MEDI-CAL ANNUAL REDETERMINATION FORM

You must fill out this form and return it to the county to keep your Medi-Cal!

Case Number *(optional)*	**Social Security Number** *(optional)*	
Print Your Full Name *(if you have not moved, put address label here if one is provided)*	**Birth Date** *(optional)* **(mm/dd/yyyy)**	
Current Street Address, Apartment Number ❑ *(check here if address is new)*	**City/State**	**Zip Code**
Mailing Address *(if different from above)*	**City/State**	**Zip Code**

Use ink and **PRINT** your answers. Make sure you sign and date the form. Use the postage paid envelope to return it. If you need more space, attach a separate sheet to this form. If you have any questions or need help filling out this form, call your worker at the telephone number listed on the Annual Redetermination Notice.

Section 1. Income

(a) Do you or any family member in the home get money from a job, child support or alimony, social security, veteran benefits, unemployment or disability benefits, retirement, gifts, or interest or dividends? ❑ Yes ❑ No

If yes, complete below and list each source of income on a separate line.

Attach most recent pay stubs showing income before taxes or deductions, benefit or award letters, checks received or signed statement from employer, or last year's federal income tax return. If income is from self-employment, send a copy of your most recent tax return or profit and loss statement.

Name of Person with Income *(include first and last name)*	**Source of Income**	**Income Amount** *(before any deductions)*	**How Often Paid** *(weekly, monthly, twice a month)*	**Hours Worked** *(per week or month)*

(b) Do you or any family member in the home get rent, utilities, food, or clothing entirely free? ❑ Yes ❑ No

If yes, who? _____

What was free? _____

(c) Was the free rent, utilities, food, or clothing received in exchange for work done? ❑ Yes ❑ No

Section 2. Expenses and Deductions

Do you or any family member in the home pay for child or adult care, health insurance or Medicare premiums, court-ordered child support or alimony, or educational expenses? ❑ Yes ❑ No

If yes, complete below and list each expense/deduction on a separate line.

Attach proof of expenses/deductions.

Name of Person with Expense/Deduction *(include first and last name)*	**Type of Expense or Deduction**	**Amount of Payment**	**Paid to Whom**	**How Often Paid** *(weekly, monthly, twice a month)*

Section 3. Other Health Insurance

(a) Did you or any family member have a change in, or get new health, dental, vision, or Medicare coverage or insurance within the last 12 months? ❑ Yes ❑ No

If yes, who has the coverage/insurance? _____

Which type of coverage/insurance? _____

(b) Is any family member living in the home receiving kidney dialysis-related services? ❑ Yes ❑ No

If yes, who? _____

(c) Has any family member living in the home received an organ transplant within the last 2 years? ❑ Yes ❑ No

If yes, who? _____

Section 4. Living Situation

(a) Did anyone move into or out of your home, move in with someone else, get married, or have a baby within the last 12 months? *(Examples: newborn, child, or adult moved in or out of the home, absent parent returns home.)* ❑ Yes ❑ No

If yes, complete below:

Name *(include first and last name)*	**Relationship to You**	**What Changed?**	**Date Changed**

(b) Does anyone in the home want Medi-Cal who is not already receiving it? ❑ Yes ❑ No

If yes, who? _____

(c) If a new baby is in home, where was the baby's place of birth? _____ (City) | _____ (State) | _____ (Country)

Section 4. Living Situation *continued*

(d) Did anyone in the home get inpatient care in a nursing facility or medical institution? ❑ Yes ❑ No

If yes, who? _____

(e) Is anyone in the home pregnant? ❑ Yes ❑ No

If yes, who? _____

Number of babies expected _____ Due date: _____

Section 5. Real or Personal Property

(a) Indicate the total amount of cash and uncashed checks held by any family member in the home $ _____

(b) Does anyone have a checking or savings account, life insurance, long-term care insurance, motor vehicle, court-ordered settlement or judgement, stocks, bonds, retirement funds, trusts where money or property is held for the benefit of any family member in the home, real estate, motor vehicles for a business, business accounts or property, promissory notes, mortgages, deeds of trust, recreational vehicles, burial trusts or funds, annuities, jewelry (not heirloom or wedding), or oil or mineral rights? ❑ Yes ❑ No

(c) Did you or any family member in the home sell or give away any money or property in the past 12 months, or have any of the items listed in this section been spent or used as security for medical costs? ❑ Yes ❑ No

Note: If you have answered "yes" to questions (b) or (c), you will also have to fill out a property supplement form, submit the form to the county and provide verification.

Section 6. Immigration or Citizenship Status Change

Has there been a change in immigration or citizenship status for anyone in the home that has Medi-Cal or wants Medi-Cal within the last 12 months? *(If your immigration status has changed, you might qualify for full scope Medi-Cal benefits.)* ❑ Yes ❑ No

If yes, list the name(s) below and send proof of new status.

Name of Person *(include first and last name)*	**Status Change** *(send proof of status)*

Section 7. Blindness/Disability/Incapacity

(a) Do you or any family member in the home have a physical or emotional condition that makes it difficult to work, take care of personal needs, or take care of your children? ❑ Yes ❑ No

If yes, who? _____

(b) Was the physical, mental, or health condition a result of an injury or accident? ❑ Yes ❑ No

If yes, explain _____

_____

Section 8. Other Health Program Information and Referrals

(a) Check this box if you do **not** want your child's information shared with the low-cost Healthy Families Program if your child gets Medi-Cal with a share of cost. ❑

(b) Do you want information on the no-cost health program for children under 21 *(Child Health and Disability Prevention Program, also known as CHDP?)* ❑ Yes ❑ No

(c) Do you want information on the no-cost supplemental food program for pregnant or breast feeding women and children under 5 *(Women, Infants, and Children Program, also known as WIC)?* ❑ Yes ❑ No

(d) Do you want information on the Personal Care Services Program, an in-home care program for aged, blind, or disabled persons (also known as In-Home Supportive Services)? ❑ Yes ❑ No

Section 9. Signature and Certification

Person completing this form must read and sign below.

➤ I have received and read a copy of the *Important Information for Persons Requesting Medi-Cal* form (MC 219).

➤ I am aware of, understand, and agree to meet all my responsibilities as described on the MC 219 form.

➤ I certify that I will report all income, property, and/or other changes that may affect Medi-Cal eligibility within ten days of the change.

➤ I understand that all of the statements, including benefit and income information, that I have made on this form, may be subject to investigation and verification.

➤ I declare, under penalty of perjury, under the laws of the State of California that all information provided on this form is true and correct.

Signature	**Date**

Daytime or Message Telephone Number	**Home Telephone Number** ❑ *(check here if new number)*

Signature of Witness *(if signed by a mark),* **Interpreter or Person Assisting**

— County Use Only —

Referrals

❑ HF ❑ WIC
❑ CHDP ❑ PCSP

Follow-up Forms

❑ MC 13 ❑ MC 210 PS ❑ Other:
❑ DDSD Packet