CEC Network Meeting

AGENDA

September 4, 2014
9:00-11:30 am

Mercy Hospital Downtown
Mercy Conference Center
1600 D Street
Bakersfield, CA 93301

- Welcome / Introductions
- Workshop: Completing a Medi-Cal Renewal Application
- CalHEERS System Updates
  - Identity Proofing
  - Changes to Employment Income
  - "Incarcerated" Glitch
  - SEP "Life Events"
- Covered CA Updates
  - Authorization for Enrollment Assistance
  - Letters to Consumers
  - Dental Benefits
- CHI Updates
  - Outreach
  - Database
  - Successful Application Stipend
- CEC Feedback
- Future Topics
- Announcements

Register for future trainings at *training.kernchi.org*

Important Information for Persons Requesting Medi-Cal

Privacy and Confidentiality Notification

Sections 14011 and 14012 of the Welfare and Institutions Code allow the local social services offices to get certain facts from you to decide if you, or the persons you represent, can get Medi-Cal benefits. You must provide these facts to get Medi-Cal benefits. The information will be used:

1. By the local social services office to establish first time and ongoing Medi-Cal eligibility.
2. By the Administrative Vendor (AV) to process claims and make Benefits Identification Cards (BICs).
3. By the United States (U.S.) Department of Health and Human Services to make audit and quality control reviews and verify Medicare Buy In and Social Security Numbers (SSNs).
4. To verify alien status with the U.S. Department of Homeland Security (DHS) only for aliens who claim to be lawfully admitted for permanent residence or Permanently Residing in the U.S. Under Color of Law (PRUCOL) or Amnesty Aliens with a valid and current I-688 card. The information the DHS receives can only be used to determine Medi-Cal eligibility, and cannot be used for immigration enforcement unless you are committing fraud.
5. By medical services providers and health maintenance organizations to certify eligibility.
6. To identify health insurance coverage and take recovery actions.

Medi-Cal Applicant/Beneficiary Rights, Responsibilities, and Understandings

I Have The Right To:

1. Ask for an interpreter to help me in applying for Medi-Cal if I have difficulty in speaking or understanding the English language
2. Request a face-to-face interview with a county representative.
3. Be treated fairly and equally regardless of my race, color, religion, national origin, sex, age, or political beliefs.
4. Apply as a disabled person if I think I am disabled.
5. Receive information about the rules for retroactive Medi-Cal eligibility.
6. Apply for Medi-Cal and to be told in writing whether I qualify for any Medi-Cal program.
7. Review Medi-Cal program rules and regulation manuals if I want to question the basis on which my eligibility is approved or denied.
8. Have all facts that I give to the local social services office kept in the strictest confidence and to look at those facts during regularly scheduled office hours.

I Have The Right To: *continued from page 1*

9. Receive an immediate need card, when possible and eligible, if I have a medical emergency or I am pregnant.

10. Receive Medi-Cal, as authorized, while my satisfactory immigration status is being documented and verified, if I am otherwise eligible. Aliens who are lawfully admitted for permanent residence or PRUCOL or Amnesty Aliens with a valid and current I-688 card are in a satisfactory immigration status.

11. Receive information about the Child Health and Disability Prevention Program (CHDP) and the Special Supplemental Food Program for Women, Infants, and Children (WIC), and to ask for help in receiving those services.

12. Receive information about the Personal Care Service Program (PCSP), and to ask for help in receiving those services.

13. Receive information about the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT).

14. Ask for and receive information about the Family Planning Program and be told if I am eligible for those services.

15. Speak to a social worker about other public or private services or resources that I can get.

16. Receive information about Medi-Cal Health Care Plans that my family and I can join to get a doctor and other medical care, and to choose the option I prefer.

17. Lower my share of cost by providing past unpaid medical bills (that I still owe).

18. Reduce my property reserve to within the Medi-Cal property limit by the last day of a month for which I want Medi-Cal, including the month I apply and to be told how I may spend my excess property.

19. Divide countable (nonexempt) community (MY SPOUSES AND MY) property by written agreement into equal shares of separate property if either of us entered a long term care (LTC) facility before September 30, 1989.

20. Keep a certain amount of countable separate and community property if I enter an LTC facility on or after January 1, 1990. My spouse and I have the right to be told the amount.

21. Have a state hearing if I am dissatisfied with an action taken (or not taken) by the local social services office or the State Department of Health Care Services, except actions relating to the Health Insurance Premium Payment (HIPP) and Employer Group Health Plan (EGHP) programs. If I want a state hearing to appeal the decision, I must ask for it within **90 days** of the date the Notice of Action (NOA) was mailed to me. If I do not receive a NOA, I must request a hearing within **90 days** from the date I discover the action (or inaction) with which I am dissatisfied. The date of discovery is the date I know, or should have known, of the action. The best way to ask for a hearing is to contact the nearest local social services office.

I Have The Responsibility To Tell My County Representative Within Ten (10) Days Whenever:

1. Income received by me or any member of my family increases, decreases, starts, or stops. This includes income from the Social Security Administration (SSA), loans, settlements, or any other source.
2. I plan to change or have already changed my place of residence or mailing address.
3. A person, including a newborn child, whether or not related to me or my family, moves into or out of my home.
4. An absent parent returns to the home.
5. I or a member of my family gives birth, becomes pregnant, or ends a pregnancy.
6. I, my spouse, or any member of my family enters or leaves a nursing home or an LTC facility.
7. I receive, transfer, give away, or sell real or personal property (including money), or when someone gives me or a member of my family such things as a car, house, insurance payments, etc.
8. I have any expenses that are paid for by someone other than myself.
9. I or a member of my family gets a job, changes jobs, or no longer has a job.
10. I have a change in expenses related to my job or education. (For example: child care, transportation, etc.)
11. I or a member of my family becomes physically or mentally impaired (this would include a child in the family)
12. I or a member of my family applies for disability benefits with the SSA, Veterans Administration, or Railroad Retirement.
13. One of my children drops out of school or returns to school.
14. There is a change in the citizenship/immigration status of any family member applying for or receiving Medi-Cal.
15. Health insurance coverage for me or a member of my family changes.

I Have The Responsibility To:

1. Complete and return a status report by the date required when requested.

2. Give proof that I am a resident of California.

3. Make a declaration about my citizenship/ immigration status.

4. Provide an SSN for myself and/or for any member of my family who has an SSN and wants Medi-Cal benefits. If I am a U.S. citizen, a U.S. national, or an alien in a satisfactory immigration status, I must apply for an SSN and provide it to the county if I do not already have one. If I need to apply for an SSN, I can get help from my eligibility worker, but I must work with the SSA to clear up any questions or my Medi-Cal will be denied or stopped. (Aliens who are not in a satisfactory immigration status and do not have an SSN can get restricted Medi-Cal without applying for an SSN if they meet all the rules.)

5. Apply for any income that may be available to me or any member of my family.

6. Apply for Medicare benefits if I am blind, disabled, have End Stage Renal Disease, or am 64 years and 9 months of age or older and eligible. I am responsible for telling my providers that I have both Medi-Cal and Medicare coverage.

7. Apply for and enroll in any health insurance if that is available to me and my family at no cost. I have the responsibility to remain enrolled in the health plan when Medi-Cal approves payment of plan premiums by the State of California.

8. Report to the county department, and to the health care provider, any health care coverage/ insurance I carry or am entitled to use, including Medicare. If I willfully fail to give this fact, I may be guilty of a criminal offense, or may be billed by my provider.

9. Go to my health care plan (such as Kaiser, TRICARE, or a Medicare HMO) for medical care. (Medi-Cal will not pay for any services covered by the plan.)

10. Give any insurance payments I receive to the State if Medi-Cal has already paid for my care.

11. Go to a presentation, if presentations are given, and make a written choice, or answer if received by mail, about how I want to get my Medi-Cal benefits. If I do not go and make a choice, or choose by mail, my eligible family members and I may be signed up in a Medi-Cal Health Care Plan near my home.

12. Sign my BIC when I get it and ensure it is used only to get necessary health care for myself or eligible family members.

13. Take my BIC to my medical provider when I am sick or have an appointment. In emergencies when the BIC is not in hand, I must get the BIC to the medical provider when possible.

14. Report to the county department when I receive health care services because of an accident or injury caused by another person's action or failure to act, for which Medi-Cal has been, or may be billed.

15. Cooperate with the State or county in establishing paternity and identifying any possible medical coverage I or my family may be entitled to through an absent parent.

16. Cooperate with the State of California if my case is selected for review by the quality control review team. If I refuse to cooperate, my Medi-Cal benefits will be stopped.

I Understand That:

1. Failure to give necessary facts or deliberately giving false facts can result in Medi-Cal benefits being denied or stopped. My case may also be investigated for suspected fraud.

2. The facts I give will be checked by computer with facts given by employers, banks, SSA, Franchise Tax Board, welfare, and other agencies. I will have the right to give proof to correct any facts which are found to be wrong.

3. Aliens who are not in a satisfactory immigration status and do not have an SSN can get restricted Medi-Cal without applying for an SSN if they meet all the rules.

4. Immigration status data given as part of the Medi-Cal application is confidential.

5. Based on my income, I may have to pay or be billed for part of my medical expenses before I can get Medi-Cal.

6. If I do not report changes promptly, and because of this, receive Medi-Cal benefits that I am not eligible for, I may have to repay the State Department of Health Care Services.

7. I or any member of my family receiving Medi-Cal must not be receiving public assistance from another state.

8. If I am receiving Medi-Cal based on disability and I apply for disability benefits from the SSA, and the SSA denies my disability claim, my Medi-Cal may be stopped. If I appeal my SSA denial right away, my Medi-Cal will continue until the SSA makes a final decision. If the SSA allows my claim, then my Medi-Cal benefits will continue. If the SSA does not allow my claim, then my Medi-Cal benefits will stop.

9. As a condition of Medi-Cal eligibility, all rights to medical support and/or payment for medical services for myself and any eligible persons that I have legal responsibility for, are automatically assigned to the State.

10. If medical support is court-ordered from an absent parent for my children, the insurance carrier must allow me to enroll and provide benefits to my children without the absent parent's consent.

11. If I don't apply for or keep no-cost health coverage or state-paid coverage, my Medi-Cal benefits and/or eligibility will be denied or stopped.

12. When I apply for Medi-Cal, I will be evaluated for potential eligibility under other medical assistance programs, including the HIPP and EGHP programs.

13. If I ask a Medi-Cal provider for any services not covered by my non Medi-Cal health insurance plan, I must give the medical provider a written statement from my health plan saying it does not offer the Medi-Cal covered services.

14. Medi-Cal providers cannot collect insurance co-payment, coinsurance, or deductibles from me unless the payment is used to meet my Medi-Cal share of cost and/or co-payment.

15. If I am admitted to a nursing facility and I have no intention of returning to my home, the State may impose a lien against my property.

I Understand That: *continued from page 5*

16. After my death, the State has the right to seek reimbursement from my estate for all Medi-Cal benefits I received after age 55 unless I have a surviving spouse or registered domestic partner (during his or her lifetime), minor children, blind or permanently and totally disabled children, or it would create a hardship for my heirs.

17. After the death of my surviving spouse or registered domestic partner, the State has the right to claim from the part of his or her estate received from me, all Medi-Cal benefits I received after age 55 up to the amount of property my spouse or registered domestic partner received from my estate.

(Keep for your records) I hereby state that I have reviewed the information on this form with a county representative and that I fully understand my Rights and Responsibilities to have my eligibility determined for Medi-Cal and to maintain that eligibility.

Applicant/Representative Signature *(optional)* Date

County Use Section

I have provided this form to the applicant: (check one) ☒ In Person ☐ By Mail

Eligibility Worker's Name (print) | Worker Number | Date

Eligibility Worker's Signature

BREAST AND CERVICAL CANCER TREATMENT PROGRAM (BCCTP)

The BCCTP may provide Medi-Cal to low-income people that live in California and have breast and/or cervical cancer.

If you have been denied Medi-Cal or you are no longer eligible for Medi-Cal through your county and you have breast and/or cervical cancer, tell your county Eligibility Worker (EW). Your EW can make a referral for you to the BCCTP.

