CHEAT SHEET 2015

48 Contiguous States and DC

Note: The 100% column shows the federal poverty level for each family size, and the percentage columns that follow represent income levels that are commonly used as guidelines for health programs.

Household Size	100%	138%	400%
1	11,770	16,243	47,080
2	15,930	21,983	63,720
3	20,090	27,724	80,360
4	24,250	33,465	97,000
5	28,410	39,206	113,640
6	32,570	44,947	130,280
7	36,730	50,687	146,920
8	40,890	56,428	163,560
For each additional person, add	4,160	5,741	16,640

100% = Base Line

138% = Federal Poverty Level for ACA New Adults Ages 19-64.

400% = Allowable qualification for advanced tax credit (Subsidy) for Covered California. (Open Enrollment 11/15/14 thru 2/15/15.

As of **1-22-2015**

Medi-Cal provides a comprehensive set of health benefits which may be accessed as medically necessary:

Ambulatory Patient Services
- Physician Services
- Hospital Outpatient & Outpatient Clinic Services
- Outpatient Surgery (Includes anesthesiologist services.)
- Podiatry
- Chiropractic
- Allergy Care
- Treatment Therapies (Chemotherapy, radiation therapy, etc.)
- Dialysis/Hemodialysis

Prescription Drugs
- Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class.
- Beneficiaries may receive up to a 100-day supply of many medications.

Emergency Services
- ER:
All inpatient and outpatient services that are necessary for the treatment of an emergency medical condition, including dental services, as certified by the attending physician or other appropriate provider.
- Ambulance Services

Rehabilitative and Habilitative Services and Devices
- Physical Therapy
- Durable Medical Equipment
- Hearing Aids
- Speech Therapy
- Occupational Therapy
- Acupuncture
- Cardiac Rehabilitation
- Pulmonary Rehabilitation
- Medical Supplies, Equipment, Appliances (Including implanted hearing devices).
- Orthotics/Prostheses
- Home Health Services
- Skilled Nursing Facility Services (90 days)

Hospitalization
- Inpatient Hospital Services
- Anesthesiologist Services
- Surgical Services (Bariatric, Reconstructive Surgery, etc.)
- Organ & Tissue Transplantation

Laboratory Services
- Outpatient Laboratory and X-Ray Services
  - o Various advanced imaging procedures are covered based on medical necessity.

Maternity and Newborn Care
- Prenatal Care
- Delivery and Postpartum Care
- Breastfeeding Education
- Nurse Midwife Services

Preventive and Wellness Services and Chronic Disease Management
- United States Preventive Services Task Force A & B Recommended preventitive services
- Advisory Committee for Immunization Practices recommended Vaccines
- HRSA's Bright Futures Recommendations
- Preventive services for women recommended by the Institute of Medicine
- Family Planning Services
- Smoking Cessation Services

Mental health and Substance Use Disorder (SUD) services including behavioral health treatment.
- Outpatient Mental Health Services
- Outpatient Specialty Mental Health Services
- Inpatient Specialty Mental Health Services
- Outpatient Substance Use Disorder Services
  - o Residential Treatment Services
- Voluntary Inpatient Detoxification

Pediatric Services Including Oral and Vision Care
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a Medi-Cal benefit for individuals under the age of 21 who have full-scope Medi-Cal eligibility. EPSDT provides for periodic screenings to determine health care needs and in addition to the standard Medi-Cal benefits, a beneficiary under the age of 21 may receive extended services as medically necessary.

OTHER:

Dental	• Emergency dental services • Dentures • Dental implants and implant-retained prostheses • EPSDT and Pregnant Women receive extended dental benefits.
Vision	• 1 routine eye exam in 24 months: test for prescription eyeglasses or contact lenses, test for low vision. • EPSDT and Pregnant Women receive extended vision benefits.
Non-Emergency Medical Transportation Services	Ambulance, litter van, or wheelchair van only when ordinary public or private conveyance is medically contra-indicated and transportation is required for obtaining needed medical care for a Medi-Cal benefit.
Long Term Services and Supports	• Skilled Nursing Facility Services (91+days) • Personal Care Services • Self-Directed Personal Assistance Services • Community First Choice Option • Home and Community Based Services

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APPLICATION FOR MEDI-CAL

To complete this form, use the instructions. Print clearly. Use black or blue ink only.

SECTION 1

Tell us about the person who wants Medi-Cal for themselves, their family or children in their care.

