City and County of San Francisco
Department of Human Services
Medi-Cal Health Connection

Medi-Cal Record of Contacts
Form 5008 (rev 07/06)

Case Name: **Case Number:**

Contacts and Transactions

Date: **Contact Type:** **Worker:**

1. Transaction: **2. Received:** **3. Linkage:**

4. Language: **5. Program Requested:** ☐MC ☐FS ☐CALM ☐ CAPI

6. Household Composition: ☐ Adult ☐Children ☐ Minor ☐ Single ☐ Married

7. Immigration Status: ☐ US Citizen ☐ LPR ☐ Work Visa ☐ Asylee ☐ Refugee ☐ Undoc ☐ Other

8. Client received: ☐ MC 219 ☐ MC 007 ☐ Voter Registration

9 . Collect Case Questions

Income

Type	Source	Amount
		$
		$
		$
		$

Resource

Source	Amount
	$
	$
	$
	$

Expense

Source	Amount
	$
	$
	$
	$

Notes:

10. Other Health Coverage: ☐ Yes ☐ No _____ ☐ DHS 6155 sent

11. MEDICARE Coverage: ☐ Yes ☐ No ☐ Part A ☐ Part B ☐ Part D

12. Disposition: Effective Date: SOC $

Retro months: