Application for Medi-Cal for Former Foster Care Youth

☐ New Application
☐ Redetermination
☐ Request for retroactive coverage for _____ months

COUNTY USE ONLY

Case Name: _____

Case Number: _____

Date of Discontinuance: _____

Name	Date of Birth (mm/dd/yy)	Gender ☐ Male ☐ Female	
Telephone Number	Cell Phone Number	Social Security Number	
Address (Number, Street)	City	State	Zip Code
Mailing Address (if different) (Number, Street, P.O. Box)	City	State	Zip Code
Email Address			

Were you in foster care on your 18th birthday or later? ☐ Yes ☐ No ☐ Not Sure

Which state were you in foster care (for example, California)? _____

I declare under penalty of perjury under the laws of the State of California that the answers I have given in this application are true and correct to the best of my knowledge and belief.

Signature	Date

Instructions

If you are completing this application it is because you were in foster care. If you were in foster care in any state or tribe, you may qualify for the Medi-Cal program for former foster youth. You may be eligible to receive Medi-Cal benefits at no cost. Your income or resources (such as a car) do not matter, and you do not need to give your income or resource information for you to be eligible for Medi-Cal.

Once you have completed this form, you can turn it in to your local county social services office in person, by fax, or by mail. You may also be able to apply over the phone by calling your local county social services office. Check a phone book for the nearest office or visit:

http://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx

If you move within California, you will still be eligible for Medi-Cal, but you will have to notify your county eligibility worker of your address change. If you move out of the county that you lived in when you applied, the county worker will have to change the information on your case so that you can continue to get medical coverage without difficulty.

If you move out of state, you may still be eligible for medical benefits in your new state, but you will have to apply for benefits in the new state of residence.

DHCS Privacy Statement

This form is for receiving benefits through the Department of Health Care Services (DHCS). The personal and medical information you provide on it is private and confidential. DHCS needs it to identify you and the other people on this form and to administer our programs. We will share your information with other state, federal, and local agencies, contractors, health plans, and programs only to administer programs, and with other state and federal agencies as required by law.

You must answer all of the questions on this form unless they are marked "optional." If your form is missing anything that we require, we will contact you to get it. If you do not provide it, we will not be able to make a decision on your benefits. You may have to submit a new application, or services may be denied.

In most cases, you have the right to see personal information about you that is in federal and state records. You can see it in an alternative format (such as large print) if you need that. For more information, contact the DHCS Information Protection Unit at:

P.O. Box 997413, MS 4721
Sacramento, CA
95899-7413
Phone: 1-866-866-0602
TTY: 1-877-735-2929

These state laws give us the right to collect and keep the information: CA Welfare and Institutions Code § 14011 and Article 3, Chapters 5 and 7, Parts 2 and 3, Division 9. We must give you this Privacy Statement under CA Civil Code § 1798.17.