APPLICANT'S SUPPLEMENTAL STATEMENT OF FACTS FOR MEDI-CAL

County Use Only

County Number/Aid Code/Case Number

— —

PART I—PERSONAL INFORMATION

1a. Applicant Name (Last, First, MI)	1b. Social Security Number — —		1c. Date of Birth / /
1d. Other Name(s) used (Last, First, MI)	1e. Sex ❑ Male ❑ Female	1f. Height Feet Inches	1g. Weight Pounds
2a. Home address City State ZIP Code			
2b. Mailing address (if different) City State ZIP Code			
3. Daytime telephone number ( )	Check if: ❑ No Phone ❑ Message Phone ( )		Best time to call
4a. Do you speak English? ❑ Yes **If YES, go to Part II** ❑ No **If NO, what language(s) do you speak:**	4b. Do you have an interpreter? ❑ Yes ❑ No	If YES, interpreter's name: / Interpreter's phone number: ( )	Best time to call

PART II—MEDICAL INFORMATION

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5. Have you applied for Social Security Disability or Supplemental Security Income (SSI) Disability benefits in the past two (2) years? ❑ Yes ❑ No

If YES, please answer the following:

a. Was/Is your Social Security or SSI Disability application:
❑ Approved? ❑ Denied? ❑ Pending? ❑ On Appeal? ❑ Unknown?

b. If approved or denied, give the date of the most recent decision on your Social Security or SSI disability application:

c. Has your medical problem(s) worsened since the date in 5b above? ❑ Yes ❑ No

If YES, please explain:

d. Do you have any NEW medical problem(s) since the date in 5b, above, which you did NOT have when your Social Security or SSI disability decision was made? ❑ Yes ❑ No

If YES, what medical problem(s)?

6. List all medical problems (physical or mental) that keep you from working or taking care of your personal needs. (Please attach additional sheet, if necessary.)

MEDICAL PROBLEM(S)	WHEN DID IT START (Month/Year)

7. Have you received care in a clinic or hospital for your illness(es) or injury(ies) in the last 12 months? ❑ Yes ❑ No

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If YES, please fully answer the following:

Name of clinic/hospital

Patient/clinic or member number

Clinic/hospital telephone number ( )

Name of doctor(s) seen

ADDRESS of clinic/hospital (number, street, suite) City State ZIP Code

Date first seen | Date last seen | Date of next appointment

Reason for the visit(s)

Did you stay in the hospital overnight? ❑ Yes ❑ No

If YES, date(s) entered: date(s) left:

Were you seen in the emergency room? ❑ Yes ❑ No

If YES, date(s) seen:

List **ALL** medicines received:

List **ALL** treatments received and the dates the treatments were received:

8. List any additional clinic or hospital where you have been seen in the last 12 months.

❑ MC 220 Signed

Name of clinic/hospital

Patient/clinic or member number

Clinic/hospital telephone number ( )

Name of doctor(s) seen

ADDRESS of clinic/hospital (number, street, suite) City State ZIP Code

Date first seen | Date last seen | Date of next appointment

Reason for the visit(s)

Did you stay in the hospital overnight? ❑ Yes ❑ No

If YES, date(s) entered: date(s) left:

Were you seen in the emergency room? ❑ Yes ❑ No

If YES, date(s) seen:

List **ALL** medicines received:

List **ALL** treatments received and the dates the treatments were received:

If you have been seen at additional clinics or hospitals in the last 12 months, complete page 8.

9. Have you been seen by any doctor outside of the clinic(s) or hospital(s) you have already listed in the last 12 months? ❑ Yes ❑ No

If NO, go to number 10. If YES, please fully answer the following, if more than one doctor was seen please complete page 8 for all additional information:

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Name of doctor(s)

Patient/clinic or member number

Doctor's telephone number
( )

ADDRESS of clinic/hospital (number, street, suite) City State ZiP Code

Date first seen | Date last seen | Date of next appointment

Reason for the visit(s)

List **ALL** medicines received:

List **ALL** treatments received and the dates the treatments were received:

10. Please list below if you have had any of the following tests in the last 12 months. Be sure to check yes or no next to each test. **(IF ADDRESS OF DOCTOR, CLINIC, OR HOSPITAL WAS GIVEN ALREADY, LIST <u>ONLY</u> THE NAME AND DATE.)**

TEST PERFORMED	YES	NO	NAME AND ADDRESS OF OFFICE, CLINIC, OR HOSPITAL WHERE TEST WAS COMPLETED	DATE (MO/YR)	
Electrocardiogram (EKG)			Name Address (number, street, suite) City State ZiP Code		❑ MC 220 Signed
Treadmill (Exercise heart test)			Name Address (number, street, suite) City State ZiP Code		❑ MC 220 Signed
Chest X-ray			Name Address (number, street, suite) City State ZiP Code		❑ MC 220 Signed
Breathing Test (PFT)			Name Address (number, street, suite) City State ZiP Code		❑ MC 220 Signed
Blood Tests			Name Address (number, street, suite) City State ZiP Code		❑ MC 220 Signed
Other (Specify)			Name Address (number, street, suite) City State ZiP Code		❑ MC 220 Signed

11. Have you had any other medical treatment or testing in the past 12 months? ❑ Yes ❑ No

If **NO**, go to number 12.
If **YES**, complete page 8.

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12. Is there anyone else (a friend, relative, social worker, rehab counselor, attorney, physical therapist, etc.) we may contact for information regarding your illness or injury and how it limits your daily activities or keeps you from working? ❑ Yes ❑ No

If YES, please list below:

Name

Address (number, street, suite)

Telephone number ( )	Relationship to you

Name

Address (number, street, suite)

Telephone number ( )	Relationship to you

Name

Address (number, street, suite)

Telephone number ( )	Relationship to you

13. You may be asked to go to additional medical examinations to help evaluate your medical problem(s). (These examinations are free to you.)

Are you willing to go to additional medical examinations if needed? ❑ Yes ❑ No

PART III—SOCIAL AND EDUCATIONAL INFORMATION

14. Describe your daily activities and tell us how much your condition limits your activities.

15. Describe your educational background.

a. Check the highest grade you finished in school:

❑1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑10 ❑11 ❑12 or

❑ GED (same as finishing 12th grade) ❑12+

b. When finished? Month/Year:

c. Did you take special education classes? ❑ Yes ❑ No

16. Have you done any type of work for more than 30 days during the last 15 years? (This includes work done in another country.)

❑ Yes ❑ No

If **NO**, skip Part IV, go to Part V, page 7, for your signature.
If **YES**, answer Part IV, page 5, beginning with number 17.

PART IV—WORK HISTORY I

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17. Describe all of the jobs you have done for at least 30 days during the **last 15 years**. Start with your most recent job. (If you had more than two jobs, ask your county worker for additional pages.)

a. Job Title	Type of Business
Dates Worked (month/year) From: To:	Hours Per Week Rate of Pay Per hour/wk/mo

DESCRIPTION OF THE JOB (This is what I did and how I did it.)

These are the tools, machines, and equipment I used:

I took this long to learn the job for: day(s) or month(s).

I wrote, completed reports, or performed similar duties: ❑ Yes ❑ No

I had supervisory responsibilities: ❑ Yes ❑ No

PHYSICAL ACTIVITY

	(Circle One)
I walked this many hours in an average workday:	0 1 2 3 4 5 6 7 8
I stood this many hours in an average workday:	0 1 2 3 4 5 6 7 8
I sat this many hours in an average workday:	0 1 2 3 4 5 6 7 8

I climbed this much in an average workday: ❑ Never ❑ Occasionally ❑ Frequently ❑ Constantly

I bent over this much in an average workday: ❑ Never ❑ Occasionally ❑ Frequently ❑ Constantly

Heaviest weight I lifted: ❑ 10 lbs ❑ 20 lbs ❑ 50 lbs ❑ Over 100 lbs

I often lifted/carried up to: ❑ 10 lbs ❑ 20 lbs ❑ 50 lbs ❑ Over 100 lbs

Did you have any of your current medical problem(s) when you performed this job? ❑ Yes ❑ No

If NO, and you have had NO other jobs go to Part V, page 7, for your signature.

If NO, but you have had other jobs, go to 17b, next page.

If YES, please complete the following information.

Name of medical problem(s):

Did your employer make special arrangements (such as extra breaks, special equipment, change in job duties, etc.) so you could continue to work? ❑ Yes ❑ No

If YES, describe the special arrangements made:

Did you have to stop working because of your medical problem(s)? ❑ Yes ❑ No

If YES, when? Month Day Year

Have you done **any** other work for more than 30 days during the **last 15 years?** ❑ Yes ❑ No

If NO, go to Part V, page 7 for your signature. If YES, continue on 17b, next page.