An Eligibility Specialist (ES) from the BCCTP will call or write to you for more information. The requested information will help us to see if you are eligible for the program. You may be Medi-Cal eligible through the BCCTP if you are a woman and you meet the following requirements:

- Have been screened and found in need of treatment for breast and/or cervical cancer, follow-up care for cancer, or precancerous cervical lesions/conditions by an Every Woman Counts (EWC) or Family Planning, Access, Care and Treatment (FamPACT) provider; and
- Are a California resident; and
- Are under age 65; and
- Are a United States citizen or have satisfactory immigration status; and
- Have no other health insurance including full-scope no share-of-cost Medi-Cal, or Medicare; and
- Have a monthly gross family income, at the time of screening and diagnosis, that is at or below 200 percent of the federal poverty level.

If you have been screened for breast and/or cervical cancer by a provider that is not with EWC or FamPACT, you can still be referred to the BCCTP. Your BCCTP worker will help you find an EWC or FamPACT provider that can confirm your diagnosis.

Even if you do not meet all the above requirements, you may still receive BCCTP through the State-funded BCCTP. The State-funded BCCTP can help you for up to18 months for breast cancer or up to 24 months for cervical cancer. The State-funded BCCTP is available to men and women, regardless of immigration status.

For additional information or questions on the BCCTP, call 1-800-824-0088

department directly. (Look in your phone book for the toll-free telephone number, or call the state mental health ombudsman.)

What if I don't get the services I want from my county mental health department?

You can file a grievance with the county mental health department if the county mental health department denies the EPSDT services requested by your doctor or provider. You may also file a grievance if you think you need mental health services and your provider or county mental health department does not agree. Call the county mental health department's toll-free number to talk to a grievance coordinator for information and help. You may also call the county patient's rights advocate or the State Mental Health Ombudsman Office.

You can ask for a state hearing at the same time. Call 1-800-952-5253, TTY 1-800-952-8349, send a fax to 916-229-4110, or write to the California Department of Social Services, State Hearings Division, P.O. Box 944243, Mail Station 19-37, Sacramento CA 94244-2430. You must ask for a hearing within 90 days after you learn that your request for services was denied. Protection & Advocacy, Inc. is also available to assist with complaints, appeals, and grievances.

Who can I call for more information?

For more information please contact the following offices at the telephone numbers below.

County Mental Health Department toll-free access number	Look in your local phone book
Department of Mental Health Ombudsman Office	1-800-896-4042
Child Health and Disability Prevention (CHDP) Program located in your county or city health department.	Look in your local phone book.
Protection & Advocacy, Inc.	1-800-776-5746 or www.pai-ca.org TTY 1-800-719-5798

Department of Health Care Services

MC Information Notice 003 (06/07)

Medi-Cal Services for Children and Young People:

Early and Periodic Screening, Diagnostic and Treatment

Mental Health Services

This notice is for children and young people who qualify for Medi-Cal EPSDT services because they are under 21. This notice is also for caregivers or guardians of children and young people who qualify for EPSDT.

What are Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services?

EPSDT services are extra Medi-Cal services. You can get them in addition to other Medi-Cal services. **You must be under age 21 and have full scope Medi-Cal to get these services.** EPSDT services correct or improve medical problems that your doctor or other health care provider finds, even if the health problem will not go away entirely.

How can I get EPSDT services for my child or, if I am under age 21, for myself?

Ask your doctor or clinic about EPSDT services. You may get these services if you and your doctor, or other health care provider, clinic (such as Child Health and Disability Prevention Program [CHDP]), or county mental health department agree that you need them.

What are EPSDT mental health services?

EPSDT mental health services are Medi-Cal services that correct or improve mental health problems. These problems may be sadness, nervousness, or anger that makes your life difficult.

Some of the services you can get from your county mental health department are:

- Individual therapy
- Group therapy
- Family therapy
- Crisis counseling
- Case management
- Special day programs
- Medication for your mental health
- EPSDT mental health services to treat alcohol and drug problems you may have that affect your mental health.

You can also ask for counseling and therapy as often as once per week or more if you think you need it. You may be able to get these services in your home or in the community.

In most cases, your county mental health department, you, and your doctor or provider will decide if the services you ask for are medically necessary. County mental health departments must approve your EPSDT services. Every county mental health department has a toll-free phone number that you can call for more information and to ask for EPSDT mental health services.

What are EPSDT Therapeutic Behavior Services (TBS)?

Therapeutic Behavioral Services (TBS) is a EPSDT mental health service. TBS helps children and young people who:

- Have severe emotional problems
- Live in a mental health placement or are at risk of placement, or
- Have been hospitalized recently for mental health problems.

If you get other mental health services and still feel very sad, nervous, or angry, you may be able to have a trained mental health coach help you. This person could help you when you have problems that might cause you to get mad, upset, or sad. This person would come to your home, group home, or go with you on trips and activities in the community.

Your county mental health department can tell you how to ask for an assessment to see if you need mental health services including TBS.

Who can I talk to about EPSDT mental health services?

You can talk to your doctor, psychologist, counselor, or social worker about EPSDT mental health services. For children and young people in a group home or residential facility, you can talk to the staff about getting additional EPSDT services.
For children in foster care, you can also ask the child's court-appointed attorney. You can also call your county mental health

What Does CHDP Offer?

Routine Physical Check-Ups:

- ♥ Growth and Development Check
- ♥ All Needed Shots
- ♥ Dental Screening
- ♥ Vision Screening
- ♥ Hearing Screening
- ♥ Nutrition Check-Up
- ♥ Health Education
- ♥ Tobacco Education
- ♥ Test for Anemia, Blood Lead, Urine, TB, and Others as Needed
- ♥ WIC Referral for Children to Age 5

Regular Dental Check-Ups and Follow Up Care if Needed.

If further medical, dental, or mental health services are needed, we will help you find them. Diagnosis and treatment will be paid for as long as your child is on Medi-Cal.

For persons with share of cost Medi-Cal, you may have CHDP pay for the check-up or you may pay for the check-up and have the cost count toward your required payment. A co-payment is NOT charged for CHDP services.

Bring your current Medi-Cal card and shot record.

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ealth Depart
yo CHDP
ww ns.ca.gov/chdp

If you need h wi al ices, cal your co me al nt. T can tell you oth es for ch en and a fi Medi-Cal wh ave se ns.

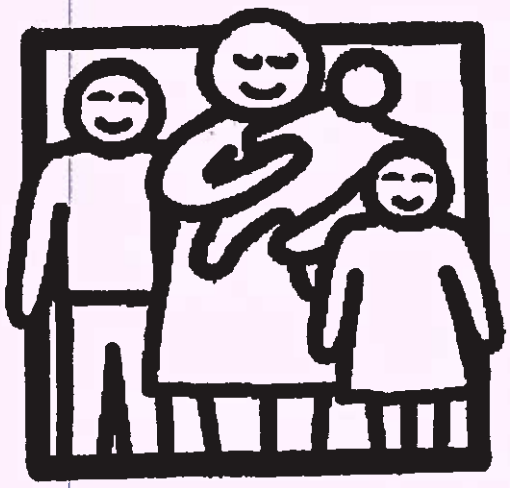
Arnold Schwarzenegger
Governor, State of California

PUB 183 (English. 1/04)

English

Child Health & Disability Prevention (CHDP) Program

Medical & Dental Health Check-Ups



FREE
For Babies, Children, and Youth Through Age 20
With Full Scope Medi-Cal

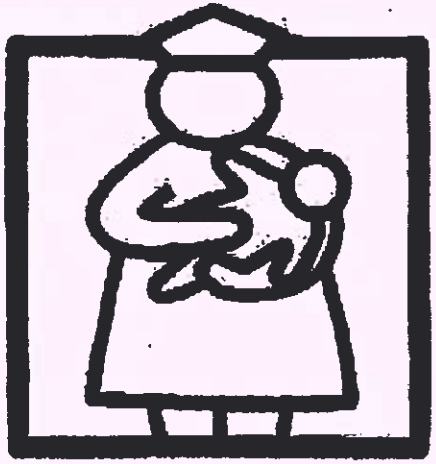
Why Check-Ups?

A complete **health** check-up may find medical, dental, and/or mental health problems before they become serious. Needed shots are given. There is time to ask questions. A health check-up may be given, when required, for foster care, sports, or camp. You can usually get CHDP Check-Ups where you get your health care.

Babies and Toddlers
Birth Through 3 Years

Regular Well-Baby Care and Shots

Babies and toddlers need health check-ups often. They need to get their shots on time.



How often?

One exam during each of these age ranges:

Under 1 month
1-2 months
3-4 months
5-6 months
7-9 months
10-12 months
13-15 months
16-23 months
2 years
3 years

School Children
4 Through 12 Years

School Check-Ups

State law requires children entering kindergarten or first grade to have a health check-up and be up-to-date on their shots.

Health check-ups may find health problems that could prevent a child from doing well in school.

How often?

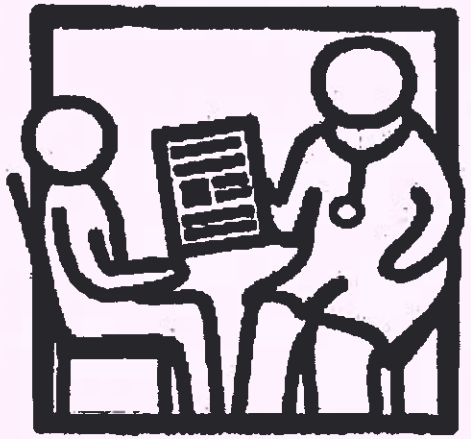
One exam during each of these age ranges:

Between 4-5 years
Between 6-8 years
Between 9-12 years

Teenagers and Young Adults
13 Through 20 Years

Health Check-Ups

Teens need check-ups too! They may have questions about their health. They can ask a health care provider.



How often?

One exam during each of these age ranges:

Between 13-16 years
Between 17-20 years

Ask your doctor or local health department for other services for teenagers.

- You cannot get your wheelchair into examination, interview rooms or restrooms.
- Men get referred to job training for better paying jobs than women.
- The county does not want you to have training because they say you are "too old."
- You are not allowed to adopt a baby because you are of a different race.

Discrimination Complaints

If you think you have been discriminated against, you may submit a complaint application separately to the County or the State, and the Federal Government. The Federal agency that you must complain to depends on which program your complaint is about.

You can file a discrimination complaint with:

1. FOR ALL PROGRAMS ADMINISTERED BY YOUR COUNTY WELFARE DEPARTMENT: The County's Civil Rights Coordinator. Ask your county office for the name, address and phone number of their Civil Rights Coordinator. He/she will independently investigate your complaint.
2. Civil Rights Bureau
   California Department of Social Services
   744 P Street, MS 8-16-70
   Sacramento, CA 95814
   (916) 654-2107
   (866) 741-6241 (Toll-Free)
3. FOR THE CALFRESH PROGRAM:
   United States Department of Agriculture
   Director, Office of Civil Rights,
   Room 326-W, Whitten Bldg.
   1400 Independence Avenue, S.W.,
   Washington, D.C. 20250-9410
   (202) 720-6382 (voice and TTY)
4. FOR ALL OTHER PROGRAMS:
   Health and Human Services
   Office of Civil Rights
   90 7th Street, Suite 4-100
   San Francisco, CA 94103
   (415) 437-8310 (voice)
   (415) 437-8311 (TDD)

Time Limits to Take Action

If you suffer discrimination, you must submit your complaint within 180 days of the actual discrimination. If the discrimination also affected the level of your benefits and services, you must also ask for a state hearing within 90 days. A discrimination investigation cannot change your benefit levels or services...only a state hearing can do that.

Limits on Certain Rights

Although you have the right to privacy and confidentiality, there are certain laws that allow limited exceptions. You can ask the county for the laws.

Questions

If you have any questions about the rights listed here, call the Public Inquiry Unit: toll free (800) 952-5253. The TDD toll-free telephone number is (800) 952-8349.

Programs Covered by This Pamphlet

- Adoption Assistance Program (AAP)
- Adult Protective Services
- Alcohol and Drug Program
- California Food Assistance Program (CFAP)
- Medi-Cal
- CalWORKs
- CalWORKs Child Care
- CalWORKs Welfare-to-Work Program/Services
- Cash Assistance Program for Immigrants (CAPI)
- Child Welfare Services
- Denti-Cal
- Early & Periodic Screening, Diagnosis, and Treatment (EPSDT)
- CalFresh (Food Stamps)
- Foster Care
- In-Home Support Services
- Kinship Guardian Assistance (Kin-GAP)
- Mental Health
- Multipurpose Senior Services Program (MSSP)
- Personal Care Services Program (PCSP)
- Refugee Cash Assistance
- Social Services

STATE OF CALIFORNIA

HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF SOCIAL SERVICES

This pamphlet is available from your Local County Welfare Office and at www.cdss.ca.gov in the following languages:

• Arabic	• Japanese	• Russian
• Armenian	• Korean	• Spanish
• Cambodian	• Lao	• Spanish Large Print
• Chinese	• Mien	• Tagalog
• Farsi	• Portugese	• Ukranian
• Hmong	• Punjabi	• Vietnamese

Also Available in large print, Braille, and Audio CD

PUB 13 (6/11)

Your Rights

Under California Welfare Programs

... for people applying for or receiving public aid in California

Tell us if you need help because of a disability

Ask for a free interpreter

Your Rights

All people and organizations providing public assistance must respect your rights. They can help you understand and apply for benefits and services.

- You have the right to an interpreter free of charge.
- Ud. tiene derecho a un intérprete gratis
- Вы имеете право на услуги Переводчика
- 你有权利自由译员
- May karapatan kang magkamon ng tag ugnay na walang bayad.
- Quý vị có quyền được một thông dịch viên miễn phí.
- .Koj muaj txoj cai yuav ib tus neeg txhais lus Hmoob rau koj.
- لديك الحق في الحصول على مترجم دون أية تكلفة.
- Դուք անվճար թարգմանչի իրավունք ունեք:
- អ្នកមានសិទ្ធិទទួលបានអ្នកបកប្រែភាសា ដោយមិនបាច់បង់ថ្លៃឈ្នួលឡើយ
- 여러분은 무료 통역 서비스를 받을 권리가 있습니다
- شما حق دارید از خدمات مترجم شفاهی رایگان برخوردار شوید.
- ທ່ານມີສິດທີ່ຈະໄດ້ນາຍແປພາສາ ໂດຍບໍ່ເສັຽຄ່າໃຊ້ຈ່າຍ
- ਤੁਹਾਨੂੰ ਬਿਨਾਂ ਲਾਗਤ ਦੇ ਅਨੁਵਾਦਕ ਦਾ ਅਧਿਕਾਰ ਹੈ।
- Ви маєте право на безкоштовного перекладача.
- Você tem o direito a um/a intérprete gratuito/a!
- あなたは無料の通訳の権利を有してもいい。
- Meih maaih leiz baih duqv dauh faan waac mienh tengx meih maiv zuqc bun nyaanh.

You Have a Right to…

1. Understand what is happening with your application and aid.
2. Get written and oral explanations about your application and aid.
3. Get a receipt for any documents you turn in.
4. See your case record.
5. See state and county laws and regulations.
6. Ask a judge to review any county decision about your eligibility, benefits, or services.
7. Not face discrimination in receiving program benefits or services.
8. File a complaint about discrimination.
9. Get extra help from county staff to make sure you get your benefits if you have a disability or impairment that makes it hard to understand the program rules.
10. Have your information kept confidential.
11. Be treated with courtesy and respect.

If You are Having Problems with Your Aid or Services:

1. Keep records of all your information, documents, and contacts with the county.
2. Get a receipt when you turn anything in.
3. You can bring someone with you to a meeting with your worker.
4. Complain. There are 4 ways to do this:

- *Informal:* You can ask to speak to a supervisor to talk about problems with a worker or to go over the rules and the proposed action on your aid or services.
- *State Hearing:* Ask for a state hearing if there is a problem with your aid or services. You must ask for a hearing within 90 days of the county's action. You may be able to file after 90 days if you have a good reason, like illness or a disability.
- *Discrimination complaint:* If you feel that the county has discriminated against you, you can make a discrimination complaint to the County's Civil Rights Coordinator or to the State Civil Rights Bureau, and to the Federal Government. You must do this within 180 days of the discrimination. For more on this, see the section beginning "Prohibited Discrimination."

  If the discrimination also affects your benefits or services, you must also ask for a state hearing if you wish to challenge the county's decision on your benefits or services.
- *Grievance:* You can file a complaint with the county if they have a grievance procedure. This does not protect your benefits in the way that asking for a state hearing does.

State Hearings

- You can ask for a state hearing any time you disagree with a county's action on your benefits or services.
- You can also ask for a state hearing if the county is not giving you benefits or services which you think you should get.
- A state hearing is heard by a state Administrative Law Judge. The county will have someone at the hearing to explain why they took their action.
- A state hearing is not a court hearing. You do have the right to have a representative with you. There are free legal services in every county. They are listed on the back of your county notices. You can bring witnesses. You have the right to a free interpreter. Ask the county how to get one.
  - If your problem is with General Assistance or general relief, you must ask for a county hearing.
  - If your problem is with Social Security benefits, you must contact the Social Security Administration.

Continuing Your Aid or Services Pending a State Hearing

The county must give you a notice at least 10 days before any action to change your aid or services takes place. If you ask for a hearing before the action takes place, you can get "aid paid pending" your hearing. This means your aid stays the same until you get a hearing decision.

You MUST ask for a hearing on any new notice you get, if you disagree.

How to Request a State Hearing

1. Phone: Ask for a State Hearing by contacting the CA Department of Social Services at (800) 743-8525 or (800) 952-5253
2. Fill out the back of your Notice of Action (NOA) or send a written request to:
   CDSS, State Hearing Division
   744 P Street M.S. 09-17-37
   Sacramento, CA 95814

Prohibited Discrimination

Under State law, welfare agencies may not provide you aid, benefits or services that is different from aid provided to others on the basis of

Race, Color, National Origin (including language), Ethnic Group Identification, Age, Disability, Religion, Sex, Sexual Orientation, Political Affiliation, Marital Status, or Domestic Partnership

Federal laws also prohibit discrimination on several, although not all, of the bases listed above.

Federal Law also prohibits :

1. Delaying or denying the placement of a child for adoption or into foster care on the basis of race, color or national origin of the adoptive or foster parents, or the child;
2. Denying to any individual the opportunity to become a foster or adoptive parent on the basis of race, color or national origin of the individual or child involved.

Examples of Discrimination

- The County does not give you a free interpreter.
- A worker tells a certain ethnic group about more programs and services than people of other ethnicities.
- The County won't help you get audio tapes of a program orientation to help you with a disability that makes it hard for you to read.
- A worker learns of your religion or politics and then treats you differently.
- You can't get to appointments because the county building does not have an elevator.

Notice of Language Services

If you do not understand this information or notification, call your county worker. You have the right to interpreter services provided by the county at no cost to you.
(English)

Si no entiende la información o notificación, póngase en contacto con el trabajador social de su condado. El condado debe proporcionarle el servicio de interpretación en forma gratuita.
(Spanish)

إذا لم تفهم هذه المعلومات أو هذا الإشعار فعليك الاتصال بموظف الإقليم. ويحق لك الحصول على خدمات مترجم يقدمها لك الإقليم بالمجان
(Arabic)

Եթե այս ինֆորմացիան չեք հասկանում, համեցեք կապվել ձեր գավառի պաշտոնյային. իրավունք ունեք առանց վճարման թարգմանիչի ծառայությանց, որ ձեզ կտրվի գավառի կողմից
(Armenian)

ប្រសិនបើអ្នកមិនយល់ព័ត៌មាន ឬការជូនដំណឹងនេះទេ សូមទូរស័ព្ទទៅកាន់បុគ្គលិកការងារសង្គមរបស់អ្នក ។ អ្នកមានសិទ្ធិ
ក្នុងការទទួលសេវាកម្មប្រែជាភាសាដោយឥតគិតថ្លៃពីស្នាក់ការរដ្ឋបាលស្រុក ។
(Cambodian)

如果您對此份資訊或通知的內容不瞭解，請與貴縣的工作人員聯繫。您有權利要求貴縣所提供的免費口譯人員服務。
(Chinese)

اگر این اطلاعات یا اطلاعیه را نمیفهمید، با کارمند بخش خود تماس بگیرید. شما قانونا حق دارید از خدمات ترجمه که بطور مجانی توسط بخش فراهم میشود بهره مند شوید.
(Farsi)

Yog koj tsis to taub cov ntaub ntawv lossis daim ntawv no, hu rau koj tus kws khiav ntaub ntawv nyob koj cheeb tsam. Koj muaj cai siv kev pab txhais lus pub dawb uas los ntawm cheeb tsam koj nyob ko.
(Hmong)

この情報やお知らせが理解できない時には、カウンティワーカーにご連絡下さい。あなたにはカウンティから通訳サービスを提供してもらう権利があり、料金は無料です。
(Japanese)

여기 실린 정보 또는 통지서의 내용을 잘 이해 못하시면, 카운티 담당 직원에게 연락하시기 바랍니다. 당신은 카운티로부터 통역 서비스를 무료로 받을 권리를 갖고 있습니다.
(Korean)

ຫາກວ່າທ່ານບໍ່ເຂົ້າໃຈຂໍ້ມູນຫລືໃບແຈ້ງຄວາມນີ້ ໃຫ້ໂທຣໄປຫາພະນັກງານຄາວຕີ້ (county) ຂອງທ່ານ. ທ່ານມີສິດທີ່ຈະຮັບບໍລິການນາຍພາສາທີ່ຈັດໃຫ້ໂດຍຝ່າຍຄາວຕີ້ (county) ໂດຍທ່ານບໍ່ເສັງຄ່າ.
(Lao)

Se gorngv meih maiv bieqc hnyouv naaiv deix mbuox mengh fienx fai mbuox hiuv fienx nor, heuc lorz meih nyei Nquenc zaangc nyei goux sou-gorn mienh. Meih maaih leiz duqv Nquenc zaangc baeqc bun tih waac mienh tengx meih nyei oc
(Mien)

ਜੇਕਰ ਤੁਸੀ ਇਸ ਜਾਣਕਾਰੀ ਜਾਂ ਸੂਚਨਾਂ ਨੂੰ ਨਹੀ ਸਮਝਦੇ, ਤਾਂ ਆਪਣੇ ਕਾਉਂਟੀ ਵਰਕਰ ਨੂੰ ਕਾਲ ਕਰੋ। ਤੁਹਾਨੂੰ ਕਾਉਂਟੀ ਦੁਆਰਾ ਪ੍ਰਦਾਨ ਕੀਤੀ ਜਾ ਰਹੀ ਦੁਭਾਸ਼ੀ ਦੀ ਸੇਵਾਵਾਂ ਲੈਣ ਦਾ ਹੱਕ ਹੈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਦੇ ।
(Punjabi)

Если вы не понимаете эту информацию или уведомление, позвоните своему окружному работнику. Вы имеете право на услуги переводчика, которые округ окажет вам бесплатно.
(Russian)

Kung hindi ninyo na-iintidihan ang information (kabatiran) o notification (patalastas), tawagan ang county worker (manggawa) ninyo. May karapatan kayo sa serbisyo ng translator (tagasalin) na ilalaan ng county na wala kayong babayaran.
(Tagalog)

Якщо ви не розмієте цю інформацію або повідомлення, зателефонуйте своему окружному працівнику. Ви маєте право на послуги перекладача, які округ надасть вам безкоштовно.
(Ukrainian)

Nếu quý vị không hiểu thông tin hoặc thông báo này, xin vui lòng gọi cho nhân viên quận. Quý vị có quyền sử dụng các dịch vụ thông dịch miễn phí của quận
(Vietnamese)

County of Kern - Eligibility Services

Phone: (661) 746-8300

Worker Name:l
Worker ID:
Worker Phone Number:(661)
Date: 07/31/2014
Case Name:
Case Number:

Shafter
PO BOX 511
BAKERSFIELD, CA 93302-0511

On the back of this sheet is the address for returning your packet.

FIRST-CLASS MAIL PERMIT NO. 1531 BAKERSFIELD CA
POSTAGE WILL BE PAID BY ADDRESSEE

Kern County Dept of Human Services
PO BOX 511
BAKERSFIELD CA 93302-9985

Please fold and ensure the County address information displays in the envelope window.

Important news about how to keep your Medi-Cal!

Beginning this year, Medi-Cal eligibility will be determined for most people using income tax rules and personal filing information. Medi-Cal will count the size of your household and your income based on your tax information. If you do not file taxes, you can still get Medi-Cal.

Because you have Medi-Cal now, we already know a lot about you. What we do not know is your tax household information. To get this information, we need you to fill out the forms that are enclosed with this letter.

We will use the information on these forms, along with the information we already know about you, to see if you still qualify for Medi-Cal. Please complete the forms for yourself and the family members either living with you or claimed on your tax return. Only the head of household (the person who files taxes) must complete the **"Request for Tax Household Information (RFTHI) Supplemental Form"** and sign the forms. You only have to fill out these forms this year as we move you from the current Medi-Cal rules to the new Medi-Cal rules. In the future, we will try to re-determine your eligibility each year based on the information we have without asking for anything more from you.

Since we will now use your tax information to determine Medi-Cal eligibility, we may be able to electronically check the information you give us to see if you are still eligible for Medi-Cal. If we are able to do so, we may not need any additional paper documents other than the enclosed forms. If we cannot check your information electronically, we will ask you for paper documents. You will only be asked to send paper documents for the information we could not check electronically.

If you are not eligible for Medi-Cal based on the new rules, you may still qualify for the other Medi-Cal programs, but we must first check your eligibility based on tax information to see what type of Medi-Cal you are eligible for.

In order to see if you still qualify for Medi-Cal, you must give us the information on the **RFTHI Supplemental Form**. You must give us this information for yourself and each person living with you or claimed on your tax return.

You must give us this information by 08/27/2014 .

There are three ways you can give us this information:

By mail:

You can give us this information by completing the forms sent with this letter. You must complete one RFTHI form for yourself and each person living with you or claimed on your tax return and one RFTHI Supplemental for your household. Please use the postage paid envelope to return the form.

By phone:

You can give us this information over the phone by calling us at (661) 746-8300 . When you call, you should have your most recent federal tax return available, if you file taxes.

In person:

You can give us information by visiting us at:

Shafter
115 CENTRAL VALLEY HWY
SHAFTER, CA 93263-2001

Remember, you must give us this information by 08/27/2014 **or you may lose your Medi-Cal benefits.**

Request for Tax Household Information (RFTHI)

How to complete this form:

1. Answer all of the questions on the form. Use ink and print your answers. If you need more space attach a separate sheet to this form.
2. Read the information about you and each member of your household, including tax dependents. Add any missing information. If any information has changed, write in the correct information.
3. Sign and date the form on page 6.
4. **Return this form by** 08/27/2014 . Use the postage paid envelope to return the form. If you do not return the form by this deadline, you will lose your Medi-Cal coverage.

What we need:

We need information about each person living in your household or listed on your tax return, including:

- Those who get Medi-Cal now
- Those who do not have Medi-Cal now but would like to apply, and
- Those who live in the household and do not have Medi-Cal but do not want to apply

If you do not qualify for Medi-Cal:

If you do not qualify for Medi-Cal, we will check to see if you qualify for other kinds of health coverage. We may send your information to another program so they can see if you qualify.

Need Help?:

Call your Medi-Cal Agency at (661) 746-8300
TTY: (800) 952-8349

You must fill out one of these forms for <u>each person</u> in your household and return it to the County

Case Number (optional)	SSN or ATIN/ITIN
Individual's Name	Birth Date (mm/dd/yyyy)
Current street address, apartment number	City Zip code SHAFTER 93263-1855
Mailing address, if different from above	City Zip code

1. Is this person: ☐ Employed ☐ Self-Employed

2. If this person is currently employed, list all of the information about all types of income received including:

Employer Name: _____ Employer Address: _____

Employer Phone Number: _____ Average Hours Worked Each Week: _____

Wages/Tips (before taxes): _____ ☐ Hourly ☐ Twice a Month ☐ Semi Monthly ☐ Monthly ☐ Yearly

3. If this person is self-employed, answer the following question:

Type of Work: _____

How much net income (profit once business expenses are paid) will you receive from this self-employment this month?

_____

4. For this person, do you plan to file a federal income tax return NEXT YEAR? ☐ Yes, complete a - c ☐ No, skip to c

a. Will you file jointly with a spouse? ☐ No ☐ Yes, name of spouse: _____

b. Will you claim any dependents? ☐ No ☐ Yes, name of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? ☐ No ☐ Yes

If yes, list the name of the tax filer: _____ How is this person related to the tax filer? _____

5. Please answer the following questions only if this person is under the age of 21 and a full time student:

Did this person have health insurance through a job and lost it within the last 12 months? ☐ Yes ☐ No

6. Were you or anyone else in your family who is age 26 or younger in foster care at age 18? ☐ Yes ☐ No

7. Has this person's immigration or citizenship status changed in the past 12 months? ☐ Yes ☐ No

If yes, please explain what changed: _____

8. Is this person: ☐ Hispanic ☐ Latino ☐ Spanish ☐ American Indian or Alaskan Native ☐ White

☐ Black or African American ☐ Filipino ☐ Chinese ☐ Japanese ☐ Cambodian ☐ Korean ☐ Vietnamese

☐ Asian Indian ☐ Laotian ☐ Other Asian, specify: _____ ☐ Native Hawaiian

☐ Guamanian or Chamorro ☐ Samoan ☐ Other or Mixed Race

You must fill out one of these forms for <u>each person</u> in your household and return it to the County

Case Number (optional)	SSN or ATIN/ITIN
Individual's Name	Birth Date (mm/dd/yyyy)
Current street address, apartment number	City Zip code
Mailing address, if different from above	City Zip code

1. Is this person: ☐ Employed ☐ Self-Employed

2. If this person is currently employed, list all of the information about all types of income received including:

Employer Name: _____ Employer Address: _____

Employer Phone Number: _____ Average Hours Worked Each Week: _____

Wages/Tips (before taxes): _____ ☐ Hourly ☐ Twice a Month ☐ Semi Monthly ☐ Monthly ☐ Yearly

3. If this person is self-employed, answer the following questions:

Type of Work: _____

How much net income (profit once business expenses are paid) will you receive from this self-employment this month?

_____

4. For this person, do you plan to file a federal income tax return NEXT YEAR? ☐ Yes, complete a - c ☐ No, skip to c

a. Will you file jointly with a spouse? ☐ No ☐ Yes, name of spouse: _____

b. Will you claim any dependents? ☐ No ☐ Yes, name of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? ☐ No ☐ Yes

If yes, list the name of the tax filer: _____ How is this person related to the tax filer? _____

5. Please answer the following question only if this person is under the age of 21 and a full time student:

Did this person have health insurance through a job and lost it within the last 12 months? ☐ Yes ☐ No

6. Were you or anyone else in your family who is age 26 or younger in foster care at age 18? ☐ Yes ☐ No

7. Has this person's immigration or citizenship status changed in the past 12 months? ☐ Yes ☐ No

If yes, please explain what changed: _____

8. Is this person: ☐ Hispanic ☐ Latino ☐ Spanish ☐ American Indian or Alaskan Native ☐ White

☐ Black or African American ☐ Filipino ☐ Chinese ☐ Japanese ☐ Cambodian ☐ Korean ☐ Vietnamese

☐ Asian Indian ☐ Laotian ☐ Other Asian, specify: _____ ☐ Native Hawaiian

☐ Guamanian or Chamorro ☐ Samoan ☐ Other or Mixed Race

You must fill out one of these forms for <u>each person</u> in your household and return it to the County

Case Number (optional)	SSN or ATIN/ITIN
Individual's Name	Birth Date (mm/dd/yyyy)
Current street address, apartment number	City Zip code
Mailing address, if different from above	City Zip code

1. Is this person: ☐ Employed ☐ Self-Employed

2. If this person is currently employed, list all of the information about all types of income received including:

Employer Name: _____ Employer Address: _____

Employer Phone Number: _____ Average Hours Worked Each Week: _____

Wages/Tips (before taxes): _____ ☐ Hourly ☐ Twice a Month ☐ Semi Monthly ☐ Monthly ☐ Yearly

3. If this person is self-employed, answer the following question:

Type of Work: _____

How much net income (profit once business expenses are paid) will you receive from this self-employment this month?

_____

4. For this person, do you plan to file a federal income tax return NEXT YEAR? ☐ Yes, complete a - c ☐ No, skip to c

a. Will you file jointly with a spouse? ☐ No ☐ Yes, name of spouse: _____

b. Will you claim any dependents? ☐ No ☐ Yes, name of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? ☐ No ☐ Yes

If yes, list the name of the tax filer: _____ How is this person related to the tax filer? _____

5. Please answer the following questions only if this person is under the age of 21 and a full time student:

Did this person have health insurance through a job and lost it within the last 12 months? ☐ Yes ☐ No

6. Were you or anyone else in your family who is age 26 or younger in foster care at age 18? ☐ Yes ☐ No

7. Has this person's immigration or citizenship status changed in the past 12 months? ☐ Yes ☐ No

If yes, please explain what changed: _____

8. Is this person: ☐ Hispanic ☐ Latino ☐ Spanish ☐ American Indian or Alaskan Native ☐ White

☐ Black or African American ☐ Filipino ☐ Chinese ☐ Japanese ☐ Cambodian ☐ Korean ☐ Vietnamese

☐ Asian Indian ☐ Laotian ☐ Other Asian, specify: _____ ☐ Native Hawaiian

☐ Guamanian or Chamorro ☐ Samoan ☐ Other or Mixed Race

9. Renewal of coverage in future years:

To make it easier to determine my eligibility for help applying for health coverage in future years, I agree to allow the Marketplace to use income data, including information from tax returns. The Marketplace will send me a notice, let me make any changes, and I may opt out at any time.

- ☐ 5 years (the maximum number of years allowed), or for a shorter number of years
- ☐ 4 years
- ☐ 3 years
- ☐ 2 years
- ☐ 1 year

☐ Don't use information from tax returns to review my coverage.

**Note: The income/tax filing information is required for all household members. If additional family members are employed or self-employed, questions 1-4 should be answered for these individuals as well.

Your Rights and Responsibilities

- I am signing this renewal form under penalty of perjury. That means that I have provided true answers to all the questions on this form to the best of my knowledge, and I know that I may be subject to penalties under federal law if I provide false or untrue information.
- I know that I must tell Covered California if anything changes and is different from what I wrote on this form. I understand that a change in my information might affect whether someone in my household qualifies for coverage.
- I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting hhs.gov/ocr/office/file.
- If I think Covered California has made a mistake, I can appeal its decision. To appeal means to tell someone at Covered California that I think the action is wrong, and ask for a fair review of the action. Someone from Covered California will explain anything about this application to me if I need that.
- I understand that if I do not qualify for other kinds of health coverage, Covered California may send my information to another program so they can see if I qualify.

I declare, under penalty of perjury, under the laws of the State of California that all information provided on this form is true and correct.

Signature	Date

Request For Tax Household Information (RFTHI) Supplemental Form
Complete this form for your household

Please copy this form if you need additional space.

Does anyone in the household have income that is not from a job? *Do not include child support payments, veteran's payments, or Supplemental Security Income (SSI). See Page 3 for additional information.*

Does anyone in the household have income that is not from a job? ☐ **Yes** *If yes,* who? _____

If yes, answer the questions below. ☐ **No** *If no,* go to *"Does anyone in your household have deductions"* on this page.

Where does this income come from?	How often does this person get this income? *(check one)*	How much?
	☐ Hourly: How many hours per week? _____ ☐ Every two weeks ☐ Daily: How many days per week? _____ ☐ Twice a month ☐ Weekly ☐ Monthly ☐ One-time payment	$ _____

Does anyone in the household have income that is not from a job? ☐ **Yes** *If yes,* who? _____

If yes, answer the questions below. ☐ **No** *If no,* go to *"Does anyone in your household have deductions"* on this page.

Where does this income come from?	How often does this person get this income? *(check one)*	How much?
	☐ Hourly: How many hours per week? _____ ☐ Every two weeks ☐ Daily: How many days per week? _____ ☐ Twice a month ☐ Weekly ☐ Monthly ☐ One-time payment	$ _____

Does anyone in your household have deductions? *If you pay for certain things that can be deducted on a federal income tax return, telling us about them may lower the cost of health insurance. Do not include self-employment expenses. See Page 3 for additional information.*

Does anyone in your household have deductions? ☐ **Yes** *If yes,* who? _____

If yes, answer the questions below. ☐ **No** *If no,* go to *"Additional information we need"* on this page.

