STATE OF CALIFORNIA--HEALTH AND WELFARE AGENCY PETE WILSON, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P Street
P.O. Box 942732
Sacramento, CA 94234-7320
(916) 657-2941

July 7, 1996

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

Letter No.: 96-36

MC 210 STATEMENT OF FACTS (MEDI-CAL) AND MC 210 S-C ADDITIONAL CHILDREN

The purpose of this letter is to transmit a sample copy of the newly revised MC 210 and MC 210 S-C. Please advise staff that these are not camera-ready forms. This letter also gives an overview of the changes made on each form. The revisions incorporate State and county staff input. The following highlights changes for each form:

MC 210 STATEMENT OF FACTS (MEDI-CAL)

- Changes print style and shading;
- Changes wording for some questions;
- Adds/removes worker prompts in the county use section;
- Adds the Visa and Border Crossing Card question in the "Residency Section";
- Adds lines for applicants to list: other household members and their relationship to the Medi-Cal Family Budget Unit (MFBU), working MFBU members, resources/property ownership, connection to military service personnel/benefits, and long-term care (LTC) insurance;
- Renumbers questions within the same subject matter;
- Identifies subquestions with alphabets; and
- Adds a line for the interpreter to sign and report his/her relationship to the applicant/beneficiary.

Instruction Sheet

- Informs the applicant to return the completed form to the county welfare department (CWD);
- Removes information regarding restricted benefits and alien status; and
- Provides information for the applicant who is applying for pregnancy related benefits and/or coverage for an infant that verification of property may not be necessary if he or she is are applying for Medi-Cal benefits under the Property Waiver Program.

Page 1

- Reflects the Department's implementation of the Appellate Court ruling in the Crespin case regarding Social Security number requirement;
- Removes the shading from the Social Security number blocks;
- Moves and renumbers the applicant's/caretaker's name, home and mailing address questions;
- Provides space for the onset date of disability if an adult family member claims blind or disability status; and
- Instructs the applicant to use Question 7 to list other household members.

Page 2

- Provides space for the applicant/beneficiary to report the relationship of other household members if he or she shares housing;
- Adds question regarding the amount of rent the applicant/beneficiary pays;
- Adds question regarding the applicant/beneficiary's entry into the United States with a Visa or Border Crossing Card;
- Renumbers the employment questions;
- Provides additional space to list working MFBU members;
- Provides space for the applicant to request the specific month(s) of retroactive coverage;
- Adds question regarding the length of disability or emotional problem if an MFBU member has a disabling condition(s);
- Adds worker prompts regarding Visa, Border Crossing Card, student exemption, CA 61, DED reexamination due date, lawsuit/hearing pending, third party liability, and TCC in the county use section; and
- Provides space for the applicant to report military service connected personnel/ benefits.

Page 3

- Changes wording for the page instruction and some questions;
- Provides additional space to list personal properties such as bank accounts and motor vehicles;
- Expands question 26 to include trust, trust account(s), and LTC insurance policy;

- Adds Pickle eligibility determination and State certified LTC insurance policy worker prompts in the county use section; and
- Instructs applicant to review the property related questions and provides a box for the applicant to indicate if he/she needs additional space to answer those questions.

Page 4

- Changes wording for the page instruction and subheadings;
- Adds question regarding money received from friends or relatives to include loans, gifts, and contributions; and
- Expands unearned income to include IRA, Keogh, annuity trust accounts, capital gain on investment accounts, promissory notes, deed of trust, contract of sales, gambling winnings, and inheritance.

Page 5

- Adds separate sideheading for other expenses and other health coverage;
- Adds worker prompts MC 272 and MC 273 in the county use section for Question 37;
- Renumbers and regroups questions regarding CHDP, WIC, Family Planning Services and other social services; and
- Aligns worker prompts in the county use section for questions 41 thru 44 to reference the correct questions.

Page 6

- Informs the applicant/beneficiary the requirement to provide a Social Security number if he or she claims satisfactory immigration status;
- Places all informing bullets and the ten-day reporting requirement notification above the signature lines; and
- Provides spaces for those who are assisting the applicant/beneficiary in the completion of the MC 210 and/or the face-to-face interview to sign and report his/her relationship to the applicant/beneficiary.

MC 210 S-C ADDITIONAL CHILDREN

The MC 210 S-C Supplement to the Statement of Facts for applicants who have more then three children has also been updated. The changes:

- Advise all applicants for Medi-Cal benefits that if they have a Social Security number, they must provide it on the form;
- Remove the shading from the Social Security number (SSN) blocks; and
- Add ID in the county use section boxes.

