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

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

March 29,2000

Medi-Cal Eligibility Branch Information Letter No.: I 00-06

TO: All County Medi-Cal Program Specialists/Liaisons

ALL COUNTY WELFARE DIRECTORS LETTER (ACWDL) No.: 00-19

The purpose of this All County Information Letter is to transmit to counties, the revised Healthy Families Annual Eligibility Review (AER) forms that should have been sent as enclosures to ACWDL No.: 00-19.

If you have any questions about the AER form or AER application procedures outlined in ACWDL No: 00-19, please contact Ms. Linda Rahmeyer of my staff at (916) 657-0398.

Sincerely,

ORIGINAL SIGNED BY

ANGELINE MRVA, CHIEF
Medi-Cal Eligibility Branch

Enclosures

«ltrdate»

«ltrfirst» «ltrlast»
«ltradrs1»
«ltradrs2»
«ltrcity», «ltrstate» «ltrZIP»

Warning: If you do not return the enclosed forms, your child(ren) will lose coverage with the Healthy Families Program.

Dear Applicant,

The Healthy Families Program offers your child(ren) health, dental, and vision coverage for 12 months. The end of this 12 month period will be here soon. To qualify for another 12 months of coverage, we must verify that your family still meets Healthy Families eligibility guidelines.

In order to re-qualify your child(ren) for Healthy Families, you must fill out the enclosed Annual Eligibility Review Form and send it with all required income documents no later than <<Anniversay Date – minus 1 day>>. Please see the enclosed Household Information Worksheet for a list of acceptable income documents to send. **If we do not receive these documents, your child(ren) will be disenrolled on <<Anniversary Date end of month>>.** If your child is disenrolled and receives health, dental, or vision services through the Healthy Families Program after the disenrollment date, you may have to pay for the cost of the services provided.

After your documents have been processed, you will receive a letter stating whether your child qualifies for another 12 months of coverage. If your child no longer qualifies for Healthy Families, you will receive a letter with the reason.

Do you wish to add additional children to the Healthy Families Program? If you would like to apply for additional children whose names do not appear on the Annual Eligibility Review Form, please fill out the enclosed **Add New Children Form**. Then, return the **Add New Children Form** along with the Annual Eligibility Review Form in the enclosed postage paid envelope.

If you have any questions, or would like to find a Certified Application Assistant in your area, call 1-888-439-4741, Monday - Friday 8:00 A.M. - 8:00 P.M. Certified Application Assistants will assist you with these forms at no cost to you.

Sincerely,
Healthy Families Program

DUE BY: «Anniversay-1day ».

- **Please Note**: The Healthy Families Program and Medi-Cal are two separate programs. If you have other children enrolled in no-cost Medi-Cal, your Medi-Cal eligibility worker will send you a separate Annual Eligibility Redetermination Packet

ANNUAL ELIGIBILITY REVIEW FORM
Please return this form immediately to continue coverage for your children

Family Member Number «ltrCASE»
«ltrfirst» «ltrlast»
«ltradrs1»
«ltradrs2»
«ltrcity», «ltrstate» «ltrZIP»

If any of the pre-printed information on this form is incorrect, please cross it out and write the correct information.

Questions?
Call 1-888-439-4741 Monday - Friday, 8:00 a.m. to 8:00 p.m.

1. Children Currently Enrolled in Healthy Families

*Fill in child(ren)'s **Monthly Income** and **Relationship to Applicant**. Cross out any children who no longer live in the household.*