Type of deduction	How often does this person get this deduction? *(check one)*	How much?
☐ Alimony paid ☐ Student loan interest ☐ Other _____	☐ Hourly: How many hours per week? _____ ☐ Every two weeks ☐ Daily: How many days per week? _____ ☐ Twice a month ☐ Weekly ☐ Monthly ☐ Quarterly ☐ One-time payment ☐ Yearly	$ _____

Does anyone in your household have deductions? ☐ **Yes** *If yes,* who? _____

If yes, answer the questions below. ☐ **No** *If no,* go to *"Additional information we need"* on this page.

Type of deduction	How often does this person get this deduction? *(check one)*	How much?
☐ Alimony paid ☐ Student loan interest ☐ Other _____	☐ Hourly: How many hours per week? _____ ☐ Every two weeks ☐ Daily: How many days per week? _____ ☐ Twice a month ☐ Weekly ☐ Monthly ☐ Quarterly ☐ One-time payment ☐ Yearly	$ _____

Additional information we need. *Please answer the questions below that apply to you or anyone in your household.*

Is anyone in your household 19 to 20 years old and a full-time student? ☐ Yes ☐ No

If yes, who? _____

Does anyone in your household have a physical, mental, emotional, or developmental disability? ☐ Yes ☐ No

If yes, who? _____

Does anyone in your household need help with long-term care or home and community-based services? ☐ Yes ☐ No

If yes, who? _____

Is anyone in your household pregnant? ☐ Yes ☐ No *If yes,* who? _____

If yes, what is their expected due date? _____ How many babies are expected? _____

Has anyone moved into or out of the home in the past 12 months? ☐ Yes ☐ No

If yes, who? _____ What is your relationship to this person? _____

What language should we write you in? _____ What language do you want us to speak to you in? _____

If anyone in your household has changed their citizenship/immigration status in the past 12 months, list the name(s) below:

Name of Person (include first and last name)	**New Immigration or Citizenship Status**

Examples of income not from a job

Use this list for "Does anyone have income that is not from a job?"

- Unemployment benefits
- Social Security benefits
- Retirement or pension income
- Rent or royalty income
- Alimony received
- Investment income
- Capital gains
- Farming or fishing income
- Canceled debts
- Court awards
- Jury duty pay
- Other income not from a job

Deductions

Use this list for "Does anyone in the household have deductions?"

- Certain self-employment expenses
- Student loan interest deduction
- Tuition and fees
- Educator expenses
- IRA contribution
- Moving expenses
- Penalty on early withdraw of savings
- Health savings account deduction
- Alimony paid
- Domestic production activities deduction
- Certain business expenses of reservists, performing artists, and fee-based government officials

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If you are not registered to vote where you live now, would you like to apply to register to vote here today?

(Check One)

☐ Already registered. I am registered to vote at my current residence address.

☐ Yes. I would like to register to vote. (Please fill out the attached voter registration form.)

☐ No. I do not want to register to vote.

NOTE: IF YOU DO NOT CHECK A BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME. YOU MAY TAKE THE ATTACHED VOTER REGISTRATION FORM TO REGISTER AT YOUR CONVENIENCE.

Applicant Name _____ Date _____

Important Notices

1. Applying to register or declining to register to vote will **not** affect the amount of assistance that you will be provided by this agency.
2. If you would like help in filling out the voter registration form, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration form in private.
3. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party preference or other political preference, you may file a complaint with the Secretary of State by calling toll-free (800) 345-VOTE (8683) or you may write to: Secretary of State, 1500 - 11th Street, Sacramento, CA, 95814. For more information on elections and voting, please visit the Secretary of State's website at www.sos.ca.gov.

MC 200 (01/13) NVRA Voter Preference Form

Información Importante Para Personas Que Solicitan Medi-Cal

Notificación de Privacidad y Confidencialidad

Las secciones 14011 y 14012 del Código de Bienestar e Instituciones permite que las oficinas locales de asistencia pública de los condados obtengan cierta información de usted, para decidir si usted, o las personas que usted representa, pueden obtener beneficios de Medi-Cal. Usted tiene que proporcionar estos datos para obtener beneficios de Medi-Cal. La información se utilizará:

1. Por la oficina local de asistencia pública del condado, para establecer la elegibilidad inicial y continua de Medi-Cal.

2. Por el Distribuidor Administrativo (Administrative Vendor-AV) para tramitar reclamos y hacer Tarjetas de Identificación de Beneficios (Benefits Identification Cards-BICs).

3. Por el Departamento de Servicios Humanos y de Salud de los Estados Unidos para llevar a cabo auditorias y evaluaciones de control de calidad, y verificar los números que el Estado asigna a los beneficiarios a quienes paga las primas de Medicare (Buy-In) y los números de Seguro Social (Social Security Numbers-SSNs).

4. Para verificar la situación de extranjeros con el Departamento de Seguridad Nacional (DHS por sus siglas en inglés) solamente de los extranjeros que dicen haber sido admitidos legalmente con residencia permanente, o que residen permanentemente en los Estados Unidos bajo el amparo de la ley PRUCOL, o de extranjeros que recibieron amnistía con una tarjeta I-688 válida y vigente. La información que el DHS recibe puede utilizarse solamente para determinar la elegibilidad de Medi-Cal, y no la pueden utilizar las autoridades de inmigración, a menos que usted esté cometiendo fraude.

5. Por proveedores de servicios médicos y organizaciones para el mantenimiento de la salud para certificar la elegibilidad.

6. Para identificar la cobertura de seguro médico y llevar a cabo medidas de recuperación.

Derechos, Responsabilidades y Acuerdos del Solicitante/Beneficiaro de Medi-Cal

Tengo derecho a:

1. Pedir que un intérprete me ayude a solicitar Medi-Cal, si tengo dificultades para hablar o entender el idioma inglés.

2. Solicitar una entrevista en persona con un representante del condado.

3. Que se me trate justamente y con igualdad, independientemente de mi raza, color, religión, origen nacional, género, edad o creencias políticas.

4. Solicitar beneficios como persona incapacitada, si creo estarlo.

Tengo derecho a:

5. Recibir información sobre las reglas para elegibilidad retroactiva de Medi-Cal.

6. Solicitar Medi-Cal, y a que se me informe por escrito si es que cumplo con los requisitos para algún programa de Medi-Cal.

7. Repasar los manuales de reglas y regulaciones del programa de Medi-Cal, si deseo cuestionar las bases bajo las cuales se aprobó o negó mi elegibilidad.

8. Que todos los datos que le dé a la oficina local de asistencia pública del condado se mantengan en la más estricta confidencialidad, y a ver esos datos durante las horas hábiles regulares.

9. Recibir una tarjeta de necesidad inmediata, cuando esto sea posible y reúna los requisitos, si tengo una emergencia médica o si estoy embarazada.

10. Recibir Medi-Cal, según se autorice, mientras mi situación migratoria satisfactoria se esté documentando y verificando, si de otra forma reúno los requisitos. Los extranjeros que son admitidos legalmente con residencia permanente, los que residen permanentemente en los Estados Unidos bajo el amparo de la ley PRUCOL o los que recibieron amnistía con una tarjeta I-688 válida y vigente que están en una situación migratoria satisfactoria.

11. Recibir información sobre el Programa Salud y Prevención de Discapacidades en los Niños y Adolescentes (Child Health and Disability Prevention Program --CHDP) y sobre el Programa de Nutrición Suplemental Especial para Mujeres, Bebés y Niños (Special Supplemental Food Program for Women, Infants, and Children --WIC), y a pedir ayuda para recibir esos servicios.

12. Recibir información sobre el Programa de Servicio de Cuidado Personal (Personal Care Service Program --PCSP), y a pedir ayuda para recibir esos servicios.

13. Recibir información sobre el Programa de Evaluación Temprana y Periódica, Diagnosis y Tratamiento (Early and Periodic Screening, Diagnosis, and Treatment Program --EPSDT).

14. Pedir y recibir información sobre el Programa de Planificación Familiar, y a que se me informe si reúno los requisitos para esos servicios.

15. Hablar con un trabajador social sobre otros servicios o recursos públicos o privados que puedo obtener.

16. Recibir información sobre los Planes de Atención Médica de Medi-Cal a los que mi familia y yo podemos subscribirnos, para seleccionar a un médico y obtener otra atención médica, y a elegir la opción que yo prefiera.

17. Reducir mi parte del costo proporcionando facturas médicas pasadas sin pagar (que yo aún deba).

18. Reducir mi reserva de bienes para que estén dentro del límite de bienes de Medi-Cal, a más tardar el último día del mes durante el cual quiero Medi-Cal, incluyendo el mes en que solicite, y a que se me informe cómo puedo gastar mi exceso de bienes.

19. Dividir los bienes comunes contables (no exentos), (MIOS Y DE MI CÓNYUGE) por medio de un acuerdo escrito, en partes iguales de bienes por separado, si cualquiera de nosotros ingresa a un establecimiento de atención a largo plazo (Long Term Care-LTC), antes del 30 de septiembre de 1989.

Tengo derecho a:

20. Conservar una cierta cantidad de bienes por separado y comunes contables, si ingreso a un establecimiento de LTC el o después del 1° de enero de 1990. Mi cónyuge y yo tenemos el derecho a que se nos diga la cantidad.

21. Tener una audiencia estatal, si no estoy satisfecho con una medida que tomó (o no tomó) la oficina local de asistencia pública del condado o el Departamento Estatal de Servicios de Cuidado de la Salud, excepto medidas relacionadas con los programas del Pago de Primas de Seguro Médico (Health Insurance Premium Payment –HIPP) y del Plan Médico Colectivo del Empleador (Employer Group Health Plan –EGHP). Si yo deseo una audiencia estatal para apelar la decisión, tengo que solicitarla en un plazo de 90 días a partir de la fecha en que se me envió por correo la Notificación de Acción (Notice of Action –NOA). Si no recibo una NOA, tengo que solicitar una audiencia en un plazo de 90 días a partir de la fecha en que descubra la medida (o no medida) con la que no estoy satisfecho. La fecha de descubrimiento es la fecha en que yo sepa o debiera haber sabido sobre la medida. La mejor manera de solicitar una audiencia es comunicarse a la oficina local de asistencia pública del condado más cercana.

Tengo la Responsabilidad de Informarle a mi Representante del Condado en un Plazo de Diez Días (10) Cuando:

1. Los ingresos recibidos por mí, o por cualquier miembro de mi familia aumenten, disminuyan, comiencen o paren. Esto incluye ingresos de la Administración del Seguro Social (Social Security Administration –SSA), préstamos, arreglos o cualquier otra fuente.

2. Yo planee cambiar, o ya he cambiado mi lugar de residencia o dirección postal.

3. Una persona, inclusive un bebé recién nacido, independientemente de que esté relacionado conmigo o con mi familia, se mude a o fuera de mi casa.

4. Uno de los padres ausentes regrese a casa.

5. Yo, o un miembro de mi familia, tenga un bebé, se embarace o termine un embarazo.

6. Yo, mi cónyuge o cualquier miembro de mi familia, ingrese o salga de un centro de convalecencia o de un establecimiento de LTC.

7. Yo reciba, transfiera, regale o venda bienes raíces o personales (incluyendo dinero), o cuando alguien me regale a mí o a un miembro de mi familia cosas como un automóvil, una casa, pagos de seguro, etc.

8. Yo tenga cualesquier gastos que alguien aparte de mí pague.

9. Yo, o un miembro de mi familia, consiga un trabajo, cambie de trabajo o ya no tenga un trabajo.

10. Yo tenga un cambio de gastos relacionados con mi trabajo o educación. (Por ejemplo: cuidado de niños, transporte, etc.)

11. Yo, o un miembro de mi familia, nos incapacitemos física o mentalmente (esto incluiría a un niño en la familia).

12. Yo, o un miembro de mi familia, solicite beneficios por incapacidad de la SSA, Administración para Veteranos o Pensión para Ferrocarrileros.

