PROVIDER DIRECTIONS FOR PRESUMPTIVE ELIGIBILITY APPLICATION

Please complete patient name and date of birth below **before** separating Presumptive Eligibility Application (PREMED 1). Remember to hold the PREMEDCARD and Application for Medi-Cal Only (PREMED 2) in a secure place until the Presumptive Eligibility (PE) determination is completed.

When issuing the PREMEDCARD to eligible PE patients, please insert the last day of the month following the current month in the date block marked "FIRST GOOD THRU" (located underneath the Medi-Cal ID number in the lower right portion of the card). This date will ensure your patient is eligible for ambulatory prenatal care for up to sixty (60) days while she files her Medi-Cal application.

Remember, after you complete the PE eligibility determination and find the patient eligible, you must realign the PREMEDCARD with the rest of the forms package and press firmly so that the signature transfers to all the forms in the correct location. Only the Qualified Provider or an authorized representative may sign the PREMEDCARD. Signatures on the PREMED package may be carbons or originals, but no stamped or electronically produced.

TOLL FREE NUMBER: 1-800-824-0088

FAX NUMBER: 1-800-409-1498

COMPLETE FORMS IN BLACK INK ONLY

MEDI-CAL IDENTIFICATION CARD
PRESUMPTIVE ELIGIBILITY

DO NOT DESTROY THIS CARD/NO DESTRUYA ESTA TARJETA

SIGNATURE/FIRMA:________________________ DATE/FECHA: ____________

THE PERSON NAMED ON THIS CARD IS ELIGIBLE TO RECEIVE BENEFITS UNDER PRESUMPTIVE ELIGIBILITY

VALID FOR AMBULATORY PRENATAL CARE AND PHARMACY SERVICES ONLY

PROVIDER USE ONLY

MEDI-CAL APPLICATION FILED:
PE PROVIDER SIGNATURE:
PE PROVIDER TITLE:

PROVIDER STAMP HERE

SECOND GOOD THRU:

MEDI-CAL ID:
FIRST GOOD THRU:
PATIENT NAME:
DOB (MM/DD/YYYY):

PE Provider Signature:________________________

PE Provider Title: ________________________ Date: ____________

APPLICATION FOR PRESUMPTIVE ELIGIBILITY ONLY

Before completing this application, read the directions. If you need help completing this form, please ask your provider for assistance.

SECTION A. APPLICANT INFORMATION

Please list your Social Security number here if you have one:

___________—_______________—___________

Home address:	Number	Street	City	ZIP code
Mailing address (if different):	Number	Street	City	ZIP code
Telephone number(s):	Home	Work	Message	

If no permanent address, tell us where you can be reached:

SECTION B. HOUSEHOLD/INCOME INFORMATION

1. Please list in COLUMN I all family members (spouse, children, parents, siblings) living in your household, their relationship to you, and their date of birth.
2. Has anyone ever asked for or gotten aid anywhere? ☐ YES ☐ NO
   If YES, explain: under what name, where, when, and type(s) of aid.
3. If you or any family member in your household receive earned or unearned income (include income from employment, self-employment, tips, commissions, pensions, Social Security, child/spousal support, gifts, disability, VA or unemployment benefits, etc.), list the total amount in COLUMN II under Gross Monthly Income, and where you got the money from under Source.

COLUMN I			COLUMN II	
Name: Last, First, Middle Initial	**Relationship**	**Date of Birth**	**Gross Monthly Income**	**Source**
	SELF			
	UNBORN			

If you need more space to answer, please write on the back of this sheet of paper and check this box. ☐

I CERTIFY I HAVE READ AND UNDERSTAND THIS FORM. I DECLARE THAT THE INFORMATION I HAVE PROVIDED IS TRUE, CORRECT, AND COMPLETE.

