MEDI-CAL TUBERCULOSIS PROGRAM

APPLICATION

If you are applying only for the Medi-Cal Tuberculosis Program, please complete this form.

NOTE: You must be a U.S. citizen or have satisfactory immigration status to receive benefits under this program.

1. PATIENT/APPLICANT NAME:		
2. MAILING ADDRESS:	City/State:	ZIP Code:
3. IF NO PERMANENT ADDRESS, TELL US WHERE YOU CAN BE REACHED.		
4. Telephone Number:		
5. DATE OF BIRTH:	6. SOCIAL SECURITY NUMBER	

7. THE LAW SAYS WE MUST GET YOUR ETHNIC GROUP AND PRIMARY LANGUAGE. IF YOU DO NOT WANT TO COMPLETE THESE ITEMS, THE COUNTY WILL DO IT FOR YOU. THIS WILL NOT AFFECT YOUR ELIGIBILITY.

a. Ethnic Group: ☐ White ☐ Black ☐ Hispanic ☐ Filipino ☐ Chinese
☐ Hawaiian ☐ Asian Indian ☐ Laotian ☐ Cambodian
☐ Japanese ☐ American Indian or Alaskan Native ☐ Pacific Islander
☐ Guamanian ☐ Samoan ☐ Vietnamese ☐ Korean
☐ Other (specify): _____

b. Language: ☐ English ☐ Cantonese ☐ Lao ☐ Tagalog ☐ Spanish
☐ Cambodian ☐ Vietnamese ☐ American Sign
☐ Other (specify): _____

If applicant is under 18 years of age, parent/spouse information:

Name:

ORIGINAL—County Welfare Department *COPY—Provider* *COPY—Patient*

Address:	City/State	Zip Code

CERTIFICATION AND PERJURY STATEMENT	
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.	
Applicant or Authorized Representative Signature:	Date signed:

MEDI-CAL TUBERCULOSIS PROGRAM

REFERRAL

COUNTY USE ONLY

EW name: _____

EW number: _____

Case number: _____

This form must be completed in order to determine the person's eligibility for the Medi-Cal Tuberculosis Program.

Please print clearly.

PATIENT NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

PATIENT CONSENT

I consent to this information being forwarded to the county welfare office.

SIGNATURE OF PATIENT OR PARENT/GUARDIAN (if patient is under 18 years of age)

➢

PROVIDER USE ONLY

If either question is answered "Yes," the patient,_____ , is Tuberculosis infected.

1. Requires preventive therapy for Tuberculosis infection. ☐ Yes ☐ No

2. Requires treatment for active Tuberculosis. ☐ Yes ☐ No

RETROACTIVE ELIGIBILITY

This person has been under therapy for Tuberculosis within the past three months prior to application.

☐ Yes—Date Tuberculosis therapy began: _____

☐ No

Provider or clinic staff: Please complete the MC 210 A if answer to the above question is "Yes" and patient believes he/she is eligible for retroactive benefits.

If this person is Tuberculosis infected, please mail Parts A, B, and C of the MC 274 TB form to the local county welfare office for a Medi-Cal determination under the Tuberculosis program.

PHYSICIAN NAME (Please stamp, print, or type.)	TELEPHONE NUMBER

ORIGINAL—County Welfare Department *COPY—Provider* *COPY—Patient*

PHYSICIAN TITLE	MEDI-CAL PROVIDER NUMBER	DATE

PROVIDER ADDRESS (Number/Street)	City/State	ZIP Code

AUTHORIZED PROVIDER SIGNATURE

ORIGINAL—County Welfare Department *COPY—Provider* *COPY—Patient*

MEDI-CAL TUBERCULOSIS PROGRAM AUTHORIZATION FOR CLINIC ASSISTANCE

I hereby designate any staff member, authorized by the clinic to perform intake and/or treatment functions, to assist me in my application for Tuberculosis Program benefits at no cost to me.

This assignment enables the authorized clinic staff to:

- Submit request verifications to the county welfare department;
- Assist me in the completion of the "Application for Medi-Cal Tuberculosis Program" and MC210, Statement of Facts forms; and
- Obtain information from the county welfare department regarding the status of my application.

I understand that I do not have to apply for Medi-Cal benefits under this program and that I will not be denied treatment if I choose not to apply. I also understand that I have the responsibility to complete and sign the Statement of Facts and to provide all requested verifications before my Medi-Cal eligibility can be determined.

I hereby state that I make this assignment voluntarily and that I may revoke it at any time by notifying my Medi-Cal eligibility worker and the clinic.

Signature of Applicant:	Date:
Signature of Authorized Clinic Staff Assistant:	Name of Clinic:
Clinic Address:	Clinic Telephone Number:

ORIGINAL—County Welfare Department *COPY—Provider* *COPY—Patient*