**Presumptive Eligibility for Pregnant People Program Application**

If you need help filling out this form, please ask your provider for help.

## APPLICANT INFORMATION

| Last Name | First Name | Middle Name | Date of Birth (mm/dd/yyyy) |
|---|---|---|---|
| | | | |

**Social Security Number (optional)**

**Do You Live in California?** Yes No

**What County Do You Live In?**

| Home Address Number and Street | City | State | Zip Code |
|---|---|---|---|
| | | | |

| Mailing Address (if different) Number and Street | City | State | Zip Code |
|---|---|---|---|
| | | | |

| Phone Number | Other Phone Number | Email Address |
|---|---|---|
| | | |

☐ If experiencing homelessness, check the box and indicate (above) where to send any written correspondence.

**What language do you speak best?**

**What language do you read best?**

☐ If "Safe at Home" participant, check the box and answer the questions below.

1. What is your P.O. Box address, if known?
2. What is your Safe at Home Participant ID, if known?

## MEDI-CAL

**Do you have a Benefits Identification Card (BIC)?** Yes No

**What is the identification number on the card?**

**Have you received presumptive eligibility services during this current pregnancy?** Yes No

## FAMILY MEMBERS

**Please list all family members below (Include: your spouse and any children under age 21 living with you)**

| Last Name | First Name | Middle Initial | Relationship to you |
|---|---|---|---|
| | | | Self |
| No need to list names of unborn child/ren | | | If expecting multiple births, how many children are you expecting? |

| | | | |
|---|---|---|---|
| | | | Spouse |
| | | | Child |
| | | | Child |
| | | | |

| | |
|---|---|
| **If you need more space to answer, please write on the back of this form or a separate sheet of paper and check this box.** | **Total Number of Family Members** (including all unborn children in the household) |

**ANNUAL OR MONTHLY INCOME**

| | | |
|---|---|---|
| **Please include money you and/or family members listed on this application receive from jobs, tips, commissions, pensions, Social Security, spousal support, or unemployment benefits.** | **Annual Income** | **Monthly Income** |

**SIGNATURE AND DECLARATION**

**By signing, I declare that what I provided below is true and correct.**

- **I have read and understand this Presumptive Eligibility for Pregnant People Medi-Cal Application.**
- **I have received the insurance affordability program application.**
- **I understand that I must complete and submit the Medi-Cal or insurance affordability application by the end of my Presumptive Eligibility period to be eligible for continued coverage.**
- **The information I provided is true, correct, and complete.**

| | |
|---|---|
| **Signature** | **Date** |
| **Signature of Witness** | **Date** |

**PROVIDER USE ONLY**

| Did the patient self - attest to pregnancy? | Was a pregnancy test given today? | If a test was given, what was the result? | Expected Date of Delivery (mm/dd/yyyy) |
|---|---|---|---|
| Yes No | Yes No | Positive<br>Negative | |

An individual has a right to review records containing their personal information. The official entity responsible for keeping the information contained in this application is the California Department of Health Care Services and Covered California. This information may be shared with the County Department of Social Services in the county in which the individual resides. The individual's medical information will be kept with the Presumptive Eligibility for Pregnant People Provider and Covered California.