SF HIV FOG
Open Enrollment
Boot Camp V

Monday, October 7, 2019

UCSF Mission Bay
550 16th Street
San Francisco

Resource Guide

Part III
Medi-Cal

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What documents do I need to apply for Medi-Cal?

If the county is not able to verify your information, you will be notified. If you are notified, the following is a list of acceptable documents:

Category	Documents
Identity of applicant	• Birth certificate • Driver's license • Paycheck • School records • U.S. Passport • U.S. American Indian/Alaska Native Tribal document • U.S. military ID • Fed, State or local ID
Social Security Numbers	• Social Security cards • Award letter • Medicare card
Immigration status	• INS documents (if not born in the US)
Residence	• Driver's license • Check stub • Rent or mortgage receipt • Utility bill • School, Government or any document showing a CA address
Earned income	• Dated check stubs for the last 30 days • Statement from your employer • Copy of last year's tax return • Bank statement showing direct deposit
Other income	• A current benefit check • Copies of child support checks • Alimony checks • Award letter
Resources	• Bank statements showing savings and checking accounts • Mortgage statements • Life insurance policies • Statements of stocks, bonds or certificates of deposit (CDs) • Trust documents
Vehicle registration	• Department of Motor Vehicle registration certificate

How Long Does It Take?

Forty-five (45) days are allowed to process a Medi-Cal application not involving a disability. If you are applying for Medi-Cal based on a disability, your application process may take up to 90 days depending on how quickly you complete the disability information and when your doctors and hospitals submit your medical records. To avoid processing delays, submit all information requested of you as soon as possible. Ask your eligibility worker for help if you cannot get the information. If you have an immediate medical or dental need, such as pregnancy or a severe illness, indicate this need on your application and your application may be processed more quickly.

Additional Proof Needed for Health Coverage

- Information about any job related health insurance available to your family.
- Policy numbers for any current health insurance.

(information gathered from MyBenefitsCalWIN.org)

APPLICATION FOR CALFRESH , CASH AID , AND/OR MEDI-CAL/HEALTH CARE PROGRAMS

If you have a disability or need help with this application, let the County Welfare Department (County) know and someone will help you.

If you prefer to speak, read, or write in a language other than English, the County will get someone to help you at no cost to you.

How do I apply?
Use this application if you are applying for food assistance (CalFresh), cash aid (California Work Opportunity and Responsibility to Kids, Refugee Cash Assistance, General Assistance or General Relief), Medi-Cal and/or other health care programs. If you want to apply for CalFresh only, you can ask the County for the CalFresh only application. CalFresh is a food assistance program to help you with the cost of buying food for your household. If you want to apply for health care only, you can ask the county for a health care only application. Health care includes: low-cost insurance for Medi-Cal; affordable private health insurance; or a tax credit that can help you pay your premiums for health coverage. Do not use this application if you are applying for only health care. Your County may have a separate application for General Assistance or General Relief. Ask your County to be sure.

You can also apply for these programs online by going to http://www.benefitscal.org/.

- Fill out the whole application form, if you can. You must at least give the County your name, address, and signature (question 1 on page 1 of the application) to begin the application process for CalFresh. For cash aid you must fill out questions 1 through 5 on pages 1 and 2 of the application and sign it to begin the application process. For General Assistance or General Relief ask the County which questions must be answered to begin the application process.
- Each program has a symbol (shown at the top of this page) showing what questions pertain to what programs. For cash aid, it is a dollar sign; for CalFresh, it is a shopping cart; and for health coverage, it is an ambulance. For example, if you are not applying for cash aid, you don't need to answer questions marked only with a dollar sign.
- Give the application to the County in person, by mail, by fax or online.
- The day the County receives your signed application starts the time to give you an answer on whether you can get benefits. If you are in an institution, this time starts from the day you leave.

What do I do next?
- Read about your rights and your responsibilities (Program Rules pages) before you sign the application.
- You must have an interview with the County to discuss your application. If you have a disability, other arrangements can be made.
- If you did not fill out all of the application, you can finish it during your interview.
- You will need to give proof of your income, expenses, and other circumstances to see if you are eligible.

How long will it take?
It may take up to 30 days to process your application for CalFresh. For cash aid and Medi-Cal, it may take up to 45 days. Ask the County how to get your benefits or health care right away if you have an emergency.

You may be able to get CalFresh benefits within 3 calendar days if:

- Your household's monthly gross income (income before deductions) is less than $150 and your cash on hand or in checking or savings accounts is not more than $100; or
- Your household's housing costs (rent/mortgage and utilities) are more than your monthly gross income and money in checking or savings; or
- You are a migrant or seasonal farmworker household with less than $100 in checking or savings and 1) your income stopped, or 2) your income has started but you do not expect to get more than $25 in the next 10 days.

For cash aid, you may get immediate assistance if:

- You are homeless or have an eviction notice or a notice to pay rent or move; or
- Your food will run out within three days; or
- Your utilities have been or will be shut off; or
- You don't have sufficient clothing or diapers; or
- You have another kind of emergency important to health and safety.

Informational Page - Please take and keep for your records.

To help the County see if you can get benefits faster, please complete questions 1, 6 through 9, 15, and 24, and give the County proof of your identity (if you have it) with the application. For General Assistance or General Relief, ask the County how long it will take and about any special rules for getting benefits faster.

The County will send you a letter to let you know if your household is approved or denied for the benefits you applied for.

What do I need for my interview?
To avoid delays, bring proof of the following items with you to your interview. Keep your interview even if you do not have the proof. The County may be able to help if you need help getting proof. During the interview, the County will go over the information on the application and will ask you questions to see if you can get benefits and the amount of benefits you can get.

Proof Needed to Get Benefits

- Identification (Driver's License, State ID card, passport).
- Birth certificates for everyone applying for cash aid.
- Proof of where you live (rental agreement, current bill with your address listed).
- Social Security numbers for everyone applying for aid (see note below about certain noncitizens).
- Money in the bank for all the people in your household (recent bank statements).
- Earned income of everyone in your household for the past 30 days (recent pay stubs, a work statement from an employer). **NOTE:** If self-employed, income and expenses or tax records.
- Unearned income (Unemployment benefits, SSI, Social Security, Veteran's benefits, child support, worker's compensation, school grants or loans, rental income, etc.).
- Lawful immigration status **ONLY** for legal noncitizens applying for benefits (an Alien Registration Card, visa).
  NOTE: Certain noncitizens applying for immigration status based on domestic violence, crime prosecution or trafficking may not need this proof. They also may not need a Social Security Number.

Proof Needed to Get <u>More</u> CalFresh Benefits

- Housing costs (rent receipts, mortgage bills, property tax bill, insurance documents).
- Phone and utility costs.
- Medical expenses for anyone in your household who is elderly (60 and older) or disabled.
- Child and adult care costs due to someone working, looking for work, attending training or school, or participating in a required work activity.
- Child support paid by a person in your household.

Additional Proof Needed for Health Coverage

- Information about any job related health insurance available to your family.
- Policy numbers for any current health insurance.

Additional Proof Needed for Cash Aid

- Proof of immunizations for children six years of age or younger.
- Vehicle registration for vehicles owned by you or someone you are applying for.

What if I am homeless?
Please let the County know right away if you are homeless so they can help you figure out an address to use to accept your application and get notices from the County regarding your case. For CalFresh and cash aid, homeless means you are:

A. Staying in a supervised shelter, halfway house, or similar place.
B. Staying at the home of another person or family for no more than 90 days straight.
C. Sleeping in a place not designed for, or normally used as, a place to sleep (a hallway, a bus station, a lobby, or similar places).

Informational Page - Please take and keep for your records.

RIGHTS AND RESPONSIBILITIES

You have a responsibility to:

- Give the County all information needed to determine your eligibility.
- Give the County proof of the information you have when it is needed.
- Report changes as required. The County will give you information about what, when, and how to report. For CalFresh and cash aid if you don't meet your household's reporting requirements, your case may be closed or your benefits may be lowered or stopped.
- Look for, get, and keep a job or participate in other activities if the County tells you that it is required in your case.
- Fully cooperate with county, state, or federal personnel if your case is selected for review or investigation to ensure that your eligibility and benefit level were correctly figured. Failure to cooperate in these reviews will result in loss of your benefits.
- Pay back any cash aid or CalFresh benefits that you were not eligible to get.

You have the right to:

- Turn in an application for CalFresh giving only your name, address, and signature.
- Have an interpreter provided by the State at no cost if you need one.
- Have information given to the County kept confidential, unless directly related to the administration of County programs.
- Withdraw your application at any time prior to the County determining eligibility.
- Ask for help to fill out your application or help getting the proof that you need and get an explanation of the rules.
- Be treated with courtesy, consideration, and respect, and not be discriminated against.
- Get CalFresh benefits within 3 days if you qualify for Expedited Service.
- Get cash aid within one day if you qualify for Immediate Need.
- Be interviewed in a reasonable amount of time by the County when you apply and to have your eligibility determined within 30 days for CalFresh or 45 days for cash aid and Medi-Cal.
- Get at least 10 days to give to the County proof that is needed to make a determination of eligibility.
- Get written notice at least 10 days before the County lowers or stops your CalFresh or cash aid benefits.
- Discuss your case with the County and to review your case when you ask to do so.
- Ask for a State hearing within 90 days if you do not agree with the County about your case. If you ask for a hearing before an action on your case takes place, your benefits will stay the same until the hearing or the end of your certification period, whichever is earlier. You can ask the County to let your benefits change until after the hearing to avoid having to pay back any overpaid benefits. If the Administrative Law Judge rules in your favor, the County will give back to you any benefits that were cut.
- Ask about your hearing rights or for a legal aid referral at the toll-free phone numbers – **1-800-952-5253** or for hearing or speech impaired who use TDD, **1-800-952-8349.** You may get free legal help at your local legal aid or welfare rights office.
- Bring a friend or someone with you to the hearing if you do not want to go alone.
- Get help from the County to register to vote.
- Report changes that you are not required to report, if it may increase your CalFresh benefits or cash aid.
- Give proof of your household's expenses that may help you get more CalFresh benefits. Not giving proof to the County is the same as saying that you do not have that expense and you will not be able to get more CalFresh benefits.
- Let the County know if you would like someone else to use your CalFresh benefits for your household or help with your CalFresh case (Authorized Representative).

  You are also giving the Medi-Cal agency the right to pursue and get medical support from a spouse or parent. If you think that cooperating to collect medical support will harm you or your children, you can tell the Medi-Cal agency and you may not have to cooperate.

Please take and keep for your records

Program Rules and Penalties

You are committing a crime if you give false or wrong information, or do not give all the information on purpose to try to get CalFresh, cash aid, and Medi-Cal, that you are not eligible to receive, or to help someone else get benefits that they are not eligible to receive. You must pay back any benefits you get that you were not eligible to receive. If you do this on purpose and receive more than $950 in benefits you were not eligible to receive, you can be charged with a felony.

For CalFresh: I understand that if I commit an intentional program violation by doing any of the following:	**I may...**
• hide information or make false statements	• lose CalFresh benefits for 12 months for the first offense and be required to repay all CalFresh benefits overpaid to me
• use electronic benefit transfer (EBT) cards that belong to someone else or let someone else use my card	• lose CalFresh benefits for 24 months for the second offense and be required to repay all CalFresh benefits overpaid to me
• use CalFresh benefits to buy alcohol or tobacco	• lose CalFresh benefits permanently for the third offense and be required to repay all CalFresh benefits overpaid to me
• trade, sell, or give away CalFresh benefits or EBT cards	• be fined up to $250,000, imprisoned up to 20 years, or both
• trade CalFresh benefits for controlled substances, such as drugs	• lose CalFresh benefits for 24 months for the first offense • lose CalFresh benefits permanently for the second offense.
• give false information about who I am and where I live so I can get extra CalFresh benefits	• lose CalFresh benefits for 10 years for each offense
• have been convicted of trading or selling CalFresh benefits worth more than $500, or trading CalFresh benefits for firearms, ammunition, or explosives	• lose CalFresh benefits forever
For cash aid I understand that if I...	**I may...**
• am convicted of an intentional program violation	• lose my cash aid
• do not follow cash aid rules	• be fined up to $10,000 and/or sent to jail/prison for 5 years
• am found guilty by a court of law or an administrative hearing of committing certain types of fraud	• lose cash aid for 6 months, 12 months, 2 years, 4 years, 5 years, or forever.

Important Information for Noncitizens

- You can apply for and get CalFresh benefits, cash aid, or health care for people who are eligible, even if your family includes others who are not eligible. For example, immigrant parents may apply for CalFresh benefits, cash aid, or health care for their U.S. citizen or qualified immigrant children, even though the parents may not be eligible.
- Getting food benefits will not affect you or your family's immigration status. Immigration information is private and confidential.
- The immigration status of noncitizens who are eligible and apply for benefits will be checked with the U.S. Citizenship and Immigration Services (USCIS). Federal law says the USCIS cannot use the information for anything else except cases of fraud.

Opting Out

You do not have to give immigration information, Social Security numbers, or documents for any noncitizen family member(s) who are not applying for benefits. The County will need to know their income and resource information to correctly determine your household's benefits. The County will not contact USCIS about the people who don't apply for benefits.

Use of Social Security Numbers (SSN)

CalFresh and Cash Aid: Everyone applying for CalFresh benefits or cash aid needs to provide a SSN, if you have one, or proof that you have applied for a SSN (such as a letter from the Social Security office). We can deny you or any member of your household who does not give us a SSN. Some people do not have to give SSNs to get help such as, victims of domestic abuse, crime prosecution witnesses, and trafficking victims.
Health Coverage/Medi-Cal: We need your SSN if you want health coverage and have a SSN. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting a SSN, Call 1-800-772-1213 or visit the website: www.socialsecurity.gov

Overissuance

This means you got more CalFresh benefits than you should have. You will have to pay it back even if the county made an error or if it wasn't on purpose. Your benefits may be lowered or stopped. Your SSN may be used to collect the amount of benefits owed, through the courts, other collection agencies, or federal government collection action.

Please take and keep for your records

Overpayment
This means that you got more cash aid than you should have gotten. Just like with CalFresh benefits, you will have to pay it back even if the County made an error or if it wasn't on purpose. Your cash aid may be lowered or stopped. Your SSN may be used to collect the amount of benefits owed, through the courts, other collection agencies, or federal government collection action.

Reporting
Every household that gets benefits must report certain changes. Your county will tell you what changes to report, how to report them, and when to report them. Failure to report the changes may result in your benefits being lowered or stopped. You can also report if things happen that may increase your benefits, such as getting less income.

State Hearings
You have the right to a State hearing if you do not agree with any action taken regarding your application or your ongoing benefits. You can request a State hearing within 90 days of the County's action and you must tell why you want a hearing. The approval or denial notice you receive from the County will have information on how to request an appeal. If you ask for a hearing before the action happens, you may be able to keep your cash aid and CalFresh benefits the same until a decision is made.

Privacy Act and Disclosure
You are giving personal information in the application. The County uses the information to see if you are eligible for benefits. If you do not give the information, the County may deny your application. You have a right to review, change, or correct any information that you gave to the County. The County will not show your information or give it to others unless you give them permission or federal and state law allows them to do so. The County will verify this information through computer matching programs, including the Income and Earnings Verification System (IEVS). This information will be used to monitor compliance with program regulations and for program management. The County may share this information with other federal and state agencies for official examination, with law enforcement officials for the purpose of arresting persons fleeing to avoid the law, and with private claims collection agencies for claims collection action. The County may verify immigration status of household members applying for benefits by contacting the USCIS. Information the County gets from these agencies may affect your eligibility and level of benefits.

