STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY GRAY DAVIS, *Governor*

**DEPARTMENT OF HEALTH SERVICES**
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February 8, 2000

Medi-Cal Eligibility Branch Information Letter No.: I 00-04

TO: All County Medi-Cal Program Specialists/Liaisons

NEW MEDI-CAL MAIL-IN APPLICATION

The purpose of this information notice is to update counties on the development of the new Medi-Cal mail-in application. As you know, the Department of Health Services (DHS) is required to implement a family Medi-Cal mail-in application by July 1, 2000.

DHS requested county representatives to attend application workgroup meetings in Los Angeles and Sacramento to review the draft application materials developed pursuant to the statutory mandate. We would like to thank the county representatives who either attended our workgroup meetings or submitted their comments and suggestions by mail and fax. Your valuable input has been taken into consideration in the development of the application. Enclosed for your information are the draft application materials that contain the input from county representatives.

DHS also requested members of the health care advocacy community to review the enclosed draft application materials. DHS is currently reviewing the policy recommendations advanced by the advocacy community. Counties and advocates will be notified of the policy decisions, once DHS's review is completed and a stakeholders meeting is scheduled.

If you need additional information, please contact Ms. Glenda Arellano, Chief, Policy Section B, Medi-Cal Eligibility Branch, at (916) 657-0710. Thank you.

ORIGINAL SIGNED BY
Angeline Mrva, Chief
Medi-Cal Eligibility Branch

Enclosure

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# MEDI-CAL APPLICATION

EXHIBIT A

# MEDI-CAL APPLICATION

DRAFT

**SECTION 1: Read all instructions before completing this application. Tell us about the person applying for Medi-Cal**

| | | | | |
|---|---|---|---|---|
| 1 Last Name | First Name | Middle Initial | 2 *County Number/Worker Number (Official use)* | |
| **The rest of this Section applies to where we should obtain and send information** | | | | |
| 3 Home Address (number and street) | | Apartment Number | 4 Home Phone # ( ) | |
| 5 City | 6 Zip Code | 7 County | 8 Work Phone # ( ) | |
| 9 Mailing Address (number and street) if different from above | | Apartment Number | 10 Message Phone # ( ) | |
| 11 City | 12 Zip Code | 13 County | 14 What primary language do you speak? | |

15 Check other program(s) that you want to apply for (see instructions for explanation of programs):
❑ WIC ❑ CHDP ❑ Healthy Families ❑ AIM ❑ County medical program, if not eligible for Medi-Cal.

*(For County Use)*

**SECTION 2: Tell us about members of the household, including self, husband/wife, children, parents of children, and step-parent. If there are more than three children, check this box ❑ and complete the Additional Family Members Supplement.**

| | ADULT 1 | ADULT 2 | CHILD 1/UNBORN | CHILD 2 | CHILD 3 |
|---|---|---|---|---|---|
| 16 Name: Last | | | | | |
| First | | | | | |
| Middle | | | | | |
| 17 Name on Birth Certificate Last | | | | | |
| First | | | | | |
| *(If same as #16 above, leave blank)* Middle | | | | | |
| 18 Date of Birth: | / / MO DAY YR | / / MO DAY YR | / / MO DAY YR | / / MO DAY YR | / / MO DAY YR |
| 19 Sex: | ❑ Male ❑ Female ❑ Pregnant | ❑ Male ❑ Female ❑ Pregnant | ❑ Male ❑ Female ❑ Pregnant | ❑ Male ❑ Female ❑ Pregnant | ❑ Male ❑ Female ❑ Pregnant |
| 20 Marital Status: | ❑ Married ❑ Divorced ❑ Single ❑ Widowed ❑ Separated | ❑ Married ❑ Divorced ❑ Single ❑ Widowed ❑ Separated | ❑ Married ❑ Divorced ❑ Single ❑ Widowed ❑ Separated | ❑ Married ❑ Divorced ❑ Single ❑ Widowed ❑ Separated | ❑ Married ❑ Divorced ❑ Single ❑ Widowed ❑ Separated |
| 21 Relationship to person in Section 1: | | | | | |
| 22 Mother's Name: Last | | | | | |
| First | | | | | |
| Middle | | | | | |
| *Check all that apply to the mother.* | | | ❑ In Home ❑ Unable to Work ❑ Deceased | ❑ In Home ❑ Unable to Work ❑ Deceased | ❑ In Home ❑ Unable to Work ❑ Deceased |
| 23 Father's Name: Last | | | | | |
| First | | | | | |
| Middle | | | | | |
| *Check all that apply to the father.* | | | ❑ In Home ❑ Unable to Work ❑ Deceased | ❑ In Home ❑ Unable to Work ❑ Deceased | ❑ In Home ❑ Unable to Work ❑ Deceased |

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**SECTION 2: Continued**

| | ADULT 1 | ADULT 2 | CHILD 1/UNBORN | CHILD 2 | CHILD 3 |
|---|---|---|---|---|---|
| 24 Wants Medi-Cal? | ☐ Yes ☐ No *If No, you do not have to answer any other questions for this person in this section.* | ☐ Yes ☐ No *If No, you do not have to answer any other questions for this person in this section.* | ☐ Yes ☐ No *If No, you do not have to answer any other questions for this person in this section.* | ☐ Yes ☐ No *If No, you do not have to answer any other questions for this person in this section.* | ☐ Yes ☐ No *If No, you do not have to answer any other questions for this person in this section.* |
| 25 Social Security # | | | | | |
| | Social Security Numbers are not required for persons who want emergency or pregnancy related services. | | | | |
| 26 Place of Birth *County, State or Country if outside the U.S.* | | | | | |
| 27 Ethnic Code *(see instructions)* | | | | | |
| 28 U.S. Citizen or National? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| *If No, is person a Lawful Permanent Resident or PRUCOL alien? (see instructions)* | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 29 Has other health, dental or vision insurance? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 30 Has Medicare? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 31 Intends to stay in California or works in California? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 32 Filed a lawsuit because of accident or injury? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 33 Past medical expenses? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | Check "Yes" for person(s) that has any UNPAID medical expenses for the 3 months prior to this application and wants Medi-Cal for those months. | | | | |
| 34 In nursing home, hospital or board and care home? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| If Yes | Name of Facility: | | Date Entered: / / | | Intend to Return Home: ☐ Yes ☐ No |
| 35 Asked for or gotten aid benefits, including cash, SSI, Medi-Cal? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| If Yes, where: | (County, State, Country): | | When: | | Type(s) of benefit: |
| 36 Current or past U.S. Military service for child's parents or adult? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| *(For County Use)* | | | | | |

