

## STATEMENT OF CALIFORNIA RESIDENCY

### (Supplement to Application for Presumptive Eligibility Only—MC 263)

1. Name	Date of Birth
2. Do you now live in California and plan to continue living here? <input type="checkbox"/> Yes, and I can prove this when I apply for Medi-Cal. <input type="checkbox"/> No, I do not live in California and I do not plan to stay in California. If you answered "No" to question 2, or did not answer at all, you cannot get Presumptive Eligibility for Pregnant Women program benefits.	
<b><i>I certify I have read and understand this form. I declare that the information I have given is true, correct, and complete.</i></b>	
Signature or mark of applicant (or legal guardian)	Date
Signature or witness to mark of applicant (or legal guardian)	Date
<b>FOR PROVIDER USE ONLY</b>	
<p><b>INSTRUCTIONS TO PROVIDER:</b> <i>If your patient answers "Yes" to question 2, you may proceed with the Presumptive Eligibility for Pregnant Women program determination. You must attach this form to the Application for Presumptive Eligibility Only (MC 263 PE for Pregnancy).</i></p> <p><i>If your patient answers "No" to question 2, or does not answer at all, you cannot offer Presumptive Eligibility for Pregnant Women coverage to the patient.</i></p> <p><i>You must complete the section below and give a copy of this form to the patient.</i></p>	

### WHY YOU CANNOT GET PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN BENEFITS (RESIDENCY)

You cannot get Presumptive Eligibility benefits because when you were asked to answer question 2 above:

- You said you do not live in California and do not plan to stay in this state, or
- You did not answer question 2 at all.

Even though you cannot get Presumptive Eligibility for Pregnant Women benefits, you may still apply for Medi-Cal at your county social services office, by telephone at 1-800-880-5305 or on-line through <http://www.benefitscal.org/BenefitsPortal/landing.html> or [www.healthapp.net](http://www.healthapp.net)

Provider Signature	Provider Printed Name	Date
--------------------	-----------------------	------

## **Presumptive Eligibility for Pregnant Women Program PATIENT FACT SHEET**

### **What is Presumptive Eligibility (PE) for Pregnant Women?**

PE for Pregnant Women is immediate, temporary pregnancy related health care for low-income women.

### **Who is eligible for PE for Pregnant Women?**

Any woman who thinks she is pregnant and whose family income is under a certain amount is eligible for PE for Pregnant Women. (For example, from April 2011 to March 2012 monthly income is \$2452 for a family size of two; a pregnant woman counts as two.) You must apply through a participating Qualified Provider. Ask your health care provider if they offer PE for Pregnant Women. Coverage starts the day of your first health care visit.

### **How long can I get PE for Pregnant Women?**

PE for Pregnant Women is good for the month you apply and all of the following month. Your Proof of Eligibility card will have the exact end date written on it. Your coverage will end on that date unless you apply for Medi-Cal. You must bring proof of your Medi-Cal application to your PE for Pregnant Women provider to extend your coverage. You only need to bring the proof one time. Your coverage will be extended until you get your plastic Medi-Cal card in the mail or the county denies your application.

### **What health care does PE for Pregnant Women cover?**

PE for Pregnant Women pays for pregnancy related care, including abortion and miscarriage. Most doctor, clinic, and emergency room visits are covered. Prenatal vitamins and most medications are covered. PE for Pregnant Women covers some dental and mental health visits related to pregnancy. PE for Pregnant Women does NOT cover hospital labor and delivery care or any other hospital in-patient care.

### **What if I get bills for health care services?**

You might get care that PE for Pregnant Women does not pay for. **Apply for Medi-Cal before your PE for Pregnant Women ends OR within three months of the date of the service (NOT the date of the bill—that might be too late).** Answer “yes” to the question on the Medi-Cal application form about medical expenses in the last three months, even if you have not received any bills yet. If you do not want Medi-Cal because you had a miscarriage or for any other reason, you should still apply for Medi-Cal and check “yes” for the three-month Medi-Cal coverage. Medi-Cal may cover health care received during the three months before your Medi-Cal application that PE for Pregnant Women does not cover.

### **What if I have already paid for my health care?**

After you apply and get Medi-Cal, ask your provider to bill Medi-Cal and give you back your money. If the provider will not, call or write the Medi-Cal Program in Sacramento about the *Conlan* Beneficiary Reimbursement Program.

For Medical Claims  
Department of Health Care Services  
Beneficiary Services  
P.O. Box 138008  
Sacramento, CA 95813-8008  
(916) 403-2007  
TDD: (916) 635-6491

For Dental Claims  
Denti-Cal  
Beneficiary Services  
P.O. Box 526026  
Sacramento, CA 95852-6026  
(916) 403-2007  
TDD: (916) 635-6491

**IF YOU WOULD LIKE PE FOR PREGNANT WOMEN OR TO APPLY FOR MEDI-CAL, ASK YOUR PROVIDER.**

## PROVIDER DIRECTIONS FOR PRESUMPTIVE ELIGIBILITY APPLICATION

Please complete patient name and date of birth below **before** separating Presumptive Eligibility Application (PREMED 1). Remember to hold the PREMEDCARD and Application for Medi-Cal Only (PREMED 2) in a secure place until the Presumptive Eligibility (PE) determination is completed.

When issuing the PREMEDCARD to eligible PE patients, please insert the last day of the month following the current month in the date block marked “FIRST GOOD THRU” (located underneath the Medi-Cal ID number in the lower right portion of the card). This date will ensure your patient is eligible for ambulatory prenatal care for up to sixty (60) days while she files her Medi-Cal application.

**Remember**, after you complete the PE eligibility determination and find the patient eligible, you must realign the PREMEDCARD with the rest of the forms package and press firmly so that the signature transfers to all the forms in the correct location. Only the Qualified Provider or an authorized representative may sign the PREMEDCARD. Signatures on the PREMED package may be carbons or originals, but no stamped or electronically produced.

**TOLL FREE NUMBER:** 1-800-824-0088

**FAX NUMBER:** 1-800-409-1498

*COMPLETE FORMS IN BLACK INK ONLY*

<b>MEDI-CAL IDENTIFICATION CARD PRESUMPTIVE ELIGIBILITY</b>	
DO NOT DESTROY THIS CARD/NO DESTRUYA ESTA TARJETA	
SIGNATURE/FIRMA: _____	DATE/FECHA: _____
THE PERSON NAMED ON THIS CARD IS ELIGIBLE TO RECEIVE BENEFITS UNDER PRESUMPTIVE ELIGIBILITY	
<b>VALID FOR AMBULATORY PRENATAL CARE AND PHARMACY SERVICES ONLY</b>	
	<p style="text-align: center; margin: 0;"><small>PROVIDER USE ONLY</small></p> <p>MEDI-CAL APPLICATION FILED: _____</p> <p>PE PROVIDER SIGNATURE: _____</p> <p>PE PROVIDER TITLE: _____</p> <p style="text-align: right; font-size: 1.2em; color: gray;">PROVIDER STAMP HERE</p> <p>SECOND GOOD THRU: _____</p>
	<p>MEDI-CAL ID: _____</p> <p>FIRST GOOD THRU: _____</p> <p>PATIENT NAME: _____</p> <p>DOB (MM/DD/YYYY): _____</p>
PE Provider Signature: _____	Date: _____
PE Provider Title: _____	

## APPLICATION FOR PRESUMPTIVE ELIGIBILITY ONLY

Before completing this application, read the directions. If you need help completing this form, please ask your provider for assistance.

SECTION A. APPLICANT INFORMATION				
Please list your Social Security number here if you have one: _____				
Home address:	Number	Street	City	ZIP code
Mailing address (if different):	Number	Street	City	ZIP code
Telephone number(s):	Home	Work	Message	
If no permanent address, tell us where you can be reached:				

SECTION B. HOUSEHOLD/INCOME INFORMATION	
1.	Please list in COLUMN I all family members (spouse, children, parents, siblings) living in your household, their relationship to you, and their date of birth.
2.	Has anyone ever asked for or gotten aid anywhere? <span style="float: right;">n YES   n NO</span> If YES, explain: under what name, where, when, and type(s) of aid.
3.	If you or any family member in your household receive earned or unearned income (include income from employment, self-employment, tips, commissions, pensions, Social Security, child/spousal support, gifts, disability, VA or unemployment benefits, etc.), list the total amount in COLUMN II under Gross Monthly Income, and where you got the money from under Source.

COLUMN I			COLUMN II	
Name: Last, First, Middle Initial	Relationship	Date of Birth	Gross Monthly Income	Source
	SELF			
	UNBORN			

If you need more space to answer, please write on the back of this sheet of paper and check this box.

*I CERTIFY I HAVE READ AND UNDERSTAND THIS FORM. I DECLARE THAT THE INFORMATION I HAVE PROVIDED IS TRUE, CORRECT, AND COMPLETE.*

Signature or mark of applicant (or legal guardian)	Date
Signature of witness to mark of applicant (or legal guardian)	Date

**STOP!! THIS COMPLETES YOUR APPLICATION FOR PRESUMPTIVE ELIGIBILITY STOP!!**

FOR PROVIDER USE ONLY			
Total Family Income: _____	Number in Family: _____	Income Eligible: <input type="checkbox"/> Yes <input type="checkbox"/> No	
MEDI-CAL ID: FIRST GOOD THRU: PATIENT NAME: DOB (MM/DD/YYYY):			
PE Provider Signature: _____	Pregnancy Test Results? <input type="checkbox"/> Positive <input type="checkbox"/> Negative		
PE Provider Title: _____	Date: _____	E.D.C.: _____	

**APPLICATION FOR MEDI-CAL PROGRAM ONLY**

If you are applying for the Medi-Cal Program only, please complete this form. If you wish to apply for other programs such as AFDC, do not complete this form; take this form to the County Welfare Department and tell the receptionist you wish to apply for these programs. NOTE: You must return this form (PREMED 2) to your County Welfare Department by the end of next month in order for PE coverage to continue. Please complete items 1 through 8 and sign the Certification and Perjury Statement below.