Signature or mark of applicant (or legal guardian)	Date
Signature of witness to mark of applicant (or legal guardian)	Date

STOP!! *THIS COMPLETES YOUR APPLICATION FOR PRESUMPTIVE ELIGIBILITY* ***STOP!!***

FOR PROVIDER USE ONLY

Total Family Income: ___________ *Number in Family:* _________ *Income Eligible:* ☐ Yes ☐ No

MEDI-CAL ID:
FIRST GOOD THRU:
PATIENT NAME:
DOB (MM/DD/YYYY):

PE Provider Signature:____________________________________ Pregnancy Test Results? ☐ Positive ☐ Negative
PE Provider Title: _______________________________________ Date:____________ E.D.C.: ________________________

APPLICATION FOR MEDI-CAL PROGRAM ONLY

If you are applying for the Medi-Cal Program only, please complete this form. If you wish to apply for other programs such as AFDC, do not complete this form; take this form to the County Welfare Department and tell the receptionist you wish to apply for these programs. NOTE: You must return this form (PREMED 2) to your County Welfare Department by the end of next month in order for PE coverage to continue. Please complete items 1 through 8 and sign the Certification and Perjury Statement below.

1. Home address: (number/street/city/ZIP code)

   Mailing address if different: (number/street/city/ZIP code)

2. Telephone number(s): (home/work/message)

3. If no permanent address, tell us where you can be reached:

4. Social Security number (SSN):

5. How much liquid resources does everyone, including children, have?
   - ☐ Cash, uncashed checks or money orders $____________
   - ☐ Checking/savings or credit union account(s) $____________
   - ☐ Trust deeds, notes receivable, stocks or bonds $____________
   - ☐ Other (explain): $____________

6. Has anyone ever asked for or gotten aid anywhere? ☐ YES ☐ NO
   If YES, explain: under what name, where, when, and type(s) of aid.

7. Does anyone have a personal emergency: ☐ YES ☐ NO
   If YES, what kind?
   ☐ Medical ☐ Pregnancy ☐ Child Abuse ☐ Spousal Abuse ☐ Other
   Do you have another kind of emergency which threatens your health or safety ☐ YES ☐ NO
   If YES, explain:

8. The law says we must get your ethnic group and primary language. If you don't want to complete these items, the county will do it for you. This won't affect your eligibility.
   a. Ethnic Group:
   ☐ White ☐ Hispanic ☐ Black ☐ Filipino
   ☐ American Indian or Alaskan Native ☐ Asian Indian ☐ Chinese
   ☐ Cambodian ☐ Japanese ☐ Korean ☐ Laotian
   ☐ Samoan ☐ Vietnamese ☐ Hawaiian ☐ Guamanian
   ☐ Other Pacific Islander (specify): ____________

   b. Language:
   ☐ English ☐ Spanish
   ☐ Cantonese ☐ Cambodian
   ☐ Lao ☐ Vietnamese
   ☐ Tagalog ☐ Other (specify): ____________
   ☐ American Sign

COUNTY USE ONLY

COUNTY OF APPLICATION:

Co. of Residence (If Different):

Date Received:

Case Name:

Case Number:

TYPE OF APPLICATION
- ☐ Full
- ☐ Restricted
- ☐ MEDS CDB cleared
- ☐ IEVS initiated
- ☐ CWD records cleared

Ethnic Group:

Primary Language:

CERTIFICATION AND PERJURY STATEMENT

- I certify that I understand and agree that I have to comply with eligibility rules. I understand that the statements I have made on this form may be checked and verified.
- I declare under penalty of perjury under the laws of the United States of America and the State of California that the information I have given on this form is true, correct, and complete.

Signature (or mark) of applicant or authorized representative	Date signed
Signature of witness to mark or interpreter	Date signed

FOR PROVIDER USE ONLY—PREGNANCY VERIFICATION

MEDI-CAL ID:
FIRST GOOD THRU:
PATIENT NAME:
DOB (MM/DD/YYYY):

PE Provider Signature: ______________________ Pregnancy Test Results? ☐ Positive ☐ Negative
PE Provider Title: ______________________ Date:____________ E.D.C.: ______________________