As of September 1, 1996, counties are instructed to begin using the MC 210 (5/96) and MC 210 S-C (5/96) for all new applications and annual redeterminations. Counties must discard or recycle all previous versions of these forms. A three-month supply of the MC 210 and MC 210 S-C forms will be shipped to counties by August 1, 1996.

The MEB would like to take this opportunity to thank CWD staff for their comments/ suggestions regarding the MC 210, and their participation in the revision workshops. Due to time constraints to implement the Appellate Court ruling in the Crespin case and legality of wording used, this revision could not incorporate all suggestions made by CWD staff. Suggestions such as reformatting the form and moving questions to other subheadings/pages were reviewed and noted for future MC 210 revisions.

The MEB appreciates CWD staff input in improving the application forms and continues to welcome suggestions to make the MC 210 "USER FRIENDLY" for applicants and CWD staff. The MEB will, with the next revision, transmit a draft to county staff for review. All comments, suggestions, and/or questions regarding the new MC 210 may be directed to Alice Mak at (916) 654-0573 or via facsimile at (916) 657-3224.

Sincerely,

ORIGINAL SIGNED BY

FRANK S. MARTUCCI, CHIEF
Medi-Cal Eligibility Branch

Enclosures

ENCLOSURE

READ THIS FIRST

USE THESE INSTRUCTIONS TO HELP YOU FILL OUT THE ATTACHED MEDI-CAL STATEMENT OF FACTS

(Please return the completed form to your county welfare department)

1. ***PRINT*** all answers in ink (black ink is best).
2. Please note the following:

   "Applicant" means: (a) you, if you are an adult applying for yourself and/or your family; (b) you, if you are a child applying for minor consent services; or (c) the person you are filling in this form for (including the person in long-term care).

   "Caretaker" means a relative other than a parent who is applying on behalf of children under 21 years. A caretaker may ask to be included in the children's Medi-Cal case.

   "Family Member" means: (a) you, even if you are a single person; (b) your spouse or other parent of the children, living with you; (c) your children under 21 years, who are living with you or are away at school; (d) your spouse's or other parent's children under 21 years, who are living with you or are away at school; (e) your unborn child.
3. If you answer ***"Yes"*** to any question from 23 through 39, you must give proof. *However, if you are interested in pregnancy related benefits only, or coverage for an infant (up to age one year), you may not need to bring in proof of property. Ask your eligibility worker about the Property Waiver program.*
4. If you have a problem with any question, ***ask your worker for help.***
5. If you need more space to answer any question, ***use Item 40.***

READ THIS FIRST

USE THESE INSTRUCTIONS TO HELP YOU FILL OUT THE ATTACHED MEDI-CAL STATEMENT OF FACTS

(Please return the completed form to your county welfare department)

1. *PRINT* all answers in ink (black ink is best).
2. Please note the following:

"Applicant" means: (a) you, if you are an adult applying for yourself and/or your family; (b) you, if you are a child applying for minor consent services; or (c) the person you are filling in this form for (including the person in long-term care).

"Caretaker" means a relative other than a parent who is applying on behalf of children under 21 years. A caretaker may ask to be included in the children's Medi-Cal case.

"Family Member" means: (a) you, even if you are a single person; (b) your spouse or other parent of the children, living with you; (c) your children under 21 years, who are living with you or are away at school; (d) your spouse's or other parent's children under 21 years, who are living with you or are away at school; (e) your unborn child.
3. If you answer *"Yes"* to any question from 23 through 39, you must give proof. *However, if you are interested in pregnancy related benefits only, or coverage for an infant (up to age one year), you may not need to bring in proof of property. Ask your eligibility worker about the Property Waiver program.*
4. If you have a problem with any question, *ask your worker for help.*
5. If you need more space to answer any question, *use Item 40.*

MC 210 (5/96) INSTRUCTION SHEET–PROPOSED

STATEMENT OF FACTS (MEDI-CAL)

Every applicant asking for Medi-Cal who has a Social Security number must provide it on this form.

ADULT FAMILY MEMBERS

1 Applicant or Caretaker's Name (First, Middle, Last) | Applicant/Caretaker Relationship to Children

Social Security Number | Marital Status (check one) ☐ Married ☐ Never Married ☐ Common Law ☐ Widowed ☐ Divorced ☐ Separated (Date)________ | Sex ☐ Male ☐ Female

Birth Date | Is the Person Blind or Disabled ☐ Yes, Date of Disability: ________ ☐ No | Pregnant ☐ Yes ☐ No | Medi-Cal Requested ☐ Yes ☐ No

2 Home Address (Number and Street) | City | ZIP Code

Mailing Address (If different from above) | City | ZIP Code

(Area Code) Home Phone ( ) | (Area Code) Work Phone ( ) | (Area Code) Message Phone ( ) | Person with whom to leave Message:

3 Spouse/Other Parent (First, Middle, Last) | Relationship to Applicant

Social Security Number | Marital Status (check one) ☐ Married ☐ Never Married ☐ Common Law ☐ Widowed ☐ Divorced ☐ Separated (Date)________ | Sex ☐ Male ☐ Female

Birth Date | Is the Person Blind or Disabled ☐ Yes, Date of Disability: ________ ☐ No | Pregnant ☐ Yes ☐ No | Medi-Cal Requested ☐ Yes ☐ No

CHILDREN

LIST CHILDREN AND UNBORN HERE ↓ (Family members only. List Other People on Question 7)

4 Child's Name (First, Middle, Last) or "Unborn" | Relationship to Applicant

Social Security Number | In School ☐ Yes ☐ No | Sex ☐ Male ☐ Female

Birth Date or Date Unborn is Due | Is the Person Blind or Disabled ☐ Yes ☐ No | Pregnant ☐ Yes ☐ No

Father's Name | Is Either Parent (✔) ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed

Mother's Name | Child Living in Home ☐ Yes ☐ No | Medi-Cal Requested ☐ Yes ☐ No

5 Child's Name (First, Middle, Last) or "Unborn" | Relationship to Applicant

Social Security Number | In School ☐ Yes ☐ No | Sex ☐ Male ☐ Female

Birth Date or Date Unborn is Due | Is the Person Blind or Disabled ☐ Yes ☐ No | Pregnant ☐ Yes ☐ No

Father's Name | Is Either Parent (✔) ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed

Mother's Name | Child Living in Home ☐ Yes ☐ No | Medi-Cal Requested ☐ Male ☐ Female

6 Child's Name (First, Middle, Last) or "Unborn" | Relationship to Applicant

Social Security Number | In School ☐ Yes ☐ No | Sex ☐ Male ☐ Female

Birth Date or Date Unborn is Due | Is the Person Blind or Disabled ☐ Yes ☐ No | Pregnant ☐ Yes ☐ No

Father's Name | Is Either Parent (✔) ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed

Mother's Name | Child Living in Home ☐ Yes ☐ No | Medi-Cal Requested ☐ Yes ☐ No

DO YOU HAVE MORE THAN THREE CHILDREN? ☐ Yes ☐ No

IF YES, LIST NAME ONLY AND ASK YOUR WORKER FOR ADDITIONAL FORM(S): ________________

COUNTY USE

(Person 1)

Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID

Case Name: ________

Case No.: ________

Worker No.: ________

Date: ________

(Person 3)

Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID

(Child 4)

Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID

Medical Support ☐ YES ☐ NO
☐ CA 2.1
☐ Not in home, 18–21 & tax dep.?

(Child 5)

Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID

Medical Support ☐ YES ☐ NO
☐ CA 2.1
☐ Not in home, 18–21 & tax dep.?

(Child 6)

Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID

Medical Support ☐ YES ☐ NO
☐ CA 2.1
☐ Not in home, 18–21 & tax dep.?

☐ MC 210 S-C
☐ Potential Sneede

You may be asked to give proof and/or more detailed information on your residency, property/resources, income, or work history before your application is approved.

