STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY

GRAY DAVIS *Governor*

DEPARTMENT OF HEALTH SERVICES
714/744 P Street
P.O. Box 942732
Sacramento, CA 94234-7320
(916) 657--258

October 16, 2000

TO: All County Welfare Directors
All County Administrative Officers
All County Medi-Cal Program Specialists/Liaisons
All County Public Health Directors
All County Mental Health Directors

Letter No.: 00-52

HEALTHY FAMILIES ADD NEW CHILDREN FORM FOR THE MEDI-CAL PROGRAM

Ref.: All County Welfare Directors Letter No. 99-48

The purpose of this All County Welfare Directors Letter (ACWDL) is to instruct counties in the use of the Healthy Families Add New Children Form (7/13/00 non-AER).

Counties are instructed to accept the Healthy Families Add New Children Form (7/13/00 non-AER) when Medi-Cal is requested for a child new to the family composition.

This new form was developed to add a child to an existing Healthy Families case at any time during the year rather than request the applicant to complete another Healthy Families/Medi-Cal for Children (MC 321 HFP) application. It is hoped that this form will simplify the process to add a child and minimize the potential for duplicate cases.

When counties have an active Medi-Cal case and receive the Healthy Families Add New Children Form (7/13/00 non-AER), counties are to add the child to the Medi-Cal case.

Enclosed is a copy of the Healthy Families Add New Children Form (7/13/00 non-AER). If you have any questions on this matter, please contact Ms. Kim McCord of my staff at (916) 657-3723.

Sincerely,

ORIGINAL SIGNED BY

Glenda Arellano, Acting Chief
Medi-Cal Eligibility Branch

Enclosure

ADD NEW CHILDREN FORM

APPLICANT NAME	PHONE NUMBER

FAMILY MEMBER NUMBER											

Please fill out all information for the child(ren) you would like to add to Healthy Families. To add more than 4 children, make a photocopy of this form if necessary. If a pregnant woman is within 90 days of the estimated date of delivery, she may pre-enroll the unborn child in the Healthy Families Program. Healthy Families insurance coverage will become effective 13 days after documentation of birth is received. This information must be received within 30 days of birth.

	Child 1 (or unborn)	Child 2	Child 3	Child 4
Name: Last				
First				
Middle				
Birthname: Last *(if different from above)*				
First				
Middle				
If the child's address is NOT the same as the Applicant, give address	Street City ZIP	Street City ZIP	Street City ZIP	Street City ZIP
Relationship to Applicant:				
Sex:	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Date of Birth (or estimated date of delivery)	/ / MO DAY YEAR	/ / MO DAY YEAR	/ / MO DAY YEAR	/ / MO DAY YEAR
Place of Birth: **California County, State or Country**				
Ethnicity Code				

1	White	2	Hispanic	3	Black/African American	4	Asian
5a	American Indian	5b	Alaskan Native	7	Filipino	A	Amerasian
C	Chinese	H	Cambodian	J	Japanese	M	Samoan
N	Asian Indian	P	Hawaiian	R	Guamanian	T	Laotian
V	Vietnamese	K	Korean	Z	Other		

U.S. Citizen or National? If no, please write date of entry into U.S.	☐ Yes ☐ No / / MO DAY YEAR	☐ Yes ☐ No / / MO DAY YEAR	☐ Yes ☐ No / / MO DAY YEAR	☐ Yes ☐ No / / MO DAY YEAR
Social Security # *(optional)*	- -	- -	- -	- -
Mother's Name: Last				
First				
Does the Mother live in the home?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Father's Name: Last				
First				

CONTINUED	Child 1 (or unborn)	Child 2	Child 3	Child 4
Does the father live in the home?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Does this child have no cost Medi-Cal? If yes, give date coverage will end.	☐ Yes ☐ No / / MO DAY YEAR	☐ Yes ☐ No / / MO DAY YEAR	☐ Yes ☐ No / / MO DAY YEAR	☐ Yes ☐ No / / MO DAY YEAR
Was the child insured by an employer in the last 90 days? If yes, check the main reason why insurance stopped and give the date it stopped.	☐ Yes ☐ No ☐ Lost Job ☐ Moved and no insurance available ☐ Employer ended benefits to all employees ☐ COBRA coverage ended ☐ Other _____ _____ / / MO DAY YEAR	☐ Yes ☐ No ☐ Lost Job ☐ Moved and no insurance available ☐ Employer ended benefits to all employees ☐ COBRA coverage ended ☐ Other _____ _____ / / MO DAY YEAR	☐ Yes ☐ No ☐ Lost Job ☐ Moved and no insurance available ☐ Employer ended benefits to all employees ☐ COBRA coverage ended ☐ Other _____ _____ / / MO DAY YEAR	☐ Yes ☐ No ☐ Lost Job ☐ Moved and no insurance available ☐ Employer ended benefits to all employees ☐ COBRA coverage ended ☐ Other _____ _____ / / MO DAY YEAR
Monthly countable income of the child	$ From where?	$ From where?	$ From where?	$ From where?
Monthly countable income of the applicant and the other adult in the household (including frequency of payment) and from where the income is received. For example: Applicant $500.00 per week From where? Job Relationship to children: Father			Applicant $_____ From where? Relationship to children:	Other Adult $_____ From where? Relationship to children:
Monthly income deductions	Child care expenses: $	Dependent care expenses: $	Monthly court ordered payment of child support or alimony: $	

