State of California—Health and Human Services Agency
Department of Health Services

California Department of Health Services

DIANA M. BONTÁ, R.N., Dr. P.H.
Director

GRAY DAVIS
Governor

September 24, 2002

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

Letter No: 02-48

REVISION TO MEDI-CAL REQUEST FOR INFORMATION FORM (MC 355)

Ref: All County Welfare Directors Letter (ACWDL) No. 01-39

The MC 355 has been revised as follows:

FRONT SIDE

The **REMINDER** section has been renamed and divided into two sections, **REMEMBER** and **IMPORTANT**. This change is intended to better capture the beneficiary's attention about eligibility for ongoing Medi-Cal benefits.

BACK SIDE

The "Identity of Family Members – Provide for Each Family Member" section has been renamed to *"Information on Person(s) Requesting Medi-Cal"* to clarify requested information is for a specific individual rather than the entire household.

The *"Other"* section has been changed to include an additional box for beneficiaries to check if they believe they or any other family member is disabled.

Flex your POWER

Do your part to help California save energy. To learn more about saving energy, visit the following web site: www.consumerenergycenter.org/flex/index.html

714 P STREET, ROOM 1692, P.O. BOX 942732, SACRAMENTO, CA 94234-7320
(916) 657-2941
Internet Address: www.dhs.ca.gov

Currently, the revised MC 355 is available in English through the DHS warehouse, however, other languages will be available in the near future. If you have questions regarding this revision, please contact Mack Guynn at (916) 657-1064.

Sincerely,

ORIGINAL SIGNED BY

Richard Brantingham
Acting Chief
Medi-Cal Eligibility Branch

Attachment: revised MC 355 (08/02)

MEDI-CAL REQUEST FOR INFORMATION

ATTENTION: READ THIS SIDE FIRST

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

The information requested on the back of this form is needed to complete our review of your continued eligibility for Medi-Cal benefits.

REMEMBER!!!

- Even if you are employed you may be eligible to receive Medi-Cal benefits.
- Receipt of Medi-Cal does not count against any CalWORKs time limits.
- You do not have to receive CalWORKs to receive Medi-Cal benefits.

IMPORTANT!!!

- You may still be eligible if you are:
  - under the age of 21;
  - at least age 65 or older;
  - disabled;
  - blind;
  - pregnant;
  - a parent or caretaker relative of a child (under the age of 21) who has at least one parent either absent, deceased, incapacitated, or unemployed/underemployed;
  - have tuberculosis or receive dialysis;
  - living in a long-term care facility;
  - a refugee who has been in the country eight months or less;
  - receiving SSI benefits;
  - receiving CalWORKs benefits; or
  - eligible for special programs (i.e., TMC, QMB, percentage programs, etc.).

If you have any questions or need more information about this form, call your eligibility worker whose name and telephone number are listed at the top of this form.

IMPORTANT!
PLEASE READ THE OTHER SIDE OF THIS FORM.

MEDI-CAL REQUEST FOR INFORMATION

WE NEED ***ONLY*** THE INFORMATION REQUESTED BELOW.

Income

- ☐ A copy of the most recent pay stub or statement from your employer about your job (how much you are paid, how often you are paid, how many hours you work) for each of your jobs (if you have more than one) or a copy of your most recent tax return. This will help us decide if you are eligible for free Medi-Cal or will have a "share-of-cost."
- ☐ Your signed statement about your job (or jobs) if you do not get pay stubs and cannot get a statement from your employer (or employers).
- ☐ Schedule C if self-employed.
- ☐ Proof of unemployment or disability benefits—a copy of benefits stub or award letter.
- ☐ Proof of social security benefits received—a copy of paid benefits stub or award letter.

Income Deductions

- ☐ A copy of checks or receipts of child care, child support, alimony, or health insurance paid.

Personal or Real Property

- ☐ A copy of vehicle registration (if more than one vehicle owned).
- ☐ A copy of your most recent bank statement (checking, savings account, etc.)
- ☐ A copy of life insurance policy, stocks, bonds, retirement account statement.

Information on Person(s) Requesting Medi-Cal

(If you are an immigrant and don't have a social security card or immigration documentation to give us, you may still qualify for emergency and pregnancy-related services.)

- ☐ Social security number for: _____.
- ☐ A copy of your California driver's license or a photo ID for: _____.
- ☐ A copy of immigration documentation or card (if card, a copy of both sides) for: _____.

Residence

- ☐ Verification of your current address (rent receipt, utility bill, etc.).

Disability/Incapacity

- ☐ Social security award letter for disability.
- ☐ Other proof that you have a physical, mental, or emotional disability that will last 12 months or more.
- ☐ Proof of incapacity—such as a doctor's statement that you can't work for at least 30 days.

Other

- ☐ _____
- ☐ *Check this box if you think you or any family member receiving Medi-Cal is disabled.*

We must receive this information by _____. *Otherwise*, we may begin the process to stop your Medi-Cal benefits! (A prepaid self-addressed envelope is provided for your convenience.)

HELP US TO KEEP IN TOUCH WITH YOU!

Call your eligibility worker if you have a change of address or telephone number.
(The name and telephone number are listed on the other side of this page at the top.)