Annual Eligibility Review Form

To continue your Healthy Families health care coverage

Instructions

To continue Healthy Families coverage, you must fill out this form, attach all papers, and mail everything to us so that we receive it by

Questions?

If you have any questions about the form, call Healthy Families: ***1-888-439-4741,*** *Monday to Friday, 8 a.m. to 8 p.m., or on Saturday from 8 a.m. to 5 p.m. The call is free.*

Mailing

Residence

,

FAMILY MEMBER NUMBER:

Home: Work: Message:

Are your name and address right?

If any of this is wrong, please cross it out. Write the correct information next to it.

1. Children *now* in Healthy Families.

Do the children listed below still live in your household? If not, cross out their names. Do any of the children have income? For example, child support. If so, write their income. You need to mail proof of income with this form. *If you have questions about income, see the* ***Family Members and Income*** *brochure that came with this form.*

Child *in* Healthy Families	Date of Birth	Relationship to	Child's monthly income, if any

2. Have any of these persons received health insurance sponsored by an employer within the last 3 months? ❑ **Yes** ❑ **No**

If yes, which persons? _____

When did the insurance end? _____ Why did it end? _____

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3. Income of Applicant and other adult.

Fill in the information below. You need to mail proof of income with this form. *If you have questions about income or about who counts as an adult living in the home, see the* ***Family Members and Income*** *brochure that came with this form.*

If the adults below do not live in the house, please cross them out and add the names of adults who live in the house.

Adult family member living in the house	Relationship to	Relationship to children	Gross income amount (income before taxes)	How often do you get income?
	Applicant	❑ Parent ❑ Stepparent ❑ Other _____	$ Send proof of income	❑ once every week ❑ every two weeks ❑ twice a month ❑ once a month
		❑ Parent ❑ Stepparent ❑ Other _____	$ Send proof of income	❑ once every week ❑ every two weeks ❑ twice a month ❑ once a month

4. Children living in the house who are <u>not</u> in Healthy Families now.

- Cross out any children who don't live in the house anymore. *Note:* If a child is away at school and claimed as a tax dependent, the child is considered living in the home.
- Fill in children's monthly income if they have income.
- Would you like any of these children to be in Healthy Families? Check the Yes box or the No box.
- If you want a child to be in Healthy Families who is not listed here, you need to fill out the **Add a Person form**.

Child *not* in Healthy Families	Date of Birth	Relationship to	Child's monthly income, if any	Want child in Healthy Families?

5. Have any of these persons received health insurance sponsored by an employer within the last 3 months? ❑ Yes ❑ No

If yes, which persons? _____

When did the insurance end? _____ Why did it end? _____

6. Are there children living in the house *who* are not listed in Questions 1 or 4?

- If there are other children in the house list them here. *If you have questions about who to list, see the* ***Family Members and Income*** *brochure that came with this form.*
- If you or the other adult in the household is pregnant, write "Unborn child" in the Child area below.
- If you would like to apply for these people now, check the Yes box. You will need to fill out the **Add a Person form.**

Child who *is not* in Healthy Families	Date of birth	Child's monthly income, if any	Relationship to	Want child in Healthy Families?
		$ Send proof of income	❑ child ❑ step child ❑ other	❑ Yes ❑ No
		$ Send proof of income	❑ child ❑ step child ❑ other	❑ Yes ❑ No
		$ Send proof of income	❑ child ❑ step child ❑ other	❑ Yes ❑ No

7. Is anyone else in your household pregnant? ❑ Yes ❑ No

If yes, write the name of the person who is pregnant _____

8. Income Deductions for expenses.

If you pay for child care or care for a person who is disabled, or if you pay court-ordered child support or alimony, you might be able to subtract (deduct) those costs from your household income. Fill in the information below. Only list expenses paid by the parents on this form. You need to mail proof of expenses with this form. Proof might be copies of your bills or copies of a court order. *If you have questions about deductible expenses, see the* ***Family Members and Income*** *brochure that came with this form.*

Child care expenses you pay each month for children under age 2. (The maximum amount allowed is $200 per child.)	$ Send proof of expense
Child care expenses you pay each month for children age 2 and over. (The maximum amount allowed is $175 per child.)	$ Send proof of expense
Disabled dependent care expenses you pay each month. (The maximum amount allowed is $175 per person receiving care).	$ Send proof of expense
Monthly court ordered alimony you pay	$ Send proof of expense
Monthly court ordered child support you pay.	$ Send proof of expense
For each working parent, we will deduct up to $90 for work-related expenses.	

9. Sign the form.

I, the applicant, certify that the information provided is true and correct. I understand that a change in income from last year may result in a change in monthly premium or may make my child(ren) ineligible for the Healthy Families Program.

➨ Signature: _____ Date: _____

10. Read these statements and sign your name below each statement if it is true.

Authorization to forward Annual Eligibility Review form to Medi-Cal:
If my child is ineligible for Healthy Families because my income is below Healthy Families guidelines, I request that this form be forwarded to the county and treated as a Medi-Cal application. I declare under penalty of perjury that the information on this form is true and correct to the best of my knowledge and belief.

➨ Signature: _____ Date: _____

Medi-Cal needs Social Security Numbers. If you want your children to get Medi-Cal, go back to Questions 1, 4 and 6 and write the Social Security Number next to each child's name.

Permission to share information with the following application assistant:
I give permission to Healthy Families to share information about what is happening with my Annual Eligibility Review (AER) with:

Name: _____

➨ Signature: _____ Date: _____

Certified Application Assistance:
(Reimbursement is subject to the Healthy Families Program's budget appropriations. The state will not issue a reimbursement unless this section is completely filled out at the time this form is submitted.)

I certify that I had help completing this form by the Certified Application Assistant (CAA) listed below. This CAA help was free of charge.

CAA# _____ EE# _____ CAA's Signature _____

11. Mail or fax the form to Healthy Families.

Mail the form, proof of income papers and proof of expenses papers to:

Healthy Families
PO Box 138010
Sacramento, CA 95813-8010

Or, you can fax the form and papers to:

Fax: 1-866-848-4975 The fax number is free.

Write your Family Member Number on each paper you send. Your Family Member Number is: