including:

- **Preventive Care**
- **Prenatal Care**
- **Doctor Visits**
- **Vision/Dental Care**
- **Mental Health**
- **Prescriptions**
- **Hospital Stays**
- **Emergency Visits**

See Inside

This application is available in: Spanish, Vietnamese, Chinese, Korean, Russian, Armenian, Farsi, Khmer, Hmong, Arabic and Tagalog
Español, Việt Ngữ, 中文, 한국어, Русский, Հայերեն, فارسی, ភាសាខ្មែរ, Hmoob, العربية, Tagalog

MC 321 HFP (rev. 07/10)
Instructions

Apply now for Medi-Cal *and* Healthy Families.

Follow these steps:

1. Fill out the application inside.
2. Send us copies of the documents listed on page 2.
3. If you are pregnant, see page 5.
4. Sign and mail the application.

Who can apply?

- Children under the age of 19 from low-income and working families
- Pregnant women

Children and pregnant women who do not have immigration papers may still qualify for some Medi-Cal.

How much does it cost?

Medi-Cal is free. Healthy Families is $4 – $24 per child, per month.

Want to know if you qualify?

It depends on your family size, income, and age of the child. See the chart on the back cover.

We can help you apply *for free!*

- On the phone – We can help you fill out your application on the phone.
- In-person – A trained assistant can meet with you.
- We can help you in any language!

Call: **1-800-880-5305** or TDD: **1-800-735-2929**

Monday – Friday: 8 a.m. – 8 p.m.,
Saturday: 8 a.m. – 5 p.m.

Sponsored by the State of California

Here's how to apply:

Pregnant? *See page 5.*

1 Fill out the 4-page application.

If you do not understand a question, or do not have any of the documents, call: **1-800-880-5305**. Or, look for the information you need on pages 3–7.

2 Send us copies of income and expense documents.

(You may be able to use other documents not listed here.)

☐ **One document for each person living in the home who has a job:**

- A recent pay stub (from less than 45 days ago), ***or***
- A signed, dated statement from your employer showing your gross income and how often you are paid, ***or***
- Last year's federal income tax return.

☐ **One document for each person living in the home who is self-employed:**

- Last year's federal income tax form with Schedules C, C-EZ, or F, ***or***
- A signed, itemized profit and loss statement for the last 3 months. For a sample profit and loss statement, go to: www.healthyfamilies.ca.gov, then click on the *"Downloads"* tab.

☐ **If you have income from Disability, Pensions, Retirement, Social Security, Veteran's Benefits, Workers' Compensation, or Unemployment, send a copy of:**

- The award letter, check, **or** bank statement showing direct deposit for the most recent payment.

☐ **If you receive or pay child support or spousal support, send a copy of:**

- The court order, paycheck stub showing support deduction, receipts, or the monthly support check, ***or***
- A statement from the Department of Child Support Services or the person who pays support that lists: the amount of monthly support, who the support is for, who pays for it, and who receives it.

☐ **If you pay for child day care or disabled dependent care, send a copy of:**

- A cancelled check **or** receipt, **or** a signed statement from your child day care provider showing how much you pay each month.

3 Send citizenship or immigration documents for each person applying.

(Send this now or as soon as you can.)

☐ **Citizens or Nationals:** Send a copy of the birth certificate, passport, certificate of U.S. citizenship or naturalization or other proof of citizenship for each person applying. We may ask you for more information later.

☐ **Non-citizens:** Send proof of immigration status. Make copies of front and back sides of documents. Or send a receipt from Immigration (USCIS) showing that you have applied to replace a lost document.
Even if the person applying does not have immigration papers, you can still apply for Medi-Cal.

4 ☐ Send one document per household that proves California residency.

(You may be able to use other documents not listed here.)

- A pay stub that shows your address in California, ***or***
- California Driver's license or ID card from DMV, ***or***
- Rent receipt or utility bill, ***or***
- Proof of your child's enrollment in school.

5 Sign and Mail the Application *(The application is on pages A1-A4.)*

Mail your application and copies of the documents in the attached envelope. No stamps needed!
Mail it to: **Healthy Families/Medi-Cal, P.O. Box 138005, Sacramento, CA 95813-9984**

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: _____	

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	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

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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				$	

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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.

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Need Help?

We can help you!

