Here's how to apply:

1 Fill out the 4-page application.

If you do not understand a question, or do not have any of the documents, call your CAA: 1-714-531-5933. The "Declaration and Signature" and "Fill out below ONLY if a Certified Applicant Assistant (CAA) helped you fill out this form" sections MUST BE SIGNED.

2 Send us copies of income and expense documents.

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

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

- A recent pay stub (from less than 30 days ago), ***or***
- A signed, dated statement from your employer showing your gross income and how often you are paid, (Samples are available, please contact your CAA), ***or***
- Last year's federal income tax return.

☐ **<u>One</u> 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, please contact your CAA.

☐ **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 <u>one</u> document per household that proves California residency.

(If you are already sending a pay stub for #2 above, nothing further is needed for this section)

- 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.

Mail it to: **Michael Rivas, Healthy Families CAA, 15600 Begonia Street, Westminster, CA 92683-6909**

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
15600 Begonia Street
Westminster, CA 92683-6909

Need Help?
Call: 1-714-531-5933

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.**
First					
Middle					
⑨ Name on birth certificate *(If different from name above)* — *Last*					☐ Check here to apply for Healthy Families for your baby before he/she is born.
First					
Middle					You must:
⑩ Is this child living away from home?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		• Be at least 6 months pregnant,
⑪ Home address *(If different from home address in ②)*					• Send proof of pregnancy from your doctor or clinic with the application, and
⑫ Mailing address *(If different from mailing address in ④)*					• Send proof of birth when the baby is born.
⑬ Date of Birth	___/___/___ mo day yr	___/___/___ mo day yr	___/___/___ mo day yr	___/___/___ mo day yr	*(More information on page 5.)*
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* *(For more information, see page 6.)*					
17	Birthplace — *County:*					
	State:					
	***Or** foreign country:*					
18	Social Security No. *(For more information, 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? *(More information on 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	Was this child covered by a health plan paid by your employer in the last 3 months? *(For more information, see page 6.)*	☐ No ☐ Yes *(If yes, write the date it ended and check reason below.)* ____/____/____ mo day yr Health coverage ended because: ☐ Lost job ☐ Job status changed ☐ Moved and no insurance available ☐ All employees' benefits ended ☐ Death, divorce or legal separation ☐ COBRA ended ☐ Other__________	☐ No ☐ Yes *(If yes, write the date it ended and check reason below.)* ____/____/____ mo day yr Health coverage ended because: ☐ Lost job ☐ Job status changed ☐ Moved and no insurance available ☐ All employees' benefits ended ☐ Death, divorce or legal separation ☐ COBRA ended ☐ Other__________	☐ No ☐ Yes *(If yes, write the date it ended and check reason below.)* ____/____/____ mo day yr Health coverage ended because: ☐ 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? *(For more information, 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					
	Does this child live with the mother?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		
25	Father's Name: *Last*					
	First					
	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				$	

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 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

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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: **1-714-531-5933.** 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: ____________

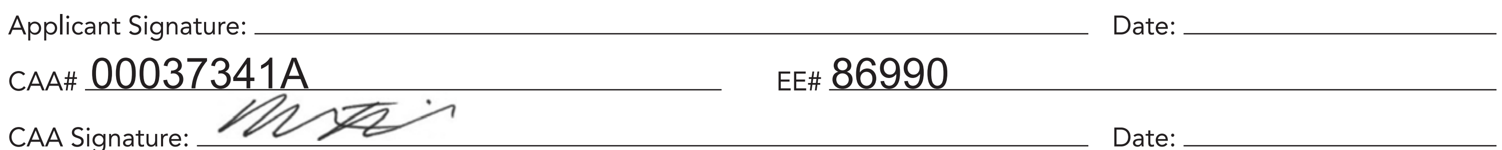
Witness signs here *(If applicant signed with a mark)*: ________________________ Date: ____________

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# 00037341A EE# 86990

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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