PART IV—WORK HISTORY II

County Use Only

17. b. Job Title	Type of Business
Dates Worked (month/year) From: To:	Hours Per Week Rate of Pay Per hour/wk/mo

DESCRIPTION OF THE JOB (This is what I did and how I did it.)

These are the tools, machines, and equipment I used:

I took this long to learn the job: day(s) or month(s).

I wrote, completed reports, or performed similar duties: ❑ Yes ❑ No

I had supervisory responsibilities: ❑ Yes ❑ No

PHYSICAL ACTIVITY

	(Circle One)
I walked this many hours in an average workday:	0 1 2 3 4 5 6 7 8
I stood this many hours in an average workday:	0 1 2 3 4 5 6 7 8
I sat this many hours in an average workday:	0 1 2 3 4 5 6 7 8

I climbed this much in an average workday: ❑ Never ❑ Occasionally ❑ Frequently ❑ Constantly

I bent over this much in an average workday: ❑ Never ❑ Occasionally ❑ Frequently ❑ Constantly

Heaviest weight I lifted: ❑ 10 lbs ❑ 20 lbs ❑ 50 lbs ❑ Over 100 lbs

I often lifted/carried up to: ❑ 10 lbs ❑ 20 lbs ❑ 50 lbs ❑ Over 100 lbs

Did you have any of your current medical problem(s) when you performed this job? ❑ Yes ❑ No

If NO, and you have had NO other jobs go to Part V, page 7, for your signature.

If NO, but you have had other jobs, ask your county worker for additional pages.

If YES, please complete the following information.

Name of medical problem(s):

Did your employer make special arrangements (such as extra breaks, special equipment, change in job duties, etc.) so you could continue to work? ❑ Yes ❑ No

If YES, describe the special arrangements made:

Did you have to stop working because of your medical problem(s)? ❑ Yes ❑ No

If YES, when? Month Day Year

Have you done **any** other work for more than 30 days during the **last 15 years?** ❑ Yes ❑ No

If NO, go to Part V, page 7 for your signature. If YES, ask your county worker for additional pages to complete.

PART V—SIGNATURE AND CERTIFICATION

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information contained in this Supplemental Statement of Facts is true and correct.

Signature of Applicant ▶	Date
Signature of Witness (If applicant signed with a mark) ▶	Date
Signature of person helping applicant fill out form ▶	Date

You will need to sign an authorization for release of information for each clinic, hospital, and testing facility that you list and for each doctor you saw outside of a clinic or hospital. Your county worker will provide you with additional forms which you will need to sign.

Continued answer(s) to question(s) number 8 on page 2, number 9 on page 3, and number 10 on page 3. If you need more room, please ask your county worker for additional pages to complete.

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List any additional clinic or hospital where you have been seen in the last 12 months.

❑ MC 220 Signed

Name of clinic/hospital

Patient/clinic or member number

Clinic/hospital telephone number
( )

Name of doctor(s) seen

ADDRESS of clinic/hospital (number, street, suite) City State ZIP Code

Date first seen

Date last seen

Date of next appointment

Reason for the visit(s)

Did you stay in the hospital overnight? ❑ Yes ❑ No

If YES, date(s) entered: date(s) left:

Were you seen in the emergency room? ❑ Yes ❑ No

If YES, date(s) seen:

List **ALL** medicines received:

List **ALL** treatments received and the dates the treatments were received:

List any additional doctor you saw outside of the clinic(s) or hospital(s) you have already listed:

❑ MC 220 Signed

Name of doctor(s)

Patient/clinic or member number

Doctor's telephone number
( )

Name of doctor(s) seen

ADDRESS of doctor (number, street, suite) City State ZIP Code

Date first seen

Date last seen

Date of next appointment

Reason for the visit(s)

List **ALL** medicines received:

List **ALL** treatments received and the dates the treatments were received:

List any additional tests you have had in the last 12 months:

TEST PERFORMED	NAME AND ADDRESS OF OFFICE, CLINIC, OR HOSPITAL WHERE TEST(S) WAS COMPLETED.	DATE (Month/Year)
	Name Address (number, street, suite) City State ZIP Code	
	Name Address (number, street, suite) City State ZIP Code	

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❑ MC 220 Signed