The County will use the information from your application to check your eligibility for help with paying for health coverage. The County will check your answers using information in state and federal electronic databases and databases from the Internal Revenue Service (IRS), Social Security Administration, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, the County may ask you to send proof.

Nondiscrimination
It is the State and County's policy that all people be treated equally, and with respect and dignity. In accordance with federal law and the U.S. Department of Agriculture (USDA) Policy, discriminating on the basis of race, color, national origin, sex, age, religion, political beliefs, or disabilities is strictly prohibited.

To file a complaint of discrimination, either contact your County's Civil Rights Coordinator, or write to or call the USDA or California Department of Social Services (CDSS):

USDA, Director
Office of Civil Rights, Room 326-W
Whitten Building
1400 Independence Ave.
Washington D.C. 20250-9410
1-202-720-5964 (voice and TDD)

CDSS
Civil Rights Bureau
P.O. BOX 944243, M.S. 8-16-70
Sacramento, CA 94244-2430
1-866-741-6241 (Toll-Free)

USDA is an equal opportunity employer.

Work Rules for CalFresh
The county may assign you to a work program. They will tell you if it is voluntary or if you must do the work program. If you have a mandatory work activity and you do not do it, your benefits may be lowered or stopped.

You may not be eligible for CalFresh if you have recently quit a job.

Please take and keep for your records

Work Rules for CalWORKs (Welfare-to-Work)

If you get cash aid, you must participate in Welfare-to-Work (WTW) unless you are exempt. The county will tell you if you are exempt from WTW. If you do not do your assigned activities your cash aid may be lowered or stopped.

CalWORKs - Fingerprinting/Photo Imaging

All eligible adult household members for cash aid must be fingerprinted/photo-imaged. If anyone who is required to cooperate with these rules does not get fingerprinted/photo-imaged, no benefits will be issued to the entire household. The fingerprint/photo images are confidential and can only be used to prevent or prosecute welfare fraud.

How do I get/use my benefits?
CalFresh and Cash Aid:

- The County will mail or give you a plastic Electronic Benefit Transfer (EBT) card. Benefits will be put on the card when your application is approved. Sign your card when you get it. You will set up a Personal Identification Number (PIN) to get cash from ATMs or to buy food and/or other items.
- If your EBT card is lost, stolen, destroyed or you think someone may know your PIN number that you don't want to use your benefits call (877) 328-9677 or call the County right away to report it and change your PIN number. Make sure all responsible adults and your authorized representative also know how to report one of these problems right away. Any benefits taken from your account before you report the EBT card or PIN lost or stolen will **NOT** be replaced.
- You can use your CalFresh benefits to buy almost all foods, as well as seeds and plants to grow your own food. You cannot buy alcohol, tobacco, pet food, some types of cooked food, or anything that is not food (like toothpaste, soap, or paper towels).
- CalFresh benefits are accepted at most grocery stores and other places that sell food. Cash aid can be used at most stores and most ATMs. Some ATMs may charge a fee. There may also be a fee if you use an ATM to get cash after three withdrawals. For a list of locations near you that accept EBT, please go to: https://www.ebt.ca.gov or https://www.snapfresh.org. You can also find out where you can get cash without paying a fee.
- CalFresh benefits are only for you and your household members. Your cash aid is only for you and the members of your family who were approved for cash aid. Your cash aid is to help meet the basic needs of your family (housing, food, clothing, etc.). Keep your benefits safe. Do not give out your PIN number. Do not keep your PIN number with your EBT card.
- Any use of your EBT card by you, a household member, your authorized representative, or anyone you voluntarily give your EBT card and PIN to will be considered approved by you and any benefits taken from your account will **NOT** be replaced.

Medi-Cal and Health Care:

- For Medi-Cal, you will receive a Benefits Identification Card (BIC).
  - Sign your BIC when you get it and use it only to get necessary health care services.
  - Never throw your BIC away (unless we give you a new BIC). You need to keep your BIC even if you stop getting Medi-Cal. You can use the same BIC if you get cash aid or Medi-Cal again.
  - Take the BIC to your medical provider when you or a family member is sick or has an appointment.
  - Take the BIC to the medical provider who treated you or your family member(s) in an emergency situation as soon as possible after the emergency.
- For other health care programs you will receive a health plan card from your particular carrier.

General Assistance and General Relief:

- General Assistance and General Relief are County run programs for adults without children. The County will tell you about your rights and responsibilities and the program rules if you are applying for one of these programs.

Please take and keep for your records

Please use black or blue ink because it is easy to read and copies best. Please print your answers.
If you need more space to answer a question(s), attach additional sheets of paper to provide the information. Please be sure to identify which question you are writing about on the additional sheets of paper.

1. APPLICANT'S INFORMATION

NAME (FIRST, MIDDLE, LAST)	OTHER NAMES (MAIDEN, NICKNAMES, ETC.)	SOCIAL SECURITY NUMBER (IF YOU HAVE ONE AND ARE APPLYING FOR BENEFITS)

HOME ADDRESS OR DIRECTIONS TO YOUR HOME	APARTMENT #	CITY	COUNTY	STATE	ZIP CODE
MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	APARTMENT #	CITY	COUNTY	STATE	ZIP CODE

I want to get information about this application by email. ☐ Yes ☐ No

I want to get messages about my case by email. ☐ Yes ☐ No

HOME PHONE	WORK/ALTERNATE/MESSAGE PHONE	EMAIL ADDRESS

What programs are you applying for? ☐ CalFresh ☐ Cash Aid ☐ Health Coverage ☐ Other_____

Do you have a disability and need help applying? ☐ Yes ☐ No

Are you homeless? ☐ Yes ☐ No If **yes,** please let the County know right away if you are homeless, so they can help you figure out an address to use to accept your application and get notices from the county about your case.

What language do you prefer to read (if not English)?_____
What language do you prefer to speak (if not English)?_____

The County will provide an interpreter at no cost to you. If you are deaf or hard of hearing please check here ☐

Is your household's gross income less than $150 and cash on hand, checking and savings accounts $100 or less?	☐ Yes ☐ No	Have your utilities been shut off or do you have a shut-off notice?	☐ Yes ☐ No
Is your household's combined gross income and liquid resources less than the combined rent/mortgage and utilities?	☐ Yes ☐ No	Will your food run out in 3 days or less?	☐ Yes ☐ No
Is your household a migrant/seasonal farm worker household with liquid resources not exceeding $100?	☐ Yes ☐ No	Do you need help with transportation to get food, clothing, medical care or other emergency item(s)?	☐ Yes ☐ No
Do you have an eviction notice or a notice to pay rent or leave?	☐ Yes ☐ No	Do you need essential clothing, such as diapers or clothing needed for cold weather?	☐ Yes ☐ No

Is anyone pregnant? ☐ Yes ☐ No If yes, did she get a Presumptive Eligibility card? ☐ Yes ☐ No

Does anyone in your household have a personal emergency? ☐ Yes ☐ No If **yes**, check box: ☐ Pregnancy ☐ Immediate Medical Need ☐ Child Abuse ☐ Domestic Abuse ☐ Elder Abuse ☐ Other emergency which threatens health or safety. Explain:

I understand that by signing this application under penalty of perjury (making false statements), that:

- I read, or had read to me, the information in this application and my answers to the questions in this application.
- Any answers I have given on pages 1 through 17 and appendices A through E of the SAWS 2 Plus are true, correct, and complete to the best of my knowledge.
- I read or had read to me and I understand and agree to the Rights and Responsibilities (Program Rules Page 1).
- I read, or had read to me, the Program Rules and Penalties (Program Rules Pages 2 - 4).
- I understand that giving false or misleading statements or misrepresenting, hiding or withholding facts to establish eligibility is fraud and that I may be subject to penalties under federal law if I provide false or untrue information. Fraud can cause a criminal case to be filed against me and/or I may be barred for a period of time (or life) from getting CalFresh benefits and cash aid.
- I understand that Social Security Numbers or Immigration Status for household members applying for benefits may be shared with the appropriate government agencies as required by federal law.
- I am giving the Medi-Cal agency the right to pursue and get any money from other health insurance, legal settlements, or other third parties.

SIGNATURE OF APPLICANT, CARETAKER RELATIVE (OR ADULT HOUSEHOLD MEMBER/ AUTHORIZED REPRESENTATIVE*/GUARDIAN) ***If you have an Authorized Representative, please complete Question 2 on the next page.**	DATE
SIGNATURE OF SPOUSE, OTHER PARENT, OTHER AIDED ADULT, OR REGISTERED DOMESTIC PARTNER	DATE

2. HOUSEHOLD'S AUTHORIZED REPRESENTATIVE

You may authorize someone 18 years or older to help your household with your CalFresh benefits. This person can also speak for you at the interview, help you complete forms, shop for you, and report changes for you. You will have to repay any benefits you may get by mistake because of information this person gives the County and any benefits you didn't want them to spend will not be replaced. If you are an Authorized Representative you will need to give the County proof of identity for yourself and the applicant.

Do you want to name someone to help you with your CalFresh case? ☐ Yes ☐ No

If **yes**, complete the following section:

AUTHORIZED REPRESENTATIVE NAME	AUTHORIZED REPRESENTATIVE PHONE NUMBER

Do you want to name someone to receive and spend CalFresh Benefits for your household? ☐ Yes ☐ No

If **yes**, complete the following section:

NAME	PHONE NUMBER

ADDRESS CITY, STATE, ZIP CODE

2a. HEALTH INSURANCE AUTHORIZED REPRESENTATIVES

You can give a trusted person permission to talk about your application for health insurance, see your information, and act for you on things about this part of your application. Do you want to choose an authorized representative for the health insurance part of your application? ☐ Yes ☐ No If yes, fill out the information in Appendix C.

3. Are you or any member of your family American Indian or Alaskan Native? ☐ Yes ☐ No
If **yes**, and applying for health care, please go to Appendix B for additional questions.

RACE/ETHNICITY

Race and ethnicity information is optional. It is requested to assure that benefits are given without regard to race, color, or national origin. Your answers will not affect your eligibility or benefit amount. Check all that apply to you. The law says the County must record your ethnic group and race.

☐ Check this box if you do not want to give the County information about your race and ethnicity. If you do not, the County will enter this information for civil rights statistics only.

ETHNICITY	ARE YOU OF HISPANIC, LATINO, OR SPANISH ORIGIN? ☐ Yes ☐ No	IF YOU ARE OF HISPANIC, OR LATINO ORIGIN, DO YOU CONSIDER YOURSELF ☐ Mexican ☐ Puerto Rican ☐ Cuban ☐ Other_____

RACE/ETHNIC ORIGIN

☐ White ☐ American Indian or Alaskan Native ☐ Black or African American ☐ Other or Mixed _____

☐ Asian (If checked, please select one or more of the following):

☐ Filipino ☐ Chinese ☐ Japanese ☐ Cambodian ☐ Korean ☐ Vietnamese ☐ Asian Indian ☐ Laotian

☐ Other Asian (specify)_____

☐ Native Hawaiian or Other Pacific Islander (If checked, please select one or more of the following): ☐ Native Hawaiian

☐ Guamanian or Chamorro ☐ Samoan

4. INTERVIEW PREFERENCE

You will need to have an interview with the County to discuss your application and to receive cash aid or CalFresh benefits. Interviews for CalFresh are usually done by phone, unless you can be interviewed when giving your application to the County in person or would prefer an in-person interview. Cash aid applicants must have an in person interview. If you are applying for CalWORKs and CalFresh, your CalFresh interview will be done at the same time as your CalWORKs interview during normal office hours.

☐ Please check this box if you would prefer an in-person interview for CalFresh.

☐ Please check this box if you need other arrangements due to a disability.

5. OTHER PROGRAMS

Has anyone in your household ever received public assistance (Temporary Assistance for Needy Families, Tribal TANF, Medicaid, Supplemental Nutrition Assistance Program [food stamps], General Assistance/General Relief, etc.)? ☐ Yes ☐ No

IF **YES,** WHO?	WHERE *(COUNTY/STATE)*?
IF **YES**, WHO?	WHERE *(COUNTY/STATE)*?

6. HOUSEHOLD'S INFORMATION: ADULTS

Complete the following information for all adults in the home. If applying for health care coverage, also include any adults claimed on your tax return.
If you are applying for cash aid and there is more than one adult in the home who is applying for cash aid or who is the parent of a child applying for aid, please go to Appendix D for additional questions.
For noncitizens you are applying for, please complete additional questions 6e and 6f.

APPLYING FOR BENEFITS *(check each type)*									**Marital Status**							Only answer the question below for each person applying for benefits.	Social Security number is optional for members not applying for benefits.
CalFresh	*Cash Aid	Medi-Cal Health Care	None	**NAME** (Last, First, Middle Initial)	How is the person related to you?	**DATE OF BIRTH**	**GENDER** (M OR F)	Single	Married	Separated	Divorced	Widowed	Full-Time Student (check if yes)	Disabled (check if yes)		**U.S. CITIZEN** or **NATIONAL** (check Yes or No) **If no, complete question 6e.**	**SOCIAL SECURITY NUMBER**
☐	☐	☐	☐					☐	☐	☐	☐	☐	☐	☐		☐ Yes ☐ No	
☐	☐	☐	☐					☐	☐	☐	☐	☐	☐	☐		☐ Yes ☐ No	
☐	☐	☐	☐					☐	☐	☐	☐	☐	☐	☐		☐ Yes ☐ No	
☐	☐	☐	☐					☐	☐	☐	☐	☐	☐	☐		☐ Yes ☐ No	
☐	☐	☐	☐					☐	☐	☐	☐	☐	☐	☐		☐ Yes ☐ No	

* **Cash Aid also includes General Assistance and General Relief programs.**

6a. Does everyone listed in question 6 have the same contact information? ☐ **Yes** ☐ **No** **If no, please fill in the person's contact information below. If yes, please skip to the next question.**

NAME (FIRST, MIDDLE, AND LAST)	HOME (STREET) ADDRESS	APARTMENT #	CITY	STATE	ZIP CODE
HOME PHONE NUMBER	MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	APARTMENT #	CITY	STATE	ZIP CODE
WORK/ALTERNATE/MESSAGE PHONE	EMAIL ADDRESS (OPTIONAL)				

NAME (FIRST, MIDDLE, AND LAST)	HOME (STREET) ADDRESS	APARTMENT #	CITY	STATE	ZIP CODE
HOME PHONE NUMBER	MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	APARTMENT #	CITY	STATE	ZIP CODE
WORK/ALTERNATE/MESSAGE PHONE	EMAIL ADDRESS (OPTIONAL)				

6b. HOUSEHOLD'S INFORMATION: CHILDREN

Complete the following information for all children in the home. If applying for health care coverage, also include any children claimed on your tax return.
For noncitizens you are applying for, please complete additional questions 6e and 6f.

APPLYING FOR BENEFITS (check each type): CalFresh	Cash Aid	Medi-Cal Health Care	None	**NAME** (Last, First, Middle Initial)	How is the person related to you?	**DATE OF BIRTH**	**PLACE OF BIRTH**	**SEX** (M / F)	Check all that applies to one or both of the child's parents: Not in home	Unemployed	Disabled	Deceased	None	Full-Time Student (check if yes)	Shots up to date? (check if yes)	Only answer the question below for each person applying for benefits. **U.S. CITIZEN** or **NATIONAL** (check Yes or No) **If no, complete question 6e.**	Social Security number is optional for members not applying for benefits. **SOCIAL SECURITY NUMBER**
☐	☐	☐	☐						☐	☐	☐	☐	☐	☐	☐	☐ Yes ☐ No	
☐	☐	☐	☐						☐	☐	☐	☐	☐	☐	☐	☐ Yes ☐ No	
☐	☐	☐	☐						☐	☐	☐	☐	☐	☐	☐	☐ Yes ☐ No	
☐	☐	☐	☐						☐	☐	☐	☐	☐	☐	☐	☐ Yes ☐ No	
☐	☐	☐	☐						☐	☐	☐	☐	☐	☐	☐	☐ Yes ☐ No	

6c. SOCIAL SECURITY INFORMATION

Does everyone applying for aid have a Social Security Number? ☐ Yes ☐ No If **no**, please fill in the information below.
We need the Social Security Number for everyone who is applying for aid. There are some exceptions for people who are victims of domestic violence or other crimes such as human trafficking. If you need help getting a Social Security Number call 1-800-772-1213 or go online to www.socialsecurity.gov.

NAME	REASON FOR NOT HAVING A SOCIAL SECURITY NUMBER	APPLIED FOR SSN
	☐ The person is a child who is less than one year old. ☐ It is against this person's religion. ☐ This person does not qualify for an SSN. ☐ Other ____________	Has this person applied for a Social Security Number? ☐ Yes ☐ No
	☐ The person is a child who is less than one year old. ☐ It is against this person's religion. ☐ This person does not qualify for an SSN. ☐ Other ____________	Has this person applied for a Social Security Number? ☐ Yes ☐ No

6d. Has anyone been in the U.S. Military service or are they the spouse, parent or child of a person who was? ☐ Yes ☐ No

If **yes**, please complete the information below. If **no**, please continue to the next question.

Name	U.S. Citizen?	(✔) Status	Honorable Discharge?	Dates of Service
	☐ Yes ☐ No	☐ Active duty ☐ Veteran ☐ Spouse, parent, or child of person in active duty or a veteran	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Active duty ☐ Veteran ☐ Spouse, parent, or child of person in active duty or a veteran	☐ Yes ☐ No	

6e. NONCITIZEN INFORMATION - Please complete for noncitizens you are applying for.

Name	Date entered U.S. (if known)	Does this person have an eligible immigration status? If yes, please provide their immigration document and number.	Has this person lived in the U.S. continuously since 1996?	Is this person a Naturalized Citizen?	Sponsored? (check Yes or No) If yes, complete question 6f
		DOCUMENT TYPE: DOCUMENT NUMBER:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
		DOCUMENT TYPE: DOCUMENT NUMBER:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
		DOCUMENT TYPE: DOCUMENT NUMBER:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Does anyone listed above have at least 10 years *(40 quarters)* of work history? ☐ Yes ☐ No

If **yes**, who? _____

Does anyone listed above have, or have they applied for, or do they plan to apply for a T-Visa or U-Visa, VAWA petition? ☐ Yes ☐ No

If **yes**, who? _____

Has anyone changed their immigration status in the last 12 months? ☐ Yes ☐ No

If **yes**, please complete the information below.

If **no,** please continue to the next question.

NAME	WHAT CHANGED?	DATE OF CHANGE	ALIEN NUMBER (IF APPLICABLE)
NAME	WHAT CHANGED?	DATE OF CHANGE	ALIEN NUMBER (IF APPLICABLE)

6f. Sponsored Noncitizen Information - Please answer for sponsored noncitizens you are applying for.

Did the sponsor sign an I-864? ☐ Yes ☐ No If **yes**, please answer the rest of the question.
If the sponsor signed an I-134 then **skip** this question.

Does the sponsor regularly help with money? ☐ Yes ☐ No If yes, how much? $ _____

Does the sponsor regularly help with any of the following (check all that apply)?

☐ rent ☐ clothes ☐ food ☐ other_____

SPONSOR'S NAME	WHO IS SPONSORED?	SPONSOR'S PHONE NUMBER
SPONSOR'S NAME	WHO IS SPONSORED?	SPONSOR'S PHONE NUMBER

6g. Does anyone listed in question 6 who is under the age of 21 have a parent who does not live in the home?

☐ Yes ☐ No If **yes**, please list the name of the child(ren) and the name(s) of the parents who do not live in the home.
If **no**, please continue to the next question.

NAME OF CHILD	NAME OF PARENT(S) NOT LIVING IN THE HOME
NAME OF CHILD	NAME OF PARENT(S) NOT LIVING IN THE HOME

6h. Does anyone in question 6 live with at least one child under the age of 19 and are they the main person taking care of the child?

☐ Yes ☐ No If **no**, skip to the next question. **If yes, who?**_____

6i. Does anyone listed in question 6 have a physical, mental, emotional, or developmental disability that causes limitations in activities (such as bathing, dressing, daily chores)? ☐ Yes ☐ No If **yes**, please list the name(s) of the person with the disability. If **no**, please continue to the next question.

Name:_____ Name:_____

6j. Complete for each disabled person listed in question 6.

Name of person	Does this person need help with activities of daily living through personal assistance or a medical facility? ☐ Yes ☐ No If **yes**, explain:
Disability is expected to last: ☐ 30 days or more ☐ 12 months or more	Does this person work and have medical expenses that are needed to help them keep working? For example, a wheelchair, leg braces, etc. ☐ Yes ☐ No If **yes**, please explain.
Does this person need care so that someone else can work or attend school? ☐ Yes ☐ No	Is this person in a medical facility or nursing home? ☐ Yes ☐ No If **yes**, what is the name of the medical facility or nursing home?

Name of person	Does this person need help with activities of daily living through personal assistance or a medical facility? ☐ Yes ☐ No If **yes**, explain:
Disability is expected to last: ☐ 30 days or more ☐ 12 months or more	Does this person work and have medical expenses that are needed to help them keep working? For example, a wheelchair, leg braces, etc. ☐ Yes ☐ No If **yes**, please explain.
Does this person need care so that someone else can work or attend school? ☐ Yes ☐ No	Is this person in a medical facility or nursing home? ☐ Yes ☐ No If **yes**, what is the name of the medical facility or nursing home?

6k. Is there a child or disabled person in the household who needs care from another household member?

☐ Yes ☐ No If **yes**, please explain. If **no**, skip to the next question.

6l. Students
Is anyone who is applying for benefits attending a college or vocational school? ☐ Yes ☐ No
If **yes**, please answer this queston. If **no**, skip to the next question.

Name of Person	Name of School/Training	Enrolled Status (✔ check one)	Working?
		☐ Half-time or more ☐ Less than half-time Number of Units:_____	Average work hours per week: _____
		☐ Half-time or more ☐ Less than half-time Number of Units:_____	Average work hours per week: _____

6m. Is anyone listed in question 6 or 6b pregnant or a teen parent? ☐ Yes ☐ No
If **yes**, please answer the question. If **no**, skip to the next question.

Name	Is this person under the age of 20? ☐ Yes ☐ No Is this person a teen parent? ☐ Yes ☐ No	School status if under the age of 20 ☐ Has a high school diploma ☐ Has a GED ☐ Is attending school regularly ☐ Is not attending school regularly (explain why):	Due date (if known)	How many babies are expected with this pregnancy?
Name	Is this person under the age of 20? ☐ Yes ☐ No Is this person a teen parent? ☐ Yes ☐ No	School status if under the age of 20 ☐ Has a high school diploma ☐ Has a GED ☐ Is attending school regularly ☐ Is not attending school regularly (explain why):	Due date (if known)	How many babies are expected with this pregnancy?

6n. Has anyone ever gotten a cash bonus or penalty, or help with child care, transportation or other service from the Cal-Learn Program? ☐ Yes ☐ No
If **yes**, please answer the question. If **no**, skip to the next question.

Name	**Where** (County)	Date(s) Received

6o. Was anyone listed in question 6 ever in foster care? ☐ Yes ☐ No
If **yes**, please explain.

Name:	When:	State:	Is this person 26 years of age or younger and were they in foster care on their 18th birthday? ☐ Yes ☐ No
Name:	When:	State:	Is this person 26 years of age or younger and were they in foster care on their 18th birthday? ☐ Yes ☐ No

6p. Is there a foster child currently living in your home who is receiving foster care services? ☐ Yes ☐ No
If **yes**, who?_____
Please answer the following questions about the foster child(ren):

Was this child(ren) placed in your home under a dependency order of the court? ☐ Yes ☐ No
Do you want the foster care child(ren) counted in your CalFresh case? ☐ Yes ☐ No
If **yes**, the foster care income you receive will be counted as unearned income.
If **no**, the foster care income will not be counted as unearned income.

6q. Does everyone listed in question 6 live in California and expect to keep living here? ☐ Yes ☐ No
If **no**, please explain.

6r. Does anyone listed in question 6 plan to leave California for more than 30 days? ☐ Yes ☐ No
If **yes**, please explain.

NAME	WHEN DO THEY PLAN TO LEAVE?	DOES THIS PERSON PLAN TO RETURN TO CALIFORNIA? ☐ YES ☐ NO IF YES, WHEN:
NAME	WHEN DO THEY PLAN TO LEAVE?	DOES THIS PERSON PLAN TO RETURN TO CALIFORNIA? ☐ YES ☐ NO IF YES, WHEN:

7. Unearned Income
Does anyone get income that does not come from work (unearned)? ☐ Yes ☐ No If **yes**, please answer this question.
If **no**, skip to the next question.

Check all types of unearned income that apply from these examples (there may be others not listed here):

- ☐ Social Security Disability
- ☐ SSI/SSP
- ☐ Cash aid
- ☐ CalWORKs/TANF/GA/GR/CAPI/RCA
- ☐ Room and board (from a renter)
- ☐ Pension
- ☐ Child/Spousal support
- ☐ Rental/Royalties
- ☐ Social Security retirement or survivors benefits
- ☐ Per capita payments
- ☐ Work study/welfare to work or other program
- ☐ Sales of notes, contracts, trust deeds, promissory notes
- ☐ Veterans education benefits/income
- ☐ Government/railroad disability or retirement
- ☐ Veteran benefits or Military pension
- ☐ Financial aid (school grants/loans/scholarships)
- ☐ Gifts of money or other loans
- ☐ Unemployment Insurance/ State Disability Insurance (SDI)
- ☐ Worker's Compensation
- ☐ Net Farming/Fishing
- ☐ Lottery/gambling winnings
- ☐ Help with rent/food/clothing
- ☐ Insurance or legal settlements
- ☐ Private disability or retirement
- ☐ Dividend and interest income
- ☐ Strike benefits
- ☐ Other_____ _____

Person Getting the Money?	**From Where?**	**How Much?**	**How Often Received?** (once, weekly, monthly, or other)	**Expect to Continue?** (Check **Yes** or **No**)
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

If this income is not expected to continue, please explain:

8. Earned income

Does anyone get income from a job (earned income)? ☐ Yes ☐ No If **yes**, please answer this question.
If **no**, skip to the next question.
NOTE: If self-employed, fill out question 8a below.
Please list all income **before** taxes or other deductions are taken out (gross income).
Examples of earned income are (these examples can be full-time, temporary seasonal work, or training, and there may be others not listed here):

- Wages
- Commissions
- Tips
- Salaries
- Work study (students)
- Include any paid jobs the County helped you get.

Person Working	Employer's Name and Address	Employer's Phone Number	Hourly Rate	Average hours per week	How Often Paid? (Once weekly, monthly, other)	Total Gross Earned Income Received This Month?	Expect to Continue? (✔ Check **Yes** or **No**)
			$			$	☐ Yes ☐ No
			$			$	☐ Yes ☐ No
			$			$	☐ Yes ☐ No
			$			$	☐ Yes ☐ No

If this income is not expected to continue, please explain:

Has anyone lost a job, changed jobs, quit a job, or reduced work hours within the last 60 days? ☐ Yes ☐ No
In the last year? ☐ Yes ☐ No
Did the County help the person get this job? ☐ Yes ☐ No

IF YES, WHO?	DATE OF JOB LOSS, QUIT, OR CHANGE	DATE OF LAST PAY	REASON?

IS ANYONE ON STRIKE?	IF YES, WHO?	DATE WENT ON STRIKE	DATE OF LAST PAY	REASON?
☐ Yes ☐ No				

8a. Self-Employment

Self-employed household members may take actual self-employment expenses (or for CalFresh or cash aid, take a standard 40% deduction off of self-employment income). For cash aid, you may also choose to use a monthly average (yearly business costs divided by 12 months). If you choose actual expenses, you must list your business expenses on a separate sheet of paper.

Person Self-Employed	Business Name	Type of Business	Date Business Started	Gross Monthly Income	Self-Employment Expenses (please ✔ check one)	*Net Monthly Income
				$	☐ 40% flat Rate (CalFresh/cash aid) ☐ Actual Expenses $ _____ ☐ Monthly Average $ _____	$
				$	☐ 40% flat Rate (CalFresh/cash aid) ☐ Actual Expenses $ _____ ☐ Monthly Average $ _____	$
				$	☐ 40% flat Rate (CalFresh/cash aid) ☐ Actual Expenses $ _____ ☐ Monthly Average $ _____	$

* Net monthly income is gross monthly income minus expenses.

9. Other Income

Does anyone get housing or rent, utilities, food or clothing free or in exchange for work? ☐ Yes ☐ No

If **yes**, please answer this question.

If **no**, skip to the next question.

Item Received	Free	For Work	Who gets the item?	Value	Who gives the item?
Housing or Rent	☐	☐		$	
Utilities	☐	☐		$	
Food	☐	☐		$	
Clothing	☐	☐		$	

10. Yearly Income

Does anyone's total income (unearned, earned, and self employment) change from month to month? ☐ Yes ☐ No

If **yes**, please answer this question.

If **no**, skip to the next question.

Name of Person	What will be their total income this year?	What will be their total income next year (if you think it will be different)?
	$	$
	$	$

11. Household's Child/Adult Care Expenses (The actual amount of cost incurred if allowing the expenses to potentially be a deduction).

Does anyone pay for care of a child, disabled adult, or other dependent so you or the other person can go to work, school, or look for a job? ☐ Yes ☐ No If **yes**, please answer this question.

If **no**, skip to the next question.

Who gets care?	Who gives care? (name and address of provider)	Amount paid?	How Often Paid? (weekly/monthly, other)
		$	
		$	
		$	
		$	

Does anyone help your household pay all or part of your child/adult care cots listed above? ☐ Yes ☐ No If y**es,** complete below.

Who gets care?	Who helps pay?	Amount paid?	How Often Paid? (weekly/monthly, other)
		$	
		$	

12. Child Support Payments

Is anyone listed in question 6 legally obligated to pay child support, including back child support? ☐ Yes ☐ No

If **yes**, please answer this question.

If **no**, skip to the next question.

Who pays child support?	Name of child(ren) for whom child support is paid:	Amount paid?	How Often? (weekly/monthly, other)
		$	
		$	

13. Spousal Support/Alimony

Is anyone listed in question 6 legally obligated to pay spousal support/alimony? ☐ Yes ☐ No

If **yes**, please answer the questions below.

If **no**, skip to the next question.

Who pays spousal support/alimony?	Amount paid?	How often? (weekly, bi-weekly. monthly, other)
	$	
	$	

14. Special Needs Expenses

Does anyone have a special medical condition or situation that requires any of the following?