1. Home address: (number/street/city/ZIP code)	<b>COUNTY USE ONLY</b>  <b>COUNTY OF APPLICATION:</b>  Co. of Residence (If Different):  Date Received:  Case Name:  Case Number:  <b>TYPE OF APPLICATION</b> <input type="checkbox"/> Full  <input type="checkbox"/> Restricted  <input type="checkbox"/> MEDS CDB cleared  <input type="checkbox"/> IEVS initiated  <input type="checkbox"/> CWD records cleared  Ethnic Group:  Primary Language:
Mailing address if different: (number/street/city/ZIP code)	
2. Telephone number(s): (home/work/message)	
3. If no permanent address, tell us where you can be reached:	
4. Social Security number (SSN):	
5. How much liquid resources does everyone, including children, have? <input type="checkbox"/> Cash, uncashed checks or money orders \$ _____ <input type="checkbox"/> Checking/savings or credit union account(s) \$ _____ <input type="checkbox"/> Trust deeds, notes receivable, stocks or bonds \$ _____ <input type="checkbox"/> Other \$ _____ (explain):	
6. Has anyone ever asked for or gotten aid anywhere? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, explain: under what name, where, when, and type(s) of aid.	
7. Does anyone have a personal emergency: <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, what kind? <input type="checkbox"/> Medical <input type="checkbox"/> Pregnancy <input type="checkbox"/> Child Abuse <input type="checkbox"/> Spousal Abuse <input type="checkbox"/> Other Do you have another kind of emergency which threatens your health or safety <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, explain:	
8. The law says we must get your ethnic group and primary language. If you don't want to complete these items, the county will do it for you. This won't affect your eligibility. a. Ethnic Group: <input type="checkbox"/> White <input type="checkbox"/> American Indian or <input type="checkbox"/> Cambodian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific <input type="checkbox"/> Hispanic <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Japanese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Islander <input type="checkbox"/> Black <input type="checkbox"/> Asian Indian <input type="checkbox"/> Korean <input type="checkbox"/> Hawaiian (specify): _____ <input type="checkbox"/> Filipino <input type="checkbox"/> Chinese <input type="checkbox"/> Laotian <input type="checkbox"/> Guamanian _____ b. Language: <input type="checkbox"/> English <input type="checkbox"/> Cantonese <input type="checkbox"/> Lao <input type="checkbox"/> Tagalog <input type="checkbox"/> American Sign <input type="checkbox"/> Spanish <input type="checkbox"/> Cambodian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other (specify): _____	

• I certify that I understand and agree that I have to comply with eligibility rules. I understand that the statements I have made on this form may be checked and verified.  
 • I declare under penalty of perjury under the laws of the United States of America and the State of California that the information I have given on this form is true, correct, and complete.

Signature (or mark) of applicant or authorized representative	Date signed
Signature of witness to mark or interpreter	Date signed

**FOR PROVIDER USE ONLY—PREGNANCY VERIFICATION**

MEDI-CAL ID: \_\_\_\_\_  
 FIRST GOOD THRU: \_\_\_\_\_  
 PATIENT NAME: \_\_\_\_\_  
 DOB (MM/DD/YYYY): \_\_\_\_\_

PE Provider Signature: \_\_\_\_\_ Pregnancy Test Results?  Positive  Negative  
 PE Provider Title: \_\_\_\_\_ Date: \_\_\_\_\_ E.D.C.: \_\_\_\_\_

Provider Name	Provider Telephone Number
Provider Address	
Patient Name	
Patient Address	
Date	

***EXPLANATION OF INELIGIBILITY FOR THE  
PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN PROGRAM***

This is to advise you that based on the information you provided, you are not eligible for the Presumptive Eligibility for Pregnant Women program because of the reason checked below:

- Your total family income is more than 200 percent of the Federal Poverty Level for your family size.
- You are not pregnant.

Signature	
Name of person completing determination	Title

**NOTICE:**

You may be eligible for the regular Medi-Cal program or other county medical programs. You may apply in person at the social services agency in your county, by telephone at 1-800-880-5305 or on-line at <http://www.benefitscal.org/BenefitsPortal/landing.html> or [www.healthapp.net](http://www.healthapp.net)