State of California
Health and Human Services Agency

Department of Health Care Services

PRESUMPTIVE ELIGIBLITY FOR PREGNANT WOMEN 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)

Live in California? ☐ Yes ☐ No

County 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 homeless, 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

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 Women 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 in order 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	☐ Yes ☐ No	

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, MS 8100, P.O. Box 997413, Sacramento, CA 95899-7413. 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 Women provider and Covered California.