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

DAVID MAXWELL-JOLLY
Director

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March 22, 2010

Medi-Cal Eligibility Division Information Letter No.: I 10-04

TO: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIAISONS

SUBJECT: MC 210 Rev. (2/10) - MEDI-CAL MAIL-IN APPLICATION

This Medi-Cal Eligibility Division Information Letter (MEDIL) informs counties of the new process to order the Medi-Cal Mail-In Application and the recent updates that have been made to the English language version.

Ordering English and Spanish MC 210 Forms
The Department of Health Care Services (DHCS) warehouse will be closing in June 2010. As a result, certain Medi-Cal publications will be ordered from the DHCS contractor, MAXIMUS. Effective March 15, 2010, the MC 210 English form will be available through MAXIMUS. The MC 210 Spanish is being printed now and will be available in April 2010 from MAXIMUS.

The new order form, MC 0026, must be used to obtain the designated Medi-Cal forms from MAXIMUS. It can be found in the DHCS forms index located at http://www.dhcs.ca.gov/formsandpubs/forms/Pages/MCEBbyNumber.aspx. Ongoing, DHCS will update the MAXIMUS order form and will issue MEDILs to announce the availability of the additional Medi-Cal publications that counties will order from MAXIMUS.

MC 210 Application Changes
In order to accommodate the new text in Page 7, the photos and text boxes were deleted. As a result, the page has more white space and it is easier to read. Please note, in the sections below, that strikethrough text indicates deleted text and underlined text indicates added or modified text.

Medi-Cal Rights, Responsibilities and Declarations
I have the right to:

- Ask for a fair hearing if I think a decision on my Medi-Cal case is unfair or wrong. I must ask for a hearing within 90 days after the notice of action is mailed to me. ~~I get a "Notice of Action."~~ To find out about Medi-Cal fair hearings, call toll-free, 1-800-952-5253.

I have the responsibility to:

- Report any changes in the information I give on this application within 10 days.
- Let the local social services office know if a family member applies for disability benefits; is in a public institution; or gets medical care for any accident or injury caused by another person.
- Assign ~~ment of~~ rights to medical support to the State of California.

I declare that each person I am applying for:

- Lives in California
- Is not getting public assistance from outside California
- Is not in jail, prison or any other correctional facility

Medi-Cal Confidentiality Notice
The information given in this application is private and confidential under Welfare and Institutions Code 14100.2. The information will be disclosed only if required by law.

Access to Records
You have the right to access records maintained by the DHCS that contain your personal information.

Contact your local social services office to request your records.

The updated English MC 210 will be available electronically at http://www.dhcs.ca.gov/services/medi-cal/Pages/MediCalApplications.aspx. The updated Spanish application will be available in print and electronically in mid-April. A separate MEDIL will be issued at that time. The MC 210 in other threshold languages will be updated on a flow basis in the next few months. Additionally, within the next few months, DHCS will modify the English and Spanish versions of the electronic application form to be "fillable."

If you have any questions regarding this MEDIL, please contact Ms. Maria Delk at Maria.Delk@dhcs.ca.gov or (916) 552-9508.

Original Signed by

René Mollow, MSN, RN, Chief
Medi-Cal Eligibility Division

Order Form

To process your order choose one of the following methods:

FAX: (916) 364-6612

OR

EMAIL: medpublicationorders@maximus.com

Expect delivery in 7-10 business days.

Form number	Title	Language	Quantity	Form number	Title	Language	Quantity
☐ MC 210	Medi-Cal Mail-In Application	☐ English					
		☐ Spanish					

All information is *required* to process your order.

Mailing Information

Organization Name:

Delivery Address:
(No P.O. Boxes)

City: **Zip Code:**

Contact Person Name:

Phone: ( ) - **Fax:** ( ) -

Email Address:

Organization Category

Please indicate the category your Organization represents.

Organization/Person ordering the material:

Check the appropriate box:

☐ CBO

☐ Hospitals

☐ Social Services Office

For Internal Use Only ▸	Shipping Date	Order ID
	Shipping ID	