1 LAST NAME	FIRST NAME	MIDDLE INITIAL

2 HOME ADDRESS (NUMBER AND STREET). **DO NOT LIST A P.O. BOX** UNLESS HOMELESS	3 APARTMENT NUMBER	4 HOME PHONE # ( )
5 CITY/STATE / 6 COUNTY	7 ZIP CODE	8 WORK PHONE # ( )
9 MAILING ADDRESS (IF DIFFERENT FROM ABOVE) OR P.O. BOX	10 APARTMENT NUMBER	11 MESSAGE PHONE # ( )
12 CITY		13 ZIP CODE

14A WHAT LANGUAGE/DIALECT DO YOU SPEAK BEST?	14B WHAT LANGUAGE DO YOU READ BEST?

SECTION 2

Tell us about the person listed in Section 1, his or her family and the children they care for, even if they don't want coverage.

	Adult 1/Self	Adult 2	Child 1	Child 2	Child 3
15 Name: Last					
First					
Middle					
16 Relationship to person in Section 1.					
17 If address where living is not the same as listed in Section 1, put address where living:					
18 Gender:	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
19 Marital Status:	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
20 Name of spouse(s) of married minors in the home.					
21 Date of Birth:	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR
22 Pregnant:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Due Date:	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR
23 Has a physical, mental or emotional disability?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Disability expected to last:	☐ 30 Days or More ☐ 12 Months or More	☐ 30 Days or More ☐ 12 Months or More	☐ 30 Days or More ☐ 12 Months or More	☐ 30 Days or More ☐ 12 Months or More	☐ 30 Days or More ☐ 12 Months or More

TEAR HERE

CONTINUED

SECTION 2 Continued

	Adult 1/Self	Adult 2	Child 1	Child 2	Child 3
24 Has any one ever received **cash aid, SSI, Food Stamps** or **Medi-Cal**?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If "Yes," under what name?					
25 Medi-Cal benefits card number (BIC), if you have it:					
26 Wants medical benefits?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
27 Do you own or are you buying a home outside California?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

SECTION 3 Answer for *all* children in Section 2.

Child 1	Child 2	Child 3	Unborn
28 Mother's Name:	Mother's Name:	Mother's Name:	Mother's Name:
Is Mother: ☐ Employed ☐ Disabled ☐ Unemployed ☐ Deceased ☐ Absent	Is Mother: ☐ Employed ☐ Disabled ☐ Unemployed ☐ Deceased ☐ Absent	Is Mother: ☐ Employed ☐ Disabled ☐ Unemployed ☐ Deceased ☐ Absent	Is Mother: ☐ Employed ☐ Disabled ☐ Unemployed
29 Father's Name:	Father's Name:	Father's Name:	Father's Name:
Is Father: ☐ Employed ☐ Disabled ☐ Unemployed ☐ Deceased ☐ Absent	Is Father: ☐ Employed ☐ Disabled ☐ Unemployed ☐ Deceased ☐ Absent	Is Father: ☐ Employed ☐ Disabled ☐ Unemployed ☐ Deceased ☐ Absent	Is Father: ☐ Employed ☐ Disabled ☐ Unemployed ☐ Deceased ☐ Absent

SECTION 4 List *all* income/money received by persons listed in Section 2.

30 NAME OF PERSON RECEIVING INCOME/MONEY	31 SOURCE OF INCOME/ MONEY RECEIVED (Employment, social security)	32 HOW MUCH INCOME/MONEY IS RECEIVED	33 HOW OFTEN INCOME/ MONEY RECEIVED (Monthly, bimonthly, weekly, biweekly, daily)

SECTION 5 Give information about the listed expenses/cost paid by *all* persons listed in Section 2.

TYPE OF PAYMENT YOUR FAMILY MAKES	34 NAME OF PERSON WHO PAYS	35 MONTHLY AMOUNT PAID
Child Support		
Alimony		
Other Health Insurance Premium		
Medicare Premium		

36 CHILD CARE OR DEPENDENT CARE *(List child's or dependent's name)*	37 AGE	38 NAME OF PERSON WHO PAYS	39 MONTHLY AMOUNT PAID
1.			
2.			
3.			
4.			

TEAR HERE

SECTION 6 *Skip this Section if you are **only** applying for children under 19 and/or pregnant women (pregnancy related services only).*

Otherwise answer for *all* persons listed in Section 2.