**SECTION 3: List all the gross income received (before taxes) of all persons in Section 2 whether aid is requested for those persons or not. See instructions for types of documents we need.**

| 37 NAME OF PERSON(S) WITH INCOME | 38 SOURCE OF INCOME | 39 HOW OFTEN RECEIVED *(weekly, biweekly, monthly, bimonthly, yearly or daily)* | 40 HOW MUCH GROSS INCOME? *(each pay period)* |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

41 Answer these questions only if both parents of a child or children are in the home.

Have both parents worked within the past two years? ❑ Yes ❑ No

If Yes, complete the following:

List the name of the parent that earned the most money in the past two years: _____ Number of hours: _____

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*(For County Use)*

**SECTION 4: Deductions from Income. The answers in this section will help determine what amounts may be deducted from income. See instructions for types of documents we need.**

| 42 TYPE OF PAYMENT YOUR FAMILY MAKES | 43 NAME OF PERSON WHO PAYS | 44 MONTHLY AMOUNT PAID |
|---|---|---|
| Court Ordered Child Support | | |
| Court Ordered Alimony/ Spousal Support | | |
| Health Insurance | | |
| Educational Expenses | | |
| Other *(See instructions for examples)* | | |

*(For County Use)*

| 45 CHILD CARE OR DISABLED ADULT DEPENDENT CARE *(List name)* | 46 AGE OF CHILD | 47 MONTHLY AMOUNT PAID |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

*(For County Use)*

**SECTION 5: Physical or emotional disability for persons listed in Section 2.**

48 Do you or any family members have a physical/emotional problem that makes it difficult to work, or take care of personal needs? ❑ Yes ❑ No

a. If yes, name(s): _____

b. Is disability or emotional problem expected to last at least a year? ..... ❑ Yes ❑ No

c. Is the physical or emotional problem a result of an injury or accident? ..... ❑ Yes ❑ No

d. Have you applied for Social Security or State Disability Benefits? ..... ❑ Yes ❑ No

e. Have you appealed a denial of SSI or Social Security benefits within the past two years? .... ❑ Yes ❑ No

*(For County Use)*

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**SECTION 6: Property of applicant, parent, stepparent, child, spouse or caretaker of an applicant.**
**If you are applying for children and/or pregnant related services only, you do not need to complete Section 6**

49 Does anyone have cash or uncashed checks? ❑ Yes ❑ No If Yes, indicate amount of cash or uncashed checks $ _____

50 Does anyone have a checking or savings account, motor vehicle or life insurance? ..... ❑ Yes ❑ No
If Yes, send in needed documents *(see instructions)*.

**If you check "Yes" to Questions #51, #52, #53, #54 or #55, you must complete and sign the property supplement.**

51 Does anyone own any items such as bonds, retirement funds, trusts, real estate, motor vehicles for a business, recreational vehicles, burial items or funds, annuities, oil or mineral rights? ..... ❑ Yes ❑ No

52 Have any items such as those listed in #49, #50, or #51 been spent or used in payment or security for medical expenses? ..... ❑ Yes ❑ No

53 Does anyone have a court-ordered settlement, judgement, order for child/spousal support or pre-nuptial or post-nuptial agreement? ..... ❑ Yes ❑ No

54 Does anyone have long-term care insurance? ..... ❑ Yes ❑ No

55 Has anyone above transferred, sold, traded or given away any items such as those listed above within the last 30 months? ..... ❑ Yes ❑ No

*(For County Use)*

**SECTION 7: Additional services and information.**

56 If you want information on any of the following programs or want to talk to an Eligibility or Social Worker, check the box(es).

❑ Food Stamps ❑ CalWORKs ❑ IHSS (In-Home Supportive Services) ❑ Want Family Planning Information
❑ Talk to an Eligibility Worker ❑ Talk to a Social Worker

*(For County Use)*

**SECTION 8: Comments. (optional)**

57

**SECTION 9: Declaration.**

58 I declare under penalty or perjury under the laws of the State of California that the answers I have given in this application and the documents submitted are correct and true to the best of my knowledge and belief. I declare that I have read and understand the application instructions, the declarations, and all information printed on this application.

Signature: _____ Date: _____

Witness Signature: _____ Date: _____
*(If person signed with a mark)*

Signature of Person helping Fill Out the Form: _____ Telephone Number: _____

Relationship to Applicant: _____ Date: _____

*(For County Use)*

# APPLICATION INSTRUCTIONS

EXHIBIT B

DRAFT

# Medi-Cal Application and Instructions

## HOW TO APPLY

Medi-Cal is a governmental program which provides medical services to children and adults with low income. Children, parents/caretaker relatives of children, and adults who are disabled, blind or over 65 can qualify for **Medi-Cal**. **Medi-Cal** pays or helps pay for a variety of medical services. This new application can be mailed and is designed to make it easier to complete. You do not have to visit the county social service agency.

To apply for **Medi-Cal**, follow instructions below and fill out the application. **Mail** the application, supplements and documents to the address listed on the enclosed envelope or leave it with your local county health and human services/social services office.

If you have an **immediate need** for **Medi-Cal, do not mail** this form, but take it to your local county office. To find the nearest county health and human services/social services office, look in the local telephone directory under the name of your county.

If you are a child and want **confidential minor consent services** Medi-Cal, take this form to the nearest county social services office. **DO NOT MAIL.**

If you "checked" that are interested in other programs, you will receive information from those programs.

