MEDI-CAL STATUS REPORT

ATTENTION: STATE LAW REQUIRES YOU TO COMPLETE A MID-YEAR STATUS REPORT

YOU MUST RETURN THIS FORM BY_____ TO KEEP YOUR MEDI-CAL. PLEASE PRINT AND USE INK.

Notice Date: _____
Case Number: _____
Worker Name: _____
Worker Number: _____
Worker Telephone Number: _____
Office Hours: _____

Do not fill out this form if the only persons in your family receiving Medi-Cal are aged 65 or older, blind, children under the age of 21, CalWORKs recipients or someone who has already reported their pregnancy or disability to their Medi-Cal worker.

To keep your Medi-Cal, you are required to fill out this form if you are a parent who receives Medi-Cal. Tell us about changes you have had in the last 6 months. If you need help filling out this form, call your worker. Your worker's name and telephone number are listed above.

Section 1: If you have no changes to report in the last 6 months:

- Review items listed in Section 2 (go to back side).
- If no changes to report, check this box ☐ **No Changes**
- Do NOT fill out Section 2.
- Go to Section 3 on back side. You must sign and date this form.
- Return the completed form to the county by the date on the top of this page.
- Use the enclosed pre-addressed envelope. No stamps are needed.

If you DO have changes to report in the last 6 months

- Go to the back side. Fill out Section 2.
- Go to Section 3. You must sign and date this form.
- Return the completed form to the county by the date on the top of this page.
- Do not send any documents.
- Use the enclosed pre-addressed envelope. No stamps are needed.

REMEMBER: You must sign the back of this form **GO TO BACK SIDE ▶**

DO NOT SEND ANY DOCUMENTS WITH THIS FORM

Section 2: Check "Yes" for all changes in the last 6 months and explain

Income Changes ☐Yes
Did you or a family member in the home get more or less money from a job, child support or alimony, social security, veteran benefits, unemployment or disability benefits, retirement, gifts or interest or dividends?
Please Explain:

Expenses Paid Changes ☐Yes
Have you or any family member in the home changed the amount paid for child or adult care, health insurance, court-ordered child support, alimony or educational expenses?
Please Explain:

Living Situation Changes ☐Yes
Did anyone move into or out of your home, move in with someone else, get married, or have a baby?
Please Explain:

If yes, do they want Medi-Cal? [ ] Yes [ ] No

Other Changes ☐Yes
Did someone in your household have a change in the amount of property they have (for example; money in bank accounts, vehicles, real estate, etc.), their immigration status or other health insurance benefits?
Please Explain:

Disabled ☐Yes
Has anyone in your household become mentally or physically disabled? If yes, who?

Pregnant ☐Yes
Has anyone in your household become pregnant? If yes, who?
What is the expected due date?
How many babies are expected?

Section 3: Signature and Certification

I understand that I must report all changes in income, property, and/or other changes to the county. I declare under penalty of perjury that all information provided above is true and correct.

Signature:_____ Phone: ( )_____ Date:_____

Witness Signature:_____ Phone: ( )_____ Date:_____
(If person signed with a mark)

Signature of person acting for Beneficiary:_____ Relationship to Beneficiary_____ Date:_____