Tengo La Responsabilidad De Informarle A Mi Representante Del Condado En Un Plazo De Diez Días Cuando:

13. Uno de mis hijos se salga de la escuela o regrese a la escuela.

14. Haya un cambio en la ciudadanía o situación migratoria de cualquier miembro de mi familia que solicite o reciba Medi-Cal.

15. La cobertura de seguro médico para mí, o para un miembro de mi familia, cambie.

Tengo la Responsabilidad de:

1. Completar y regresar un reporte sobre la situación, a más tardar en la fecha que se requiera, cuando se solicite.

2. Dar prueba de que soy residente de California.

3. Hacer una declaración sobre mi ciudadanía o situación migratoria.

4. Proporcionar un número de Seguro Social (SSN) para mí, o para cualquier miembro de mi familia que tenga un SSN, y que desee recibir beneficios de Medi-Cal. Si yo soy ciudadano de los Estados Unidos, nacional de los Estados Unidos o extranjero con una situación migratoria satisfactoria, tengo que solicitar un SSN, y proporcionárselo al condado, si todavía no tengo uno. Si necesito solicitar un SSN, puedo obtener ayuda de mi trabajador de elegibilidad, pero tengo que colaborar con la Administración del Seguro Social (SSA) para aclarar cualquier pregunta, o mi Medi-Cal se negará o interrumpirá. (Los extranjeros que no tienen una situación migratoria satisfactoria, y que no tienen un SSN, pueden obtener Medi-Cal limitado, sin solicitar un SSN, si ellos cumplen con todas las reglas.)

5. Solicitar cualesquier ingresos que posiblemente estén a mi disposición, o a la disposición de cualquier miembro de mi familia.

6. Solicitar beneficios de Medicare si estoy ciego, incapacitado, padezco de una Enfermedad Renal en su Etapa Final (End Stage Renal Disease) o tengo 64 años y 9 meses o más y reúno los requisitos. Soy responsable de informarle a mis proveedores que tengo cobertura tanto de Medi-Cal, como de Medicare.

7. Solicitar e inscribirme en cualquier seguro médico, si éste está a mi disposición, o a la disposición de mi familia, sin costo alguno. Tengo la responsabilidad de permanecer inscrito en el plan médico, cuando Medi-Cal apruebe el pago de las primas del plan por el Estado de California.

8. Reportar al departamento del condado, y al proveedor de atención médica, cualquier cobertura o seguro de atención médica que tenga, o a la que tenga derecho a usar, incluyendo Medicare. Si yo, intencionalmente, no doy esta información, es posible que sea culpable de una ofensa criminal, o que mi proveedor me cobre.

9. Ir a mi plan de atención médica (como por ejemplo Kaiser, TRICARE o una HMO de Medicare) para recibir atención médica. (Medi-Cal no pagará por ningún servicio cubierto por el plan.)

10. Dar cualesquier pagos de seguro que reciba al Estado, si Medi-Cal ya ha pagado mi atención médica.

Tengo la Responsabilidad de:

11. Ir a una presentación, si se dan presentaciones, y hacer una elección por escrito, o contestar, si se recibe por correo, acerca de cómo deseo obtener beneficios de Medi-Cal. Si no voy y hago una elección, o elijo por correo, es posible que a mí, y los miembros de mi familia que reúnen los requisitos, se nos inscriba en un Plan de Atención Médica de Medi-Cal cercano a mi hogar.

12. Firmar mi BIC, cuando la reciba, y asegurarme de que se utilice solamente para obtener atención médica necesaria para mí, o para los miembros de mi familia que reúnen los requisitos.

13. Llevar mi BIC a mi proveedor médico cuando me enferme o tenga una cita. En emergencias, cuando la BIC no está a la mano, tengo que llevar la BIC al proveedor médico en cuanto me sea posible.

14. Reportar al departamento del condado cuando reciba servicios de atención médica a causa de un accidente o lesión causado por los actos de otra persona o por no actuar ésta, por los cuales a Medi-Cal se le ha cobrado o se le podría cobrar.

15. Colaborar con el Estado o el condado para establecer la paternidad e identificar cualquier cobertura médica posible a la que yo, o mi familia, podríamos tener derecho, a través de uno de los padres ausentes.

16. Colaborar con el Estado de California, si mi caso se selecciona para que lo evalúe el equipo de evaluación del control de calidad. Si me niego a colaborar, se me interrumpirán mis beneficios de Medi-Cal.

Entiendo Que:

1. El no dar los datos necesarios, o dar datos falsos deliberadamente, puede resultar en que se me nieguen o interrumpan los beneficios de Medi-Cal. Además, es posible que mi caso sea investigado por sospechas de fraude.

2. Los datos que doy se verificarán por medio de computadora con los datos proporcionados por empleadores, bancos, la SSA, el Departamento de Impuestos del Estado (Franchise Tax Board), la agencia de asistencia pública y otras agencias. Tendré el derecho a dar pruebas para corregir cualesquier datos que se encuentren que son erróneos.

3. Los extranjeros que no tienen situación migratoria satisfactoria, y que no tienen un SSN, pueden recibir Medi-Cal limitado, sin solicitar un SSN, si ellos cumplen con todas las reglas.

4. Los datos sobre la situación migratoria proporcionados como parte de la solicitud de Medi-Cal son confidenciales.

5. En base a mis ingresos, es posible que yo pague, o se me cobre, parte de mis gastos médicos, antes de que pueda recibir Medi-Cal.

6. Si no reporto cambios con prontitud, y debido a esto, recibo beneficios de Medi-Cal por los cuales no reúno los requisitos, es posible que tenga que pagar al Departamento de Servicios de Cuidado de la Salud.

7. Yo o algún miembro de mi familia recibiendo Medi-Cal no estamos recibiendo asistencia publica de otro estado.

8. Si recibo Medi-Cal, en base a una incapacidad, y solicito beneficios por incapacidad de la SSA,

Entiendo Que:

y la SSA rechaza mi reclamo por incapacidad, es posible que mi Medi-Cal se interrumpa. Si apelo mi rechazo de la SSA inmediatamente, mi Medi-Cal continuará hasta que la SSA tome una decisión final. Si la SSA aprueba mi reclamo, entonces mis beneficios de Medi-Cal continuarán. Si la SSA no aprueba mi reclamo, entonces mis beneficios de Medi-Cal se interrumpirán.

9. Como una condición de elegibilidad de Medi-Cal, todos los derechos a apoyo médico o a pago por servicios médicos para mí, y para cualesquier personas que reúnan los requisitos, por las cuales yo tengo la responsabilidad legal, se asignan automáticamente al Estado.

10. Si un tribunal ordena el apoyo médico de uno de los padres ausentes para mis hijos, la compañía de seguros tiene que permitirme inscribirme y proporcionar beneficios a mis hijos, sin el consentimiento del padre ausente.

11. Si no solicito o mantengo cobertura médica sin costo alguno, o cobertura pagada por el estado, mis beneficios y/o elegibilidad de Medi-Cal se negarán o interrumpirán.

12. Cuando solicite Medi-Cal, se me evaluará para la posible elegibilidad bajo otros programas de asistencia médica, incluyendo los programas de HIPP y EGHP.

13. Si yo solicito a un proveedor médico cualesquier servicios que no cubre mi plan de seguro médico que no es Medi-Cal, tengo que dar al proveedor médico una declaración por escrito de mi plan médico en donde se indique que no brinda los servicios cubiertos por Medi-Cal.

14. Los proveedores de Medi-Cal no pueden cobrarme copagos, coseguro o cantidades deducibles de seguro, a menos que el pago se utilice para cumplir con mi parte del costo y/o copago de Medi-Cal.

15. Si se me ingresa a un centro de convalecencia, y no tengo intenciones de regresar a mi casa, es posible que el Estado imponga un gravamen sobre mi propiedad.

16. Después de mi muerte, el Estado tiene derecho a buscar reembolso de mi patrimonio sucesorio por todos los beneficios de Medi-Cal que recibí después de los 55 años, a menos que me sobrevivan mi cónyuge o mi pareja doméstica registrada (durante su vida), hijos menores de edad, hijos ciegos o permanentemente y totalmente incapacitados, o si esto crearía dificultades para mis herederos.

17. Después de que muera mi cónyuge o mi pareja doméstica registrada que me sobrevivió, el Estado tiene derecho a reclamar de la parte de su patrimonio sucesorio que recibió de mí, todos los beneficios de Medi-Cal que recibí después de los 55 años, hasta la cantidad máxima de bienes que mi cónyuge o mi pareja doméstica registrada recibió de mi patrimonio sucesorio.

Conserve para sus archivos.

Por este medio, declaro que he repasado la información en este formulario con el representante del condado, y que entiendo completamente mis Derechos y Responsabilidades para que mi elegibilidad de Medi-Cal se determine, y para mantener esa elegibilidad.

Firma del Solicitante/Representante *(opcional)* Fecha

County Use Section

I have provided this form to the applicant: (check one) ☐ In Person ☐ By Mail

Eligibility Worker's Name (print) Worker Number Date

Eligibility Worker's Signature

Programa de Tratamiento del Cáncer de Seno y de la Cerviz (BCCTP)

El Programa BCCTP podría proporcionar Medi-Cal a residentes de California de bajos recursos que sufren cáncer de seno o de la cerviz.

Si se le ha negado Medi-Cal o ya no es elegible para recibir Medi-Cal en su condado y tiene cáncer de seno o de la cerviz, informe a su trabajador(a) de elegibilidad (Eligibility Worker - EW) de su condado. Su EW puede referirla al programa BCCTP.

Un Especialista de Elegibilidad (Eligibility Specialist - ES) del BCCTP la contactará por teléfono o por escrito para solicitarle más información. La información solicitada nos ayudará a saber si usted es elegible para el programa. Podría ser elegible para Medi-Cal a través del BCCTP si usted es mujer y cumple con los requisitos siguientes:

- **Un proveedor de Every Woman Counts (EWC) o de Family Planning, Access, Care and Treatment (FamPACT) le ha realizado pruebas y se encontró que necesita tratamiento para el cáncer de seno o de la cerviz, control médico de seguimiento para el cáncer o lesiones/enfermedad cervical precancerosa; y**
- **Es residente de California; y**
- **Es menor de 65 años; y**
- **Es ciudadana de Estados Unidos o tiene una condición migratoria satisfactoria; y**
- **No tiene otro seguro médico, incluyendo Medi-Cal de cobertura completa sin pago de parte del costo, o Medicare ; y**
- **Tiene un ingreso familiar mensual, al momento de las pruebas y diagnóstico, que sea igual o menor a 200 por ciento del índice de pobreza a nivel federal.**

Si un proveedor que no sea EWC o FamPACT le ha realizado pruebas de cáncer de seno o de la cerviz, puede también ser referida al BCCTP. Su trabajador(a) de BCCTP le ayudará a encontrar a un proveedor de EWC o FamPACT que pueda confirmar su diagnóstico.

Aún si usted no cumple con todos los requisitos mencionados arriba, podría recibir el BCCTP a través de un BCCTP financiado por el estado. El BCCTP financiado por el estado puede ayudarle hasta 18 meses para el cáncer de seno y hasta 24 meses para el cáncer de la cerviz. El BCCTP financiado por el estado está disponible para hombres y mujeres, independientemente de su estatus migratorio.

Para más información o preguntas acerca del BCCTP, llame al 1-800-824-0088

¿Qué sucede si no recibo los servicios que quiero del departamento de salud mental de mi condado?

Usted puede presentar una queja en el departamento de salud mental del condado, si el departamento de salud mental del condado le niega los servicios de *EPSDT* que su médico o proveedor solicitó. Además, usted puede presentar una queja, si usted cree que necesita servicios de salud mental, y su proveedor o el departamento de salud mental de su condado no están de acuerdo en esto. Llame al número gratuito del departamento de salud mental del condado para hablar con un/a coordinador/a de quejas para que le dé información y ayuda. Además, usted puede llamar al defensor de los derechos de los pacientes del condado o a la Oficina del Protector de los Derechos de las Personas del Departamento de Salud Mental del Estado.

Usted puede solicitar una audiencia estatal al mismo tiempo. Llame al 1-800-952-5253, TTY 1-800-719-5798 envíe un fax al 916-229-4110, ó escriba a California Department of Social Services, State Hearings Division, P.O. Box 944243, Mail Station 19-37, Sacramento CA 94244-2430. Usted tiene que pedir una audiencia en un plazo de 90 días a partir de que se entere de que se negó su solicitud de servicios. Además, *Protection & Advocacy, Inc.* está a su disposición para ayudarle con quejas, apelaciones y agravios.