Special diet prescribed by a doctor? ☐ Yes ☐ No

Special phone or other equipment? ☐ Yes ☐ No

Housework (no one in the home can do it)? ☐ Yes ☐ No

Very high use of utilities? ☐ Yes ☐ No

Special laundry service? ☐ Yes ☐ No

Other special need? (specify) ☐ Yes ☐ No

_____

Please list the name of the person with the special need and explain:

_____

15. Household Expenses

Does anyone you purchase and prepare food with get billed for any household expenses? ☐ Yes ☐ No

If **yes**, please answer this question.

If **no**, skip to the next question.

NOTE: Do no enter amounts paid by housing assistance such as HUD or Section 8. The heating and cooling, telephone, other utilities, and the homeless shelter are set allowances. It is not necessary to fill in the actual amount owed.

Type of Expenses	Have Expense?	Who Pays?	Amount Owed	How Often Billed? (weekly/monthly)
Rent or house payment	☐ Yes ☐ No		$	
Property taxes and insurance (if billed separate from rent or mortgage)	☐ Yes ☐ No		$	
Gas, electric, or other fuel used for heating or cooling, such as firewood or propane (if separate from rent or mortgage)	☐ Yes ☐ No			
Telephone/cell phone	☐ Yes ☐ No			
Homeless Shelter Expense	☐ Yes ☐ No			
Water, sewage, garbage	☐ Yes ☐ No			
Does anyone not in your household help you pay for the expenses listed above? ☐ Yes ☐ No If **yes**, please complete.		Who helps pay?	How much? $	How often paid?

Does your household get, or expect to get any payments from the Low Income Home Energy Assistance Program (LIHEAP)? ☐ Yes ☐ No

16. Medical Expenses:
Are you or anyone you buy and prepare food with an elderly (60 or older) or disabled person that has any out-of-pocket medical expenses? ☐ Yes ☐ No
If **yes**, please answer this question.
If **no,** skip to the next question.
NOTE: Do not list spouses or children receiving dependent payments for an SSI or disability and blindness recipient. List expenses you expect to have in the near future.
Allowable medical expenses are:

- ☐ Medical or dental care
- ☐ Hospitalization/outpatient treatment/nursing care
- ☐ Prescribed medications
- ☐ Health and Hospitalization insurance policy premiums
- ☐ Medicare premiums (Medi-Cal share of costs, etc.)
- ☐ Dentures, hearing aids and prosthetics
- ☐ Maintaining an attendant necessary due to age, illness, or infirmity
- ☐ The number and cost of meals furnished to an attendant
- ☐ Prescribed over the counter medications
- ☐ Cost of transportation (mileage or fee) and lodging to obtain medical treatment or services
- ☐ Prescribed eye glasses and contact lenses
- ☐ Prescribed medical supplies and equipment
- ☐ Service animals expenses (food, vet bills, etc.)

Name of Elderly/Disabled Person	Amount of Expense	How often paid? (monthly, weekly, other)	What type of expense? (prescriptions, dentures, # of meals for attendant, etc.)	Will the household be reimbursed for any medical expenses? (by Medi-Cal, insurance, family member, etc.)
	$			IF YES, BY WHO: HOW MUCH: $
	$			IF YES, BY WHO: HOW MUCH: $

17. Other Tax-Deductible Expenses
If anyone pays for anything that can be deducted on a federal income tax return, telling us about it here could make the cost of health insurance a little lower. Do not include anything that you already included in self-employment expenses. If you have other deductible expenses, please answer this question. If **no**, skip to the next question.

Type of Expenses	Have Expense?	Who pays?	How often paid? (weekly/monthly)
Alimony	☐ Yes ☐ No		
Student loan interest	☐ Yes ☐ No		
Other deductions (please identify)	☐ Yes ☐ No		

18. Does anyone in question 6 get food from any of the following? ☐ Yes ☐ No
If **yes**, please answer this question. If **no**, skip to the next question.

- Communal dining facility for the elderly/disabled
- Food distribution program operated by a Native American reservation
- Other food program

IF YES, WHO?	WHAT PROGRAM?
IF YES, WHO?	WHAT PROGRAM?

19. Does anyone in question 6 live at any of the following? ☐ Yes ☐ No
If **yes**, please answer this question. If **no**, skip to the next question.

- Homeless Shelter
- Shelter for battered women
- Reservation for Native Americans
- Drug/Alcohol rehabilitation center
- Correctional facility/Penal institution (Jail or Prison)
- Group living arrangement for the blind/disabled
- Federally subsidized housing
- Psychiatric hospital/mental institution
- Hospital
- Long-Term Care or Board and Care Facility

Person's Name	Name of Institution (Center, Shelter, Facility, etc.)	Expected Date of Release (if applicable)

20. Is anyone getting In-Home Supportive Services (IHSS)? ☐ Yes ☐ No
If **yes**, fill in the information below.

WHO GETS SERVICES?	HOW MUCH DO YOU PAY EACH MONTH FOR THE SERVICES?
	$

21. Does everyone listed in question 6 buy and prepare food with you? ☐ Yes ☐ No
If **no**, list the people who don't buy and prepare food with you.

NAME	NAME
NAME	NAME

21a. Is anyone living with you age 60 or older and unable to buy food and fix meals separately because of a disability?
☐ Yes ☐ No If **yes**, who:_____

22. Answer these questions for anyone who needs health coverage. Is anyone enrolled in health coverage now from the following? ☐ Yes ☐ No
If **yes,** check the type of coverage and write the person(s)' name(s) next to the coverage they have.

☐ Medicaid/Medi-Cal	☐ Employer Insurance
☐ CHIP	Name of health insurance
☐ Medicare	Policy number:
☐ TRICARE (Don't check if you have direct care or Line of Duty)	Is this COBRA coverage? ☐ Yes ☐ No Is this a retiree health plan? ☐ Yes ☐ No
☐ VA health care programs	Is this a state employee benefit plan? ☐ Yes ☐ No
☐ Peace Corps	☐ Other
	Name of health insurance
	Policy Number:
	Is this plan a limited-benefit plan like a school accident policy? ☐ Yes ☐ No

22a. Is anyone listed on this application offered health care coverage from a job? ☐ Yes ☐ No
If **yes**, you'll need to complete and include Appendix A.

22b. Is anyone's health insurance expected to end or has it ended in the last 90 days? ☐ Yes ☐ No
If **yes**, please answer the question. If **no**, skip to the next question.

Insurance Company	Person Insured	Expiration Date	Reason it ended or will end

22c. Does anyone want help for medical bills from the last three months? ☐ Yes ☐ No
If **yes**, who:_____

23. Does anyone listed in question 6 plan to file a federal income tax return next year? ☐ Yes ☐ No
If **yes**, complete the questions below for each tax filer.
If **no**, skip to 23f.

23a. Please complete this section for each person who plans to file a federal income tax return **next year** if you answered **yes** to question 23. You can still apply for health insurance even if you don't file a federal income tax return.

23b. Name of person planning to file a federal income tax return:_____

23c. Will this person file jointly with a spouse? ☐ Yes ☐ No
If **yes**, name of spouse:_____

23d. Will this person claim any dependents on their tax return: ☐ Yes ☐ No
If **yes**, please list the name(s) of the dependents you are claiming:_____

23e. How is the dependent(s) listed in 23d related to the tax filer who will claim them?:_____

23f. To make it easier to determine my eligibility for paying health coverage in future years. I agree to allow you to use income data, including information from tax returns. You will send me a notice, let me make any changes, and I can opt out at any time.
Yes, renew my eligibility automatically for the next (check one): ☐ 5 years ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year
☐ **No**, don't use information from tax returns to renew my coverage.

24. Household's Resources

Does anyone have any resources (cash, money in the bank, Certificate of Deposit, stocks and bonds, etc.)? ☐ Yes ☐ No If y**es**, please answer this question. If **no**, skip to the next question.

Optional for health care; only answer if someone applying is 65 or older or disabled. If applying for cash aid and CalFresh, you must answer the question.

Check each resource listed below that you or anyone in your household has:

- ☐ Bank/Credit Union account (Checking)
- ☐ Bank/Credit Union account (Savings)
- ☐ Safe Deposit box
- ☐ Savings Bond(s)
- ☐ Oil, Mining or Mineral Rights
- ☐ Money Market Account(s)
- ☐ Mutual funds/Trust funds
- ☐ Certificate of Deposit (CD)/IRA
- ☐ Cash on hand
- ☐ Notes, Mortgages, Deeds of Trust
- ☐ Stocks
- ☐ Bonds
- ☐ Uncashed checks
- ☐ Life or Burial insurance
- ☐ Other: _____

If joint account with another person please say so below.

For each box checked above, complete the following information.

In Whose Name is the Resource Listed?	Type of Resource	How Much is it Worth?	Where is the Resource? (include the name of the bank or company where money is held)
		$	
		$	
		$	
		$	

Have you or anyone in your household sold, traded, given away, or transferred a resource in the last thirty (30) months? ☐ Yes ☐ No

WHEN?	WHAT WAS THE RESOURCE?	WHAT WAS IT WORTH?	HOW MUCH DID YOU GET FOR IT
		$	$

If you traded or gave the resource away, please explain:_____

_____

Optional for health care; only answer if someone applying is 65 or older or disabled.

25. Personal Property

Does anyone own any personal or business-related property? ☐ Yes ☐ No
If y**es**, please answer the question. If **no**, skip to the next question.

- ☐ Tools
- ☐ Business inventory
- ☐ Livestock
- ☐ Business equipment
- ☐ Sporting equipment, Guns
- ☐ Non-Motor boats and/or trailers
- ☐ Camper shells
- ☐ Personal tools
- ☐ Jewelry, Artwork, Antiques, Collections, Musical instruments (Piano, Organ, etc.)

Please include the item even if it is jointly owned with someone else. Do not include wedding or engagement rings, family heirlooms, etc. List any other jewelry worth $100 or more and household goods or personal items worth more than $500 per item.

Item	Is it listed for Sale?	Purchase Price or Current Value	Amount Owed
	☐ Yes ☐ No	$	$
	☐ Yes ☐ No	$	$
	☐ Yes ☐ No	$	$
	☐ Yes ☐ No	$	$
	☐ Yes ☐ No	$	$
	☐ Yes ☐ No	$	$
	☐ Yes ☐ No	$	$
	☐ Yes ☐ No	$	$

Optional for health care; only answer if someone applying is 65 or older or disabled. If you are applying for cash aid, you must answer the question.

26. Vehicles

Does anyone own, have the use of, or have their name on any registration of any motor vehicle, such as: a car, motorcycle, snowmobile, recreational vehicle (RV), or motorboat, etc., even if it isn't running? ☐ Yes ☐ No

If **yes**, please fill out the information in Appendix E.

27. Does anyone in question 6 own or are they buying a home, land, or property anywhere including in another state or country? ☐ Yes ☐ No If **yes**, please explain.

Optional for health care; only answer if someone applying is 65 or older or disabled.

Who owns or is buying the home/property?	Address of the home/property	Is someone renting the home from the owner?	How much rent does the owner get?		Not living in now but owner expects to move back into the home someday?
		☐ Yes ☐ No	$	☐ Not rented	☐ Yes ☐ No
		☐ Yes ☐ No	$	☐ Not rented	☐ Yes ☐ No

28. Diversion Program

Has anyone received a Diversion cash payment or non-cash services from any county or other state? ☐ Yes ☐ No

If **yes**, please answer the question. If **no**, skip to the next question.

Name	County/State Received From	Amount Received	List of Services Received	Estimated Value of Services	Date Last Received
		$		$	

29. Duplicate Benefits

Have you, or any member of your household been convicted of fraudulently receiving duplicate SNAP (federal name for food assistance program) benefits in any State after September 22, 1996? ☐ Yes ☐ No

If **yes**, who?_____

30. Trafficking Benefits

Have you, or any member of your household, ever been convicted of trafficking (allowing use of or selling EBT cards to others) SNAP benefits of $500 or more after September 22, 1996? ☐ Yes ☐ No

If **yes**, who?_____

31. Trading Benefits for Drugs

Have you or any member of your household been found guilty of trading SNAP benefits for drugs after September 22, 1996? ☐ Yes ☐ No

If **yes**, who?_____

32. Trading Benefits for Firearms or Explosives

Have you or any member of your household been found guilty of trading SNAP benefits for guns, ammunition or explosives after September 22, 1996? ☐ Yes ☐ No

If **yes**, who?_____

33. Fraud

Have you or anyone in your household had their cash aid stopped for being found guilty of Welfare Fraud? ☐ Yes ☐ No

If **yes**, who?_____ When?_____

Where?_____

34. Non-Cooperation/Sanctions

Have you or anyone in your household had their cash aid stopped for failure to cooperate with eligibility requirements, work/training sanctions or any other reason? ☐ Yes ☐ No

If **yes**, who?_____ When?_____

Where?_____Why?_____

35. Fleeing Felon

Are you or any member of your household hiding or running from the law to avoid prosecution, being taken into custody, or going to jail for a felony crime or attempted felony crime? ☐ Yes ☐ No

If **yes**, who?_____

36. Probation/Parole Violation

Have you or any member of your household been found by a court of law to be in violation of probation or parole? ☐ Yes ☐ No

If **yes**, who?_____

37. Other Special Needs

Does the household want to apply for a special need payment for housing or essential household items lost or damaged due to sudden and/or unusual circumstances, such as a fire, earthquake, or flood? ☐ Yes ☐ No

If **yes**, please explain:

38. Other Services

The following services are available. Your answers to the questions will not affect your eligibility.

A. Regular check-ups to help protect your family's health are available upon request through the Child Health and Disability Prevention Program (CHDP) for eligible members of your family under age 21.

- Do you want more information about CHDP services? ☐ Yes ☐ No
- Do you want CHDP medical services? ☐ Yes ☐ No
- Do you want CHDP dental services? ☐ Yes ☐ No
- Do you need help making appointments or with transportation to CHDP services? ☐ Yes ☐ No

B. Do you want more information about immunization services? ☐ Yes ☐ No

C. If you are pregnant, you can get help finding a doctor, getting healthy foods and other help. Do you want to talk to someone about this help? ☐ Yes ☐ No

D. Are you breastfeeding a child? ☐ Yes ☐ No
If **yes**, have you given birth within the last 12 months? ☐ Yes ☐ No
If you checked yes to 38 C or D, you may be eligible for services provided by the Special Supplemental Food Program for Women, Infants and Children (WIC).

E. Do you or any family member want free or low-cost family planning services to help plan how to prevent unwanted pregnancies and/or have the next child? ☐ Yes ☐ No
If **yes**, call your health care plan or regular doctor. Or, for facts and the location of confidential family-planning clinics, call toll-free 1-800-942-1054.

39. Third Party Liability

Is anyone who is applying for healthcare involved in a worker's compensation claim, lawsuit, or settlement because of an accident or injury? ☐ Yes ☐ No
If **yes**, please tell us who:

_____ _____

_____ _____

Additional Writing Space

Additional Writing Space

DO NOT COMPLETE - COUNTY USE ONLY

IF THE ANSWER IS "YES" TO ANY OF THE QUESTIONS BELOW - EXPEDITE

Is the household's gross income less than $150 and is the total of cash on hand, checking and savings accounts $100 or less? ☐ Yes ☐ No

Is the household's combined gross income and liquid resources less than the combined rent/mortgage and appropriate utility allowance? ☐ Yes ☐ No

Is the household a destitute migrant/seasonal farm worker household with liquid resources not exceeding $100? ☐ Yes ☐ No

Does the CalWORKs Assistance Unit have a pay-or-quit or other eviction notice? ☐ Yes ☐ No

Appendix A HEALTH COVERAGE FROM JOBS

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job. If there is more than one person who is offered health coverage from a different employer, you can copy this page and use it for the second person (or as many as you need).
First, tell us about the job (employer) who offers coverage.

