MEDICAL REPORT FOR MEDI-CAL OR MCAP POSTPARTUM CARE EXTENSION

COUNTY/MAXIMUS USE ONLY

Case name	Case number	Worker name	Worker number

SECTION I (PATIENT/CLIENT INFORMATION AND MEDICAL RELEASE)

Name of patient/client (last, first, middle) / *Nombre del paciente/cliente (apellido, primer nombre, segundo nombre)*

Birth Date/ Fecha de nacimiento	Social Security Number, Medi-Cal, or MCAP Number

I authorize / *Autorizo a* _____ of / *de* _____

Name of licensed physician or certified psychologist
Nombre del doctor con licencia o psicologo certificado

Name of clinic or medical group
Nombre de la clínica o grupo édico

to release my medical information on this form to the county Medi-Cal department or the MCAP program, as appropriate. This authorization is valid for one year from the date signed and I may ask for a copy of this authorization.
al departamento de Medi-Cal del condado o el programa di MCAP come necessario para que proporcione la información médica que se solicita en este formulario. Esta autorización es válida por un año a partir de la fecha de la firma y tengo derecho a solicitar una copia de esta autorización.

Patient/client signature / *Firma del paciente/cliente*	Date/*Fecha*

SECTION II: TREATING HEALTH CARE PROVIDER

The information requested below is needed to determine if the individual named above has been diagnosed with a maternal mental health condition, including but not limited to postpartum depression, during the pregnancy, postpartum period, or within 90 days from the end of the postpartum period. The individual may continue to be eligible for Medi-Cal or MCAP benefits for a period of one year following the last day of the individual's pregnancy. This completed and signed form must be submitted to the individual's county or the MCAP program for processing.

Has the above named individual been diagnosed with a maternal mental health condition?

Yes ☐ No ☐

Onset date: _____
(month, day, year)

(County/MAXIMUS Stamp)

I understand that the statements I have made on this form are subject to verification and investigation for welfare fraud.

I declare under penalty of perjury under the laws of the United States and the State of California that the information contained in this report is true, correct, and complete.

Signature of treating health care provider or person authorized to sign on the doctor's behalf		Date	
Printed name and title/specialty		Phone number	
Street address *(mailing address, if different)*	City	State	ZIP code