## APPLICATION INSTRUCTIONS

### SECTION 1

#### Question 1

**Give the last name, first name and middle initial of the person completing the application.**

#### Question 2

**This is for county use, leave blank.**

#### Questions 3-14

**Complete the requested information. If you do not have a mailing address, take this form to the nearest county social service office and they will arrange for you to pick up all information regarding this application.**

#### Question 15

**If you want any of the following in addition to Medi-Cal, check that item or items (additional request for information may be sent to you).**

- **WIC** – The Women, Infants & Children Supplemental Nutritional Program is only for pregnant women, breast-feeding women, infants and children under five (5). WIC helps in buying food, and provides nutritional information and breast feeding help.
- **CHDP** – Child Health and Disability Prevention Program allows children and young adults under 21 years of age to get all the health services they need to make sure health problems are found and treated early.
- **Healthy Families** – A low-cost health coverage program for children from 1 through 19.
- **AIM** – Access for Infants and Mothers provides health care for pregnant women. Must be less than 30 weeks pregnant at the time of application.
- **County medical programs** – If you are not eligible for Medi-Cal, you may be eligible for a county medical program.

### SECTION 2

**Tell us about the adult(s) and child(ren) in your household. If anyone is pregnant, show the unborn as a child. If there are more than two adults or more than three children in your household complete the Additional Household Members Form.**

#### Question 16-17

Show last, first and middle name of each person in the household. If a person has had a name change, show the birth name in Question #17.

#### Question 18

Show month, day and year of birth for each household member.

#### Question 19

Indicate sex of each person. An unborn is considered a person by **Medi-Cal**. If person is pregnant, check "Pregnant" box. In some situations we must verify pregnancy. If pregnancy verification is needed, the county will ask you to provide proof of pregnancy from a doctor or a clinic.

#### Question 20

Check marital status (married, divorced, single, separated, or widowed) for each person. Whether or not a couple is married can affect how we treat income.

#### Question 21

Show relationship of each person in Section 1. For example: daughter, spouse, stepchild, nephew, etc.

#### Question 22-23

Write the name of the mother/father of each child. Check each box that applies to the mother in #22 and to the father in #23.

**Unable to work.** Check this box if the person has a physical or mental illness, or a defect or impairment that is expected to last at least 30 days which reduces substantially or eliminates the parent's ability to support or care for a child.

#### Question 24

Check "Yes" or "No" box indicating whether or not each individual listed wants full or limited **Medi-Cal** services. Some pregnant women and undocumented aliens may only receive pregnancy related or emergency services only.

#### Question 25

Show Social Security Number for each member of the household. Social Security Numbers are not required for emergency or pregnancy related services. If a household member does not have a Social Security Number, that person can apply now and provide the number within 60 days.

For more information on how to apply for a Social Security Number, please call the Social Security Administration toll-free, 1-800-772-1213.

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# APPLICATION INSTRUCTIONS (continued)

**SECTION 2 (continued)**

## Question 26

Give county of birth if born in California. give state of birth if born in the United States but not in California. Give county of birth if born outside the United States.

## Question 27

Use the codes below to find the ethnic code number or letter. This information is used for statistics only and has no affect on your eligibility for **Medi-Cal.**

**Ethnic Codes**

| | | | | | |
|---|---|---|---|---|---|
| 1 | White | A | Amerasian | N | Asian Indian |
| 2 | Hispanic | C | Chinese | P | Hawaiian |
| 3 | Black/African American | H | Cambodian | R | Guamanian |
| 4 | Asian | J | Japanese | T | Laotian |
| 5a | Native American Indian | K | Korean | V | Vietnamese |
| 5b | Alaskan Native | M | Samoan | Z | Other |
| 7 | Filipino | | | | |

## Question 28

If "No", indicate whether or not a person is a **Lawful Permanent Resident** or a **PRUCOL alien.** A **Lawful Permanent Resident** (LPR) is a person with a valid immigration card from the INS.
A **PRUCOL** alien is any or all of the following:

- A conditional entrant admitted to the U.S. before April 1, 1980.
- An alien paroled into the U.S., including Cuban/Haitian entrants.
- An alien subject to an Order of Supervision.
- An alien granted an indefinite stay of deportation.
- An alien granted an indefinite voluntary departure.
- An alien on whose behalf an immediate relative petition (INS Form I-130) has been approved and who is entitled to voluntary departure.
- An alien who has properly filed an application for lawful permanent resident status.
- An alien granted a stay of deportation for a specified period.
- An alien granted asylum.
- A refugee admitted to the U.S. since April 1, 1980.
- An alien granted voluntary departure who is awaiting issuance of a visa.
- An alien in deferred action status.
- An alien who entered and has continuously resided in the U.S. since before January 1, 1972 who would be eligible for an adjustment of status to lawful permanent resident pursuant to INA Section 249 (eligible as a Registry alien).
- An alien granted a suspension of deportation whose departure INS does not contemplate enforcing.
- An alien granted withholding of deportation pursuant to INA Section 243(h).
- An alien, not in one of the above categories, who can show that:
  - INS knows he/she is in the U.S. and
  - INS does not intend to deport him/her, whether because of the person's status category or individual circumstance.

**Immigration information we get as part of this application is private and confidential.** The State will use this information only for eligibility determination and program administration.
Medi-Cal does not collect information on the immigration status or parents/guardians who are not seeking health coverage for themselves.

Medi-Cal will not provide information on the immigration status of such parents to the INS or use immigration information to demand or collect repayment information from recipients for services lawfully received. Give immigration information only for the people applying for health coverage. Do not give information for people (such as parents) who are not applying. Undocumented aliens can get pregnancy-related and emergency services. Immigrants who meet all income and immigration requirements can get complete Medi-Cal benefits. See **Documents Needed #2** below.

## Question 29

For each person in the household check the "Yes" or "No" box to indicate whether or not the person has health, dental or vision insurance. If you check "Yes", you will be asked to complete an additional form later. A person on **Medi-Cal** is required to use other health insurance before **Medi-Cal** is billed. **Medi-Cal** can sometimes help people on **Medi-Cal** pay other health insurance premiums.

