CONTRA COSTA HEALTH SERVICES
APPLICATION FOR HEALTH COVERAGE
BASIC HEALTH CARE • HEALTH COVERAGE INITIATIVE • MEDI-CAL EXPANSION • CHARITY • DISCOUNT

LAST NAME	FIRST NAME	MIDDLE NAME	DATE OF BIRTH	AGE

SOCIAL SEC. - LEAVE BLANK IF NONE - -	GENDER	ETHNICITY

HOME ADDRESS	CITY / STATE / ZIP	HOME PHONE ( )
MAILING ADDRESS	CITY / STATE / ZIP	CELL PHONE ( )

YOUR MAIDEN NAME	YOUR MOTHER'S MAIDEN NAME	NUMBER OF IMMEDIATE FAMILY MEMBERS LIVING IN YOUR HOME______. (COUNT SELF, SPOUSE AND CHILDREN - IF APPLICANT IS A CHILD COUNT CHILD, PARENTS, AND BROTHERS AND SISTERS.)

MARITAL STATUS ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner	NAME OF SPOUSE OR DOMESTIC PARTNER	SPOUSE LIVES WITH YOU ☐ No ☐ Yes

U.S. CITIZEN ☐ No ☐ Yes - CITY & STATE WHERE BORN ____________	IF NATURALIZED, CERT.#	PRIMARY LANGUAGE

PERMANENT RESIDENT ALIEN CARD OR I-94
☐ No ☐ Yes - **Card #:** **Issue Date:** **Exp. Date:**
IF YES, HAVE YOU LIVED IN THE UNITED STATES CONTINUOUSLY FOR THE PAST 5 YEARS? ☐ Yes ☐ No

COUNTRY WHERE BORN	STUDENT OR VISITORS VISA ☐ No ☐ Yes - **Exp. Date:**______________

ELIGIBILITY SCREENING FOR PUBLIC OR PRIVATE HEALTH INSURANCE

Do you have any medical insurance? ☐ ***Yes*** ☐ ***No***

If no, have you had medical insurance in the past 3 months other than Medi-Cal? ☐ ***Yes*** ☐ ***No***

If Yes, is your insurance an HMO / PPO? ☐ ***Yes*** ☐ ***No***

Name of Insurance______________________________ Group #______________ Policy #______________

Billing Address________________________________ City/State/Zip______________________________

Subscriber's Name ____ SS No._______-_______-__________

Are you now receiving Medi-Cal or Medicare? MEDI-CAL OR MEDICARE #________________________ ☐ ***Yes*** ☐ ***No***

Are you now receiving Social Security Disability or SSI? DATE STARTED RECEIVING________________ ☐ ***Yes*** ☐ ***No***

Are you pregnant? ☐ ***N/A*** ☐ ***Unknown*** ☐ ***Yes*** ☐ ***No***

Are you a refugee living in the U.S. for less than 9 months? ☐ ***Yes*** ☐ ***No***

Are you now disabled? ☐ ***Yes*** ☐ ***No***

If Yes, have you been or do you expect to be disabled for 1 year or longer? ☐ ***Yes*** ☐ ***No***

Have you applied for Social Security Disability or SSI? DATE APPLIED________________ ☐ ***Yes*** ☐ ***No***

Have you applied for Medi-Cal because you are disabled? DATE APPLIED________________ ☐ ***Yes*** ☐ ***No***

Do you have children living in your home who are under 21 years of age? ☐ ***Yes*** ☐ ***No***

If Yes, are both parents living in the home? ☐ ***Yes*** ☐ ***No***

If both parents live in the home, are both parents working full-time? ☐ ***Yes*** ☐ ***No***

Is either parent unemployed or temporarily unable to work for 30 days or more or working part-time? ☐ ***Yes*** ☐ ***No***

Is either parent legally blind or permanently disabled? ☐ ***Yes*** ☐ ***No***

If you are not the parent, are you a relative of the child(ren) and have legal custody? ☐ ***Yes*** ☐ ***No***

Please turn over and complete backside

INCOME, ASSETS & REAL PROPERTY

IF THE APPLICANT IS A CHILD, USE PARENTS' INCOME/ASSETS FOR ALL FINANCIAL QUESTIONS ON THIS FORM

List employment information below for both you and your spouse (or for your parents).

If you have more than one job, attach a separate piece of paper with that information.

If you do not work, tell us where and when you worked last:

WHERE____ **WHEN**____________________

	YOUR (OR PARENT'S) JOB INFORMATION	SPOUSE'S (OR PARENT'S) JOB INFORMATION
EMPLOYER'S OR BUSINESS NAME		
EMPLOYER'S OR BUSINESS ADDRESS		
TYPE OF EMPLOYMENT		
GROSS EARNINGS PERPAY PERIOD (INCLUDE TIPS)		
HOW OFTEN PAID	☐ Monthly ☐ Twice a Month ☐ Weekly ☐ Every 2 Weeks	☐ Monthly ☐ Twice a Month ☐ Weekly ☐ Every 2 Weeks

Complete this section if you are self-employed

ADJUSTED GROSS INCOME/LAST TAX STMT	INCOME CHANGE SINCE LAST TAX STATEMENT	ESTIMATED ANNUAL PROFIT	CHECKING/SAVINGS BUS. ACCT. BALANCE	AVERAGE ANNUAL CASH BUS. EXPENSES
$	☐ ***Yes*** ☐ ***No***	$	$	$

Please list the amount of income you or your spouse (parents of child) receive monthly from any of the following:

If you have no source of income or support, please enclose a written statement as to how you are supporting yourself.

A. $_________ Child Support
B. $_________ General Assistance
C. $_________ Interest Earned Income
D. $_________ IRA
E. $_________ Loans or Grants
F. $_________ Pension
G. $_________ Railroad Retirement
H. $_________ Soc. Sec. Disability
I. $_________ Soc. Sec. Retirement
J. $_________ Spousal Support
K. $_________ SSI / SSP
L. $_________ State Disability Ins.
M. $_________ Strike Benefits
N. $_________ Training Payments
O. $_________ Unemployment
P. $_________ Workers Comp.
Q. $_________ Other__________

Are you homeless?.. ☐ ***Yes*** ☐ ***No***

Do you live with someone who provides you with free room and board?.................. ☐ ***Yes*** ☐ ***No***

If Yes, Name ____________________________________ Relationship_________________

Address______________________________________ City/State/Zip___________________

Please list below the amount of all liquid assets for you & your spouse (parents of child):

A. $_________ Checking
B. $_________ Savings/Credit Union
C. $_________ Stocks / Bonds
D. $_________ Cert. of Deposit
E. $_________ IRAs
F. $_________ 401K / Retirement
G. $_________ Trust Deeds
H. $_________ Trust Funds
I. $_________ Mortgages
J. $_________ Whole Life Insurance
K. $_________ Other______________

Do you own **more** than one vehicle for yourself and one for your spouse? .... ☐ ***Yes*** ☐ ***No***

If Yes, list cars, trucks, motorcycles, boats, trailers, etc. (not used as a home).

MAKE/MODEL	YEAR	CLASS	AMT. OWED	USED AS TRANSPORTATION / EXPLAIN "NO" ANSWER
			$	☐ ***Yes*** ☐ ***No:***
			$	☐ ***Yes*** ☐ ***No:***
			$	☐ ***Yes*** ☐ ***No:***

Do you or your spouse own any real property (for example, house, land, building, trailer, mobile home) that you do not live in? .... ☐ ***Yes*** ☐ ***No***

If Yes, Description ______________________________ Full Value FROM TAX STATEMENT $_________

Address_______________________________________ City/State/Zip____________________

Amount Owed $_____________ Rent collected each month $______________

Do you or your spouse **pay** court-ordered child / spousal support? ☐ ***Yes*** ☐ ***No***

If Yes, ☐ self ☐ spouse paid $ ________ this month to________________________________

If I deliberately make false statements or withhold information, I may lose my coverage, be billed for all services received and be prosecuted for fraud. I declare under penalty of perjury that all the answers that I have given are true and correct. I have read, signed and received a copy of the "Rights and Responsibilities" for the Contra Costa Health Coverage program. I understand that a Financial Counselor will determine which program I qualify for and will notify me in writing.

____ ____________________

SIGNATURE OF APPLICANT (PARENT) DATE OF APPLICATION

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IF APPLYING FOR A CHILD, PRINT NAME OF PARENT

3/28/11
C128 / AR19-0
29

File Specification Information

Document Size	Gripper / Lock-Up	Stub	Imprint
8.5 x 11	ALL	N	NA
Punch	Numbering	Binding	Registering Plys
N	N	NA	N
Screens	Backer(s) and Percentage		
N	HH - FV - DIFFERS		
Color(s)			
BLK			
File Information / Master Page			
FILE PROVIDED BY LEEANNE ON 8-19-02 12 PT FONT			
Other			