1. EMPLOYEE NAME (FIRST NAME, MIDDLE NAME, LAST NAME)	2. EMPLOYEE SOCIAL SECURITY NUMBER — —

EMPLOYER Information

3. EMPLOYER NAME		4. EMPLOYER IDENTIFICATION NUMBER (EIN) —
5. EMPLOYER ADDRESS		6. EMPLOYER PHONE NUMBER ( )
7. CITY	8. STATE	9. ZIP CODE

10. WHO CAN WE CONTACT ABOUT EMPLOYEE HEALTH COVERAGE AT THIS JOB?

11. PHONE NUMBER (IF DIFFERENT FROM EMPLOYER'S PHONE NUMBER) ( )	12. EMPLOYER'S EMAIL ADDRESS (EMPLOYER'S REPRESENTATIVE)

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next three months?

☐ No (stop here for this section of the application)

☐ Yes (continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____
(MM/DD/YYYY)

List the names of anyone else who is eligible or will be eligible for coverage from this job.

Name:_____ Name:_____Name:_____

Tell us about the health plan offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No

14a. Is this a State employee benefit plan? ☐ Yes ☐ No

15. For the lowest-cost plan that meets the minimum value standard offered **only to the employee** (don't include family plans):
If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation (that helps the employee to quit smoking) programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $_____

b. How often? ☐ Weekly ☐ Bi-weekly ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

☐ The employer doesn't offer wellness programs.

16. What change will the employer make for the new plan year (if known)?

☐ Employer will no longer provide health coverage.

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.

a. How much would the employee have to pay in premiums for this plan? $_____

b. How often? ☐ Weekly ☐ Bi-weekly ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

c. Date of change (mm/dd/yyyy):_____

☐ No changes are expected.

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Appendix B **QUESTIONS FOR AMERICAN INDIAN AND ALASKAN NATIVE INDIVIDUALS**

Complete this section if you or a family member (spouse and/or dependents) are American Indian or Alaskan Native. Submit this with your application.

Tell us about your American Indian or Alaskan Native family member(s).

American Indians and Alaskan Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay a cost share and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible. If you have more than two people to tell us about, make a copy of this page and attach it. You may also use a separate piece of paper. Just remember to write the question number next to your answer.

		AI/AN Person 1	**AI/AN Person 2**
1.	Name (First name, Middle name, Last name)	First Middle Last	First Middle Last
2.	Member of a federally recognized tribe?	☐ Yes If **yes**, tribe name _____ ☐ No	☐ Yes If **yes**, tribe name _____ ☐ No
3.	Has this person ever gotten a service from the Indian Health Service, a tribal health program, or through a referral from one of these programs?	☐ Yes ☐ No If **no**, is this person eligible to get services from the Indian Health Services, tribal health program, urban Indian health programs or through a referral from one of these programs? ☐ Yes ☐ no	☐ Yes ☐ No If **no**, is this person eligible to get services from the Indian Health Services, tribal health program, urban Indian health programs or through a referral from one of these programs? ☐ Yes ☐ no
4.	Certain money may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that comes from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases or royalties from land designated as Indian trust land by the Department of the Interior (including reservations and former reservations) • Money from selling things that have cultural significance	☐ Yes - if **yes**, please complete information below: ☐ None to report $_____ How often? (daily, weekly, bi-weekly, monthly, yearly, etc.) _____	☐ Yes - if **yes**, please complete information below: ☐ None to report $_____ How often? (daily, weekly, bi-weekly, monthly, yearly, etc.) _____

Appendix C ASSISTANCE WITH COMPLETING THIS APPLICATION

If you want someone to be your authorized representative for the health insurance part of this application, please answer the questions on this page. If you're a legally-appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)

2. Address

3. Apartment or Suite number

4. City

5. State

6. Zip code

7. Phone number

( )

8. Organization name (if applicable)

9. I.D. Number (if applicable)

By signing you allow this person to get official information about the health insurance part of this application and act for you on all matters with Covered California or your County Human Services Agency. As a reminder you can always change your authorized representative by calling the County or going to the web at www.HealthCare.gov.

10. Your signature

11. Date

For Certified Application Counselors, Navigators, Agents and Brokers Only.

Complete this section if you are a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)

2. First name, Middle name, Last name, & Suffix

3. Organization name

4. I.D. number (if applicable)

Appendix D

EMPLOYMENT HISTORY

If you are applying for cash aid and have two or more adults in the home who are applying for aid, please fill out the information on this page for each adult. Please tell us about your work history for the past 24 months (two years). If using the paper application and you need more space, copy this page or use a separate piece of paper.

Person1

NAME:

Job 1

Is this person Native American? ☐ Yes ☐ No

Name of Tribe:_____

Reason for leaving this job?

Name and Address of Employer:

Number of hours worked:

☐ Daily ☐ Weekly ☐ Monthly

Was this your own business (self-employed)?

☐ Yes ☐ No

Dates you worked:

From_____ To_____

How much do you or did you get paid at this job and when? $_____

☐ Hourly ☐ Daily ☐ Weekly ☐ Every two weeks ☐ Monthly

Did the County help you get this job?

☐ Yes ☐ No

Job 2

Is this person Native American? ☐ Yes ☐ No

Name of Tribe:_____

Reason for leaving this job?

Name and Address of Employer:

Number of hours worked:

☐ Daily ☐ Weekly ☐ Monthly

Was this your own business (self-employed)?

☐ Yes ☐ No

Dates you worked:

From_____ To_____

How much do you or did you get paid at this job and when? $_____

☐ Hourly ☐ Daily ☐ Weekly ☐ Every two weeks ☐ Monthly

Did the County help you get this job?

☐ Yes ☐ No

Job 3

Is this person Native American? ☐ Yes ☐ No

Name of Tribe:_____

Reason for leaving this job?

Name and Address of Employer:

Number of hours worked:

☐ Daily ☐ Weekly ☐ Monthly

Was this your own business (self-employed)?

☐ Yes ☐ No

Dates you worked:

From_____ To_____

How much do you or did you get paid at this job and when? $_____

☐ Hourly ☐ Daily ☐ Weekly ☐ Every two weeks ☐ Monthly

Did the County help you get this job?

☐ Yes ☐ No

Appendix D — EMPLOYMENT HISTORY CONTINUED

If you are applying for cash aid and have two or more adults in the home who are applying for aid, please fill out the information on this page for each adult. Please tell us about your work history for the past 24 months (two years). If using the paper application and you need more space, copy this page or use a separate piece of paper.

Person 2

NAME:

Job 1

Is this person Native American? ☐ Yes ☐ No

Name of Tribe:_____

Reason for leaving this job?

Name and Address of Employer:

Number of hours worked:

☐ Daily ☐ Weekly ☐ Monthly

Was this your own business (self-employed)?

☐ Yes ☐ No

Dates you worked:

From_____ To_____

How much do you or did you get paid at this job and when? $_____

☐ Hourly ☐ Daily ☐ Weekly ☐ Every two weeks ☐ Monthly

Did the County help you get this job?

☐ Yes ☐ No

Job 2

Is this person Native American? ☐ Yes ☐ No

Name of Tribe:_____

Reason for leaving this job?

Name and Address of Employer:

Number of hours worked:

☐ Daily ☐ Weekly ☐ Monthly

Was this your own business (self-employed)?

☐ Yes ☐ No

Dates you worked:

From_____ To_____

How much do you or did you get paid at this job and when? $_____

☐ Hourly ☐ Daily ☐ Weekly ☐ Every two weeks ☐ Monthly

Did the County help you get this job?

☐ Yes ☐ No

Job 3

Is this person Native American? ☐ Yes ☐ No

Name of Tribe:_____

Reason for leaving this job?

Name and Address of Employer:

Number of hours worked:

☐ Daily ☐ Weekly ☐ Monthly

Was this your own business (self-employed)?

☐ Yes ☐ No

Dates you worked:

From_____ To_____

How much do you or did you get paid at this job and when? $_____

☐ Hourly ☐ Daily ☐ Weekly ☐ Every two weeks ☐ Monthly

Did the County help you get this job?

☐ Yes ☐ No

Appendix E **VEHICLE INFORMATION AND SELF CERTIFICATION OF EQUITY VALUE**

Optional for health care: Only answer if someone applying is age 65 or older or is disabled. If you are applying for cash aid, you MUST answer these questions for each vehicle.

Please provide information for each vehicle that anyone owns, has use of, or has their name on the registration, or even if it is not running. Vehicle means, car (including truck, van, Sport Utility Vehicle [SUV]), motorcycle, motorized scooters, snowmobile, recreational vehicle (RV) or motorboat.

	Vehicle (1)	**Vehicle (2)**	**Vehicle (3)**
Owner of vehicle			
Name of person who uses this vehicle			
Is this vehicle: • used as a home? • used for self-employment, self-support, or business? • needed to transport a disabled household member, • used to get the household's fuel or water?	☐ Yes ☐ No If **yes**, you may stop	☐ Yes ☐ No If **yes**, you may stop	☐ Yes ☐ No If **yes**, you may stop
Is this vehicle used by a child under age 18 to: • go to school? • work? • training? • job search?	☐ Yes ☐ No If **yes**, you may stop	☐ Yes ☐ No If **yes**, you may stop	☐ Yes ☐ No If **yes,** you may stop
Is this vehicle a gift, donation, or family transfer? You may be asked by the County to provide proof.	☐ Yes ☐ No ☐ Gift ☐ Donation ☐ Family Transfer If **yes**, check the box that applies, attach proof from DMV and stop here. If you do not have proof, ask the county for help.	☐ Yes ☐ No ☐ Gift ☐ Donation ☐ Family Transfer If **yes**, check the box that applies, attach proof from DMV and stop here. If you do not have proof, ask the county for help.	☐ Yes ☐ No ☐ Gift ☐ Donation ☐ Family Transfer If **yes**, check the box that applies, attach proof from DMV and stop here. If you do not have proof, ask the county for help.
Year/Make/Model			
Vehicle License Number			
Estimated value of vehicle (how much your vehicle is worth)? We call this the Fair Market Value.	$ ☐ I don't know/I need help finding out the value	$ ☐ I don't know/I need help finding out the value	$ ☐ I don't know/I need help finding out the value
How I found out the Fair Market Value	☐ For sale ads ☐ Car Dealer ☐ Kelly blue Book ☐ Mechanic ☐ Purchase price ☐ Other:_____	☐ For sale ads ☐ Car Dealer ☐ Kelly blue Book ☐ Mechanic ☐ Purchase price ☐ Other:_____	☐ For sale ads ☐ Car Dealer ☐ Kelly blue Book ☐ Mechanic ☐ Purchase price ☐ Other:_____
How much I owe on the vehicle	$ ☐ I don't know/I need help finding out the amount owed	$ ☐ I don't know/I need help finding out the amount owed	$ ☐ I don't know/I need help finding out the amount owed
What I used to find the amount owed on the vehicle	☐ Last Bill ☐ Lender statement ☐ Estimate ☐ Other:_____	☐ Last Bill ☐ Lender statement ☐ Estimate ☐ Other:_____	☐ Last Bill ☐ Lender statement ☐ Estimate ☐ Other:_____
Is this a leased vehicle?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

APPLICATION FOR CALFRESH BENEFITS

If you have a disability or need help with this application, let the County Welfare Department (County) know and someone will help you.

If you prefer to speak, read, or write in a language other than English, the County will get someone to help you at no cost to you.

How do I apply?
Use this application if you are applying for CalFresh benefits only. CalFresh is a food assistance program to help you with the cost of buying food for your household. If you wish to apply for programs other than CalFresh such as, CalWORKs or Medi-Cal, please ask for an application to apply for other programs. You can also apply for CalFresh or other programs online by going to http://www.benefitscal.org/. You can see if you may be eligible by going to http://www.cdss.ca.gov/foodstamps/PG849.htm.

- Fill out the whole application form, if you can. You must at least give the County your name, address, and signature (question 1 on page 1) to begin the application process.
- Give the application to the County in person, by mail, by fax, or online.
- The day the County receives your signed application starts the time to give you an answer on whether you can get benefits. If you are in an institution, this time starts from the day you leave.

What do I do next?

- Read about your rights and your responsibilities (Program Rules pages 1 through 5) before you sign the application.
- You must have an interview with the County to discuss your application. Most interviews are done by phone, but it can be done in person at the County office or other place arranged with the County. If you have a disability, other arrangements can be made.
- If you did not fill out all of the application, you can finish it during your interview.
- You will need to give proof of your income, expenses, and other circumstances to see if you are eligible.

How long will it take?
It may take up to 30 days to process your application. You may be able to get benefits within 3 calendar days, if you meet one of the Expedited Service criteria:

- Your household's monthly gross income (income before deductions) is less than $150 and your cash on hand or in checking or savings accounts is $100 or less; or
- Your household's housing costs (rent/mortgage and utilities) are more than your monthly gross income and cash on hand or in checking or savings accounts; or
- You are a migrant or seasonal farmworker household with less than $100 in checking or savings and 1) your income stopped, or 2) your income has started but you do not expect to get more than $25 in the next 10 days.

To help the County see if you can get benefits in three days, please answer questions 1, 6 through 8, 11, and 16, and give the County proof of your identify (if you have it) with the application.

The County will send you a letter to let you know if your household is approved or denied CalFresh benefits.

Agency Conference
Agency conference is a process that provides the household the right to request a meeting with an eligibility supervisor (this meeting may be attended by an eligibility worker and an authorized representative) to

informally resolve any dispute as to whether the household meets Expedited Service criteria.

The agency conference shall be scheduled within two working days of the request, unless the household requests that it be scheduled later or states that they do not wish to have an agency conference.

What do I need for my interview?

To avoid delays, bring proof of the following with you to your interview. Keep your interview even if you do not have the proof. The County may be able to help if you need help getting proof. During the interview, the County will go over the information on the application and will ask you questions to see if you can get CalFresh benefits and the amount of benefits you can get.

Proof Needed to Get Benefits

- Identification (Driver's License, State ID card, passport).
- Where you live (a rental agreement, current bill with your address listed).
- Social Security Numbers (see note below about certain noncitizens).
- Money in the bank for all the people in your household (recent bank statements).
- Earned income of everyone in your household for the past 30 days (recent pay stubs, a work statement from an employer). **NOTE:** If self-employed, income and expense or tax records.
- Unearned income (Unemployment benefits, SSI, Social Security, Veteran's benefits, child support, worker's compensation, school grants or loans, rental income, etc.).
- Lawful immigration status **ONLY** for noncitizens applying for benefits (an Alien Registration Card, visa). **NOTE:** Certain noncitizens applying for immigration status based on domestic violence, crime prosecution or trafficking may not need this proof. They also may not need a Social Security Number.

Proof Needed to Get More CalFresh Benefits

- Housing costs (rent receipts, mortgage bills, property tax bill, insurance documents).
- Phone and utility costs.
- Medical expenses for anyone in your household who is elderly (60 and older) or disabled.
- Child and adult care costs due to someone working, looking for work, attending training or school, or participating in a required work activity.
- Child support paid by a person in your household.

How do I get/use my CalFresh benefits?