## Question 30

Persons with Medicare are required to use Medicare in conjunction with **Medi-Cal.** Check "Yes", if anyone has Part A and/or Part B Medicare.

## Question 31

To receive **Medi-Cal** you must have an intent to remain in California or be working a job in California. See what **Documents Are Needed,** (below) for type of proof that is needed for **California residence.**

## Question 32

If **Medi-Cal** pays for medical services you need because of accident or injury, the costs may be taken out of the lawsuit settlement if you receive money.

## Question 33

Medi-Cal may be able to help pay some unpaid medical expenses you have had in the 3 months before you completed this application. If you check "Yes", you may receive a request for additional information.

## Question 34

If "Yes" is checked, give name of facility, date when person entered the facility, and whether or not the person intends to return home. **Intent to return does not mean the ability to return only a desire to return home.**

# APPLICATION INSTRUCTIONS (continued)

## SECTION 2 (continued)

### Question 35

This question allows the county to identify individuals that were previously on assistance in the county. If the county already has documents on file it does not need to get them again unless the previous record has been destroyed. For each person in the household, check the "Yes" or "No" box to indicate whether or not person received cash (CalWORKs – previously called AFDC or SSI/SSP) grant, Medi-Cal.

### Question 36

Indicate whether or not adult or child's parent is or was in the U.S. military.

## SECTION 3

**List the gross income (before taxes) of all persons in Section 2 whether Medi-Cal is requested for those persons or not.**

### Question 37

Use a separate line for each person who gets income. If a person gets income from two different sources, use two lines. **For example:** If Maria has two different jobs, use one for each job to report her earnings.

### Question 38

List where the income comes from.
**For example:** income could come from work (employer or self-employment); child support from a parent who is not in the home; alimony from an ex-spouse; benefit payments from government agencies such as Social Security and Veterans Administration; insurance policies; pension funds; rental properties; and gifts from relatives and friends, etc.
**If someone else pays for all your housing, utilities, food, and/or clothing, we call this income in-kind.** If anyone pays all or any of these items (you pay nothing), include **in-kind** (housing, utilities, food and/or clothing) as SOURCE OF INCOME. You will need to get a signed statement from the person that provides this item for you. If you receive any of these items in exchange for work, be sure the statement indicates **"earned"**, because earned in-kind income is treated differently than non-earned in-kind income.

### Question 39

How often is this income received?
**For example:** once-a-week (weekly), every two weeks, two times a month, once-a-month, once-a-year, etc. We need copies of income documents.

### Question 40

- Write the amount of income you get each time. **For example:** if the income is received once-a-week, write the weekly amount in the box.
- If the income amount changes from time to time, put the average amount received on a regular basis. We will use the pay stubs or other documents you give us to figure out the correct monthly income.
- If you know your family's income will go up or down in **the next few months** due to overtime, promotion, raise in pay, expected increases in child support/alimony, layoffs, furloughs, etc., explain on a separate sheet of paper. **For example:** Maria's income from her job this month is $1,000 but her regular monthly pay is only $800. Explain on the paper that Maria's paycheck included $200 overtime pay (or a $200 bonus), and how long the overtime will last (how often she gets bonuses).
- If self-employed, write the net profit from Schedule C of last year's federal income tax return. Or give the last 3 months' profit and loss statements.
- If using last year's federal income tax return, add all income amounts reported. Do not deduct losses.
- If you have in-kind income indicate the value of the in-kind income.

### Question 41

The purpose of this question is to determine which parent is/was most responsible for earning money. Answer this question only if both parents of any child are in the home. Adding the total earnings for the past two years, indicate which parent earned the most and the number of hours he/she is currently working per month.

## SECTION 4

**Deductions From Family Income.** The answers in this section help us determine what amounts we may use to lower your family's monthly income.

### Question 42

We may deduct payments for court-ordered child support or alimony from the family's income. We may deduct the cost of Health Insurance in some situations. We may deduct educational expenses in some cases. We may also deduct other expenses you pay, like the cost of repair and upkeep of your home for up to 6 months from the date you begin residing in a nursing home or other medical facility.

### Question 43

Write the name of the person who pays the child support or alimony.

### Question 44

Write in the total amount the person pays in one month for child support or alimony.

### Question 45-46

Write in the name of each person receiving child care or disabled adult dependent care.

### Question 47

Write in the total amount that is paid in one month for each child or disabled dependent.

We may deduct payments for child care and/or disabled adult dependent care from the families income if:

- The payments are made by a parent of the child or spouse;

and

- The parent of the child is working or in job-training and no one in the home can provide care.

We will not deduct more than the maximum allowed for each child's care or disabled adult dependent's care. Maximums depend on the age or the person receiving care. Monthly maximum deductible amount for each child and disabled dependent are:

**Child under the age of 2 . . . . . $200**
**Child age 2 and older . . . . . $175**
**Disabled dependent of any age . . . . . $175**

## SECTION 5

**Physical or emotional disability**

### Question 48

If you answered "Yes" to Question 52, we will ask for certain medical verification from you. The type of verification we ask for depends on how long you will be unable to do routine daily activities, or to care for your child(ren). We will ask you for more information about your disability at a later date. It may also make a difference to your Medi-Cal case if there is a disabled child in your household. In Question 48a be sure to list any adult and/or child who has a disabling condition which has lasted or expected to last at least 12 months in a row.

If you are applying for children and/or pregnant women only, you are not required to complete Section 6. However, if the family income exceeds the Medi-Cal limit for the size of the family, the county will ask for the information in Section 6.

## SECTION 6

**Property**

### Question 49

Indicate the amount of cash you have left over from the month previous to this application.

### Question 50

If you have a checking or savings account, a motor vehicle or life insurance policy, please give us copies of one of the following documents:

- Account statements showing balances for the month(s) that Medi-Cal is being requested.
- The most recent registration, pink slip or purchase document.
  - If none of the above is available, provide one estimate of value from a qualified source, such as a dealer or mechanic.
- Copies of all life insurance policies that have cash surrender value.

## SECTION 7

**Additional services and information.**

### Question 56

Check the box for the item that you would like to receive information on or talk to a worker. If you need immediate help contact the nearest county social services agency.

- Food Stamps provides help in buying food.
- CalWORKs is a family cash assistance program.
- IHSS (In-Home Supportive Services) helps pay for services which enable individuals to remain safely in their own homes.
- An Eligibility Worker is the person that processes your Medi-Cal application. If you indicate that you want to talk to an Eligibility Worker, the Eligibility Worker will call and/or set up an appointment for you to come into the county office.
- A Social Worker does not work with the Medi-Cal application. A Social Worker works with individuals and families with such things as problems with children, child abuse, adult abuse, etc.

## SECTION 8

**Comments. (optional)**

### Question 57

Completion of this section is optional. You may tell us about anything you want us to know or you want to clarify. Attach additional pages if you need more space.

## SECTION 9

**Signature and Certification**

### Question 57

State and federal laws require your signature on this application form. Your signature in this section indicates that your declaration answers are truthful and the documents you submit are true and correct.

# WHAT DOCUMENTS ARE NEEDED

1. **Proof of California residency:** You can use your proof of income as proof of residency, too. If your income is not from California, send in other proof of residency such as rent or utility receipts, or other items showing California residence.
2. **Proof of immigration status:** Aliens who claim to be in a satisfactory immigration status (SIS) for Medi-Cal purposes must present INS document that show their immigration status if they have an INS document or are eligible to obtain one. Aliens who claim to be in a SIS, but who cannot obtain an INS document or replacement receipt should submit other evidence establishing their immigration status. INS documents will be verified by the INS. Send copy of the document or receipt now or within 30 days.
3. **Proof of income.** Send a copy of the most recent pay stub. If a pay stub is not available, get a signed statement from employer. Gross monthly income and the dates received should be on the statement

OR

Send a copy of last year's federal income tax return. Other proof of income you may need to send:

- If a person is self-employed, send last year's federal income tax return or the last **3 months' profit and loss statements.**
- If a person has income such as **disability** or **retirement,** send **copies or award letters or bank statements** showing the direct deposits.
- If anyone gets child support and/or alimony or spousal support, send copies of the checks received or statements from the District Attorney's Family Support Division, for the last month.
- **Student loan** grant award letter(s) or loan grant papers.
- **Copies of Social Security** card(s). Social Security numbers are not required for persons who want emergency or pregnancy-related services only.

4. **Proof of the deductions listed in Section 4.** For child care and disabled adult dependent care, send receipts or cancelled checks.
5. **For documents needed for personal and real property, see Property Supplement Form.**
6. **One of the following identity items is needed:**
   - California driver's license
   - Identification card issued by the Department of Motor Vehicles
   - U.S. Citizenship or Alien Status Documents (passport)
   - School Identification Card
   - Birth Certificate
   - Social Security Card or document containing a Social Security number
   - Marriage Record
   - Divorce Decree
   - Work Badge, building pass
   - Adoption record
   - Court order for name change
   - Church membership or baptism/confirmation

   **Identity is not needed for the following:**
   - Persons in an institution. Contact is made with the facility to verify residence in the institution.
   - Children in a family, if identity of one parent has been made.
   - Children requesting Medi-Cal for minor consent services.
   - The spouse of a person whose identity has been verified.

Only one person (a parent) in a family needs to provide an identity document.

GO TO NEXT PAGE ➥

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## Medi-Cal Privacy Notice

The Information Practices Act of 1977 and the Federal Privacy Act require the Department of Health Services to provide the following information: Welfare and Institutions Code section 14011 and regulations in Title 22, CCR, require applicants for the Medi-Cal program to provide the eligibility information requested in this application. This information may be shared with federal, state, and local agencies for purposes of verifying eligibility and for other purposes related to the administration of the Medi-Cal program, including confirmation with the INS of the immigration status of only those persons seeking full scope Medi-Cal benefits. (Federal law says the INS cannot use the information for anything else except cases of fraud). The information will be used by Electronic Data Systems to process claims and make Benefits Identification Cards (BICs). Failure to provide the required information may result in denial of application.

Information required by this form is mandatory, with the exception of ethnicity information, and any other item marked voluntary or optional, Social Security numbers are required by Section 1144(a)(1) of the Social Security Act and by Welfare and Institutions Code Section 14011.2, unless applying for emergency or pregnancy related benefits only.

An individual has a right of access to records containing his/her personal information that are maintained by the Department of Health Services. Contact your county health and human services/ services office to request your records.

## Medi-Cal Confidentiality Notice

The information given in this application is private and confidential under Welfare and Institutions Code Section 10850 and 14100.2. The information will be disclosed only in accordance with those laws.

### Medi-Cal Rights, Responsibilities and Declarations

**I have the right to:**

- Be treated fairly and equally regardless of my race, color, religion, national original, sex, age or political beliefs.
- Ask for an interpreter.
- 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 I get a "Notice of Action". To find out about Medi-Cal fair hearings, call toll-free, 1-800-952-5253.
- A face-to-face interview.
- Assign rights to third party payments.
- Review Medi-Cal program rules and manuals.

**I have the responsibility to:**

- Send in a status report when the county asks me to.
- Report any changes within 10 days in the information I give on this application.
- Let the county 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.
- Cooperate if my case is reviewed.
- Apply for available income.
- Cooperate with paternity determinations and child support enforcement efforts.
- Assignment of rights to payments.

**I declare that each person I am applying for:**

- Lives in California and plans to stay here.
- Does not own or lease a principal residence outside California.
- Is not in jail, prison, or any other correctional facility.

**I further declare that:**

- I understand that as a condition of Medi-Cal eligibility, all rights to medical support are automatically assigned to the State of California.
- If I purposely do not give needed facts, or if I give false facts, I understand benefits may be denied or ended and repayment may be required. I may also be investigated for fraud.