	CHECK EACH ITEM "YES" OR "NO"	YES	NO	COUNTY USE
LIVING ARRANGEMENT	7 a. Is there anyone living in your home that you did not list? If Yes, list name and relationship.			☐ MC 210S-I
	Name _____ Relationship _____			
	Name _____ Relationship _____			
	b. Do you pay rent for a room, apartment, house, or trailer?			
	If Yes, how much rent do your pay? _____			
	8 a. Is any family member living in a nursing home, hospital, or board and care home?			☐ LTC return home in six months?
	Name of person _____			☐ Excess B & C Amount:
	Name of Home/Facility _____			$ _____
	Date Entered _____			
	b. Intend to return home?			
TAX DEPENDENT	9 Are you or any family member claimed as a tax dependent by a person not living with you?			☐ Tax dependent letter sent Date: _____
	Name and address of person claiming the tax deduction: _____			☐ CA 2.1
RESIDENCE	10 a. Do you or any family member own, lease, or maintain a home outside California?			☐ Property
	b. Are you or any family member currently receiving public assistance from outside California?			☐ PA
	11 a. Are you or any family member living outside California?			
	b. Are you or any family member in the United States on a Visa or a Border Crossing Card?			☐ Visa ☐ Border Crossing Card
	12 a. Are you or any family member planning to leave California for more than 60 days?			California Resident? ☐ Yes ☐ No
	b. Do you and your family plan to stay permanently in California?			
EMPLOYMENT QUESTIONS	13 Are you, your spouse, the other parent, or children in the home working?			☐ Under 100 hours
	List Name _____ Hours Per Week: _____			☐ Student Exemption
	List Name _____ Hours Per Week: _____			☐ # U-Parent MC 210 S-W
	List Name _____ Hours Per Week: _____			☐ UIB Referral
	14 Are the person(s) in 13 looking for work or more hours of work?			Redetermination: Fed Eligibility determined per MC 210 dated: _____
	15 Have you, your spouse, or other parent or any children worked in the last two years?			Principal wage earner
	List Name _____ Hours Per Week: _____			_____
	List Name _____ Hours Per Week: _____			
	16 Are you or any family member on strike?			
	List Name(s) _____			
RETRO	17 a. Did you or any family member have medical expenses in the last three months?			☐ MC 210A
	b. Does this person wish to apply for Medi-Cal coverage for those three months?			Retroactive Coverage
	List Name(s): _____			Mo._____ Mo._____ Mo._____
	Month(s) of Coverage: _____			
DED/TPL	18 Do you or any family member have a physical or emotional problem which makes it difficult to work or take care of personal needs?			☐ DED Packet ☐ CA 61 ☐ SGA ☐ DED Reexamination due Date _____
	If yes, list name(s). _____			
	19 a. Is disability or emotional problem expected to last at least a year?			☐ Lawsuit/Hearing pending ☐ Third Party Liability
	b. Is the physical or emotional problem a result of an injury or accident?			
PA OR OTHER PA	20 Have you or any family member ever applied for or received assistance such as AFDC, Food Stamps, Medi-Cal, SSI/SSP, IHSS, transitional child care, or other benefits?			☐ Post MC ☐ TCC
	List name and what kind: _____			
	List where last received: _____			
	List when last received: _____			
MILITARY SERVICE	21 a. Have you or any family member ever been in U.S. military service?			☐ CA 5
	Name _____ Relationship _____			
	Name _____ Relationship _____			
	b. Receiving Service connected benefits?			
	22 a. Are you or any family member the spouse, parent, or child of a person who is/has been in U.S. military service?			
	Name _____ Relationship _____			
	Name _____ Relationship _____			
	b. Receiving service connected benefits?			

The county will determine whether or not the property/resources you or any family member have will count. Please include all property/resources (even for convenience only) owned, named, used, controlled, shared, held jointly with or for other person(s).

	CHECK EACH ITEM "YES" OR "NO" →	YES	NO	NAME ON ACCOUNT/ PROPERTY/RESOURCES	VALUE/ BALANCE	COUNTY USE
LIQUID RESOURCES	**23** a. Savings or checking account(s)? (Banks, savings and loans, credit unions, etc.) Enter how many accounts: _____ Where: _____ Account number: _____ Where: _____ Account number: _____					☐ Current Month Income Included $ _____ $ _____
	b. IRA, KEOGH, deferred compensation, retirement account, or annuity? Enter how many accounts: _____					$ _____
	c. Cash or uncashed checks?					$ _____
	d. Stocks, bonds, certificates of deposit, money market, or mutual fund accounts?					$ _____
REAL ESTATE	**24** a. A home (whether you live in it or not), other houses, ranch, land, buildings, mobile homes or life estates in or outside the U.S. or the State of California?					PR ☐ YES ☐ NO $ _____
	b. Mortgages, promissory notes, deeds of trust, or sales contracts?					$ _____
VEHICLES	**25** Cars, trucks, motorcycles, trailers (any kind), off-road vehicles, recreational vehicles, airplanes, boats, campers (running or not)? Enter type and number owned: _____					EXEMPT ☐ YES ☐ NO $ _____
OTHER	**26** a. Jewelry (not wedding/engagement or heirloom) worth more than $100?					☐ Pickle ($500)
	b. Household goods or personal items valued at more than $500 per item (i.e. musical instrument, personal computer)?					$ _____ $ _____ but, jointly owned ☐ separately owned ☐
	c. Mineral rights or mining claims (oil, gas, coal, etc.)?					
	d. Burial Trusts or contracts, insurance, designated burial funds/money for cemetery plots, caskets, or other burial items?					$ _____
	e. Trust(s) or Trust Account(s)?					$ _____
	f. Life insurance? Enter how many policies owned: _____					$ _____
	g. Long Term Care insurance?					State certified LTC policy? ☐ Yes ☐ No
	h. Other assets or resources?					$ _____
BUSINESS	**27** a. Business/self-employment checking/savings account or cash?					$ _____
	b. Business equipment, vehicles, tools, inventory or materials (including livestock or poultry not for personal use)?					
	c. Type of Equipment: _____					$ _____
TRANSFER	**28** Has anyone closed, given away, transferred, sold or traded any money, vehicles, property or other resources like those listed above in the last 30 months? If yes, complete the following:					LTC only
LIENS	**29** a. Have you borrowed money against your property to pay medical bills?					Brings property within limits? ☐ Yes ☐ No
	b. Has a lien been put on any of your property as security for medical care?					☐ MC 1054 Notice to Provider
	c. Have you used any of the items in question 23 through 26 to pay for medical expenses?					

