

# Revised Joint Application for Medi-Cal & Healthy Families

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# Project History & Goals



# Project History & Goals

- Governor's Budget for 2005-2006 announced the re-design of the Joint HFP/MC Application.
- Project's Goals & Objectives:
  - Make the Application easier to fill out.
  - Eliminate barriers that discourage applicants to apply for coverage.

# Project History & Goals

- April 2005 – State presented an application prototype and met with stakeholders to solicit their feedback and input.
- September 2005 – State hired a readability consultant to restructure and re-design the Application.
- March 2006 – Another meeting with stakeholders occurred to share a revised prototype.

# Project History & Goals

- June 2006 – State conducted focus group testing:
  - Focus group testing was performed in English & Spanish:
    - Applicant population; and
    - CAA community.
  - Focus group testing occurred in northern, central, and southern California:
    - Oakland;
    - Sacramento;
    - Fresno;
    - Los Angeles; and
    - Riverside.



# Project History & Goals

- Focus Group Testing Results:
  - Many people understood what programs they were applying for.
  - Many people understood what benefits the programs offered.
  - Many people knew what documents they needed to send with the application.
  - Individuals were able to complete the application on their own.

# Project History & Goals

- In July 2007 and August 2007 – Continued to meet with stakeholders to make final changes to the Application.
- Application is being finalized.
- Next Steps:
  - Application translations into 11 languages.
    - Added 2 additional languages (Arabic & Tagalog).

# Project History & Goals

- Training Resources for CAAs:
  - CAA Reference Manual will be updated.
  - Web-Based Training Tutorial will be updated.
- Goal is for the revised Application to be available in Fall 2007.
- Health-e-App will be updated.

# New Features & Layout



# New Features & Layout

- Reduces reading grade level:
  - Today's application is close to a 10th grade reading level.
  - The revised application is at a 7th grade reading level.

# New Features & Layout

- Easier reading:
  - Larger font size.
  - More white space to make the Application easier to fill out and understand.
  - Use fewer words with more conversational language.
  - Reduce colors and pictures.
- Includes Table of Contents on the front cover, so that information can easily be located.

# New Features & Layout

- Explains the “Four Easy Steps to Apply” on the front cover.
  - The “Four Easy Steps to Apply” are:
    1. Fill out Application.
    2. Send copies of documents.
    3. If a pregnant woman is applying for coverage, see page 5 for more information.
    4. Sign and mail the application.



## 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

- How to Apply . . . . . 2
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- Family Size & Income . . . . . 4
- Pregnant? . . . . . 5
- Other Questions . . . . . 6
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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. 7/07)  
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 – \$15 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

## ■ Sample of what the application will look like:

- Still a working document.
- State and Advocates are making final changes.
- Final version will have blue and black text.



# New Features and Layout

- Includes a Document Checklist:
  - Provides samples of types of documents to submit for:
    - Income (e.g. paycheck stub issued within the last 45 days, self-employment income, etc.).
    - Income deductions (i.e. child day care expenses or child support payments).
    - U.S. Citizenship or immigration documents.
    - Proof of California residency.

## 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 required 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:

**One of these documents 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 of these documents 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](http://www.healthyfamilies.ca.gov), then click on *Download Forms and Documents*.

**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:** 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 a copy of the Permanent Resident Card, I-94, or other immigration documents for each person applying. *Even if the person applying does not have immigration papers, you can still apply for Medi-Cal's emergency and pregnancy-related services.*

### 4 Proof of California residency – Send one of these documents:

- 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**

# New Features & Layout

- New Frequently Asked Questions (FAQs) format:
  - Does not provide specific instructions on how to fill out each question.
    - Presents information in a question and answer format.
  - Communicates important information:
    - Organizes information into relevant topics.
    - Provides instructions only for questions that require more detailed explanations.

# New Features & Layout

- More information about privacy and confidentiality rules that the programs follow.
- More information for pregnant women and unborn children applying for coverage.

## 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](http://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?

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](http://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 who are applying for their children (and not themselves) only have to give information for their children.

We do not give parents' immigration information to Immigration (USCIS). 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 – \$15 per month for each child, up to \$45 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. **Not everyone or everyone's income counts. 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 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](http://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 for your newborn if you already have Medi-Cal or AIM. If you have Medi-Cal for your pregnancy, contact your eligibility worker to make sure your baby is covered. If you have AIM for your pregnancy, your baby may qualify for Healthy Families. Contact Healthy Families to report your baby's birth. Call **1-800-880-5305** or go to [www.aim.ca.gov](http://www.aim.ca.gov), then click on "Register Your Baby."

## Can I apply for Healthy Families for my baby before it is born?

Yes. You can apply for Healthy Families when you are at least 6 months pregnant, if you do not have AIM or Medi-Cal for your pregnancy. Fill out the application and check the box on page A1.