- *See the Household Information Instructions for a list of what income counts and acceptable income and deduction documentation.*
- ***You must include a birth certificate for each child (within 60 days of enrollment) and documentation of birth for a newborn (within 30 days of birth) or;***
- ***An immigration status document for each child (within 30 days of enrollment)***

I, the applicant, certify that the information provided is true and correct. I understand that adding additional family members may result in a higher monthly premium.

Applicant Signature X_____ **Date:**_____

Authorization to Forward to Medi-Cal
If my child is ineligible for Healthy Families, I request that this form be forwarded to the county and treated as a Medi-Cal application. I declare under penalty of perjury that the information on this form is true and correct to the best of my knowledge and belief. Please provide Social Security numbers of children applying for full scope Medi-Cal benefits.
Applicant Signature X_____ **Date:**_____

Please mail to: Healthy Families Attn: Add Form
P.O. Box 138005
Sacramento, CA 95813-9984

Household Information Instructions

Who counts as a family member living in the home with the child?

Adults:

- Natural or adoptive parents of the child to receive benefits
- A minor living on his or her own

Children:

- Unborn child
- All children under age 21 living in the home
- All children under age 21 away at school and claimed as tax dependents

What Income counts?

- Earnings from a job
- Self-employment net profits
- Child support
- Alimony/Spousal Support
- Pension and retirement benefits
- Government benefits such as Social Security, Retirement Survivor Disability Insurance (RSDI), Veterans, Disability, Workers' Compensation, Unemployment, etc.
- Other income such as: grants for living expenses, settlement benefits, net profit from rentals, gifts, lottery/bingo winnings, interest income

What income does NOT count?

- **Earnings from a job of a child under age 14 or a child who attends school**
- Supplementary Security Income/State Supplementary Program (SSI/SSP) Payments
- Foster Care Payments
- CalWORKS payments (replaces AFDC)
- General Relief
- Certain other government benefits
- Grants or scholarships
- Loans

Acceptable Income Documents:

- Copy of the most recent paystub. If a paystub is not available, get a signed statement from your employer. Gross monthly income and the dates received should be on the statement.
- Copy of last year's federal income tax return

Other proof of income you may send:

- If a person is self-employed, send last year's federal income tax return (including the Schedule C) or the last 3 month's profit and loss statements.
- If a person has income such as disability or retirement, send copies of award letters or bank statements showing the direct deposits.
- If anyone gets child support and/or alimony or spousal support, send copies of the checks received or statements from the District Attorney's Family Support Division, for the last month.
- A Medi-Cal "Share-of-Cost-Notice of Action" received in the last 30 days which shows the child has share-of-cost may be used if it lists your income.

Deductions

The income deductions help us determine what amounts we may use to lower your family's income. If anyone receives child support and/or alimony or spousal support, send copies of the checks received or statements from the District Attorney's Family Support Division for the last month. Also, send copies of receipts or cancelled checks for child or dependant care expenses paid during the last month.

What is Medi-Cal?

Medi-Cal offers no-cost comprehensive health, dental and vision services to children. If your family income is below the Healthy Families guidelines, your child(ren) may be eligible for no-cost Medi-Cal. If you authorize us, we will forward your information to Medi-Cal if your children do not qualify for Healthy Families.

Medi-Cal Privacy Notice

Federal and State Law requires us to provide the following information: Welfare and Institutions Code §14011. Requires Medi-Cal applicants to provide the information requested in this application. It may be shared with federal, state and local agencies for purposes of verifying eligibility, and for verification of the immigration status of those persons seeking full scope Medi-Cal benefits. (Federal law says the INS cannot use the information for anything else except cases of fraud.) It will also be used to process Medi-Cal claims and make Benefits Identification Cards (BICs). Failure to provide the required information may result in denial of the application. Information required by this form is mandatory. Social Security numbers are required by §1144(a)(1) of the Social Security Act unless applying for emergency or pregnancy benefits only.

If you have any questions or would like the location of a Certified Application Assistant in your area, call 1-800-880-5305, Monday - Friday, 8:00 A.M. - 8:00 P.M.
A Certified Application Assistant will help you with these forms at no cost.