VEHICLES — 25

Make and Model	Year	Class Code (Registration)	Used for Transportation Yes	Used for Transportation No	Used for Self Support Yes	Used for Self Support No

OTHER — 26 g.

Insurance Company	Policy Number	Date Policy Issued	Benefits Paid Out

TRANSFER — 28

Item	Date	
		☐ Transferred ☐ Sold ☐ Traded ☐ Closed ☐ Given Away

Review your answers on questions 23–28. If you need more space to complete your answers, check here. ☐

Obtain Verif. and enter nonexempt value _____
☐ MC 210 S-P

You must complete all items in questions 30 through 33 for all members in your family including yourself.

	CHECK EACH ITEM "YES" OR "NO" → Do you or any family member get, expect to get, or has anyone applied for:	YES	NO	WHOSE INCOME	AMOUNT BEFORE TAXES	WHEN PAID/HOW OFTEN	COUNTY USE
EARNED INCOME	**30** a. Money from a job (including occasional work)?..						☐ MC 210 S-W
	If yes, how many people in your home work?____						☐ Daily
	List Name _____						☐ Weekly (4.33)
	List Name _____						☐ Bi-Weekly (2.167)
	b. Expect a change in your job?.....						☐ Monthly
	(Hours or money) If yes, explain:						☐ Twice Monthly
	_____						☐ Actual
	_____						☐ Other:
							☐ Student Exemption
SELF EMPLOYED	**31** Self-employed income (includes businesses, baby sitting, out-of-home sales, swap meets, arts, crafts and income from crops or other farm income)?.....						☐ Tax Statement ☐ Profit/Loss
	If yes, how many people are self-employed? _____						
UNEARNED INCOME	**32** Social Security Benefits (Self)						Use copy of award letter or check or other verification.
	Social Security Benefits (Others).....						
	Social Security Benefits (Others).....						$ _____
	Cash aid such as: SSI, AFDC, GR/GA or any other...						$ _____
	Child/Spousal Support or Alimony.....						$ _____
	Money From Friends or Relatives (include loans gifts, and contributions)						☐ Occasional $ _____
	Railroad Retirement.....						$ _____
	Veteran's Benefits/Military Allotments.....						$ _____
	Worker's Compensation						$ _____
	Unemployment Benefits (Self).....						$ _____
	Unemployment Benefits (Others)						$ _____
	Disability or Sick Benefits						$ _____
	Pensions, Retirement, IRA, Keogh, or Annuity Trust....						$ _____
	Interest Income, Dividends, or Capital Gain.....						$ _____
	Income From Rent , Mortgages, Promissory Notes, Deed of Trust, or Contract of Sales (including room and/or meal).....						$ _____
	Scholarships, Loans, or Grants						$ _____
	Income From Training Program.....						$ _____
	Name of Program: _____						☐ MC 210 S-E
	Any Other Unearned Income (Include gambling/ lottery/bingo winnings, lump sum payments, inheritance)						$ _____ ☐ Inheritance, Insurance, etc.
IN-KIND	**33** Receive Rent/Housing, Food?.....				Value		
	If yes, check boxes:						☐ Chart Value
		FREE	WORK FOR				☐ Actual Value
	Housing	☐	☐	_____	$ _____		☐ MC 210 S-I
	Utilities	☐	☐	_____	$ _____		
	Food	☐	☐	_____	$ _____		
	Clothing	☐	☐	_____	$ _____		