Enrolled Child	Date of Birth	Child's Monthly Income (if any)	Relationship to <<Applicant>>
«M_1Cfirst» «M_1Clast» «M_1Caddress» «M_1Ccity», «M_1Cstate» «M_1CZIP»	«M_1Cbirth»	$ Document Required	_ Child _ Stepchild _ Other
«M_2Cfirst» «M_2Clast» «M_2Caddress» «M_2Ccity», «M_2Cstate» «M_2CZIP»	«M_2Cbirth»	$ Document Required	_ Child _ Stepchild _ Other
«M_3Cfirst» «M_3Clast» «M_3Caddress» «M_3Ccity», «M_3Cstate» «M_3CZIP»	«M_3Cbirth»	$ Document Required	_ Child _ Stepchild _ Other
«M_4Cfirst» «M_4Clast» «M_4Caddress» «M_4Ccity», «M_4Cstate» «M_4CZIP»	«M_4_Cbirth»	$ Document Required	_ Child _ Stepchild _ Other
«M_5Cfirst» «M_5Clast» «M_5Caddress» «M_5Ccity», «M_5Cstate» «M_5CZIP»	«M_5_Cbirth»	$ Document Required	_ Child _ Stepchild _ Other
«M_6Cfirst» «M_6Clast» «M_6Caddress» «M_6Ccity», «M_6Cstate» «M_6CZIP»	«M_6Cbirth»	$ Document Required	_ Child _ Stepchild _ Other
«M_7Cfirst» «M_7CLast» «M_7Caddress» «M_7Ccity», «M_7Cstate» «M_7CZIP»	«M_7Cbirth»	$ Document Required	_ Child _ Stepchild _ Other

2. Are any of these children now enrolled in employer sponsored health insurance? ❑ Yes ❑ No

If yes, please list the children:_____

3. Adults in the Household

*Fill in the following sections. **Refer to the Household Information Worksheet to determine what income counts and who counts as a family member.***

Adult Family Members living with the Children	Relationship to <<Applicant>>	Relationship to Children	How often received:	How much Gross Income
<<Applicant Name>>	APPLICANT		_ once every week _ every two weeks _ twice a month _ once a month	$
	_ Spouse _ Other_____	_ Parent _ Stepparent _ Other _____	_ once every week _ every two weeks _ twice a month _ once a month	$

Most recent income documents MUST be attached.

4. Children living in the household NOT enrolled in Healthy Families

Fill in the child(ren)'s ***Monthly Income*** *and* ***Relationship to Applicant****. Cross out any children who no longer live in the household. Check the box by the child's name if you now want to enroll the child in Healthy Families.* ***If you wish to enroll children whose names are not listed, you must fill out and return the ADD NEW CHILDREN Form.***

Child	Date of Birth	Child's Monthly Income (if any)	Relationship to <<Applicant>>
☐ «NC1first» «NC1last»	«NC1birth»	$ Document Required	_ Child _ Stepchild _ Other
☐ «NC2first» «NC2last»	«NC2birth»	$ Document Required	_ Child _ Stepchild _ Other
☐ «NC3first» «NC3last»	«NC3birth»	$ Document Required	_ Child _ Stepchild _ Other
☐ «NC4first» «NC4last»	«NC4birth»	$ Document Required	_ Child _ Stepchild _ Other
☐ «NC5first» «NC5last»	«NC5birth»	$ Document Required	_ Child _ Stepchild _ Other

5. Other Children living in Household who you *do not* wish to apply for Healthy Families.

Refer to the Household Information worksheet to determine which children to list. If there is an unborn child, write "Unborn Child" in the space for Child Name. Attach a separate sheet if necessary.

Child Name	Date of Birth	Monthly Income if any	Relationship to <<Applicant>>
	- -	$ Document Required	_ Child _ Stepchild _ Other _____

6. *Is the applicant or anyone else in the home pregnant?* ☐ Yes ☐ No

If Yes, please list name_____

7. Income Deductions (Remember to send documentation for the following, if applicable)

The parent(s) *who the child(ren) live with* must answer the following:

Monthly child care expenses you pay for children under age 2. The maximum amount allowed is $200.	$
Monthly child care expenses you pay for children age 2 and over. The maximum amount allowed is $175.	$
Monthly disabled dependent care expenses you pay. The maximum amount allowed is $175.	$
Monthly court ordered alimony you pay	$
Monthly court ordered child support you pay	$

For each working parent, we will deduct up to $90 for work-related expenses

I, the applicant, certify that the information provided is true and correct. I understand that a change in income from last year may result in a higher monthly premium or may make my child(ren) ineligible for the Healthy Families Program.

