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APPLICATION

Please use the instructions to complete this application.
Print clearly. Use black or blue ink only.

SECTION 1: Tell us about the person applying for the child, the pregnant woman, the unborn child, or him or herself.

1 LAST NAME	FIRST NAME	MIDDLE INITIAL	2 BIRTHDATE / / MO DATE YR
3 HOME ADDRESS (NUMBER AND STREET). **DO NOT USE A P.O. BOX**		4 APARTMENT NUMBER	5 HOME PHONE # ( )
6 CITY	7 COUNTY	8 ZIP CODE	9 WORK PHONE # ( )
10 MAILING ADDRESS (IF DIFFERENT FROM ABOVE) OR P.O. BOX		11 APARTMENT NUMBER	12 MESSAGE PHONE # ( )
13 CITY			14 ZIP CODE
15A WHAT LANGUAGE DO YOU SPEAK BEST?		15B WHAT LANGUAGE DO YOU READ BEST?	

16 We will enroll the child or pregnant woman in the program they qualify for. If you do not want to be enrolled in one of these programs, check the box(es) below.

I DO NOT WANT:
❑ **Healthy Families**: Do not send birth certificates. Do not complete the Healthy Families Page.
❑ **Medi-Cal**

SECTION 2: Tell us about the children under 19 and/or the pregnant woman who want health coverage.

	Child 1 or Unborn (*Check box ❑ if unborn*)	Child 2	Child 3	Child 4	Pregnant Woman
17 Name: Last					
First					
Middle					
18 Name on Birth Certificate: Last					
First					
Middle (*If same as #17 above, leave blank.*)					
19 If the child's address is **not** the same as in Section 1, Question 3, give complete address:					
20 Relationship to person in Section 1:					
21 Sex:	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female
22 Date of Birth:	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR
23 Place of Birth: County or State or Country, if outside the U.S.					
24 Ethnic Code: (*See #24 Instructions*)					
25 U.S. Citizen or National? If "no", please write date of entry into U.S.	❑ Yes ❑ No / / MO DAY YR	❑ Yes ❑ No / / MO DAY YR	❑ Yes ❑ No / / MO DAY YR	❑ Yes ❑ No / / MO DAY YR	❑ Yes ❑ No / / MO DAY YR
26 Social Security #:					

Social Security Numbers are not required for Healthy Families or for persons who want emergency or pregnancy related services only.

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SECTION 2: Continued

	Child 1 or Unborn (Check box ❑ if unborn)	Child 2	Child 3	Child 4	Pregnant Woman
27 Mother's Name: Last					
First					
Does the mother live in the home?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
28 Father's Name: Last					
First					
Does the father live in the home?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
29 Name of teen's spouse or pregnant woman's husband: *(If living in the home)*					
30 Does any person(s) being applied for have **no-cost Medi-Cal**? If "yes", give date coverage ends/ended.	❑ Yes ❑ No / / MO DAY YR	❑ Yes ❑ No / / MO DAY YR	❑ Yes ❑ No / / MO DAY YR	❑ Yes ❑ No / / MO DAY YR	❑ Yes ❑ No / / MO DAY YR
31 Does the pregnant woman and/or children have other health, dental or vision insurance?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
32 Were any of the children insured by an employer in the last 90 days? If "yes", check the main reason why health insurance stopped and give the date it stopped.	❑ Yes ❑ No ❑ Lost job ❑ Moved and no insurance available ❑ Employer ended benefits to all employees ❑ COBRA coverage ended ❑ Other ________ / / MO DAY YR	❑ Yes ❑ No ❑ Lost job ❑ Moved and no insurance available ❑ Employer ended benefits to all employees ❑ COBRA coverage ended ❑ Other ________ / / MO DAY YR	❑ Yes ❑ No ❑ Lost job ❑ Moved and no insurance available ❑ Employer ended benefits to all employees ❑ COBRA coverage ended ❑ Other ________ / / MO DAY YR	❑ Yes ❑ No ❑ Lost job ❑ Moved and no insurance available ❑ Employer ended benefits to all employees ❑ COBRA coverage ended ❑ Other ________ / / MO DAY YR	❑ Yes ❑ No ❑ Lost job ❑ Moved and no insurance available ❑ Employer ended benefits to all employees ❑ COBRA coverage ended ❑ Other ________ / / MO DAY YR

SECTION 3: Family members living in the home. Family size is taken into consideration when determining which program your children are eligible for.

33 List any other children living in the home under age 21 who are not listed in Section 2. Give their relationship to the person in Section 1, Question 1.

LAST NAME, FIRST NAME	RELATIONSHIP	LAST NAME, FIRST NAME	RELATIONSHIP
LAST NAME, FIRST NAME	RELATIONSHIP	LAST NAME, FIRST NAME	RELATIONSHIP

34 Are any family members who are living in the home pregnant? ❑ Yes ❑ No

If yes, who: ________________ Date Due: __________

35 List any stepparent living in the home not already listed: ________________
LAST NAME, FIRST NAME

36 Do any of the people listed in this Section, or any of the parents listed in Section 2, want **Medi-Cal**? ❑ Yes ❑ No

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SECTION 4: List the gross income (before taxes) of all persons listed in Section 2, Questions 17, 27, 28, 29 and Section 3 who live in the home. If self-employed or using federal income tax return to prove income, only complete Questions 37, 38 and 40 in this section.

37 NAME OF PERSON WITH INCOME	38 SOURCE OF INCOME?	39 HOW OFTEN RECEIVED?	40 HOW MUCH GROSS INCOME?	41 SOCIAL SECURITY # *(Optional)*
1.				
2.				
3.				
4.				

SECTION 5: Deductions from Family Income. The answers in this section will help determine what amounts will be deducted from your family's gross monthly income.