Send a statement from your doctor or clinic saying you are pregnant and your due date.

## How do I let Healthy Families know when my baby is born?

Within 30 days after your baby is born, send Healthy Families a copy of the baby's birth certificate, or a signed letter from the doctor who delivered the baby or the hospital where the baby was born.

The letter must say the baby's:

- first and last name,
- birth date,
- place of birth, and
- gender.

## Can my baby get Healthy Families coverage right away?

Healthy Families coverage starts 13 days after we get the eligible baby's birth certificate or letter from the doctor or hospital. The baby's coverage does *not* begin when the baby is born.

## Need help?

Call us — it's a free call!

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

## 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	Hispanic
Amerasian	Japanese
Asian Indian	Korean
Black/African American	Laotian
Cambodian	Native American Indian
Chinese	Other Asian
Filipino	Samoa
Guamanian	Vietnamese
Hawaiian	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 insurance through a parent'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 **51** 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 healthcare 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**

# New Features & Layout

- Eliminates “Section” references on the Application Form.
- HFP Rights & Declarations are now on a separate page – no longer a part of the 4 page Application Form.
- Individuals only have to sign the Application Form 1 time to apply for both the HF & MC programs. Today's application requires 2 signatures.
- CAA signature block is located at the bottom on - page A4.
  - Applicant has option to authorize the EE to follow-up on the application status on his/her behalf.
- The income chart is located on the back cover with other helpful information for families applying.

# Application Form & Specific Changes

# Changes to Specific Questions and Requirements

- Some questions or instructions are new.
- Some old questions have been deleted.
- Some old questions or instructions have been revised or clarified.

# Specific Changes on Inside Cover (Page 2)

## 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 required 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:**
  - One of these documents 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 of these documents 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](http://www.healthyfamilies.ca.gov), then click on [Download Forms and Documents](#).
  - 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:** 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 a copy of the Permanent Resident Card, I-94, or other immigration documents for each person applying. *Even if the person applying does not have immigration papers, you can still apply for Medi-Cal's emergency and pregnancy-related services.*
- 4 Proof of California residency – Send one of these documents:**
  - 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**

- Verifying Documents are in a Checklist.
- Applicants can provide other forms of acceptable proof.

# Specific Changes to Page A1 of Application Form

**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 \_\_\_\_\_ Email 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					<input type="checkbox"/> Check here to apply for Healthy Families for your baby before it is born. (Pregnant women in Medi-Cal and AIM, do not fill out this part.)  You must: • Be at least 6 months pregnant. • Send proof of pregnancy from your doctor or clinic with the application, and • Send the birth certificate or similar document when the baby is born. (For more information, see page 5.)
Last					
First					
Middle					
⑨ Name on birth certificate (if different from name above)					
Last					
First					
Middle					
⑩ Is this child living away from home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
⑪ Home address (if different from home address in ②)					
⑫ Mailing address (if different from mailing address in ③)					
⑬ Relationship to person in ①	<input type="checkbox"/> My child <input type="checkbox"/> My stepchild <input type="checkbox"/> Other: _____	<input type="checkbox"/> My child <input type="checkbox"/> My stepchild <input type="checkbox"/> Other: _____	<input type="checkbox"/> My child <input type="checkbox"/> My stepchild <input type="checkbox"/> Other: _____		
⑭ Date of Birth	mo / day / yr	mo / day / yr	mo / day / yr	mo / day / yr	Your Due Date: _____
⑮ Gender	<input type="checkbox"/> Boy <input type="checkbox"/> Girl	<input type="checkbox"/> Boy <input type="checkbox"/> Girl	<input type="checkbox"/> Boy <input type="checkbox"/> Girl		

BAR CODE

MC 321 HFP (rev. 7/07)  
Application

A1

- List the family member completing the form at the top.
- New “unborn” column.
- New question #10 where children are away from home.



# Specific Changes to Page A2 of the Application Form

	Child 1	Child 2	Child 3	Pregnant Woman	Unborn Child
16	Ethnicity - Optional <i>(For more information, see page 6.)</i>				
17	Birthplace County: _____				
	State: _____				
	Or foreign country: _____				
18	Social Security No. <i>(For more information, see page 6.)</i> <i>This is optional if you are applying for Healthy Families or for emergency or pregnancy services.</i>				
19	U.S. Citizen or National? <i>(More information on page 3 and 7.)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No				
	If No, date arrived in the U.S. 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? <input type="checkbox"/> Yes <input type="checkbox"/> No				
22	Was this child covered by a health plan paid by your employer in the last 3 months? <i>(For more information, see page 6.)</i> <input type="checkbox"/> No				
	Yes (if yes, write the date it ended and check reason below.) mo / day / yr				
	Health coverage ended because: <input type="checkbox"/> Lost job <input type="checkbox"/> Job status changed <input type="checkbox"/> Moved and no insurance available <input type="checkbox"/> All employees' benefits ended <input type="checkbox"/> Death, divorce or legal separation <input type="checkbox"/> COBRA ended <input type="checkbox"/> Other _____				
23	Does this person want to apply for Medi-Cal for medical expenses in the last 3 months? <i>(For more information, see page 6.)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No				
24	Mother's Name: Last _____ First _____				
	Does this child live with the mother? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25	Father's Name: Last _____ First _____				
	Does this child live with the father? <input type="checkbox"/> Yes <input type="checkbox"/> No				