- The County will mail or give you a plastic Electronic Benefit Transfer (EBT) card. Benefits will be put on the card when your application is approved. Sign your card when you get it. You will set up a Personal Identification Number (PIN) to use your card.
- If your EBT card is lost, stolen, or destroyed, or you think someone may know your PIN number that you don't want to use your benefits call (877) 328-9677 or call the County right away. Make sure all responsible adults and your authorized representative also know how to report one of these problems right away. If you do not report that another person you do not want to spend your benefits has your PIN and you do not get your PIN changed, any benefits used will not be replaced.
- You can use your CalFresh benefits to buy almost all foods, as well as seeds and plants to grow your own food. You cannot buy alcohol, tobacco, pet food, some types of cooked food, or anything that is not food (like toothpaste, soap, or paper towels).
- CalFresh benefits are accepted at most grocery stores and other places that sell food. For a list of locations near you that accept EBT please go to: https://www.ebt.ca.gov or https://www.snapfresh.org.
- CalFresh benefits are only for you and your household members. Keep your benefits safe. Do not give out your PIN number. Do not keep your PIN number with your EBT card.

What if I am homeless?

Please let the County know right away if you are homeless so they can help you figure out an address to use to accept your application and get notices from the County regarding your case. For CalFresh, homeless means you are:

A. Staying in a supervised shelter, halfway house, or similar place.
B. Staying at the home of another person or family for no more than 90 days straight.
C. Sleeping in a place not designed for, or normally used as, a place to sleep (e.g., a hallway, a bus station, a lobby, or similar places).

Informational Page - Please take and keep for your records.

RIGHTS AND RESPONSIBILITIES

You have a responsibility to:

- Give the County all information needed to determine your eligibility.
- Give the County proof of the information you have when it is needed.
- Report changes as required. The County will give you information about what, when, and how to report. If you don't meet your household's reporting requirements your case will be closed or your CalFresh benefits may be lowered or stopped.
- Look for, get, and keep a job or participate in other activities if the County tells you that it is required in your case.
- Fully cooperate with County, State, or federal personnel if your case is selected for review or investigation to ensure that your eligibility and benefit level were correctly figured. Failure to cooperate in these reviews will result in loss of your benefits.
- Pay back any CalFresh benefits that you were not eligible to get.

You have the right to:

- Turn in an application for CalFresh giving only your name, address, and signature.
- Have an interpreter provided by the State at no cost if you need one.
- Have information given to the County kept confidential, unless directly related to the administration of County programs.
- Withdraw your application at any time prior to the County determining eligibility.
- Ask for help to fill out your application for CalFresh and get an explanation of the rules.
- Ask for help to get proof that is needed.
- Be treated with courtesy, consideration, and respect, and not be discriminated against.
- Get CalFresh benefits within 3 days if you qualify for Expedited Service.
- Be interviewed in a reasonable amount of time by the County when you apply and to have your eligibility determined within 30 days.
- Get at least 10 days to give the County proof that is needed to make a determination of eligibility.
- Get written notice at least 10 days before the County lowers or stops your CalFresh benefits.
- Discuss your case with the County and to review your case when you ask to do so.
- Ask for a State hearing within 90 days if you do not agree with the County about your CalFresh case. If you ask for a hearing before an action on your CalFresh case takes place, your CalFresh benefits will stay the same until the hearing or the end of your certification period, whichever is earlier. You can ask the County to let your benefits change until after the hearing to avoid having to pay back any over paid benefits. If the Administrative Law Judge rules in your favor, the County will give back to you any benefits that were cut.
- Ask about your hearing rights or for a legal aid referral at the toll-free phone number – **1-800-952-5253** or for hearing or speech impaired who use TDD, **1-800-952-8349.** You may get free legal help at your local legal aid or welfare rights office.
- Bring a friend or someone with you to the hearing if you do not want to go alone.
- Get assistance from the County to register to vote.
- Report changes that you are not required to report, if it may increase your CalFresh benefits.
- Give proof of your household's expenses that may help you get more CalFresh benefits. Not giving proof to the County is the same as saying that you do not have that expense and you will not be able to get more CalFresh benefits.
- Let the County know if you would like someone else to use your CalFresh benefits for your household or help with your CalFresh case (Authorized Representative).

Please take and keep for your records

Program Rules and Penalties

You are committing a crime if you give false or wrong information, or do not give all the information on purpose to try to get CalFresh benefits that you are not eligible to receive, or to help someone else get benefits that they are not eligible to receive. You must pay back any benefits you get that you were not eligible to receive.

Program Violations **For CalFresh: I understand I may have committed an intentional program violation if I do any of the following:**	**Penalties** **I may:**
• Hide information or make false statements • Use Electronic Benefit Transfer (EBT) cards that belong to someone else or let someone else use my card • Use CalFresh benefits to buy alcohol or tobacco • Trade, buy, sell, steal or give away CalFresh benefits or EBT cards, or attempt to trade, buy, sell, steal or give away CalFresh benefits or EBT cards • Try to get dual benefits, for example, apply in two or more different counties or states at the same time • Submit false documents for children or adult household members who are not eligible or who do not exist • Violate conditions of my probation or parole • Flee after a felony conviction • Purchase (buy) a product with CalFresh benefits that has a return deposit, intentionally (on purpose) throw away the contents and return the container for the deposit amount or attempt to return the container for the deposit amount • Buy a product with CalFresh benefits and intentionally resell it for cash or anything other than eligible food	• Lose CalFresh benefits for 12 months for the first offense and be required to repay all CalFresh benefits overpaid to me • Lose CalFresh benefits for 24 months for the second offense and be required to repay all CalFresh benefits overpaid to me • Lose CalFresh benefits permanently for the third offense and be required to repay all CalFresh benefits overpaid to me • Be fined up to $250,000.00, imprisoned up to 20 years or both
• Trade CalFresh benefits or attempt to trade CalFresh benefits for: cash, firearms, non-eligible goods or controlled substances such as drugs	• Lose CalFresh benefits for 24 months for the first offense • Lose CalFresh benefits permanently for the second offense
• Give false information about who I am and where I live so I can get extra CalFresh benefits	• Lose CalFresh benefits for 10 years for each offense
• Have been convicted of trading, selling or attempting to trade CalFresh benefits worth more than $500, or trading or attempting to trade CalFresh benefits for firearms, ammunition or explosives	• Lose CalFresh benefits permanently

Please take and keep for your records

Important Information for Noncitizens

- You can apply for and get CalFresh benefits for people who are eligible, even if your family includes others who are not eligible. For example, immigrant parents may apply for CalFresh benefits for their U.S. citizen or qualified immigrant children, even though the parents may not be eligible.
- Getting food benefits will not affect you or your family's immigration status. Immigration information is private and confidential.
- The immigration status of noncitizens who are eligible and apply for benefits will be checked with the U.S. Citizenship and Immigration Services (USCIS). Federal law says the USCIS cannot use the information for anything else except cases of fraud.

Opting Out

You do not have to give immigration information, Social Security numbers, or documents for any noncitizen family member(s) who are not applying for CalFresh benefits. The County will need to know their income and resource information to correctly determine your household's benefits. The County will not contact USCIS about the people who don't apply for CalFresh benefits.

Privacy Act and Disclosure: You are giving personal information in the application. The County uses the information to see if you are eligible for benefits. If you do not give the requested information, the County may deny your application. You have the right to review, change, or correct any information that you gave to the County. The County will not show your information or give it to others unless you give them permission or federal and state law allows them to do so. 273.2(b)(4) *Privacy Act statement.* As a County agency, we must notify all households applying and being recertified for CalFresh benefits of the following:

(i) The collection of this information, including the social security number (SSN) of each household member, is authorized under the Food Stamp Act of 1977, as amended, 7 U.S.C. 2011-2036. The information will be used to determine whether your household is eligible or continues to be eligible to participate in the CalFresh Program. We will verify this information through computer matching programs, including the Income and Earnings Verification System (IEVS). This information will also be used to monitor compliance with program regulations and for program management.

(ii) This information may be disclosed to other Federal and State agencies for official examination, and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law.

(iii) If a CalFresh claim arises against your household, the information on this application, including all SSNs, may be referred to Federal and State agencies, as well as private claims collection agencies, for claims collection action.

(iv) Providing the requested information including the SSN of each household member, is voluntary. However, failure to provide an SSN will result in the denial of CalFresh benefits to each individual failing to provide an SSN. Any SSNs provided will be used and disclosed in the same manner as SSNs of eligible household members.

The County may verify immigration status of household members applying for benefits by contacting the USCIS. Information the County gets from these agencies may affect your eligibility and level of benefits.

The County will check your answers using information in state and federal electronic databases from the Internal Revenue Service (IRS), Social Security Administration, the Department of Homeland Security, and/or a **consumer reporting agency**. If the information does not match, the County may ask you to send proof.

Please take and keep for your records

Use of Social Security Numbers (SSN)

Everyone applying for CalFresh benefits needs to provide a SSN, if they have one, or proof that they have applied for a SSN (such as a letter from the Social Security Office). The County may deny CalFresh benefits for you or any member of your household who does not give us a SSN. Some people do not have to give SSN's to get help such as, victims of domestic abuse, crime prosecution witnesses, and trafficking victims.

Overissuance

This means you got more CalFresh benefits than you should have. You will have to pay it back even if the County made an error or if it wasn't on purpose. Your benefits may be lowered or stopped. Your SSN may be used to collect the amount of benefits owed, through the courts, other collection agencies, or federal government collection action.

Reporting

Every household that gets CalFresh benefits must report certain changes. Your County will tell you what changes to report, how to report them, and when to report them. Failure to report the changes may result in your CalFresh benefits being lowered or stopped. You can also report if things happen that may increase your benefits, such as getting less income.

State Hearing

You have the right to a State hearing if you do not agree with any action taken regarding your application or your ongoing benefits. You can request a State hearing within 90 days of the County's action and you must tell why you want a hearing. The approval or denial notice you receive from the County will have information on how to request a State hearing. If you ask for a hearing before the action happens, you may be able to keep your CalFresh benefits the same until a decision is made.

Nondiscrimination Statement: In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.) should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD 3027) found online at http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or contact your County's Civil Rights Coordinator, or write a letter addressed to USDA and provide in the letter all of the information requested in the form or write to California Department of Social Services (CDSS) address below. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, S.W.
Washington D.C. 20250-9410

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov

CDSS
Civil Rights Bureau
P.O.BOX 944243, M.S. 8-16-70
Sacramento, CA 94244-2430
1-866-741-6241 (Toll Free)

This institution is an equal opportunity provider.

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Case File Reviews

Your case may be selected for additional review to ensure that your eligibility was correctly figured. You must cooperate fully with the County, State, or federal personnel in any investigation or review, including a quality control review. Failure to cooperate in these reviews could result in loss of your benefits.

Work Rules for CalFresh

The County may assign you to a work program. They will tell you if it is voluntary or if you must do the work program. If you have a mandatory work activity and you do not do it, your benefits may be lowered or stopped. You may not be eligible for CalFresh if you have recently quit a job without a good reason.

EBT Usage

Any benefit taken from your account before you, another household member, or your authorized representative report the EBT card or PIN has been lost or stolen will **not** be replaced.

Any use of your EBT card by you, a household member, your authorized representative, or anyone you voluntarily give your EBT card and PIN to will be considered approved by you and any benefits taken from your account will **not** be replaced.

If you do not report that another person you do not want to spend your benefits has your PIN and you do not get your PIN changed, any benefits used will **not** be replaced.

Please take and keep for your records

NOTES

Please use black or blue ink because it is easy to read and copies best. Please print your answers.
If you need more space to answer a question(s), use page 10 "Additional Writing Space" section and attach additional sheets of paper if needed to provide the information. Please be sure to identify which question you are writing about in the extra space or on the additional sheets of paper.

1. APPLICANT'S INFORMATION

NAME (FIRST, MIDDLE, LAST)	OTHER NAMES (MAIDEN, NICKNAMES, ETC.)	SOCIAL SECURITY NUMBER (IF YOU HAVE ONE AND ARE APPLYING FOR BENEFITS)

HOME ADDRESS OR DIRECTIONS TO YOUR HOME	CITY	STATE	ZIP CODE
MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	CITY	STATE	ZIP CODE

CONTACT AUTHORIZATION

Please give the county the best contact information to reach you. This will help in processing your application. By providing your contact information below, you are authorizing the county to contact you by phone, email or text, or to leave a phone message regarding your application.

HOME PHONE	CELL PHONE	CHECK BOX FOR TEXT
		☐
WORK/ALTERNATE/MESSAGE PHONE	EMAIL ADDRESS	

Are you homeless? ☐ Yes ☐ No If **yes,** please let the County know right away if you are homeless, so they can help you figure out an address to use to accept your application and get notices from the county about your case.

What language do you prefer to read (if not English)?_____
What language do you prefer to speak (if not English)?_____

The County will provide an interpreter at no cost to you. If you are deaf or hard of hearing please check here ☐

	(PLEASE CHECK ONE)
Do you have a disability and need help with applying?	☐ Yes ☐ No
Are you interested in applying for Medi-Cal? If you answer **yes** the County will use your answers to find out if you can get Medi-Cal.	☐ Yes ☐ No
Is your household's monthly gross income less than $150 and cash on hand, or in checking and savings accounts is $100 or less?	☐ Yes ☐ No
Is your household's combined monthly gross income and cash on hand or in checking and savings accounts is less than the combined cost of rent/mortgage and utilities?	☐ Yes ☐ No
Is your household a migrant/seasonal farm worker household with liquid resources not exceeding $100 and either your income stopped or you will not get more than $25 in the next 10 days?	☐ Yes ☐ No

I understand that by signing this application under penalty of perjury (making false statements), that:

- I read, or had read to me, the information in this application and my answers to the questions in this application.
- My answers to the questions are true and complete to the best of my knowledge.
- Any answers I may give for my application process will be true and complete to the best of my knowledge.
- I read or had read to me and I understand and agree to the Rights and Responsibilities (Program Rules Page 1) for the CalFresh Program.
- I read, or had read to me, the CalFresh Program Rules and Penalties (Program Rules Page 2).
- I understand that giving false or misleading statements or misrepresenting, hiding or withholding facts to establish eligibility for CalFresh is fraud. Fraud can cause a criminal case to be filed against me and/or I may be barred for a period of time (or life) from getting CalFresh benefits.
- I understand that Social Security Numbers or immigration status for household members applying for benefits may be shared with the appropriate government agencies as required by federal law.

SIGNATURE OF APPLICANT(OR ADULT HOUSEHOLD MEMBER/ AUTHORIZED REPRESENTATIVE*/GUARDIAN)	DATE

***If you have an Authorized Representative please complete question 2 on the next page.**

2. HOUSEHOLD'S AUTHORIZED REPRESENTATIVE

You may authorize someone 18 years or older to help your household with your CalFresh benefits. This person can also speak for you at the interview, help you complete forms, shop for you, and report changes for you. You will have to repay any benefits you may get by mistake because of information this person gives the County and any benefits you didn't want them to spend will not be replaced. If you are an Authorized Representative you will need to give the County proof of identity for yourself and the applicant.

Do you want to name someone to help you with your CalFresh case? (Please Check One) ☐ Yes ☐ No

If **yes**, complete the following section:

AUTHORIZED REPRESENTATIVE NAME:	AUTHORIZED REPRESENTATIVE PHONE NUMBER:

Do you want to name someone to receive and spend CalFresh benefits for your household? (Please Check One) ☐ Yes ☐ No

If **yes**, complete the following section:

NAME:	PHONE NUMBER:

ADDRESS: CITY STATE ZIP CODE

3. RACE/ETHNICITY

Race and ethnicity information is optional. It is requested to assure that benefits are given without regard to race, color, or national origin. Your answers will not affect your eligibility or benefit amount. Check all that apply to you. The law says the County must record your ethnic group and race.

