Medi-Cal Access Program

Instructions

- *To find out if the Medi-Cal Access Program can lower your monthly contribution, you must fill out this form. Only fill out the form if you think you might qualify for a lower contribution or to have your contribution waived because your income or deductions have changed.*
- *You will need to send proof of your income and deductions with the form.*
- *If you have any questions about the form, call Medi-Cal Access Program: 1-800-433-2611 Monday to Friday, 8 a.m. to 7 p.m., or on Saturday from 8 a.m. to 12 p.m. The call is free.*

Mailing

Residence

⇦ *Are your name and address right?*

If any of this is wrong, please cross it out. Write the correct information next to it.

FAMILY MEMBER NUMBER:

Home:

1. Pregnant woman *now* in Medi-Cal Access Program.

- Enter below the name of the pregnant woman who lives in the household.
- You need to mail proof of income with this form.

Pregnant woman *in* Medi-Cal Access Program	Date of Birth	Pregnant woman's monthly income, if any

Contribution Re-Evaluation Form, Page 2

2. Family size and Income:

Part A: To be completed by the applicant for the father of the unborn child. **Only** complete this section if the father of the unborn child is living with the pregnant woman **and** is married to her and is part of the federal tax household		
Name of father of baby		Birthdate
Are you married to the pregnant woman? YES/NO	Are you part of her federal tax household? YES/NO	Social Security Number or Individual Taxpayer Identification Number (if you have one)

Part B	**Household member 1**	**Household member 2**	**Household member 3**	**Household member 4**	**Household member 5**
Federal Tax Household Person Name (*F or D and Member #)	**(First, Last Name)**	**(First, Last Name)**	**(First, Last Name)**	**(First, Last Name)**	**(First, Last Name)**
Relationship to Pregnant Woman					
Social Security Number or Taxpayer Identification Number (if you have one)					
Current Income					
Currently employed? Yes/No					
Employer Name					
How often is income received (weekly, bi-weekly, twice a month, monthly, yearly)					
How much income is received? (total gross income)					
Self-Employment Income					
Are you Self-employed? Yes/No					
Type of self-employed business?					
Net Self-Employment Income Amount					
How often is income received (weekly, bi-weekly, twice a month, monthly, yearly)					

Contribution Re-Evaluation Form, Page 3

Family size and Income (Continue)

Other Income not listed above					
Do you have other income? Yes/No (income from something other than your job)					
Type of Income					
Gross Income Amount					
How often is income received (weekly, bi-weekly, twice a month, monthly, yearly)					
Information on Modified Adjusted Gross Income (MAGI) and household composition					
Did you file taxes last year? Yes or No					
Were you the primary tax filer? Yes or No					
If you filed taxes last year what did you file as? Head of household, Single, Married filing jointly, Married filing separately, or dependent					
Are you going to file taxes for the benefit year? Yes or No					
If *yes,* how will you file? Head of household, Single, Married filing jointly, Married filing separately, or dependent					

*Please indicate if Tax Household Person is Tax Filer or Dependent. F=Tax Filer D=Dependent. If D indicate household member # of who claims you as a dependent
** If more than 5 people in household, add names on separate sheet of paper**

Contribution Re-Evaluation Form, Page 4

3. Child(ren) living in the house who were NOT listed in the initial application.

- List below the name of the child(ren) who were not listed in the initial Medi-Cal Access Program Application. *Note:* If a child under age 21 is away at school and claimed as a tax dependent, the child is considered living in the home.

Child(ren) who were *not* in the initial application.	Date of birth	Relationship to Applicant
		☐ child ☐ stepchild ☐ other _____
		☐ child ☐ stepchild ☐ other _____
		☐ child ☐ stepchild ☐ other _____

4. Federal Tax Deductions.

- If you pay for any of the expenses listed in the table below, fill in the amounts you pay.
- Only list expenses paid by the parents on this form.

Does the pregnant woman pay alimony? YES/NO If yes, how much alimony? $_____ How often does the pregnant woman get or pay for this deduction? ☐ Hourly: How many hours per week? _____ ☐ Daily: How many hours per week? _____ ☐ Weekly ☐ Every two weeks ☐ Monthly ☐ Twice a month ☐ One-time payment Does the pregnant woman pay student loan interest? YES/NO If yes, how much student loan interest? $_____ How often does the pregnant woman get or pay for this deduction? ☐ Hourly: How many hours per week? _____ ☐ Daily: How many hours per week? _____ ☐ Weekly ☐ Every two weeks ☐ Monthly ☐ Twice a month ☐ One-time payment Does the pregnant woman have another federal deduction? YES/NO $_____ If yes, indicate frequency	Does the father of the baby, listed in part 2, pay alimony? YES/NO If yes, how much alimony? $_____ How often does the father of the baby get or pay for this deduction? ☐ Hourly: How many hours per week? _____ ☐ Daily: How many hours per week? _____ ☐ Weekly ☐ Every two weeks ☐ Monthly ☐ Twice a month ☐ One-time payment Does the father of the baby, listed in part 2, pay student loan interest? YES/NO If yes, how much student loan interest? $_____ How often does the father of the baby pay for this deduction? ☐ Hourly: How many hours per week? _____ ☐ Daily: How many hours per week? _____ ☐ Weekly ☐ Every two weeks ☐ Monthly ☐ Twice a month ☐ One-time payment Does the father of the baby have another federal deduction? YES/NO $_____ If yes, indicate frequency

5. Sign the form.

I, the applicant, certify that the information provided is true and correct. I understand that a change in income may result in a change in monthly premium.

⇨Signature: _____ Date:_____

6. Write your Family Member Number on each paper you send.

Your Family Member Number is:

7. Mail or fax the form to Medi-Cal Access Program.

Mail the form, proof of income papers and proof of deduction papers to:

Medi-Cal Access Program
PO Box 15559
Sacramento, CA 95852-0559

Or, you can fax the form and papers to:

Fax: 1-888-889-9238 The fax number is free.