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# PROPERTY SUPPLEMENT

EXHIBIT C

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# MEDI-CAL PROPERTY SUPPLEMENT

**You must complete and sign this supplement if you answered YES to questions 54, 55, 56, 57 or 58 on the Medi-Cal Application. Please answer each question below with a YES or NO. If you check YES to any questions, you must provide Acceptable Verification.**

| | ITEM | NO | YES | ACCEPTABLE VERIFICATION |
|---|---|---|---|---|
| CASH | Do you have **Cash** or uncashed **Checks**? | | | a) List amount of cash on Application.<br>b) Provide copies of any uncashed checks. |
| BANKING | Do you have bank or financial institution accounts such as: **Savings**; **Checking**; or **Money Market Deposit**? | | | Provide copies of statements showing balances for the month(s) that Medi-Cal is being requested. |
| STOCKS | Do you have **Certificates of Deposit**; **Stocks**; **Mutual Fund Shares**; or **Bonds**? | | | a) Provide statements from your financial institution showing cash value (after penalties for early withdrawal) for month Medi-Cal is being requested.<br>b) Provide statements from your brokerage indicating the lowest closing price during the month for which Medi-Cal is being requested. |
| IRAs | Do you have **Individual Retirement Accounts (IRAs)**; **Keoghs**; or **Work-related Pension Funds**? | | | Provide copies or statements from your employer or financial institution or brokerage showing cash value (after penalties for early withdrawal). Include the dates and amounts of any payments of dividends or interest on the copies of statements. |
| ANNUITIES | Do you have any **Annuities**? | | | a) Provide copies of your contract and payment schedule.<br>b) If the contract or payment schedule is unavailable, provide a statement from your annuity company indicating the purchase price, date of purchase, cash value, and, if payments are scheduled, the payment schedule and years of expected life upon which your annuity payments were scheduled. |
| REAL ESTATE | Do you own a **House, Condominium, Ranch, Land, Mobile Home or Life Estate** that is your home that you live in, or is your former home and is lived in by your a) spouse, b) child under 21, c) disabled son or daughter, d) dependent relative or, e) a sibling who lived in the property continuously and provided care for one year which enabled you to remain in the home rather than a nursing facility? | | | Provide address of property. |
| | Assuming the previous question does not apply to you; do you own your own **Home or Former Home** and are absent for any reason (including admission into long-term care) and intend to return home someday? The word "intend" here means a desire to return home regardless of your physical or mental ability to do so. | | | Provide address of the property. |
| | Do you own other **Houses, Condominiums, Ranches, Land, Buildings, Mobile Homes, Life Estates**? | | | a) Provide a current appraisal value from a qualified real estate appraiser (if lower than the asset value, the county will use the appraised value).<br>b) Provide copies of loan documents showing amount owed on property.<br>c) If rented, indicate amount of rent and provide monthly or annual expenses. |
| LOANS | Do you own **Promissory Notes, Mortgages or Deeds of Trust**? (Do not include those that you pay). | | | a) Provide copies of your documents.<br>b) Provide a list of payments received and balances owed.<br>c) If you obtain an appraised value of the note, mortgage or deed of trust from a mortgage broker and the amount is lower than the balance owed, Medi-Cal will use the appraised value.<br>d) If statements are provided from three brokers indicating that they will not appraise a loan, it will not be counted by Medi-Cal. |
| JEWELRY | Do you have **Jewelry** worth more than $100? (Do not include wedding rings, engagement rings or heirlooms). | | | Provide statements from jewelers with estimates of value. |
| MINERALS | Do you own **Oil** or **Mineral Rights** or **Mining Claims**? | | | Provide copies of your most recent tax assessment or ownership documents. |
| COURT ORDERS | Do you have **Court-ordered Settlements, Judgements, Orders for Support**, or **Pre-nuptial** or **Post-nuptial Agreements**? | | | Provide copies of Orders, Judgements, Pre-nuptial or Post-nuptial Agreements affecting or benefiting you or your family. |

| | ITEM | NO | YES | ACCEPTABLE VERIFICATION |
|---|---|---|---|---|
| TRUSTS | Do you have **Trusts or Blocked Accounts?** | | | a) Provide copies of all Trust documents.<br>b) Provide copies of investments and distributions from the trust for the months tha Medi-Cal is requested.<br>c) Indicate on the copies if you have property held in trust by the United State Government for a Native American. |
| | Do you have **Burial Trusts, Burial Contracts or Burial Insurance?** | | | Provide copies of your Trusts or Contracts. |
| INSURANCE | Do you have **Life Insurance?** | | | Provide copies of all life insurance policies except term policies that have no cas surrender value. |
| | Do you have **Long-term Care Insurance?** | | | a) Provide copies of all long-term care insurance policies that you have for you an your spouse.<br>b) If your policy is certified by the California Partnership for Long-Term Care, pleas provide a copy of your most current benefit statement. |
| BUSINESS | Do you have **Business Bank Accounts or Business Related Property?** | | | a) Provide copies of documents to show the existence of a business, such as ta returns, invoices, letterhead, receipts, licenses, leases, etc.<br>b) Provide ownership documents for all property belonging to your business and/o being listed on your taxes as business property.<br>c) Provide documentation that will establish the value of your business property including statements from qualified sources.<br>d) If your business is not in current operation, please explain why and indicate whe you intend to begin operation again. Please include copies of statements of al financial institution accounts. |
| OTHER ASSETS | Do have any **other Real or Personal Property, Assets, or Resources?** (Do Not include personal items or household goods valued at less than $500). | | | Provide copies of any ownership documents available to establish the value of the item or statements such as verification of value from qualified sources. |
| VEHICLES | Do you have **Cars, Trucks, Motorcycles, Trailers, or other Motorized Vehicles** that are not used by you as a home?<br>DRAFT | | | a) Provide copies of the most recent registration, pink slip or purchase document fo each item.<br>b) If none of the above is available, provide one estimate of value from a qualified source, such as a dealer or mechanic for each item.<br>c) Indicate if used on the job, such as a taxi.<br>d) Indicate if used to travel long distances to work, such as a truck used by a contractor working out of town.<br>e) Indicate if used to carry the main supply of fuel or water for your home.<br>f ) Indicate if used to transport a disabled or incapacitated family member living in the home.<br>g) Indicate if the item is business property; if so provide verification. |
| LIENS | Do you **Owe Money** on any of the items listed above or have liens on them? | | | Provide copies of the lien, loan or security documents. |
| MEDICAL | Have you spent or used any **Real or Personal Property** in payment or security for medical services for you or your family? | | | Provide copies of the security agreements, lien documents or receipts for medica expenses paid. |

