PUBLIC ASSISTANCE SCREENING FORM

INSURANCE ASSISTANCE SECTION

Please print clearly and answer all questions. Failure to provide complete information may delay processing of your application and receiving insurance premium assistance.

Applicant's Name (First, MI, Last)	Date of Birth (mm/dd/yyyy)	Mother's Maiden Name

I. Medi-Cal Screening

Does applicant currently receive Medi-Cal: ☐ Yes ☐ No

Has applicant recently applied for Medi-Cal: ☐ Yes ☐ No If yes, Date:
Type of proof attached: Status: ☐ Denied ☐ Pending

Was applicant referred to apply: ☐ Yes ☐ No If yes, referral date:

If not referred to apply for Medi-Cal, select the specific reason and indicate the documentation provided to support the Medi-Cal non-referral reason:

☐ Disability Denial ☐ Excess Assets ☐Employed ☐ Receiving Unemployment ☐ Ineligible Immigrant

Medi-Cal non-referral proof:

☐ Medi-Cal, SSI, SSDI disability denial letter ☐ Excess assets documentation
☐ Employment income documentation ☐ Unemployment insurance documentation ☐ Other

II. Medicare Screening

Does applicant currently receive Medicare?
☐ Yes ☐ No
Will the applicant qualify for Medicare in the next 12 months?
☐ Yes ☐ No
Is the applicant currently receiving income from Social Security Disability Insurance (SSDI)?
☐ Yes ☐ No

III. Veteran's Administration (VA) Screening

Is applicant eligible for Veteran's Administration (VA) health care benefits?
☐ Yes ☐ No
Is applicant able to access health care services and prescription medications through the VA system?
☐ Yes ☐ No If no explain here:

Please note that the information on this form is being collected to determine eligibility for benefits under the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87) and is required by the California Department of Public Health (CDPH), Office of AIDS (OA). The information will be used to determine eligibility for insurance assistance. Failure to provide the mandatory information may result in the application not being processed. You have the right to review the information maintained by CDPH unless access is exempt by law. To access the information contact CDPH Insurance Assistance Section, MS 7704, P.O. Box 997426, Sacramento, CA 95899-7426, or by phone at (800) 367-2437.

I certify that the information on this form is true and correct to the best of my knowledge. I understand that failure to provide accurate information may result in termination of insurance premium assistance.

_____ _____
Applicant's Signature Date