	CHECK EACH ITEM "YES" OR "NO"	YES	NO	WHO PAYS	MONTHLY AMOUNT	COUNTY USE
OTHER EXPENSES	34 Does the self-employed person have business expenses?					☐ MC 210 S-W ☐ Verification
	35 Does anyone in your home pay child/spousal support, alimony or make other payments (medical, dental, etc.) for someone who does not live in the home?					☐ Court Order ☐ Actual Payment $ _____
	36 Does anyone in your home pay someone to care for a child, a disabled or elderly adult so that a household member can work, attend training or school or look for work?					☐ Dependent Care Receipts
	List person(s) cared for:					☐ MFBU Member
	37 Is anyone in your home a working disabled person who has medical expenses necessary to keep the job, such as wheelchair?					☐ Receipts ☐ MC 272 ☐ MC 273 $ _____ ☐ QDWI
	38 Is anyone paying college or educational costs?					☐ MC 210 S-E
OTHER HEALTH COVERAGE	39 a. Is anyone currently covered by health/dental insurance or Medicare?					☐ QMB ☐ Card ☐ SLMB
	List name(s) _____					☐ DHS 6155
	List name of insurance _____					☐ HIPP ☐ EGHP
	b. Is health/dental insurance available through employment?					OHC CODE: _____ $ _____
	c. Do you or any family member have a high cost medical condition?					☐ SSA Referral
	d. Have your health/dental insurance stopped in the last 60 days?					
ADDITIONAL INFORMATION	40 Additional Information: (List any additional information for questions 1 through 39.) _____ _____ _____ _____					

	YOUR ANSWERS TO THE FOLLOWING QUESTIONS WILL NOT AFFECT YOUR ELIGIBILITY FOR MEDI-CAL	YES	NO	COUNTY USE
SERVICES	41 Regular check-ups to help protect your family's health are available upon request through the Child Health and Disability Prevention Program (CHDP) for eligible members of your family under age 21.			☐ CHDP Brochure and Explanation Given ☐ CHDP Referral
	a. Do you want more information about CHDP Services?			
	b. Do you want CHDP medical or dental services?			
	42 Pregnant women may get help finding a doctor and transportation to see the doctor.			☐ Pregnant ☐ Parent or Guardian of child under 5.
	a. Do you want to talk to someone about this help?			
	b. Have you given birth within the last three months?			☐ WIC referral
	c. Are you breast feeding a child?			☐ Breastfeeding ☐ Postpartum
	If you answered "YES" to either b or c, you may be eligible for services provided by the Special Supplemental Food Program for Women, Infants and Children (WIC).			
	43 Do you want information about Family Planning Services?			☐ Family Planning Information Given
	44 Do you want to talk to a social worker about other services which may be available to you?			☐ Social Services Referral
	If "YES," briefly describe: _____ _____			

CERTIFICATION

- I have read and received a copy of the Important Information for Persons Requesting Medi-Cal form (MC 219).
- I am aware of, understand, and agree to meet all my responsibilities as described on the MC 219.
- I understand that all of the statements, including benefit and income information, that I have made on this form are subject to investigation and verification.
- I understand that Section 1137 of the Social Security Act requires that I provide Social Security numbers (SSNs) for myself and/or any family members if I/we claim to be in a satisfactory immigration status. I understand that my/our SSNs will be verified and will be used in a computer match to check the income and resources I/we report with information from welfare, state employment, income tax, Social Security Administration, and other agencies. I understand that this is done to make sure that my/our family's eligibility and share-of-cost level, if any, are correct.

It is the responsibility of the applicant/beneficiary and person acting for the applicant/beneficiary to report to the Eligibility Worker within ten (10) days any changes that occur.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information contained in this Statement of Facts and any of its supplemental form(s) that I may be asked to complete is true and correct.

Signature of Applicant/Beneficiary			Date
Signature of Witness (If Applicant Signed With a Mark)	Telephone Number	Relationship to Applicant/Beneficiary	Date
Signature of Person Helping Applicant Fill Out the Form	Telephone Number	Relationship to Applicant/Beneficiary	Date
Signature of Interpreter	Telephone Number	Relationship to Applicant/Beneficiary	Date
Signature of Person Acting for Applicant/Beneficiary		Relationship to Applicant/Beneficiary	Date
Address of Person Acting for Applicant/Beneficiary			Telephone Number of Person Acting for Applicant/Beneficiary

COUNTY USE ONLY

Supplemental Forms Issued	Client Initial	Date
EW Signature	Worker Number	Date

ADDITIONAL CHILDREN
(SUPPLEMENT TO THE MEDI-CAL STATEMENT OF FACTS—MC 210)

IF YOU HAVE MORE THAN THREE CHILDREN, *LIST HERE* AND GIVE THIS FORM TO YOUR WORKER.

Every applicant asking for Medi-Cal who has a Social Security number must provide it on this form.

COUNTY USE ONLY
Case name:
Case number:
Worker number:
Date:

	Relationship to applicant		Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID
A Child's name (first, middle, last) or "unborn"							
Social Security number	In school ☐ Yes ☐ No	Sex ☐ Male ☐ Female					
Birthdate or date unborn is due	Is the person blind or disabled ☐ Yes ☐ No	Pregnant ☐ Yes ☐ No					
Father's name	Is either parent (✓) ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed		Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18–21 and tax dep.?				
Mother's name	Child living in home ☐ Yes ☐ No	Medi-Cal requested ☐ Yes ☐ No					
B Child's name (first, middle, last) or "unborn"	Relationship to applicant		Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID
Social Security number	In school ☐ Yes ☐ No	Sex ☐ Male ☐ Female					
Birthdate or date unborn is due	Is the person blind or disabled ☐ Yes ☐ No	Pregnant ☐ Yes ☐ No					
Father's name	Is either parent (✓) ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed		Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18–21 and tax dep.?				
Mother's name	Child living in home ☐ Yes ☐ No	Medi-Cal requested ☐ Yes ☐ No					
C Child's name (first, middle, last) or "unborn"	Relationship to applicant		Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID
Social Security number	In school ☐ Yes ☐ No	Sex ☐ Male ☐ Female					
Birthdate or date unborn is due	Is the person blind or disabled ☐ Yes ☐ No	Pregnant ☐ Yes ☐ No					
Father's name	Is either parent (✓) ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed		Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18–21 and tax dep.?				
Mother's name	Child living in home ☐ Yes ☐ No	Medi-Cal requested ☐ Yes ☐ No					
D Child's name (first, middle, last) or "unborn"	Relationship to applicant		Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID
Social Security number	In school ☐ Yes ☐ No	Sex ☐ Male ☐ Female					
Birthdate or date unborn is due	Is the person blind or disabled ☐ Yes ☐ No	Pregnant ☐ Yes ☐ No					
Father's name	Is either parent (✓) ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed		Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18–21 and tax dep.?				
Mother's name	Child living in home ☐ Yes ☐ No	Medi-Cal requested ☐ Yes ☐ No					
E Child's name (first, middle, last) or "unborn"	Relationship to applicant		Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID
Social Security number	In school ☐ Yes ☐ No	Sex ☐ Male ☐ Female					
Birthdate or date unborn is due	Is the person blind or disabled ☐ Yes ☐ No	Pregnant ☐ Yes ☐ No					
Father's name	Is either parent (✓) ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed		Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18–21 and tax dep.?				
Mother's name	Child living in home ☐ Yes ☐ No	Medi-Cal requested ☐ Yes ☐ No					
F Child's name (first, middle, last) or "unborn"	Relationship to applicant		Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID
Social Security number	In school ☐ Yes ☐ No	Sex ☐ Male ☐ Female					
Birthdate or date unborn is due	Is the person blind or disabled ☐ Yes ☐ No	Pregnant ☐ Yes ☐ No					
Father's name	Is either parent (✓) ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed		Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18–21 and tax dep.?				
Mother's name	Child living in home ☐ Yes ☐ No	Medi-Cal requested ☐ Yes ☐ No					

5-4-96

State of California—Health and Welfare Agency

Department of Health Services
Medi-Cal Program

NIÑOS ADICIONALES
(SUPLEMENTO A LA DECLARACION DE DATOS DE MEDI-CAL—MC 210)

SI TIENE MAS DE TRES NIÑOS, *ANOTELOS AQUI* Y DELE ESTA FORMA A SU TRABAJADOR(A)

Cada solicitante pidiendo por Medi-Cal que tiene un número de Seguro Social debe facilitarlo en este formulario.