40 Does anyone have cash or uncashed checks? ☐ Yes ☐ No
If "Yes," list amount here ________________________ (See instructions)

41 Does anyone have a checking, savings account, or life insurance? (See instructions) ☐ Yes ☐ No

42 Is there one car or more in the household? (See instructions) ☐ Yes ☐ No

43 Does anyone have a court ordered settlement or judgement? (See instructions) ☐ Yes ☐ No

44 Does anyone have Long-Term Care insurance? (See instructions) ☐ Yes ☐ No

45 Does anyone own any items such as stocks, bonds, retirement funds, trusts, real estate, motor vehicles for a business, business accounts, promissory notes, mortgages, deeds of trust, recreational vehicles, burial trusts or funds, annuities, jewelry (not heirloom or wedding), oil or mineral rights? (See instructions) ☐ Yes ☐ No

46 Has anyone listed on this form transferred, sold, traded or given away any items such as those listed above in the last 30 months? (See instructions) ☐ Yes ☐ No

47 Have any items listed in this section been spent or used as security for medical costs? (See instructions) ☐ Yes ☐ No

SECTION 7 Answer ***only*** for persons who want Medi-Cal.

	Adult 1/Self	Adult 2	Child 1	Child 2	Child 3
48 Social Security #:					
You may be able to receive Medi-Cal even if you do not have a Social Security Number.					
49 Place of Birth: *State or Country.*					
50 U.S. Citizen or National? If "No," write in date of entry into U.S.	☐ Yes ☐ No / / MO DAY YR	☐ Yes ☐ No / / MO DAY YR	☐ Yes ☐ No / / MO DAY YR	☐ Yes ☐ No / / MO DAY YR	☐ Yes ☐ No / / MO DAY YR
51 Living in a Long-Term Care or Board and Care Facility?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If "Yes," name of facility:					
Do you intend to return home?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Do you intend to return home within six months?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
52 Has health/dental or vision coverage?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
53 Had medical expenses within the 3 months before the month you applied and want Medi-Cal for those expenses.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
54 Lawsuit pending due to accident or injury?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

TEAR HERE

SECTION 7 Continued

	Adult 1/Self	Adult 2	Child 1	Child 2	Child 3
55 Current or past U.S. Military Service for adults, spouse or child's parents?	☐ Yes ☐ No ☐ Self ☐ Spouse ☐ Parent	☐ Yes ☐ No ☐ Self ☐ Spouse ☐ Parent	☐ Yes ☐ No ☐ Self ☐ Spouse ☐ Parent	☐ Yes ☐ No ☐ Self ☐ Spouse ☐ Parent	☐ Yes ☐ No ☐ Self ☐ Spouse ☐ Parent
56 Ethnicity (race): (optional)					
57 In school full time?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
58 Living away from home?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

SECTION 8 Information Release (Optional).

59 Check this box if you do not want Medi-Cal to share your child's application with the low-cost Healthy Families if your child does not qualify for no-cost Medi-Cal. ☐

60 I got help from (give name of person) ______________________________ when I filled out this application. I agree that the local social services office may give them information about the status of this application. ***Applicant please initial*** ________

SECTION 9 Signature and Certification.

61 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 given 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 *(If person signed with a mark)* ______________________ Date ________

Signature of person helping Applicant fill out the form ________ Telephone Number ________ Relationship to Applicant ________ Date ________

Signature of person acting for Applicant/Beneficiary ________ Telephone Number ________ Relationship to Applicant ________ Date ________

For information about any of the following programs, check the box(es) below and information will be sent to you. Visit our website, www.dhcs.ca.gov

☐ Personal Care Service Program (PCSP). A program for in-home care.

☐ Access for Infants, and Mothers (AIM). A program to help pregnant women with moderate income obtain health care.

☐ Woman, Infants and Children Nutrition Program (WIC). A nutrition program for pregnant and postpartum women and children under 5.

☐ Family Planning

☐ Child Health and Disability Prevention (CHDP) program. Preventive healthcare for children and youth.

Do you want your children or youth referred to the CHDP program for follow-up? ☐ Yes ☐ No

Medi-CAL Processing Instructions

You can mail your completed and signed application to:

Covered California
Attn: Medi-CAL enrollment team
P.O. Box 989725
West Sacramento, CA 95798-9725

Department of Public Social Services (Los Angeles County)
1 (877) 597-4777 Toll Free
1 (866) 613-3777 Customer Service Center

http://dpss.lacounty.gov/dpss/health/default.cfm (Search for the nearest District office to Apply)

Department of Human Services (Kern County)
100 E. California Avenue,
Bakersfield, CA 93307
(661) 631-6807

Social Services Agency (Orange County)
1 (800) 281-9799 Existing Clients
(949) 389-8456 24-Hour Automated Assistance
(714) 541-4895 24-Hour Automated Assistance

To apply for benefits:
1 (855) 478-5386
http://ssa.ocgov.com/health/ (Call for the nearest district office)