¿A quién puedo llamar para obtener más información?

Para obtener más información, por favor comuníquese con las siguientes oficinas, a los números de teléfono enseguida.

Número de acceso gratuito del Departamento de Salud mental del Condado	Busque en su guía telefónica local.
Oficina del Protector de los Derechos de las Personas del Departamento de Salud Mental	1-800-896-4042
Programa de Salud Infantil y Prevención de Incapacidades (*CHDP*) localizado en el departamento de salud de su condado o ciudad.	Busque en su guía telefónica local.
Protection & Advocacy, Inc.	1-800-776-5746 ó www.pai-ca.org TTY 1-800-719-5798

Department of Health Care Services

MC Information Notice 003 (SP) (06/07)

Servicios de Medi-Cal para Niños y Jóvenes:

Detección, **D**iagnóstico y **T**ratamiento **O**portunos y **P**eriódicos

Servicios de Salud Mental

Esta notificación es para niños y jóvenes que reúnen los requisitos para los servicios de *EPSDT* de Medi-Cal por ser menores de 21 años de edad. Además, esta notificación es para los tutores legales o personas encargadas del cuidado de niños y jóvenes que reúnen los requisitos para los servicios de *EPSDT*.

¿Qué son los servicios de Detección, Diagnóstico y Tratamiento Oportunos y Periódicos (*EPSDT*)?

Los servicios de Detección, Diagnóstico y Tratamiento Oportunos y Periódicos *(Early and Periodic Screening, Diagnosis and Treatment—EPSDT)* son servicios adicionales de Medi-Cal. Usted puede obtenerlos, adicionalmente a otros servicios de Medi-Cal. **Para obtener estos servicios, usted tiene que ser menor de 21 años de edad y tener Medi-Cal con beneficios completos.** Los servicios de *EPSDT* corrigen o mejoran problemas médicos que su médico u otro proveedor de atención médica detecta, aunque el problema médico no desaparezca del todo.

¿Cómo puedo recibir servicios de EPSDT para mi niño/a, o para mí mismo/a, si yo soy menor de 21 años de edad?

Pregúntele a su médico o clínica sobre los servicios de *EPSDT*. Es posible que reciba estos servicios si usted y su médico, u otro proveedor de atención médica, clínica [como por ejemplo el Programa de Salud Infantil y de Prevención de Incapacidades (*Child Health and Disability Prevention Program–CHDP*)], o el departamento de salud mental del condado están de acuerdo en que usted los necesita.

¿Qué son los servicios de *EPSDT* de salud mental?

Los servicios de *EPSDT* de salud mental son servicios de Medi-Cal que corrigen o mejoran los problemas de salud mental. Es posible que estos problemas consistan en tristeza, nerviosismo o enojo que le dificulta la vida a usted.

Algunos de los servicios que usted puede recibir del departamento de salud mental de su condado son:

- Terapia individual
- Terapia en grupo
- Terapia familiar
- Consejos en caso de crisis
- Administración de casos
- Programas especiales durante el día
- Medicamentos para su salud mental
- Servicios de EPSDT de salud mental para tratar problemas de alcoholismo y drogadicción que usted podría tener que afectan su salud mental.

Además, usted puede pedir consejos y terapia tan frecuentemente como una vez a la semana o más días, si cree que los necesita. Es posible que usted pueda obtener estos servicios en su hogar o en la comunidad.

En la mayoría de los casos, el departamento de salud mental de su condado, usted y su médico o proveedor decidirán si los servicios que usted pide son necesarios desde el punto de vista médico. Los departamentos de salud mental del condado tienen que aprobar sus servicios de *EPSDT*. Cada departamento de salud mental del condado tiene un número de teléfono gratuito, al que usted puede llamar para obtener más información, y para solicitar servicios de *EPSDT* de salud mental.

¿Qué son los Servicios Terapéuticos de Conducta (TBS) de EPSDT?

Los Servicios Terapéuticos de Conducta *(Therapeutic Behavioral Services-TBS)* es un servicio de *EPSDT* de salud mental. Los *TBS* ayudan a los niños y a los jóvenes que:

- Tienen problemas emocionales graves
- Viven en un establecimiento de salud mental o están en riesgo de ingresar a uno, o
- Han sido hospitalizados recientemente por problemas de salud mental.

Si usted recibe otros servicios de salud mental y sigue sintiéndose muy triste, nervioso/a o enojado/a, es posible que a usted le pueda ayudar una persona capacitada en salud mental. Esta persona podría ayudarle cuando tiene problemas que podrían causarle que se enoje, altere o entristezca. Esta persona vendría a su hogar, hogar colectivo o iría con usted a excursiones y actividades en la comunidad.

El departamento de salud mental de su condado puede decirle cómo pedir una evaluación para ver si necesita servicios de salud mental, incluyendo *TBS*.

¿Con quién puedo hablar sobre los servicios de EPSDT de salud mental?

Usted puede hablar con su doctor a, psicólogo a, consejero/a o trabajador/a social sobre los servicios de *EPSDT* de salud mental. Para niños y jóvenes en un hogar colectivo o establecimiento residencial, puede hablar con el personal sobre cómo obtener servicios adicionales de *EPSDT*.

Para los niños en cuidado de crianza temporal, también puede preguntar al/a la abogado a designado/a por el tribunal. Además, usted puede llamar directamente al departamento de salud mental de su condado. (Busque el número de teléfono gratuito en su guía telefónica, o llame al protector de los derechos de las personas del departamento de salud mental del estado.)

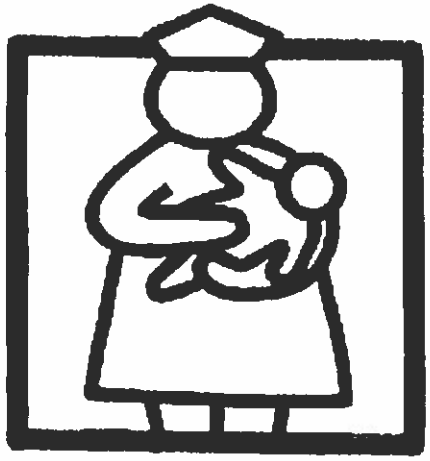
¿Por qué hacerles exámenes médicos?

En un examen de **salud** completo se pueden encontrar problemas médicos, dentales y/o de salud mental antes de que sean serios. También se dan las vacunas necesarias. Tendrá tiempo para hacer preguntas. Si está requerido, se puede hacer un examen de salud para cuidado de crianza, deportes o campamentos. Por lo general, los exámenes CHDP se hacen en el mismo lugar donde recibie sus otros servicios de salud.

Bebés y niños pequeños
Nacimiento a los 3 años

Atención y vacunación del bebé sano programadas

Los bebés y los niños pequeños necesitan exámenes de salud frecuentes. Necesitan sus vacunas a tiempo.



¿Cada cuánto?

Necesitan un examen a estas edades:

Menos de 1 mes
1 a 2 meses
3 a 4 meses
5 a 6 meses
7 a 9 meses
10 a 12 meses
13 a 15 meses
16 a 23 meses
2 años
3 años

Niños en edad escolar
4 a 12 años

Exámenes para entrar a la escuela

La ley estatal requiere que niños que entren al jardín de niños o al primer grado se hagan un examen de salud y tengan las vacunas al día.

Los exámenes de salud pueden encontrar problemas que podrían el desempeño escolar del niño.

¿Cada cuánto?

Necesitan un examen a estas edades:

Entre los 4 y 5 años
Entre los 6 y 8 años
Entre los 9 y 12 años

Adolescentes y adultos jóvenes
13 a 20 años

Exámenes de salud

¡Los adolescentes también necesitan exámenes de salud! Es posible que tengan preguntas sobre su salud. Pueden hablar con un proveedor de salud.

¿Cada cuánto?

Necesitan un examen a estas edades:

Entre los 13 y 16 años
Entre los 17 y 20 años

Pregunte a su médico o al departamento de salud local sobre otros servicios para adolescentes.

¿Qué servicios ofrece CHDP?

Exámenes físicos de rutina:

- ♥ Examen del crecimiento y el desarrollo
- ♥ Todas las vacunas necesarias
- ♥ Examen de los dientes
- ♥ Examen de la vista
- ♥ Examen del oído
- ♥ Examen de nutrición
- ♥ Instrucción sobre la salud
- ♥ Instrucción sobre el tabaco
- ♥ Pruebas de anemia, plomo en la sangre, orina, tuberculosis y otras según sea necesario
- ♥ Remisión al WIC para niños de hasta 5 años de edad

Exámenes dentales con regularidad y atención adicional, si fuera necesario.

Si necesita más servicios médicos, dentales o de salud mental, le ayudaremos a encontrarlos. No tiene que pagar el diagnóstico ni el tratamiento mientras su hijo reciba Medi-Cal.

Si usted tiene Medi-Cal con costo compartido puede hacer que CHDP pague el examen o, usted puede pagar el examen, y hacer que el costo cuente hacia el pago que le corresponde. Los servicios de CHDP NO tienen ningún copago.

Lleve su tarjeta Medi-Cal vigente y el comprobante de vacunación.

Información:

Para más información, o ayuda para obtener una cita y transporte, póngase en contacto con la oficina local de CHDP. El teléfono está en la sección de gobierno del directorio telefónico. Busque bajo *Child Health and Disability Prevention* o bajo *Health Department*.

O, puede encontrar la dirección de su oficina CHDP local en:
www.dhs.ca.gov/chdp

Si necesita ayuda para obtener servicios de salud mental, llame al departamento de salud mental de su condado. Ellos le pueden dar información sobre otros servicios para niños y jóvenes con problemas emocionales serios que tienen Medi-Cal completo.

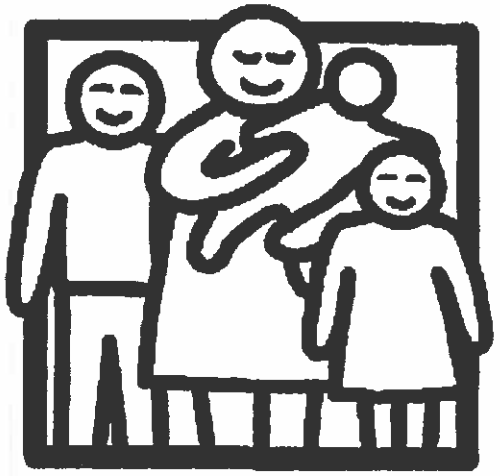
Arnold Schwarzenegger
Gobernador del Estado de California

PUB 184 (Spanish 1/04)

Spanish

Programa de Salud y Prevención de Discapacidades de Niños (CHDP)

Exámenes médicos y dentales



GRATUITOS
Para bebés, niños y jóvenes de hasta 20 años
con Medi-Cal completo (Full Scope)

- Su silla de ruedas no cabe en los baños o en las salas donde se llevan a cabo los exámenes o las entrevistas.
- Los hombres reciben entrenamiento para empleos que pagan más y las mujeres reciben entrenamiento para empleos que pagan menos.
- El Condado no quiere proporcionarle entrenamiento porque dicen que usted es "demasiado viejo".
- No le permiten adoptar a un bebé porque la raza de usted es diferente a la del bebé.

Quejas de discriminación

Si usted cree que ha sido víctima de discriminación, puede presentar una queja al Condado, al Estado, y al Gobierno Federal - una queja separada para cada uno. La oficina específica del Gobierno Federal a la cual debe comunicarse depende de que programa se trata su queja.