- On the phone – We can help you fill out the application on the phone.
- In-person – A trained assistant will help you apply. Some assistants can fill out your application online.
- We can help you in any language!
- *All Help is Free!*

Call: **1-800-880-5305**
TDD: **1-800-735-2929**

Can I get help on the Internet?

Yes. For more information about Healthy Families, go to: *www.healthyfamilies.ca.gov*

Who can apply for a child?

The child's parent, stepparent, guardian, or caregiver relative can apply. Emancipated minors can apply for themselves.

Does the child or pregnant woman have to be a U.S. citizen or National?

No. Documented and undocumented immigrants may be eligible for Medi-Cal. Some immigrants may be eligible for pregnancy and emergency services only. Others may be eligible for full Medi-Cal benefits.

For Healthy Families, a child must be a U.S. citizen, National, or qualified immigrant. For more information see the Healthy Families Handbook or go to *www.healthyfamilies.ca.gov*. Click on "FAQs".

Do I have to give you immigration information for everyone in my family?

No. Only list the immigration information for family members who are applying for health benefits.

Parents do not need to give their immigration information if only applying for their children.

The immigration information you give is private and confidential. We only use it to see if you are eligible. And, we do not use your immigration information to demand payment for services lawfully received.

Is the information I give you private?

Yes. We only use your information to see if you are eligible or to administer the programs.
See page 7.

Do I have to pay anything?

No, not for Medi-Cal.

For Healthy Families, you do not have to pay now. But, once you are enrolled, the cost is $4 – $24 per month for each child, up to $72 per family. If you pay the premiums for 3 full months now, you get one month free!

What happens after I apply?

We will send you a letter to let you know which program your children may be eligible for and when coverage would begin. It can take up to 45 days to process your application.

When can I check on my application?

Call us 10 – 15 days after you mail the application.
1-800-880-5305

Will all the children in my family be in the same program?

Maybe. It depends on your family size, income and the age of each child. You may have a younger child in Medi-Cal and an older child in Healthy Families.

What if I can't send copies of the documents you need now?

The fastest way to enroll is to send all your documents now. Or send them as soon as you can. Or fax them to us at: **1-866-848-4974**

If we need more information, we will call you and send you a letter.

Family Size and Income

How do you use my personal and financial information?

We look at the size of your family and income to see if you or your children qualify for the programs. We may not count everyone as part of your family. And we may not count everyone's income. We will figure it out for you.

Who should I list as family members living in my home?

You should list:

- Any child under age 21 living at home, or away at school and claimed as tax dependent
- The birth parents, adoptive parents, or a stepparent who lives with a child you are applying for
- The pregnant woman and her unborn child (If she is married, list her husband, too.)
- The spouse of any teenager living in the home
- An emancipated minor

Do not list:

- aunts, uncles,
- cousins,
- nieces, nephews, or
- grandparents.

But, if any of these relatives want Medi-Cal, check "Yes" on question ㊳ on your application.

What if my income is too high?

Your children may still qualify because we deduct your payments for child day care, child support, dependent care, and spousal support expenses from your family income. We also deduct up to $90 for each family member who works or receives State Disability Insurance or Workers' Compensation.

If your income is still too high, your children may qualify for Healthy Kids. See page 6.

How does child or spousal support affect my income?

If you *pay* child or spousal support, we deduct the amount you pay from your family income.

If you *receive* child or spousal support, we count the amount of support you receive, minus up to $50 from your family income.

Do you deduct child day care or disabled dependent expenses from my income?

We deduct these expenses from your family income if:

- The person who pays for it lives in the home, and
- The adults in the home cannot provide this care because they are working or in job training.

The maximum amount we can deduct depends on the age of the person receiving care. See below:

Child under 2 years old	$200
Child 2 years old or older	$175
Disabled dependent (any age)	$175

What if my income will change soon?

If you know your family income will change in the next few months because of a promotion, layoff, or other change, attach a separate sheet of paper and explain.

Example:

> *This month, my paycheck was for $1000. But usually my paycheck is for $800. Last month I got $200 extra in overtime. There will be no overtime for the next 6 months.*

What is "gross" income?

Gross income is the amount before taxes and before other deductions are taken out.

What is my gross income if I am self-employed?