Applicant Signature X_____ **Date:**_____

Authorization to Forward AER to Medi-CAL

If my child is ineligible for Healthy Families, I request that this form be forwarded to the county and treated as a Medi-Cal application. I declare under penalty of perjury that the information on this form is true and correct to the best of my knowledge and belief. Please provide Social Security numbers of children applying for full scope Medi-Cal benefits. Write the Social Security number next to the child's name in Section 1.

Applicant Signature X_____ **Date:**_____

Reimbursement for Application Assistance. For Certified Application Assistant use only.

I certify that I had help completing this form by the Certified Application Assistant listed below. This CAA help was Free of charge. The state will not issue a reimbursement unless this section is completely filled out at the time this form is submitted.

Applicant Signature X_____ **Date:**_____

CAA#_____ **EE#**_____ **CAA Signature X**_____

Household Information Worksheet

1. *Who counts as a family member living in the home with the child?*

Adults:

- Natural or adoptive parents of the child to receive benefits
- A minor living on his or her own

Children:

- Unborn child
- All children under age 21 living in the home
- All children under age 21 away at school and claimed as tax dependents

2. *What Income counts?*

- Earnings from a job
- Self-employment net profits
- Child support
- Alimony/Spousal Support
- Pension and retirement benefits
- Government benefits such as Social Security, Retirement Survivor Disability Insurance (RSDI), Veterans, Disability, Workers' Compensation, Unemployment, etc.
- Other income such as: grants for living expenses, settlement benefits, net profit from rentals, gifts, lottery/bingo winnings, interest income

3. *What income does NOT count?*

- **Earnings from a job of a child under age 14 or a child who attends school**
- Supplementary Security Income/State Supplementary Program (SSI/SSP) Payments
- Foster Care Payments
- CalWORKS payments (replaces AFDC)
- General Relief
- Certain other government benefits
- Grants or scholarships
- Loans
- College Work Study

4. *Acceptable Income Documents:*

- Copy of the most recent paystub. If a paystub is not available, get a signed statement from your employer. Gross monthly income and the dates received should be on the statement.
- Copy of last year's federal income tax return

Other proof of income you may send:

- If a person is self-employed, send last year's federal income tax return (including the Schedule C) or the last 3 month's profit and loss statements.
- If a person has income such as disability or retirement, send copies of 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.
- A Medi-Cal "Share-of-Cost-Notice of Action" received in the last 30 days which shows the child has share-of-cost may be used if it lists your income.

5. *What is Medi-Cal?*

Medi-Cal offers no-cost comprehensive health, dental and vision services to children. If your family income is below the Healthy Families guidelines, your child(ren) may be eligible for no-cost Medi-Cal. If you authorize us, we will forward your AER information to Medi-Cal if your children do not qualify for Healthy Families.

Medi-Cal Privacy Notice

Federal and State Law requires us to provide the following information: Welfare and Institutions Code §14011. Requires Medi-Cal applicants to provide the information requested in this application. It may be shared with federal, state and local agencies for purposes of verifying eligibility, and for verification of the immigration status of those persons seeking full scope Medi-Cal benefits. (Federal law says the INS cannot use the information for anything else except cases of fraud.) It will also be used to process Medi-Cal claims and make Benefits Identification Cards (BICs). Failure to provide the required information may result in denial of the application. Information required by this form is mandatory. Social Security numbers are required by §1144(a)(1) of the Social Security Act unless applying for emergency or pregnancy benefits only.

6. *Deductions*

The income deductions in section 7 of the Annual Eligibility Review help us determine what amounts we may use to lower your family's income. If anyone receives 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. Also, send copies of receipts or cancelled checks for child or dependant care expenses paid during the last month.

If you have any questions or would like the location of a Certified Application Assistant in your area, call 1-888-439-4741, Monday - Friday, 8:00 A.M. - 8:00 P.M. A Certified Application Assistant will help you with these forms at no cost.

ADD NEW CHILDREN FORM

APPLICANT NAME	PHONE NUMBER

FAMILY MEMBER NUMBER											

Please fill out all information for the child(ren) you would like to add to Healthy Families. If the child's name is already listed in Section 4 of the Income Verification form, place a check mark by that child's name and do not fill out this form. To add more than 4 children, make a photocopy of this form if necessary. If a pregnant woman is within 90 days of the estimated date of delivery, she may pre-enroll the unborn child in the Healthy Families Program. Healthy Families insurance coverage will become effective 13 days after documentation of birth is received. The birth certificate must be received within 30 days of birth. ***This form must be mailed with the Annual Eligibility Review Form.***

	Child 1 (or unborn)	Child 2	Child 3	Child 4
Name: Last				
First				
Middle				
Birthname: Last *(if different from above)*				
First				
Middle				
If the child's address is NOT the same as the Applicant, give address	Street City ZIP	Street City ZIP	Street City ZIP	Street City ZIP
Relationship to Applicant:				
Sex:	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Date of Birth (or estimated date of delivery)	/ / MO DAY YEAR	/ / MO DAY YEAR	/ / MO DAY YEAR	/ / MO DAY YEAR
Place of Birth: **California County, State or Country**				
Ethnicity Code				

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

U.S. Citizen or National? If no, please write date of entry into U.S.	☐ Yes ☐ No / / MO DAY YEAR	☐ Yes ☐ No / / MO DAY YEAR	☐ Yes ☐ No / / MO DAY YEAR	☐ Yes ☐ No / / MO DAY YEAR
Social Security # *(optional)*	- -	- -	- -	- -
Mother's Name: Last				
First				
Does the Mother live in the home?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

CONTINUED	Child 1 (or unborn)	Child 2	Child 3	Child 4
Father's Name: Last				
First				
Does the father live in the home?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Does this child have no cost Medi-Cal? If yes, give date coverage will end.	❑ Yes ❑ No / / MO DAY YEAR	❑ Yes ❑ No / / MO DAY YEAR	❑ Yes ❑ No / / MO DAY YEAR	❑ Yes ❑ No / / MO DAY YEAR
Was the child insured by an employer in the last 90 days? If yes, check the main reason why insurance stopped and give the date it stopped.	❑ Yes ❑ No ❑ Lost Job ❑ Moved and no insurance available ❑ Employer ended benefits to all employees ❑ COBRA coverage ended ❑ Other ________ ________ / / MO DAY YEAR	❑ Yes ❑ No ❑ Lost Job ❑ Moved and no insurance available ❑ Employer ended benefits to all employees ❑ COBRA coverage ended ❑ Other ________ ________ / / MO DAY YEAR	❑ Yes ❑ No ❑ Lost Job ❑ Moved and no insurance available ❑ Employer ended benefits to all employees ❑ COBRA coverage ended ❑ Other ________ ________ / / MO DAY YEAR	❑ Yes ❑ No ❑ Lost Job ❑ Moved and no insurance available ❑ Employer ended benefits to all employees ❑ COBRA coverage ended ❑ Other ________ ________ / / MO DAY YEAR
Monthly Countable Income *(if any)*	$	$	$	$

- *See the Household Information Worksheet for a list of what income counts and acceptable income documentation.*
- ***You must include a birth certificate for each child (within 60 days) and documentation of birth for a newborn (within 30 days of birth) or;***
- ***An immigration status document for each child (within 30 days)***

I, the applicant, certify that the information provided is true and correct. I understand that adding additional family members may result in a higher monthly premium.

Applicant Signature X______________________________ **Date:**________________

Authorization to Forward AER to Medi-CAL

If my child is ineligible for Healthy Families, I request that this form be forwarded to the county and treated as a Medi-Cal application. I declare under penalty of perjury that the information on this form is true and correct to the best of my knowledge and belief. Please provide Social Security numbers of children applying for full scope Med-Cal benefits.

Applicant Signature X______________________________ **Date:**________________

Reimbursement for Application Assistance. For Certified Application Assistant use only.

I certify that I had help completing this form by the Certified Application Assistant listed below. This CAA help was Free of charge. The state will not issue a reimbursement unless this section is completely filled out at the time this form is submitted.

Applicant Signature X______________________________ **Date:**________________

CAA#____________ **EE#**____________ **CAA Signature X**________________________

ADD NEW CHILDREN FORM

Open this form only if you wish to add children whose names do not appear on the Annual Eligibility Review Form.

To add these children, this form must be mailed along with the Annual Eligibility Review Form.