☐ Check this box if you do not want to give the County information about your race and ethnicity. If you do not, the County will enter this information for civil rights statistics only.

ETHNICITY

Are you Hispanic or Latino? (Please Check One)
☐ Yes ☐ No

If you are of Hispanic or Latino origin, do you consider yourself:
☐ Mexican ☐ Puerto Rican ☐ Cuban
☐ Other_____

RACE/ETHNIC ORIGIN

☐ White ☐ American Indian or Alaskan Native ☐ Black or African American ☐ Other or Mixed _____

☐ Asian (If checked, please select one or more of the following):

☐ Filipino ☐ Chinese ☐ Japanese ☐ Cambodian ☐ Korean ☐ Vietnamese ☐ Asian Indian ☐ Laotian

☐ Other Asian (specify)_____

☐ Native Hawaiian or Other Pacific Islander (If checked, please select one or more of the following): ☐ Native Hawaiian

☐ Guamanian or Chamorro ☐ Samoan

4. INTERVIEW PREFERENCE

You or another adult member in your household will need to have an interview with the County to discuss your application and to receive CalFresh benefits. Interviews for CalFresh are usually done by phone, unless you can be interviewed when giving your application to the County in person or would prefer an in-person interview. In-person interviews will only happen during the County's normal office hours.

☐ Please check this box if you would prefer an in-person interview.

☐ Please check this box if you need other arrangements due to a disability.

Please check the boxes below for your preferred day and time for an interview:

Day: ☐ Today ☐ Next available day ☐ Any day ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Time: ☐ Early morning ☐ Mid-morning ☐ Afternoon ☐ Late afternoon ☐ Anytime

5. OTHER PROGRAMS

Have you or anyone in your household ever received public assistance (Temporary Assistance for Needy Families, Medicaid, Supplemental Nutrition Assistance Program [CalFresh], General Assistance (GA)/General Relief (GR), etc.)? (Please Check One) ☐ Yes ☐ No

IF **YES,** WHO?	WHERE (COUNTY/STATE)?
IF **YES**, WHO?	WHERE (COUNTY/STATE)?

6a. HOUSEHOLD'S INFORMATION

Complete the following information for all persons in the home that you buy and prepare food with, including you. **If applying for noncitizens, please complete question 6b and 6c. If not, go to question 6d.**

Social Security number is optional for members not applying for benefits. You must answer the questions below for each person applying for benefits.

APPLYING FOR BENEFITS (✔ check Yes or No)	**NAME** (Last, First, Middle Initial)	How is the person related to you?	**DATE OF BIRTH**	**GENDER** (M OR F)	**U.S. CITIZEN** or **NATIONAL** (✔ check Yes or No) If **no**, complete question 6b below	**SOCIAL SECURITY NUMBER**
☐ Yes ☐ No		**SELF**			☐ Yes ☐ No	
☐ Yes ☐ No					☐ Yes ☐ No	
☐ Yes ☐ No					☐ Yes ☐ No	
☐ Yes ☐ No					☐ Yes ☐ No	
☐ Yes ☐ No					☐ Yes ☐ No	

Please list the names of anyone who lives with you that does not buy and prepare food with you:

NAME	NAME
NAME	NAME

6b. NONCITIZEN INFORMATION - Complete for those listed in question 6a above who are not citizens and are applying for aid.

Name	**Date of Entry into U.S.** (if known)	**Give one of the following** (if known)**: Passport Number, Alien Registration Number, etc.**	**Sponsored?** (✔ check Yes or No) If **yes,** complete question 6c below:
		DOCUMENT TYPE:_____ DOCUMENT NUMBER:_____	☐ Yes ☐ No
		DOCUMENT TYPE:_____ DOCUMENT NUMBER:_____	☐ Yes ☐ No
		DOCUMENT TYPE:_____ DOCUMENT NUMBER:_____	☐ Yes ☐ No

(PLEASE CHECK ONE)

Does anyone listed above have at least 10 years (40 quarters) of work history or military service in the USA? ☐ Yes ☐ No
If **yes**, who?_____

Does anyone listed above have, or have they applied for, or do they plan to apply for a T-Visa, U-Visa or VAWA status? ☐ Yes ☐ No
If **yes**, who?_____

6c. SPONSORED NONCITIZEN INFORMATION - Complete for those listed in question 6b above who are sponsored noncitizens and are applying for aid.

Did the sponsor sign an I-864? ☐ Yes ☐ No If **yes**, please answer the rest of the question. If the sponsor signed an I-134 then skip this question.

Does the sponsor regularly help with money? ☐ Yes ☐ No If **yes**, how much? $_____

Does the sponsor regularly help with any of the following (check all that apply)?
☐ rent ☐ clothes ☐ food ☐ other_____

SPONSOR'S NAME	WHO IS SPONSORED?	SPONSOR'S PHONE NUMBER
SPONSOR'S NAME	WHO IS SPONSORED?	SPONSOR'S PHONE NUMBER

6d. Students

Is anyone who is applying for benefits including you attending a college or vocational school? (Please Check One) ☐ Yes ☐ No

If **yes**, please answer this question. If **no**, skip to the next question.

Name of Person	Name of School/Training	Enrolled Status (✔ check one)	Are They Working?
		☐ Half-time or more ☐ Less than half-time Number of units:_____	Average work hours per week:_____
		☐ Half-time or more ☐ Less than half-time Number of units:_____	Average work hours per week:_____

6e. Is there a foster child living in your home? ☐ Yes ☐ No If **yes**, who?_____

Please answer the following questions about the child(ren):

Was this child(ren) placed in your home under a dependence order of the court? (Please Check One) ☐ Yes ☐ No

Do you want the foster care child(ren) counted in your CalFresh case? (Please Check One) ☐ Yes ☐ No

If **yes**, the foster care income you receive will be counted as unearned income.

If **no**, the foster care income will not be counted as unearned income.

7. Unearned Income

Do you or anyone you buy and prepare food with get income that does not come from a job (unearned)? (Please Check One) ☐ Yes ☐ No

If **yes**, please answer this question. If **no**, skip to the next question.

Check all types of unearned income that apply from these examples (there may be others not listed here):

- ☐ Social Security
- ☐ SSI/SSP
- ☐ Cash aid
- ☐ CalWORKs/TANF/GA/GR/CAPI
- ☐ Room and board (from your renter)
- ☐ Pension
- ☐ Child/Spousal support
- ☐ Government/railroad disability or retirement
- ☐ Veteran benefits, or Military pension
- ☐ Financial aid (school grants/loans/ scholarships)
- ☐ Gift of money
- ☐ Unemployment Insurance/ State Disability Insurance (SDI)
- ☐ Worker's compensation
- ☐ Lottery/gambling winnings
- ☐ Help with rent/food/clothing
- ☐ Insurance or legal settlements
- ☐ Private disability or retirement
- ☐ Strike benefits
- ☐ Other_____

_____

Person getting the money?	From where?	How much?	How often received? (once, weekly, monthly, or other)	Expect to continue? (✔ Check Yes or No)
		$		☐ Yes ☐ No
		$		☐ Yes ☐ No
		$		☐ Yes ☐ No
		$		☐ Yes ☐ No

If this income is not expected to continue, please explain:

8. Earned income

Do you or anyone you buy and prepare food with get income from a job (earned income)? (Please Check One) ☐ Yes ☐ No

If **yes**, please answer this question. If **no**, skip to the question 9.

NOTE: If self-employed fill out question 8a.

Please list all income **before** taxes or other deductions are taken out (gross income).

Examples of earned income are (these examples can be full-time, temporary, seasonal, or training, and there may be others not listed here):

- Wages
- Commissions
- Tips
- Salaries
- Work study (students)

Person working	Employer's name and address	Employer's phone number	Hourly rate	Average hours per week	How often paid? (Once, weekly, monthly, other)	Total gross earned income received this month	Expect to continue? (✔ Check Yes or No)
			$			$	☐ Yes ☐ No
			$			$	☐ Yes ☐ No
			$			$	☐ Yes ☐ No
			$			$	☐ Yes ☐ No

If this income is not expected to continue, please explain:

Has anyone lost a job, changed jobs, quit a job, or reduced work hours within the last 60 days? (Please Check One) ☐ Yes ☐ No

IF **YES**, WHO?	DATE OF JOB LOSS, QUIT, OR CHANGE	DATE OF LAST PAY

REASON?

Is anyone on strike? (Please Check One) ☐ Yes ☐ No

IF **YES**, WHO?	DATE WENT ON STRIKE	DATE OF LAST PAY

REASON?

8a. Self-Employment

Self-employed household members may deduct actual self-employment expenses or take a standard 40% deduction off of self-employment income. If you choose actual expenses, you will need to give the County proof of the expenses.

Person self-employed	Date business started	Type of business and name	Gross monthly income	Self-employment expenses (please ✔ check one)
			$	☐ 40% flat rate ☐ Actual expenses $ _____
			$	☐ 40% flat rate ☐ Actual expenses $ _____
			$	☐ 40% flat rate ☐ Actual expenses $ _____
			$	☐ 40% flat rate ☐ Actual expenses $ _____
			$	☐ 40% flat rate ☐ Actual expenses $ _____

9. Household's Child/Adult Care Expenses

Do you or anyone you buy and prepare food with pay for the care of a child, disabled adult, or other dependent so you or the other person can go to work, school, training, or look for a job? (Please Check One) ☐ Yes ☐ No

If **yes,** please answer this question. If **no,** skip to the next question.

Who gets care?	Who gives care? (name and address of provider)	Amount paid?	How often paid? (weekly/monthly, other)
		$	
		$	
		$	
		$	

Does anyone help your household pay all or part of your child/adult care costs listed above? ☐ Yes ☐ No If **yes**, complete below:

Who gets care?	Who helps pay?	Amount paid?	How often paid? (weekly/monthly, other)
		$	
		$	

10. Child Support Payments

Are you or anyone you buy and prepare food with legally obligated to pay child support, including back child support?

☐ Yes ☐ No If **yes**, please answer this question. If **no**, skip to the next question.

Who pays child support?	Name of child(ren) for whom child support is paid:	Amount paid?	How often paid (weekly/monthly, other)
		$	
		$	

11. Household Expenses

Are you or anyone you buy and prepare food with responsible for any household expenses? ☐ Yes ☐ No If **yes**, please answer this question. If **no**, skip to the next question.

NOTE: Do not enter amounts paid by housing assistance such as HUD or Section 8. The heating and cooling, telephone, other utilities, and the homeless shelter are set allowances and you do not need to fill in the actual amount owed.

Type of Expenses	Have Expense? (Please Check One)	Who pays?	Amount Owed	How often billed? (weekly/monthly, other)
Rent or house payment	☐ Yes ☐ No		$	
Property taxes and insurance (if billed separately from rent or mortgage)	☐ Yes ☐ No		$	
Gas, electric, or other fuel used for heating or cooling, such as firewood or propane (if billed separately from rent or mortgage)	☐ Yes ☐ No			
Telephone/cell phone	☐ Yes ☐ No			
Homeless Shelter Expense	☐ Yes ☐ No			
Water, sewage, garbage	☐ Yes ☐ No			
Does anyone <u>not</u> in your household help you pay for the expenses listed above? (Please Check One) ☐ Yes ☐ No If **yes**, please complete.		**Who helps pay?**	**How much?** $	**How often paid?**

Does your household receive, or expect to receive, payment from the Low Income Home Energy Assistance Program (LIHEAP)? (Please Check One) ☐ Yes ☐ No

12. Medical Expenses:
Are you or anyone you buy and prepare food with an elderly (60 or older) or disabled person that has any out-of-pocket medical expenses? ☐ Yes ☐ No If **yes**, please answer this question. If **no,** skip to the next question.
NOTE: Do not list spouses or children receiving dependent payments for an SSI or disability and blindness recipient.
List expenses you expect to have in the near future.

Allowable medical expenses are: (Check all that apply)

- ☐ Medical or dental care
- ☐ Hospitalization/outpatient treatment/nursing care
- ☐ Prescribed medications
- ☐ Health and Hospitalization insurance policy premiums
- ☐ Medicare premiums (Medi-Cal share of costs, etc.)
- ☐ Dentures, hearing aids and prosthetics
- ☐ Maintaining an attendant necessary due to age, illness, or infirmity
- ☐ The number and cost of meals furnished to an attendant
- ☐ Prescribed over the counter medications
- ☐ Cost of transportation (mileage or fee) and lodging to obtain medical treatment or services
- ☐ Prescribed eye glasses and contact lenses
- ☐ Prescribed medical supplies and equipment
- ☐ Service animals expenses (food, vet bills, etc.)

Name of elderly/disabled person	**Amount of expense**	**How often paid?** (monthly, weekly, other)	**What type of expense?** (prescriptions, dentures, number of meals for attendant, etc.)	**Will the household be reimbursed for any medical expenses?** (by Medi-Cal, insurance, family member, etc.)
	$			IF **YES,** BY WHO: HOW MUCH: $
	$			IF **YES,** BY WHO: HOW MUCH: $
	$			IF **YES,** BY WHO: HOW MUCH: $
	$			IF **YES,** BY WHO: HOW MUCH: $

13. Does anyone who is applying for benefits, including you, get food from any of the following? (Please Check One) ☐ Yes ☐ No
If **yes**, please answer this question. If **no**, skip to the next question.

- Communal dining facility for the elderly/disabled
- Food distribution program operated by a Native American reservation
- Other food program

IF **YES,** WHO?	WHERE?
IF **YES,** WHO?	WHERE?

14. Does anyone who is applying for benefits, including you, live at any of the following? (Please Check One) ☐ Yes ☐ No
If **yes**, please answer this question. If **no**, skip to the next question.

- Homeless Shelter
- Shelter for battered women
- Reservation for Native Americans
- Drug/Alcohol rehabilitation center
- Correctional facility/Penal institution *(Jail or Prison)*
- Group living arrangement for the blind/disabled
- Federally subsidized housing
- Psychiatric hospital/mental institution
- Hospital
- Long-Term Care or Board and Care Facility

Person's Name	**Name of Institution** (center, shelter, facility, etc.)	**Expected Date of Release** (if applicable)

15. Are you or anyone living with you age 60 or older and unable to buy food and fix meals separately because of a disability? (Please Check One) ☐ Yes ☐ No

IF **YES,** WHO?

16. Household's Resources

Do you or anyone you buy and prepare food with have any resources (cash, money in the bank, Certificate of Deposit, stocks and bonds, etc.)? ☐ Yes ☐ No If y**es**, please answer this question. If **no**, skip to the next question.

Check all that apply:

- ☐ Bank/Credit Union account (Checking)
- ☐ Bank/Credit Union account (Saving)
- ☐ Safe Deposit box
- ☐ Savings Bond(s)
- ☐ Money Market Account
- ☐ Mutual Funds
- ☐ Certificate of Deposit (CD)
- ☐ Cash on hand
- ☐ Stocks
- ☐ Bonds
- ☐ Other: _____

If joint account with another person please say so below.

For each box checked above, complete the following information.

In whose name is the resource listed?	What type of resource?	How much is it worth?	Where is the resource? (include the name of the bank or company where money is held)
		$	
		$	
		$	
		$	

Have you or anyone in your household sold, traded, given away, or transferred a resource in the last three months?