We look at your profit or loss (on your Schedule C from last year or your Profit & Loss statements from the last 3 months). Then we add back your expenses for meals, entertainment and depreciation. If you lost money in any month or during the year, we will count your income as $0 for that period of time.

Pregnant?

Medi-Cal for pregnant women includes:

- Pregnancy services (including some dental services), or
- Complete health services

How do I apply?

For pregnancy services *only*, fill out the application and send us the documents listed on page 2. If you want *complete* health services, you must also send proof of pregnancy from your doctor or clinic.

It may take up to 45 days to process your application and let you know if you are eligible.

Can I get pregnancy services sooner?

Yes. There is a special program that offers free immediate, temporary, pregnancy-related services to women who are applying for Medi-Cal. It's called *Presumptive Eligibility for Pregnant Women*. Ask your health care provider if they participate in this program.

For more information, call: **1-800-824-0088**

Will I get paid back for pregnancy services I get before my application is approved?

If your application is approved, Medi-Cal may pay you back for pregnancy services you received in the 3 months before you apply – even if the services were not from a Medi-Cal provider. But after you send in your application, you can only get paid back if you get services from an enrolled Medi-Cal provider.

What if I don't qualify for Medi-Cal?

If your income is too high for free Medi-Cal, you can apply to AIM. (AIM is short for *Access for Infants and Mothers*.)

AIM is a low-cost program for uninsured pregnant women whose income is too high to qualify for free Medi-Cal.

For more information, call
1-800-433-2611

Or go to: **www.aim.ca.gov**

How do I sign up my newborn if I have Medi-Cal or AIM for my pregnancy?

You do not need to fill out this application.

If you have **Medi-Cal**, contact your eligiblity worker to make sure your baby is covered from birth. Or fill out a *Newborn Referral Form*. Print the form at: **www.dhcs.ca.gov/formsandpubs/forms/Forms/mc330.pdf**.

If you have **AIM**, your baby may qualify for Healthy Families from birth. Contact Healthy Families to report your baby's birth. Call **1-800-880-5305** or go to **www.aim.ca.gov**, then click on "Register Your Baby."

If I don't have Medi-Cal or AIM for my pregnancy, can I apply for Healthy Families for my baby before he/she is born?

Yes. Follow these steps:

1. Apply for Healthy Families when you are at least 6 months pregnant. Fill out this application and check the box on page A1 (in the Unborn Child column).
2. Include a statement from your doctor or clinic saying you are pregnant and your due date with your application.
3. If your baby qualifies for Healthy Families, send proof of birth within 30 days. Proof of birth is a:
   - Signed letter from the health care provider who delivered the baby or the hospital where the baby was born, or
   - Hospital certificate of birth, or
   - Birth certificate.

   The proof of birth must have the baby's first and last name, birth date, place of birth, and gender.

Important! If you were not covered by AIM for your pregnancy, your baby's Healthy Families coverage starts **13 days** after we get the proof of birth.

Other Questions

What do I write for ethnicity?

Write the ethnic group that the child or pregnant woman belongs to.

Here is a list that may help:

Alaska Native
Amerasian
Asian Indian
Black/African American
Cambodian
Chinese
Filipino
Guamanian
Hawaiian
Hispanic
Japanese
Korean
Laotian
Native American Indian
Other Asian
Samoan
Vietnamese
White
Other

What if I want full Medi-Cal but I don't have a Social Security number?

You may be able to get full Medi-Cal if you apply for a Social Security number and give it to us within 60 days.

To get a Social Security number, contact the Social Security Administration:
1-800-772-1213 *(toll-free)*

If you cannot get a Social Security number, you may still be eligible for pregnancy and emergency services.

What if my child used to have health insurance through someone's job, but it ended?

If you are eligible, Medi-Cal can cover you right away.

Healthy Families covers eligible children 3 months after coverage ends. If the coverage ended because of a change in job status, you moved, benefits to all employees ended, a death, legal separation or divorce, or COBRA coverage ended, you may qualify for coverage sooner.

Can Medi-Cal help me pay for past medical services?

Yes. Medi-Cal may be able to help pay for paid or unpaid medical costs you had in the 3 months before you applied. Check *Yes* on ㉓ on the application.

What if I am involved in a lawsuit and I get a settlement?

If there is a legal settlement in your favor for an accident or injury and Medi-Cal covered your health care, you may have to pay Medi-Cal back for the services from the settlement.

Will Medi-Cal help me pay for medical services until my application is approved?

If you want Medi-Cal to pay, make sure your provider is an enrolled Medi-Cal provider, first. Medi-Cal may pay you back for services you get from an enrolled provider after you apply.

How do I choose my Medi-Cal health plan?

We will send you a packet. If you do not want to wait, call Health Care Options: **1-800-430-4263**. They will tell you if there are Medi-Cal health plans in your county.

Native American Indians / Alaska Natives:

If you do not qualify for free Medi-Cal, you can get Healthy Families for free. Make sure you check *Yes* in ㊷ on the application. You must also send one of these documents (for the parent or the child) now or within 2 months of enrollment:

- Enrollment document from your federally recognized tribe, *or*
- Certificate Degree of Indian Blood (CDIB) from the Bureau of Indian Affairs, *or*
- A letter of Indian Heritage from a California Indian health service clinic.

What if my children do not qualify for the programs?

They may qualify for another free or low-cost health care program for children who are not eligible for full Medi-Cal or Healthy Families.

In many counties it is called the *Healthy Kids Program*. If the program in your county can accept this application, we will send it to them.

To see if your county has a Healthy Kids Program, call: **1-800-880-5305**

Healthy Families Notices

Declarations

I declare that each person I am applying for:

- Is a resident of California
- Is not in jail or in a mental hospital
- Is not eligible for Medicare Part A and Part B
- Is not eligible for any California Public Employees Retirement System Health Benefits Program(s) or is eligible for a California Public Employees Retirement Health Benefits Program, but the employer contribution for dependent(s) is less than $10.

I also declare that:

- All individuals listed on this Application will follow the rules of participation, the utilization review process and the dispute resolution process of the plans in which the individual is enrolled.
- I attest to the identity of each person being applied for.
- I have read and understand the *Healthy Families Handbook*. I understand what it says about each health, dental and vision plan and the benefits they offer.
- I am applying for all of my children eligible for Healthy Families, unless they are already enrolled, or unless I am only applying for myself.
- I give permission to Healthy Families to check my family income, health coverage, immigration status of the people I am applying for, and all other facts on this Application Form.
- I agree to notify the program within 30 days of any change of address of any person applied for who is accepted into the program and any change in the applicant's billing address.

Privacy

The law requires you provide the information requested to apply for Healthy Families. (Title 10, CCR, § 2699.6600) The personal and medical information you provide will be used only to identify you and to administer the program. This means we will share your information with the agencies and plans you want to enroll in.

Citizenship and Immigration Information

The application asks you about your citizenship and immigration status. You must answer these questions. We use your answers to administer the program and to see if you are eligible. If you are a parent or guardian and are not applying for yourself, we will not share your immigration information with other agencies, including the immigration authorities. If you do not answer the questions, we may deny your application.

Ethnicity

Unless you are applying for benefits based on your Native American ancestry, you do not have to answer the questions about ethnicity.

Social Security Numbers

You do not have to provide your Social Security Number if you do not want to.

Access to Your Records

You have the right to access records maintained by the Managed Risk Medical Insurance Board that contain your personal information. To do so, contact:

Managed Risk Medical Insurance Board
Attn: HIPAA Coordinator
P.O. Box 2769
Sacramento, CA 95812-2769
(916) 324-4695

Medi-Cal Notices

Rights, Responsibilities and Declarations

I have the right to:

- Be treated fairly and equally regardless of my race, color, religion, national origin, sex, age, or political beliefs.
- Ask for an interpreter.
- Ask for a fair hearing if I think a decision on my Medi-Cal case is unfair or wrong. I must ask for a hearing within 90 days after the "Notice of Action" is mailed to me. To find out about Medi-Cal fair hearings, call toll-free 1-800-952-5253.

I have the responsibility to:

- Send in a status report when the county asks me to.
- Report any changes in the information I gave on this Application Form within 10 days.
- Let the county know if a family member applies for disability benefits; is in a public institution; or gets medical care for any accident or injury caused by another person.
- Cooperate if my case is reviewed.

I declare that each person I am applying for:

- Lives in California.
- Is not getting public assistance from outside California.
- Is not in jail, prison, or any other correctional facility.

I further declare that:

- I understand that as a condition of Medi-Cal eligibility, all rights to medical support and third party payments are automatically assigned to the State of California.
- If I am not eligible for this Medi-Cal Program, I understand I may qualify for other programs and have the right to apply for them.
- If I purposely do not give needed facts, or if I give false facts, I understand benefits may be denied or ended and repayment may be required. I may also be investigated for fraud.

Confidentiality

The information you give on this Application Form is private and confidential. It will only be disclosed if required by law. *(Welfare and Institutions Code Sections 10850 and 14100.2)*

Privacy

The law requires Medi-Cal applicants answer all questions on this application not marked optional. (Welfare & Institutions Code, § 14011 and Title 22, CCR regulations) The personal and medical information you provide will be used only to identify you and to administer the program. This means we will share your information with federal, state, and local agencies.

Citizenship and Immigration Information

If you are applying for benefits, you must answer the questions about citizenship and immigration status. If you are a parent or guardian and are not applying for yourself, you do not have to provide your immigration information. If you are applying for full-scope Medi-Cal, we will confirm your immigration status with Immigration (USCIS) only to see if you are eligible. We will not share your immigration information with Immigration or other agencies for any other reason. Your application will be incomplete if you do not answer these questions for persons applying and we may deny your application.

Social Security Numbers

Unless you are applying for emergency or pregnancy-related benefits only, you must provide your Social Security Number. (Welfare & Institutions Code § 14011.2 and Social Security Act §1137(a)(1)).

Access to Your Records

You have the right to access records maintained by the Department of Health Care Services that contain your personal information. To do so, contact your county health and human services or social services office.

Free and Low-Cost Health Care:

- Preventive care
- Prenatal care
- Mental health
- Hospital stays
- Doctor visits
- Vision/Dental care
- Prescriptions
- Emergency care

Want to know if you qualify?

Send your completed application and documents right away! We can tell you if you qualify within 45 days! Find your family size, monthly income (before taxes and deductions) and age of children below to see what program the person may qualify for. You are allowed to deduct some expenses. For more information, see page 4.

Valid until 3/31/2012

Child's Age ▶	0 – 1 year or pregnant woman*	0 – 1 year old	1 – 5 years old		6 – 18 years old	
Family Size A pregnant woman = 2 people* ▼	**Medi-Cal**	**Healthy Families**	**Medi-Cal**	**Healthy Families**	**Medi-Cal**	**Healthy Families**
1	$0 - $1,815	$1,816 -$2,269	$0 - $1,207	$1,208 - $2,269	$0 - $ 908	$ 909 - $2,269
2	$0 - $2,452	$2,453 -$3,065	$0 - $1,631	$1,632 - $3,065	$0 - $1,226	$1,227 - $3,065
3	$0 - $3,089	$3,090 -$3,861	$0 - $2,054	$2,055 - $3,861	$0 - $1,545	$1,546 - $3,861
4	$0 - $3,725	$3,726 -$4,657	$0 - $2,478	$2,479 - $4,657	$0 - $1,863	$1,864 - $4,657
5	$0 - $4,362	$4,363 -$5,453	$0 - $2,901	$2,902 - $5,453	$0 - $2,181	$2,182 - $5,453
6**	$0 - $4,999	$5,000 -$6,248	$0 - $3,324	$3,325 - $6,248	$0 - $2,500	$2,501 - $6,248

** If more than one baby is expected, send a statement from your health care provider that says how many babies are expected. (This increases the family size.)*

*** If there are more than 6 people in your family, call: 1-800-880-5305.*

Many children and pregnant women qualify.

It depends on your family size, income, and age of your child. If you do not have immigration papers, you may still qualify for some Medi-Cal.

If you do not qualify, we may be able to refer you to a low-cost county health insurance program called Healthy Kids or another program that may be able to cover your children.

It's free or low-cost.

Medi-Cal is free, including office visits.

Healthy Families is $4 – $24 per month for each child, up to $72 maximum per family. Preventive services, like immunizations, are free. Other visits cost $5 – $15 each.

The programs let you choose a doctor or clinic. And, most counties offer a choice of health plans.

Call today — it's a free call!
1-800-880-5305

TDD: 1-800-735-2929

Monday – Friday: 8 a.m. – 8 p.m. or Saturday: 8 a.m. – 5 p.m.

Visit Healthy Families at: **www.healthyfamilies.ca.gov**