PARA USO DEL CONDADO
Case name: _____
_____
Case number: _____
Worker number: _____
Date: _____

	Parentesco con el solicitante		Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID
A Nombre del niño (nombre, inicial, apellido) o "por nacer"							
Número del Seguro Social	¿Asiste a la escuela? ☐ Sí ☐ No	Sexo ☐ Masc. ☐ Fem.					
Fecha de nacimiento o fecha en que se espera nacerá el bebé	¿Está la persona ciega o incapacitada? ☐ Sí ☐ No	¿Embarazada? ☐ Sí ☐ No					
Nombre del padre	¿Está cualquiera de los padres (✓) ☐ Muerto ☐ Incapacitado ☐ Ausente ☐ Desempleado		Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18–21 and tax dep.?				
Nombre de la madre	¿Vive el niño en el hogar? ☐ Sí ☐ No	¿Solicitó Medi-Cal? ☐ Sí ☐ No					
B Nombre del niño (nombre, inicial, apellido) o "por nacer"	Parentesco con el solicitante		Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID
Número del Seguro Social	¿Asiste a la escuela? ☐ Sí ☐ No	Sexo ☐ Masc. ☐ Fem.					
Fecha de nacimiento o fecha en que se espera nacerá el bebé	¿Está la persona ciega o incapacitada? ☐ Sí ☐ No	¿Embarazada? ☐ Sí ☐ No					
Nombre del padre	¿Está cualquiera de los padres (✓) ☐ Muerto ☐ Incapacitado ☐ Ausente ☐ Desempleado		Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18–21 and tax dep.?				
Nombre de la madre	¿Vive el niño en el hogar? ☐ Sí ☐ No	¿Solicitó Medi-Cal? ☐ Sí ☐ No					
C Nombre del niño (nombre, inicial, apellido) o "por nacer"	Parentesco con el solicitante		Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID
Número del Seguro Social	¿Asiste a la escuela? ☐ Sí ☐ No	Sexo ☐ Masc. ☐ Fem.					
Fecha de nacimiento o fecha en que se espera nacerá el bebé	¿Está la persona ciega o incapacitada? ☐ Sí ☐ No	¿Embarazada? ☐ Sí ☐ No					
Nombre del padre	¿Está cualquiera de los padres (✓) ☐ Muerto ☐ Incapacitado ☐ Ausente ☐ Desempleado		Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18–21 and tax dep.				
Nombre de la madre	¿Vive el niño en el hogar? ☐ Sí ☐ No	¿Solicitó Medi-Cal? ☐ Sí ☐ No					
D Nombre del niño (nombre, inicial, apellido) o "por nacer"	Parentesco con el solicitante		Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID
Número del Seguro Social	¿Asiste a la escuela? ☐ Sí ☐ No	Sexo ☐ Masc. ☐ Fem.					
Fecha de nacimiento o fecha en que se espera nacerá el bebé	¿Está la persona ciega o incapacitada? ☐ Sí ☐ No	¿Embarazada? ☐ Sí ☐ No					
Nombre del padre	¿Está cualquiera de los padres (✓) ☐ Muerto ☐ Incapacitado ☐ Ausente ☐ Desempleado		Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18–21 and tax dep.?				
Nombre de la madre	¿Vive el niño en el hogar? ☐ Sí ☐ No	¿Solicitó Medi-Cal? ☐ Sí ☐ No					
E Nombre del niño (nombre, inicial, apellido) o "por nacer"	Parentesco con el solicitante		Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID
Número del Seguro Social	¿Asiste a la escuela? ☐ Sí ☐ No	Sexo ☐ Masc. ☐ Fem.					
Fecha de nacimiento o fecha en que se espera nacerá el bebé	¿Está la persona ciega o incapacitada? ☐ Sí ☐ No	¿Embarazada? ☐ Sí ☐ No					
Nombre del padre	¿Está cualquiera de los padres (✓) ☐ Muerto ☐ Incapacitado ☐ Ausente ☐ Desempleado		Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18–21 and tax dep.?				
Nombre de la madre	¿Vive el niño en el hogar? ☐ Sí ☐ No	¿Solicitó Medi-Cal? ☐ Sí ☐ No					
F Nombre del niño (nombre, inicial, apellido) o "por nacer"	Parentesco con el solicitante		Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID
Número del Seguro Social	¿Asiste a la escuela? ☐ Sí ☐ No	Sexo ☐ Masc. ☐ Fem.					
Fecha de nacimiento o fecha en que se espera nacerá el bebé	¿Está la persona ciega o incapacitada? ☐ Sí ☐ No	¿Embarazada? ☐ Sí ☐ No					
Nombre del padre	¿Está cualquiera de los padres (✓) ☐ Muerto ☐ Incapacitado ☐ Ausente ☐ Desempleado		Medical Support ☐ YES ☐ I ☐ CA 2.1 ☐ Not in home, 18–21 and tax dep.?				
Nombre de la madre	¿Vive el niño en el hogar? ☐ Sí ☐ No	¿Solicitó Medi-Cal? ☐ Sí ☐ No					