MC 321 HFP (rev. 7/07)  
Application

A2

- New question 20: Existing BIC #'s for people who had Medi-Cal in the past.
- Question 23: Ask for Retroactive Medi-Cal separately for each individual.

# Specific Changes to Page A3 of the Application Form

**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 live 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		<input type="checkbox"/> M <input type="checkbox"/> F	mo / day / yr	<input type="checkbox"/> Child <input type="checkbox"/> Boyfriend <input type="checkbox"/> Spouse <input type="checkbox"/> Stepchild <input type="checkbox"/> Girlfriend <input type="checkbox"/> Other
27		<input type="checkbox"/> M <input type="checkbox"/> F	mo / day / yr	<input type="checkbox"/> Child <input type="checkbox"/> Boyfriend <input type="checkbox"/> Spouse <input type="checkbox"/> Stepchild <input type="checkbox"/> Girlfriend <input type="checkbox"/> Other
28		<input type="checkbox"/> M <input type="checkbox"/> F	mo / day / yr	<input type="checkbox"/> Child <input type="checkbox"/> Boyfriend <input type="checkbox"/> Spouse <input type="checkbox"/> Stepchild <input type="checkbox"/> Girlfriend <input type="checkbox"/> Other

29 Is any person in the home pregnant?  Yes  No  
If yes, who? \_\_\_\_\_ Due Date: mo / day / yr

**Family Income** List the income of the person in ① and the people listed above. 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				\$	

**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: \_\_\_\_\_

### Medi-Cal for Others

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 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

### Bank Accounts and Car (Optional)

41 Is there more than one car in the household?  Yes  No  
42 Is there more than \$3,150 in household bank accounts?  Yes  No

- A teen's spouse is listed with other family size information in Questions #26 - #28.
- Question #38 asks if anyone in the home wants Medi-Cal, including people not listed (e.g. aunts, uncles, nieces/nephews and grandparents).
- New question #39 asking whether anyone in the household wants Medi-Cal and has a disability.

# Specific Changes to Page A4 of the Application Form

**The health care programs may share your information unless you check below:**

- 43  We will send your application to Healthy Kids or other 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](http://www.healthyfamilies.ca.gov)

- |   |  |
|---|--|
| 45 Health Plan _____<br>Name _____ Code _____                 | 46 Dental Plan _____<br>Name _____ Code _____                  |
| 47 Doctor or Clinic (Optional) _____<br>Name _____ Code _____ | 48 Dentist or Clinic (Optional) _____<br>Name _____ Code _____ |
| 49 Vision Plan _____<br>Name _____ Code _____                 |  |

**Check all boxes that describe you:**

- 50  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](http://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?**

- 51  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](http://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.*

- New question forwarding application to Healthy Kids.
- Referral to Healthy Families if enrolled children lose Medi-Cal; Opt Out.



# More Specific Changes to Page A4 of the Application Form

**The health care programs may share your information unless you check below:**

- ④③  We will send your application to **Healthy Kids** or other 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](http://www.healthyfamilies.ca.gov)

- ④⑤ Health Plan \_\_\_\_\_ Name \_\_\_\_\_ Code \_\_\_\_\_      ④⑥ Dental Plan \_\_\_\_\_ Name \_\_\_\_\_ Code \_\_\_\_\_
- ④⑦ Doctor or Clinic (Optional) \_\_\_\_\_ Name \_\_\_\_\_ Code \_\_\_\_\_      ④⑧ Dentist or Clinic (Optional) \_\_\_\_\_ Name \_\_\_\_\_ Code \_\_\_\_\_
- ④⑨ Vision Plan \_\_\_\_\_ Name \_\_\_\_\_ Code \_\_\_\_\_

**Check all boxes that describe you:**

- ⑤⑩  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](http://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?**

- ⑤①  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](http://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.*

- Question #51: Native Americans or Alaska Natives must answer yes to have premiums waived.
- Only one place for applicant to sign.
- CAA signs at the bottom of page A4.



# Specific Changes Rights and Declarations

## 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 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.

### 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 I get a "Notice of Action". 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.

