NOTICE AND SUPPLEMENTAL FORM FOR EXPRESS ENROLLMENT APPLICANTS

(COUNTY STAMP)

Notice date:_____
Case number: _____
Worker name: _____
Worker number: _____
Worker telephone number: _____
Office hours: _____
Notice for: _____

Your local county Medi-Cal office has received a copy of the School Meals application for _____. On that application, you asked us to determine if your child is eligible for Medi-Cal benefits. Based on the information you provided:

❒ **Your child was found temporarily eligible for Medi-Cal benefits.** If your child does not already have a California Benefits Identification Card (BIC), you will soon receive a BIC in the mail. Your child can immediately use their BIC to get medical services. This temporary eligibility will last until a Medi-Cal determination has been completed. For us to determine if your child is eligible to continue receiving Medi-Cal, we need you to complete, sign, and return this form.

❒ **Your child was not found temporarily eligible for Medi-Cal benefits. He/she may be eligible for Medi-Cal once all information is reviewed.** For us to determine if your child is eligible for Medi-Cal, we need you to complete, sign, and return this form.

IMPORTANT: Please answer the questions below and attach any necessary documents. Please return this information in the enclosed postage-paid envelope no later than _____ or your child's eligibility for Medi-Cal benefits may be discontinued or denied.

1. If your child has a social security number, please write it here. _____–_____–_____
   (IMPORTANT: If the child does not have a social security number, you can apply for a social security number now for your child and provide it to us within 60 days. Your child may be eligible to receive emergency-related Medi-Cal if he/she is unable to get a social security number.)
2. Is the child a citizen or national of the United States? . . . . . ❒ Yes ❒ No
   If **NO**, please check here if he/she has satisfactory immigration status _____ and write the date of the child's entry into the United States _____.
   (Attach documentation of his or her immigration status or a receipt from INS showing you have applied to replace a lost document. If you do not have it now, you can send the document to the above address within 30 days.)
3. Do you want Medi-Cal to cover any medical expenses your child had in the last three months? . . . . . ❒ Yes ❒ No
4. Does the child have other health, dental, or vision insurance? . . . . . ❒ Yes ❒ No
   If **YES**, Please complete the enclosed "Health Insurance Questionnaire" form (DHCS 6155).
   (IMPORTANT: Your child can still be eligible for Medi-Cal even if he/she has other health coverage.)
5. Is anyone else in your family interested in applying for Medi-Cal?. . . . . ❒ Yes ❒ No

❒ If you pay for child care services, child support, health insurance premiums, or have self-employed expenses, send a copy of your most recent payment/expenses. Proof of these expenses can be used to reduce the income we count for a Medi-Cal determination. A copy of your income from work, Workers Compensation or State Disability benefits may allow you an additional deduction.

❒ Other: _____

If you have any questions or need additional information, please contact your Medi-Cal worker listed on the top right corner of this notice.

Declaration and Signature: I declare under penalty of perjury under the laws of the State of California that the answers I have given in this application, the declarations made, and the documents submitted are true and correct to the best of my knowledge and belief. I declare that I have received, read, and understand the attachment titled "Important Information for Medi-Cal Applicants."

Signature of parent/guardian **X**_____ Date _____

According to California Code of Regulations, Title 22, Section 50175, **if you fail to return the required information and/or document(s) or if the information and/or documents you send do not verify your eligibility, your application for Medi-Cal shall be denied or eligibility shall be discontinued.**