**YOUR COUNTY ELIGIBILITY WORKER MAY REQUEST ADDITIONAL VERIFICATION DEPENDING UPON YOUR SPECIFIC CIRCUMSTANCES AND PROPERTY OWNED.**

Please note: If you have answered yes to any of the items listed above, contact your County Department of Public Social Services immediately and request a copy of "Medi-Cal General Property Limitations" (MC Information Notice 007). This form will provide you with the rules that apply to the property you own, the property limits and information on how you can spend down your property to the limits in order to be eligible in the month for which you need medical services. If you are hospitalized or entering long-term care it is very important that you do this quickly.

**I declare under penalty of perjury under the laws of the State of California that the answers I have given in this application and the documents submitted are correct and true to the best of my knowledge and belief. I declare that I have read and understand the application instructions, the declarations, and all information printed on this application.**

Signature_____ Date _____

# ADDITIONAL HOUSEHOLD MEMBERS

EXHIBIT D

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# ADDITIONAL FAMILY MEMBERS SUPPLEMENT

| 1 Applicant or Caretaker's Name (First, Middle, Last) | 2 *County Number/Worker Number (Official use)* |
|---|---|
| | |

**Tell us about additional members of the household.**

| | CHILD 4 | CHILD 5 | CHILD 6 | CHILD 7 | CHILD 8 |
|---|---|---|---|---|---|
| 16 Name: Last | | | | | |
| First | | | | | |
| Middle | | | | | |
| 17 Name on Birth Certificate Last | | | | | |
| First | | | | | |
| *(If same as #16 above, leave blank)* Middle | | | | | |
| 18 Date of Birth: | / / MO DAY YR | / / MO DAY YR | / / MO DAY YR | / / MO DAY YR | / / MO DAY YR |
| 19 Sex: | ❑ Male ❑ Female ❑ Pregnant | ❑ Male ❑ Female ❑ Pregnant | ❑ Male ❑ Female ❑ Pregnant | ❑ Male ❑ Female ❑ Pregnant | ❑ Male ❑ Female ❑ Pregnant |
| 20 Marital Status: | ❑ Married ❑ Divorced ❑ Single ❑ Widowed ❑ Separated | ❑ Married ❑ Divorced ❑ Single ❑ Widowed ❑ Separated | ❑ Married ❑ Divorced ❑ Single ❑ Widowed ❑ Separated | ❑ Married ❑ Divorced ❑ Single ❑ Widowed ❑ Separated | ❑ Married ❑ Divorced ❑ Single ❑ Widowed ❑ Separated |
| 21 Relationship to person in Section 1: | | | | | |
| 22 Mother's Name: Last | | | | | |
| First | | | | | |
| Middle | | | | | |
| *Check all that apply to the mother.* | ❑ In Home ❑ Unable to Work ❑ Deceased | ❑ In Home ❑ Unable to Work ❑ Deceased | ❑ In Home ❑ Unable to Work ❑ Deceased | ❑ In Home ❑ Unable to Work ❑ Deceased | ❑ In Home ❑ Unable to Work ❑ Deceased |
| 23 Father's Name: Last | | | | | |
| First | | | | | |
| Middle | | | | | |
| *Check all that apply to the father.* | ❑ In Home ❑ Unable to Work ❑ Deceased | ❑ In Home ❑ Unable to Work ❑ Deceased | ❑ In Home ❑ Unable to Work ❑ Deceased | ❑ In Home ❑ Unable to Work ❑ Deceased | ❑ In Home ❑ Unable to Work ❑ Deceased |
| 24 Wants Medi-Cal? | ❑ Yes ❑ No *If No, you do not have to answer any other questions for this person in this section.* | ❑ Yes ❑ No *If No, you do not have to answer any other questions for this person in this section.* | ❑ Yes ❑ No *If No, you do not have to answer any other questions for this person in this section.* | ❑ Yes ❑ No *If No, you do not have to answer any other questions for this person in this section.* | ❑ Yes ❑ No *If No, you do not have to answer any other questions for this person in this section.* |
| 25 Social Security # | | | | | |
| | Social Security Numbers are not required for persons who want emergency or pregnancy related services. | | | | |
| 26 Place of Birth *County, State or Country if outside the U.S.* | | | | | |
| 27 Ethnic Code *(see instructions)* | | | | | |

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**SECTION 2: Continued**

| | CHILD 4 | CHILD 5 | CHILD 6 | CHILD 7 | CHILD 8 |
|---|---|---|---|---|---|
| 28 U.S. Citizen or National? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| *If No, is person a Lawful Permanent Resident or PRUCOL alien? (see instructions)* | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 29 Has other health, dental or vision insurance? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 30 Has Medicare? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 31 Intends to stay in California or works in California? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 32 Filed a lawsuit because of accident or injury? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 33 Past medical expenses? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | Check "Yes" for person(s) that has any UNPAID medical expenses for the 3 months prior to this application and wants Medi-Cal for those months. | | | | |
| 34 In nursing home, hospital or board and care home? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| If Yes | Name of Facility: | | Date Entered: / / | | Intend to Return Home: ☐ Yes ☐ No |
| 35 Asked for or gotten aid benefits, including cash, SSI, Medi-Cal? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| If yes, where: | (County, State, Country): | | When: | | Type(s) of benefit: |
| 36 Current or past U.S. Military service for child's parents or adult? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

*(For County Use)*

37 I declare under penalty or perjury under the laws of the State of California that the answers I have given in this application and the documents submitted are correct and true to the best of my knowledge and belief. I declare that I have read and understand the application instructions, the declarations, and all information printed on this application.