42 TYPE OF PAYMENT YOUR FAMILY MAKES	43 NAME OF PERSON WHO PAYS	44 MONTHLY AMOUNT PAID
Child Support		
Alimony		

45 CHILD CARE OR DEPENDENT CARE *(List child's name)*	46 AGE	47 MONTHLY AMOUNT PAID
1.		
2.		
3.		
4.		

SECTION 6: Other Coverage.

48 Has anyone filed a lawsuit because of an accident or injury on behalf of the pregnant woman and/or child applying for benefits? ❑ Yes ❑ No

49 Does the pregnant woman and/or child want to apply for **Medi-Cal** coverage for any medical expenses in the last 3 months? ❑ Yes ❑ No

If "yes", list month(s): ______________________________

50 Check this box if you do not want **Medi-Cal** to share your child's application with the low-cost **Healthy Families** if your child no longer qualifies for no-cost **Medi-Cal.** ❑

SECTION 7: Voluntary Information. Not required. Your answers will not affect your eligibility but they will help the state to get additional federal money to pay for health care programs.

51 Is there more than one car in the children's household? ❑ Yes ❑ No

52 Is there more than $3,150 cash in bank accounts in the children's household? ❑ Yes ❑ No

SECTION 8: Signature and Certification.

53 I declare under penalty of perjury under the laws of the State of California that the answers I have given in this application, the declarations made, and the documents submitted are true and correct to the best of my knowledge and belief. I declare that I have read and understand the application instructions, the declarations, and all information printed on this application.

Signature ______________________________ Date: ____________

Witness Signature ______________________________ Date: ____________
(If person signed with a mark)

Authorized Representative *(If any)* ______________________________ Date: ____________

SECTION 9: Fill in ONLY if you have been helped by a Certified Application Assistant (CAA).

54 If you would like information released to a CAA, check this box:

❑ By checking this box and signing below, I give my permission for **Healthy Families** and **Medi-Cal** to give information over the telephone about the status of this Application to the representative of the Enrollment Entity organization identified below. This permission will end on the date the program mails the results of the eligibility determination on this Application.

55 I certify I had help completing this form by the Certified Application Assistant listed below. This CAA help was **FREE** of charge.

CAA#: | | | | | | | | | | EE#: | | | | | |

Applicant Signature: ______________________________ Date: ____________

CAA Signature: ______________________________ Date: ____________

The state will not issue a reimbursement to the enrollment entity unless this question is completely and correctly filled out at the time this Application Form is submitted.

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If it appears you qualify for **Healthy Families** and want to choose your health, dental and vision plan now, fill out this page. Otherwise, we will contact you later for this information. See your **Healthy Families Handbook** for more information, or visit our web site at **www.healthyfamilies.ca.gov**.

SECTION A: Health, Dental and Vision Plan Choices.

56 Health Plan/Code		57 Dental Plan/Code		58 Vision Plan/Code	
59 Name of Doctor/Clinic *(optional)*	60 Doctor/Clinic Code *(optional)*		61 Name of Dentist/Clinic *(optional)*	62 Dentist/Clinic Code *(optional)*	

SECTION B: Rural Demonstration Project.

63 If you are in any of these groups, there is a new statewide health, dental and vision plan combination offered to you. You can pick this new combination and put the code in the box below. See the **Healthy Families Handbook** for the combination code number.

Check all boxes that apply to you.

❑ Native American Indian **OR** Working in seasonal or migratory jobs: ❑ Agriculture ❑ Forestry ❑ Fishing

Plan Combination Code

SECTION C: Healthy Families 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 a member of a family that is eligible for health benefits from the California Public Employees Retirement System Health Benefits Program(s).

I further declare that:

- all individuals listed on this application will abide by the rules of participation, the utilization review process and the dispute resolution process of the participating 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 I am 18 years old or a minor and applying for myself.
- I agree to pay 6 monthly premiums. If I do not pay the premiums, I will be taken off the program and cannot participate again for 6 months. I will have to pay for any **Healthy Families** services I use in the last month after coverage ended.
- 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.
- 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.

SECTION D: Privacy Notice.

The Information Practices Act of 1977 and the Federal Privacy Act require the **Healthy Families** Program to provide the following notice to individuals who are asked by **Healthy Families** to supply information:

Personal and medical information requested is for subscriber identification and program administration purposes only. Program regulations under Title 10, CCR, Section 2699.6600 require that every individual furnish certain information when applying to the **Healthy Families** Program. Subscriber's information may be shared with State and local agencies involved in the administration of health programs. Information (including immigration status) about persons who do not become subscribers, will be used only for purposes of eligibility determination and program administration. Failure to furnish this information may result in the return of the application as incomplete.

The following information on the application is not mandatory: social security number, ethnicity information (unless the subscriber is a Native American Indian) and any other item marked voluntary or optional. An individual has a right to access records containing his/her personal information that are maintained by the Managed Risk Medical Insurance Board. The official responsible for maintaining the information is the Deputy Director of Eligibility and Enrollment, Managed Risk Medical Insurance Board, 1000 G Street, Room 450, Sacramento, California 95814, (916) 324-4695.

SECTION E: Resolving Disputes.

If you enroll in certain plans you agree to have certain claims (which may include medical malpractice claims) decided by neutral binding arbitration. Members give up their right to a jury or court trial. The **Healthy Families Handbook** has information about each plan and the arbitration requirements. You may call the plans you choose to find out more.

SECTION F: Signature and Certification.

64 **I certify** that I have read and understand the information above. **I also certify** that the information I have given on this form is true and correct.

Signature ______________________________ Date ______________

Witness Signature ______________________________ Date ______________
(If person signed with a mark)