(Please Check One) ☐ Yes ☐ No

17. Duplicate Benefits

Have you or any member of your household been convicted of fraudulently receiving duplicate SNAP (federal name for food assistance program, known as CalFresh in California) benefits in any state after September 22, 1996? (Please Check One) ☐ Yes ☐ No

If **yes**, who?_____

18. Trafficking (trading or selling) of Benefits

Have you or any member of your household ever been convicted of trafficking (trading or selling EBT cards to others) SNAP benefits of $500 or more after September 22, 1996? (Please Check One) ☐ Yes ☐ No

If **yes**, who?_____

19. Trading Benefits for Drugs

Have you or any member of your household been found guilty of trading SNAP benefits for drugs after September 22, 1996? (Please Check One) ☐ Yes ☐ No

If **yes**, who?_____

20. Trading Benefits for Firearms or Explosives

Have you or any member of your household been found guilty of trading SNAP benefits for guns, ammunition, or explosives after September 22, 1996? (Please Check One) ☐ Yes ☐ No

If **yes**, who?_____

21. Fleeing Felon

Are you or any member of your household hiding or running from the law to avoid prosecution, being taken into custody, or going to jail for a felony crime or attempted felony crime? (Please Check One) ☐ Yes ☐ No

If **yes**, who?_____

22. Probation/Parole Violation

Have you or any member of your household been found by a court of law to be in violation of probation or parole? (Please Check One) ☐ Yes ☐ No

If **yes**, who?_____

Additional Writing Space

Additional Writing Space

DO NOT COMPLETE - COUNTY USE ONLY

IF THE ANSWER IS YES TO ANY OF THE QUESTIONS BELOW - EXPEDITE

Is the household's gross income less than $150 and cash on hand, or in checking and savings accounts $100 or less? ☐ Yes ☐ No

Is the household's combined gross income and cash on hand or on checking and savings accounts less than the combined rent/mortgage and appropriate utility allowance? ☐ Yes ☐ No

Is the household a destitute migrant/seasonal farm worker household with liquid resources not exceeding $100 and does not expect to receive more than $25 in next 10 days? ☐ Yes ☐ No

MEDI-CAL ANNUAL REDETERMINATION FORM

You must fill out this form and return it to the county to keep your Medi-Cal!

Case Number *(optional)*	**Social Security Number** *(optional)*	
Print Your Full Name *(if you have not moved, put address label here if one is provided)*	**Birth Date** *(optional)* **(mm/dd/yyyy)**	
Current Street Address, Apartment Number ❑ *(check here if address is new)*	**City/State**	**Zip Code**
Mailing Address *(if different from above)*	**City/State**	**Zip Code**

Use ink and **PRINT** your answers. Make sure you sign and date the form. Use the postage paid envelope to return it. If you need more space, attach a separate sheet to this form. If you have any questions or need help filling out this form, call your worker at the telephone number listed on the Annual Redetermination Notice.

Section 1. Income

(a) Do you or any family member in the home get money from a job, child support or alimony, social security, veteran benefits, unemployment or disability benefits, retirement, gifts, or interest or dividends? ❑ Yes ❑ No

If yes, complete below and list each source of income on a separate line.

Attach most recent pay stubs showing income before taxes or deductions, benefit or award letters, checks received or signed statement from employer, or last year's federal income tax return. If income is from self-employment, send a copy of your most recent tax return or profit and loss statement.

Name of Person with Income *(include first and last name)*	**Source of Income**	**Income Amount** *(before any deductions)*	**How Often Paid** *(weekly, monthly, twice a month)*	**Hours Worked** *(per week or month)*

(b) Do you or any family member in the home get rent, utilities, food, or clothing entirely free? ❑ Yes ❑ No

If yes, who? _____

What was free? _____

(c) Was the free rent, utilities, food, or clothing received in exchange for work done? ❑ Yes ❑ No

Section 2. Expenses and Deductions

Do you or any family member in the home pay for child or adult care, health insurance or Medicare premiums, court-ordered child support or alimony, or educational expenses? ❑ Yes ❑ No

If yes, complete below and list each expense/deduction on a separate line.

Attach proof of expenses/deductions.

Name of Person with Expense/Deduction *(include first and last name)*	**Type of Expense or Deduction**	**Amount of Payment**	**Paid to Whom**	**How Often Paid** *(weekly, monthly, twice a month)*

Section 3. Other Health Insurance

(a) Did you or any family member have a change in, or get new health, dental, vision, or Medicare coverage or insurance within the last 12 months? ❑ Yes ❑ No

If yes, who has the coverage/insurance? _____

Which type of coverage/insurance? _____

(b) Is any family member living in the home receiving kidney dialysis-related services? ❑ Yes ❑ No

If yes, who? _____

(c) Has any family member living in the home received an organ transplant within the last 2 years? ❑ Yes ❑ No

If yes, who? _____

Section 4. Living Situation

(a) Did anyone move into or out of your home, move in with someone else, get married, or have a baby within the last 12 months? *(Examples: newborn, child, or adult moved in or out of the home, absent parent returns home.)* ❑ Yes ❑ No

If yes, complete below:

Name *(include first and last name)*	**Relationship to You**	**What Changed?**	**Date Changed**

(b) Does anyone in the home want Medi-Cal who is not already receiving it? ❑ Yes ❑ No

If yes, who? _____

(c) If a new baby is in home, where was the baby's place of birth? _____ (City) | _____ (State) | _____ (Country)

Section 4. Living Situation *continued*

(d) Did anyone in the home get inpatient care in a nursing facility or medical institution? ❑ Yes ❑ No

If yes, who? _____

(e) Is anyone in the home pregnant? ❑ Yes ❑ No

If yes, who? _____

Number of babies expected _____ Due date: _____

Section 5. Real or Personal Property

(a) Indicate the total amount of cash and uncashed checks held by any family member in the home $ _____

(b) Does anyone have a checking or savings account, life insurance, long-term care insurance, motor vehicle, court-ordered settlement or judgement, stocks, bonds, retirement funds, trusts where money or property is held for the benefit of any family member in the home, real estate, motor vehicles for a business, business accounts or property, promissory notes, mortgages, deeds of trust, recreational vehicles, burial trusts or funds, annuities, jewelry (not heirloom or wedding), or oil or mineral rights? ❑ Yes ❑ No

(c) Did you or any family member in the home sell or give away any money or property in the past 12 months, or have any of the items listed in this section been spent or used as security for medical costs? ❑ Yes ❑ No

Note: If you have answered "yes" to questions (b) or (c), you will also have to fill out a property supplement form, submit the form to the county and provide verification.

Section 6. Immigration or Citizenship Status Change

Has there been a change in immigration or citizenship status for anyone in the home that has Medi-Cal or wants Medi-Cal within the last 12 months? *(If your immigration status has changed, you might qualify for full scope Medi-Cal benefits.)* ❑ Yes ❑ No

If yes, list the name(s) below and send proof of new status.

Name of Person *(include first and last name)*	**Status Change** *(send proof of status)*

Section 7. Blindness/Disability/Incapacity

(a) Do you or any family member in the home have a physical or emotional condition that makes it difficult to work, take care of personal needs, or take care of your children? ❑ Yes ❑ No

If yes, who? _____

(b) Was the physical, mental, or health condition a result of an injury or accident? ❑ Yes ❑ No

If yes, explain _____

_____

Section 8. Other Health Program Information and Referrals

(a) Check this box if you do **not** want your child's information shared with the low-cost Healthy Families Program if your child gets Medi-Cal with a share of cost. ❑

(b) Do you want information on the no-cost health program for children under 21 *(Child Health and Disability Prevention Program, also known as CHDP?)* ❑ Yes ❑ No

(c) Do you want information on the no-cost supplemental food program for pregnant or breast feeding women and children under 5 *(Women, Infants, and Children Program, also known as WIC)?* ❑ Yes ❑ No

(d) Do you want information on the Personal Care Services Program, an in-home care program for aged, blind, or disabled persons (also known as In-Home Supportive Services)? ❑ Yes ❑ No

Section 9. Signature and Certification

Person completing this form must read and sign below.

➤ I have received and read a copy of the *Important Information for Persons Requesting Medi-Cal* form (MC 219).

➤ I am aware of, understand, and agree to meet all my responsibilities as described on the MC 219 form.

➤ I certify that I will report all income, property, and/or other changes that may affect Medi-Cal eligibility within ten days of the change.

➤ I understand that all of the statements, including benefit and income information, that I have made on this form, may be subject to investigation and verification.

➤ I declare, under penalty of perjury, under the laws of the State of California that all information provided on this form is true and correct.

Signature	**Date**

Daytime or Message Telephone Number	**Home Telephone Number** ❑ *(check here if new number)*

Signature of Witness *(if signed by a mark),* **Interpreter or Person Assisting**

— County Use Only —

Referrals

❑ HF ❑ WIC
❑ CHDP ❑ PCSP

Follow-up Forms

❑ MC 13 ❑ MC 210 PS ❑ Other:
❑ DDSD Packet

Case name: _____

Worker's name: _____

Worker's telephone number: _____

PROPERTY SUPPLEMENT

STOP: If you are applying for no-cost Medi-Cal only for ***children under age 19*** and/or ***pregnant women*** applying only for pregnancy-related services, you do not need to complete this form. You may be contacted later if necessary.

GO: If you are applying for full-coverage Medi-Cal for a family including adults, please complete this form and be sure to list all your property. The county worker will determine which properties are important to your application. If you have any questions, please contact your worker. **Note:** Owning a home does not make you ineligible for Medi-Cal.

Mark the box under **YES** or **NO** for each item held in the name of, or held for the benefit of any family member in the home. Please follow the instruction below each question.

	YES	NO	ITEM
1.	☐	☐	Shares of stock or mutual funds. *If yes, please provide a copy of the stock or mutual fund certificates indicating the number of shares.*
2.	☐	☐	Individual Retirement Accounts (IRAs), Keoghs, or work-related pension funds. *If yes, please provide the most recent statements from your employer, financial institution, or brokerage indicating the amount of principal and interest you are receiving or the cash value (after penalties for early withdrawal).*
3.	☐	☐	Annuities, burial trusts, burial contracts or burial insurance, trusts or agreements where money or property is held for the benefit of any family member in the home, blocked accounts, court-ordered settlements, judgments, orders for support, prenuptial and post-nuptial agreements, promissory notes, mortgages, deeds of trust, etc. *If yes, please provide copies of the policies, contracts, trusts, purchase agreements, court orders, account documents showing investments and distributions.*
4.	☐	☐	Business accounts and property. *If yes, please provide tax returns, invoices, receipts, licenses, profit and loss statements, etc.*
5.	☐	☐	House, condominium, ranch, land, mobile home, or life estate that is your home that you live in, or that is your former home and is lived in by your spouse, child under 21, disabled son or daughter, dependent relative, or a sibling who lived in the property continuously and provided care for one year which enabled you to remain in the home rather than a nursing facility. *If yes, please list address of property here:* _____ *No verification is required.*
6.			If you own a home or former home and you are absent for any reason (including admission into long-term care) but intend to return home someday, please indicate below. **NOTE:** The word "intend" means "desire or wish" to return home even though you may not be physically or mentally able to do so.

☐ Yes, I intend to return home someday.
☐ No, I do not intend to return home someday.
Please list the address of the property here: _____
*No verification is required if you answered that you do intend to return home someday. If you answered that you do **NOT** intend to return someday, please submit a copy of the most recent tax assessment. If you choose to, you may provide an appraisal from a qualified real estate appraiser and that value will be used if it is lower.*

7. ☐ ☐ Other real estate, condominiums, buildings, mobile homes, life estates, time shares, oil and mineral rights.
If yes, please provide copies of the mortgage papers, most recent tax assessment, registration, or ownership documents.

8. ☐ ☐ Motorcycles, trailers, boats, or other motorized vehicles that are not used by you as a home.
Please provide a copy of the ownership documents or most recent registrations, purchase agreements, sales receipts, or estimates of value from a qualified source. On the submitted verification for each item, indicate if the item is used:
- *on the job (such as a taxi);*
- *to travel long distances to work (such as a truck used by a contractor working out of town);*
- *to carry the main supply of fuel or water for your home;*
- *to transport a disabled or incapacitated family member living in the home or if it is business property.*

9 . ☐ ☐ Jewelry (not wedding rings, engagement rings, or heirlooms) worth more than $100.00.
If yes, please provide copies of sales receipts, appraisals, estimates of value or insurance documents.

10. ☐ ☐ Any other real or personal property, assets, or resources valued at $500 or more.
If yes, send copies verifying the property and its worth.

11. ☐ ☐ Has anyone spent or used any of the items listed above in payment for, or as security for medical services?
If yes, please explain below and attach verifications.

1 through 10. ***If you owe money on any of the items listed above, or if any of the items listed above have liens against them, please provide copies of the lien, loan, or security documents.***

12. ☐ ☐ Did you, or any family member in the home, sell or give away any money or property in the past
- 36 months (or 60 months if the transfer was made to or from a trust or agreement for holding money or property for the benefit of someone) if you are applying for Medi-Cal; or
- 12 months if you are currently receiving Medi-Cal?

If yes, please explain in the "Additional Information" section at the end of this form and attach verifications.

The following questions apply only to those individuals who are already receiving Medi-Cal.

13. ☐ ☐ Does any family member in the home have a checking account or savings account?
If yes, send copies of account statements showing current balances in the accounts.

14. ☐ ☐ Does anyone have a court-ordered settlement or judgment?
If yes, send copies of all court orders, documents, and agreements. If copies have already been provided to your worker, you do not need to provide them again.

15. ☐ ☐ Does anyone have life insurance or long-term care insurance?
If yes, send copies of your policies, contracts, and purchase agreements. If copies have already been provided to your worker, you do not need to provide them again. If your policy is a certified California Partnership for Long-term Care policy, send a copy of your most recent benefit statement.

Additional information:

MEDI-CAL CONTACT UPDATE

Please fill in numbers 1 through 4, and sign number 5 below:

1. New Contact Information	2. Old Contact Information
Name (print)	Name (print)
Address (number, street, apt.)	Address (number, street, apt.)
City State ZIP code	City State ZIP code
Mailing address (if different from above)	Mailing address (if different from above)
City State ZIP code	City State ZIP code
Telephone number ( )	Telephone number ( )

3. Your Health Plan Information	4. Personal Information
Health plan name (print)	Your date of birth
Your health plan number	Your Beneficiary Identification Card (BIC) number

PLEASE READ THE FOLLOWING BEFORE SIGNING BELOW:

You can help us keep your Medi-Cal contact information current by completing, signing, and turning in this form. It allows your managed care plan to share with your county Medi-Cal office any **name, address,** and/or **telephone number** changes you make. This form will help in making sure that you receive the most current information about your Medi-Cal benefits.

The county Medi-Cal office may not be able to update your Medi-Cal case file with your **name, address,** and **telephone number** change if this form is not completed and signed by you. **Don't forget** that Medi-Cal rules require you to report a change of address to the county Medi-Cal office within ten days.

5. PLEASE PRINT YOUR NAME, SIGN, AND DATE IN THE AUTHORIZATION BOX BELOW:

I, *(print name)* _____, give permission for the county Medi-Cal office to update my Medi-Cal case file and those of my family members with any changes in information regarding my **name, address,** and/or **telephone number** that I report to my managed care plan. I understand that I will need to complete a new form every time I have a change to my **name, address,** and/or **telephone number.**

_____ _____

Signature Date

COUNTY INFORMATION *(to be filled in by county staff)*

Case number	Worker name	Worker number	Worker telephone number ( )