Signature_____ Date _____

# QUARTERLY STATUS REPORT

EXHIBIT E

# MEDI-CAL STATUS REPORT

REPORT MONTH

NAME:

STREET ADDRESS:

CITY/STATE/ZIP CODE:

**TO MAKE SURE YOUR MEDI-CAL BENEFITS ARE NOT DELAYED OR STOPPED, YOU *MUST* RETURN THIS STATUS REPORT BY THE DUE DATE EVEN IF THERE IS NO CHANGE TO YOUR FAMILY'S SITUATION. IF YOU NEED HELP OR HAVE QUESTIONS, CONTACT YOUR MEDI-CAL WORKER. THE FRONT PAGE OF THIS REPORT GIVES YOU HELPFUL INFORMATION.**

## 1. HOUSEHOLD CHANGES

| Did you or any family member have the following changes: | NO | YES | |
|---|---|---|---|
| Income: Amount and/or Source | | | If YES, complete Question 2 |
| Expenses: Work, Child/Spousal, Rental or Insurance | | | If YES, complete Question 3 |
| Job/Training: New, More/Less Hours or Stopped | | | If YES, complete Question 4 |
| Resources and Property: Bought or Sold, Value Went Up | | | If YES, complete Question 4 |
| Living Situation: Address or Person Moved In/Out | | | If YES, complete Question 4 |
| Health: Pregnant, Unable to Work or Disabled | | | If YES, complete Question 4 |
| Marital Status: Got Married/Separated/Divorced | | | If YES, complete Question 4 |
| Immigration Status: Legal, Permanent or Citizenship | | | If YES, complete Question 4 |
| Insurance: Health, Dental, Vision and Medicare | | | If YES, complete Question 4 |

**IF YOU CHECKED NO TO ALL** of the items listed above, you may skip 2, 3, and 4. Go Directly to the Signature and Certification section. Please sign, date and mail this report back to your County.

**IF YOU CHECKED YES TO ANY OF THE ITEMS** listed in #1, please GO to #2, 3, or 4. Be sure you give proof and/or more information about the changes in your family. The County will look at your case record with the new information you gave to figure out on-going Medi-Cal benefits for you and/or your family members.



## 2. INCOME (IF YOU NEED MORE SPACE TO REPORT OTHER INCOME, PUT THE INFORMATION IN SECTION 4.)

| WHOSE INCOME CHANGED (NAME(S): | INCOME SOURCE: | GROSS INCOME AMOUNT EACH TIME |
|---|---|---|
| | | $_____ ☐ WEEKLY ☐ EVERY OTHER WEEK ☐ 2 TIMES A MONTH ☐ MONTHLY ☐ OTHER |
| WHOSE INCOME CHANGED (NAME(S): | INCOME SOURCE: | GROSS INCOME AMOUNT EACH TIME |
| | | $_____ ☐ WEEKLY ☐ EVERY OTHER WEEK ☐ 2 TIMES A MONTH ☐ MONTHLY ☐ OTHER |

## 3. EXPENSES. WE WILL LOWER YOUR FAMILY'S INCOME AMOUNT IF YOU GIVE PROOF WITH THIS REPORT.

## 4. OTHER CHANGES. EXPLAIN OR REPORT ALL OTHER CHANGES HERE AND GIVE US PROOF.

## 5. SIGNATURE AND CERTIFICATION. I understand that I must report all income, property and/or other changes to the County within ten (10) days. I declare under penalty of perjury that all information provided are true and correct.

| Signature | DATE | TELEPHONE |
|---|---|---|
| | | |
| WITNESS Signature: (INTERPRETER OR PERSON ASSISTING) | DATE | TELEPHONE |
| | | |

# Commonly Asked Questions Regarding the Status Report

*Why do you need to complete a Status Report?*
The County uses the information from the status report to make sure that you or your family's income, expenses, resources, property, and living arrangements do not change your on-going Medi-Cal benefits or monthly share-of-cost amount.

*Why is it important to report changes?*
If you do not report changes and cause the Medi-Cal Program to spend money to pay for any medical services, it could result in a charge of fraud.

*When do you need to fill out and send in the Status Report?*
You MUST fill out the report each time the county sends you one even if you do not have any change to report. The report due date is on the 5th after the report month. To make sure your Medi-Cal benefits are not delayed or stopped, attach proof of changes to your report. If you have questions or need help with filling it out, contact your caseworker. You can find the worker's name and telephone number on the report.

*Examples of proof you need to send in. (Photocopy only)*

- Paystubs or letters from government agencies or bank statements showing direct deposits of income, statement from an employer, or profit and loss statements for self-employed individuals
- Checks showing amount of child support and/or alimony received or paid
- Receipts or cancelled checks for child and dependent care
- Bank statements, car registration
- New immigration paper if status has changed



*Examples of Income*

- Earnings from a job such as wages, tips and commissions; self-employment profits.
- Government benefits such as Social Security Retirement, Survivors and Disability Insurance; workers compensation payments; pensions/retirement; unemployment insurance; disability payments; SSI/SSP or income tax refund
- Other retirement benefits
- Child support, alimony, interest income, rental income, settlement benefits, grants, loans, gifts, contributions, lottery/sweepstake winnings, etc.
- Free housing, utilities, food or clothing

*Examples of expenses*

- Child support or alimony you or a member of your family pays
- Health insurance premium payments including Medicare
- Child or dependent care you pay while you work
- Business or property

*What else do you need to report?*

- Pregnancy or birth of a baby
- Living situation changes such as address, household members moving in or out
- Household members hospitalized or placed in a nursing home
- Opened or closed bank account
- Bought or sold land, car, home or other items of value
- Health insurance starting or stopping
- Changes in immigration or martial status