### 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, to see if you are eligible and to make Benefits Identification Cards (BICs). 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 are applying for full-scope Medi-Cal, we will confirm your immigration status with the immigration authorities (USCIS). If you do not answer the questions, 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.

- Now on Page 7.
- Not on Application Form itself.

# Specific Changes to Back Cover

## 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.

Child's Age ▶	0 – 1 year or pregnant woman*	0 – 1 year old	1 – 5 years old		6 – 18 years old	
Family Size** ▼	Medi-Cal	Healthy Families	Medi-Cal	Healthy Families	Medi-Cal	Healthy Families
1	\$0 - \$1,702	\$1,703 - \$2,128	\$0 - \$1,132	\$1,133 - \$2,128	\$0 - \$851	\$852 - \$2,128
2	\$0 - \$2,282	\$2,283 - \$2,853	\$0 - \$1,518	\$1,519 - \$2,853	\$0 - \$1,141	\$1,142 - \$2,853
3	\$0 - \$2,862	\$2,863 - \$3,578	\$0 - \$1,903	\$1,904 - \$3,578	\$0 - \$1,431	\$1,432 - \$3,578
4	\$0 - \$3,442	\$3,443 - \$4,303	\$0 - \$2,289	\$2,290 - \$4,303	\$0 - \$1,721	\$1,722 - \$4,303
5	\$0 - \$4,022	\$4,023 - \$5,028	\$0 - \$2,675	\$2,676 - \$5,028	\$0 - \$2,011	\$2,012 - \$5,028
6	\$0 - \$4,602	\$4,603 - \$5,753	\$0 - \$3,061	\$3,062 - \$5,753	\$0 - \$2,301	\$2,302 - \$5,753

\* Pregnant women count as 2 people.

Valid until 3/31/2008

\*\* 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 the child. **Your family size will be bigger if you are pregnant with more than one baby.** 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 – \$15 per month for each child, up to \$45 maximum per family. Preventive services, like immunizations, are free. Other visits cost \$5 each.

The programs let you choose a doctor. 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](http://www.healthyfamilies.ca.gov)

- Income chart is now here.



# How to Help Families Apply:



# Common Scenarios: How to Help Families Apply

- Pregnant Women and Infants.
- Families with Mixed Immigration Status.
- Families where other members want Medi-Cal.
- Families where someone is disabled.
- Helping with documentation.

# How to Help Pregnant Women

- New page 5 with information on each program.
- Information about and emphasis on Presumptive Eligibility and retroactive payments.
- Unborn column helps pregnant women not on AIM/Medi-Cal get Healthy Families for their baby.
  - Apply when they are 6 months pregnant with proof of pregnancy.

# How to Help Pregnant Women

- Make sure pregnant women don't fill out Unborn column if on Medi-Cal or AIM.
  - Make sure newborns born to women on Medi-Cal do not use this application.
  - Delays coverage.
  - Contact worker or use newborn form.

# How to Help Pregnant Women

- For pregnant women on Medi-Cal, most newborns get Medi-Cal for first year of life.
- For pregnant women on AIM, children may qualify for the Healthy Families Program if the children are not enrolled in free Medi-Cal or have employer health insurance.

# How to Help Families with Mixed Immigration Status

- Only family members applying for complete Medi-Cal benefits have to provide a Social Security Number.
- Information provided is confidential and private.
- Healthy Families requires satisfactory immigration status. Anyone can get Medi-Cal. Some get limited services, others get full scope.
- Other documents than those listed on the inside covered can prove income, expenses, immigration status.

# How to Help When Other Family Members Want Medi-Cal

- Anyone in the household can start the application process: list them in Question #38.
- This includes anyone in the family size section: be sure to list them.
- This includes anyone else too (uncles, aunts, grandparents, nieces and nephews).

# How to Help When Someone is Disabled

- Answer the new Question 39.
- Any household member can be listed.
- The disabled person does not have to already have a disability determination and might be able to work.
- Disability covers many conditions; help families understand.

# How to Help Families With Documentation

- Other acceptable proof may be sent (affidavit of income).
- Don't delay the application if documents are hard to gather.
- Residency: Only one document per household is required.
- Income, expenses and immigration status: documents are required for each person applying for coverage.

# Questions

# Contact Information

Kennalee Gable (916) 552-9443

[Kennalee.Gable@dhcs.ca.gov](mailto:Kennalee.Gable@dhcs.ca.gov)

Thien Lam (916) 324-4695

[Tlam@mrmib.ca.gov](mailto:Tlam@mrmib.ca.gov)

Katie Murphy (213) 235-2626

[kmurphy@wclp.org](mailto:kmurphy@wclp.org)

Lynn Kersey (213) 749-4261

[lynnk@mchaccess.org](mailto:lynnk@mchaccess.org)