Puede presentar una queja de discriminación a:

1. PARA TODOS LOS PROGRAMAS QUE SE ADMINISTRAN POR EL DEPARTAMENTO DE BIENESTAR PÚBLICO DEL CONDADO:
   El coordinador de derechos civiles del Condado. Pídale a la oficina del Condado el nombre, dirección, y número de teléfono de su coordinador de derechos civiles. El/Ella investigará su queja independientemente.
2. Civil Rights Bureau
   California Department of Social Services
   744 P Street, MS 8-16-70
   Sacramento, CA 95814
   (916) 654-2107
   (866) 741-6241 (Gratuito)
3. PARA EL PROGRAMA DE CALFRESH:
   United States Department of Agriculture
   Director, Office of Civil Rights,
   Room 326-W, Whitten Bldg.
   1400 Independence Avenue, S.W.,
   Washington, D.C. 20250-9410
   (202) 720-6382 (voz y TTY)
4. PARA TODOS LOS OTROS PROGRAMAS:
   Health and Human Services
   Office of Civil Rights
   90 7th Street, Suite 4-100
   San Francisco, CA 94103
   (415) 437-8310 (voz)
   (415) 437-8311 (TDD)

Límites de tiempo para tomar acción

Si usted es víctima de discriminación, tiene que presentar su queja antes de que pasen 180 días a partir de cuando ocurrió la discriminación. Si la discriminación también afectó la cantidad de sus beneficios o servicios, también tiene que pedir una audiencia con el Estado antes de que pasen 90 días. Una investigación de discriminación no puede cambiar la cantidad de sus beneficios o servicios... solamente una audiencia con el Estado puede hacer eso.

Límites en cuanto a ciertos derechos

Aunque usted tenga derecho a la privacidad y la confidencialidad, hay ciertas leyes que permiten excepciones limitadas. Usted puede pedirle al Condado información sobre estas leyes.

Preguntas

Si tiene alguna pregunta sobre los derechos enumerados en este folleto, llame a la Oficina de Preguntas y Respuestas al Público: (800) 952-5253 (Gratuito). El número gratuito de TDD (aparato de telecomunicaciones para las personas sordas) es (800) 952-8349.

Programas cubiertos en este folleto

- Programa de Asistencia para Adopciones (AAP)
- Servicios para la Protección de Adultos (APS)
- Programas de Alcohol y Drogas (ADP)
- Programa de California para la Asistencia Alimentaria (CFAP)
- Programa de Asistencia Médica de California (Medi-Cal)
- Programa de California de Oportunidades de Trabajo y Responsabilidad hacia los Niños (CalWORKs)
- Cuidado de Niños del Programa de CalWORKs
- Programa para la Transición de la Asistencia Pública al Trabajo (WTW) bajo el Programa de CalWORKs
- Programa de Asistencia Monetaria para Inmigrantes (CAPI)
- Servicios para el Bienestar de los Niños (CWS)
- Programa de Asistencia Dental de California para Niños (Denti-Cal)
- Programa de Evaluación Temprana y Periódica, Diagnosis, y Tratamiento (EPSDT)
- CalFresh (estampillas para comida)
- Cuidado de Crianza Temporal (FC)
- Programa de Servicios de Apoyo en el Hogar (IHSS)
- Programa de Pagos de Asistencia para Parientes que Son los Tutores Legales de un Menor (Kin-GAP)
- Salud Mental
- Programa de Servicios Múltiples para Personas Mayores (MSSP)
- Programa de Servicios de Cuidado Personal (PCSP)
- Asistencia Monetaria para Refugiados (RCA)
- Servicios Sociales

STATE OF CALIFORNIA
(ESTADO DE CALIFORNIA)

HEALTH AND HUMAN SERVICES AGENCY
SECRETARÍA DE SALUD Y SERVICIOS HUMANOS

DEPARTMENT OF SOCIAL SERVICES
(DEPARTAMENTO DE SERVICIOS SOCIALES)

Este folleto está disponible en los siguientes idiomas en la oficina de bienestar público de su condado y en el sitio web: www.cdss.ca.gov

• Árabe	• Japonés	• Ruso
• Armenio	• Coreano	• Español
• Camboyano	• Laosiano	• Español (letra grande)
• Chino	• Mien	• Tagalo
• Farsi	• Portugués	• Ucraniano
• Hmong	• Punjabi	• Vietnamita

También está disponible en Braille, así como una versión fácil de leer (letra grande), o grabada en CD.

PUB 13 SP (6-11)

SUS DERECHOS

BAJO LOS PROGRAMAS DE ASISTENCIA PÚBLICA DE CALIFORNIA

..... para las personas que solicitan o reciben asistencia pública en California

Díganos si necesita ayuda debido a una incapacidad/ discapacidad.

Pida un intérprete gratis

Sus derechos

Todas las personas y organizaciones que proporcionan asistencia pública tienen que respetar los derechos que usted tiene. Le pueden ayudar a entender y solicitar beneficios y servicios.

- You have the right to an interpreter free of charge.
- Ud. tiene derecho a un intérprete gratis
- Вы имеете право на услуги Переводчика
- 你有权利用口译员
- May karapatan kang magkaroon ng tagapagsalin na walang bayad.
- Quý vị có quyền được một thông dịch viên miễn phí.
- Koj muaj txoj cai yuav ib tus neeg txhais lus Hmoob pub dawb.
- لديك الحق في الحصول على مترجم دون أية تكلفة.
- Դուք ունեք թարգմանիչի իրավունք անվճար:
- [illegible]
- [illegible]
- [illegible]
- [illegible]
- [illegible]
- [illegible]
- Você tem o direito a um/a intérprete gratuito/a!
- [illegible]
- Meih maaih leiz haih duqv daoh faan waac mienh tengx meih maiv zuqc bun nyaanh.

Usted tiene derecho a ...

1. Entender lo que está pasando con su solicitud y su asistencia.
2. Obtener explicaciones, por escrito y orales, sobre su solicitud y sus beneficios.
3. Obtener un recibo para cada documento que entrega.
4. Ver el expediente de su caso.
5. Ver las leyes y los ordenamientos del Estado y del Condado.
6. Pedirle a un juez que revise cualquier decisión del Condado sobre su elegibilidad, beneficios, o servicios.
7. No ser víctima de discriminación en cuanto a recibir beneficios o servicios de los programas.
8. Presentar una queja sobre cualquier discriminación.
9. Obtener ayuda adicional del personal del Condado para asegurarse de que reciba sus beneficios si tiene una incapacidad/discapacidad o un impedimento que le hace difícil entender las reglas del programa.
10. Mantener su información de una manera confidencial.
11. Ser tratado con cortesía y respeto.

Si tiene problemas con su asistencia o sus servicios:

1. <u>Mantenga un expediente</u> de toda su información, todos sus documentos, y cualquier contacto con el Condado que haya tenido.
2. <u>Obtenga un recibo</u> para cada documento que entrega.
3. <u>Pida a alguien que le acompañe</u> cuando tiene una cita con su trabajador.
4. <u>Presente una queja.</u> Hay 4 maneras de hacer esto:

- *Queja informal:* Puede pedir hablar con un supervisor sobre problemas que tiene con un trabajador o para revisar las reglas y la acción que el Condado propone tomar en relación a sus servicios o asistencia.
- *Audiencia con el Estado:* Pida una audiencia con el Estado si hay un problema con su asistencia o sus servicios. **Tiene que pedir una audiencia antes de que pasen 90 días a partir de la acción del Condado.** Es posible que pueda pedir una audiencia después de los 90 días si tiene un motivo justificado como una enfermedad o una incapacidad/discapacidad.
- *Queja de discriminación:* Si cree que el Condado ha discriminado contra usted, puede presentar una queja de discriminación - al coordinador de derechos civiles del Condado o a la Oficina de Derechos Civiles del Estado, y al Gobierno Federal.

  Tiene que hacer esto antes de que pasen 180 días a partir de la discriminación. Para más información sobre esto, vea la sección que comienza con "Prohibida la discriminación". Si la discriminación también afecta sus beneficios o servicios, **también tiene que pedir una audiencia con el Estado** si desea disputar la decisión del Condado en relación a sus beneficios o servicios.
- *Procedimiento para presentar quejas:* Puede presentar una queja al Condado si tienen un procedimiento para presentar quejas. **Esto no protege sus beneficios** de la misma manera que lo hace el pedir una audiencia con el Estado.

Audiencia con el Estado

- Puede pedir una audiencia con el Estado si no está de acuerdo con una acción del Condado en relación a sus beneficios o servicios.
- También puede pedir una audiencia con el Estado si el Condado no le da los beneficios o servicios que usted cree que debe recibir.
- Un juez de leyes administrativas del Estado está a cargo de la audiencia con el Estado. Un representante del Condado estará presente también en la audiencia para explicar por qué tomó su acción el Condado.
- Una audiencia con el Estado no es una audiencia de la corte. Usted tiene el derecho de llevar un representante a la audiencia. Hay servicios legales gratuitos en cada condado los cuales se indican en la segunda página de las notificaciones del Condado. Puede llevar testigos. Tiene el derecho de tener un intérprete gratis. Pregúntele al Condado cómo hacerlo.
  - Si tiene un problema con el Programa de Asistencia General/Ayuda General, tiene que pedir una audiencia con el Condado.
  - Si tiene un problema con sus beneficios de Seguro Social, tiene que comunicarse con la Administración del Seguro Social.

Continuación de su asistencia o sus servicios mientras que espera una audiencia con el Estado

El Condado tiene que darle una notificación por lo menos 10 días antes de que entre en vigor cualquier acción que cambie su asistencia o sus servicios. Si pide una audiencia antes de que entre en vigor la acción, puede continuar recibiendo asistencia hasta que se lleve a cabo la audiencia (*"aid paid pending"*). Esto significa que su asistencia quedará igual hasta que se emita una decisión sobre la audiencia.

USTED TIENE QUE pedir una audiencia cada vez que reciba una notificación sobre cualquier acción con la cual usted no está de acuerdo.

Cómo pedir una audiencia con el Estado

1. Por teléfono: Pida una audiencia con el Estado, comunicándose con el Departamento de Servicios Sociales de California (CDSS), al (800) 743-8525 o (800) 952-5253.
2. Complete la segunda página de su notificación de acción (NOA), o envíe una petición por escrito al CDSS a la siguiente dirección:
   CDSS, State Hearing Division
   744 P Street M.S. 09-17-37
   Sacramento, CA 95814

Prohibida la discriminación

Bajo las leyes del Estado, las oficinas que proporcionan asistencia pública no pueden proporcionarle beneficios o servicios que son diferentes a la asistencia que proporcionan a otras personas basándose en su:

Raza, Color, Origen Nacional (incluyendo su idioma), Grupo Étnico, Edad, Incapacidad/Discapacidad, Religión, Sexo, Orientación Sexual, Afiliación Política, Estado Civil o Relación Doméstica

Las leyes federales también prohíben la discriminación basada en algunas, aunque no todas, las razones antes mencionadas. Las leyes federales también prohíben:

1. El demorar o negar la colocación de un niño para su adopción o su ingreso en un hogar de cuidado de crianza temporal basándose en la raza, color, u origen nacional de los padres adoptivos de crianza temporal o del niño.
2. El negarle a cualquier persona la oportunidad de hacerse padre, madre adoptivo o de crianza temporal basándose en la raza, color, u origen nacional de la persona o del niño involucrado.

Ejemplos de discriminación

- El Condado no le proporciona un intérprete gratis.
- Un trabajador les habla a personas de cierto grupo étnico sobre más programas y servicios que a personas en otros grupos étnicos.
- El Condado no le ayuda a obtener cintas de grabación (*audio tapes*) de la orientación para un programa para ayudarle con una incapacidad/discapacidad que le hace difícil leer.
- Un trabajador le trata de una manera diferente al darse cuenta de su religión o su afiliación política.
- No puede llegar a sus citas porque el edificio del Condado no tiene un ascensor.

Notice of Language Services

If you do not understand this information or notification, call your county worker. You have the right to interpreter services provided by the county at no cost to you.
(English)

Si no entiende la información o notificación, póngase en contacto con el trabajador social de su condado. El condado debe proporcionarle el servicio de interpretación en forma gratuita.
(Spanish)

إذا لم تفهم هذه المعلومات أو هذا الإشعار فعليك الاتصال بموظف الإقليم. ويحق لك الحصول على خدمات مترجم يقدمها لك الإقليم بالمجان
(Arabic)

Եթե այս ինֆորմացիան չեք հասկանում հաձեցեք կապվել ձեր գավառի պաշտոնյային. իրավունք ունեք առանց վճարման թարգմանիչի ծառայությանց. որ ձեզ կտրվի գավառի կողմից
(Armenian)

ប្រសិនបើអ្នកមិនយល់ព័ត៌មាន ឬការជូនដំណឹងនេះទេ សូមទូរស័ព្ទទៅកាន់បុគ្គលិកធ្វើការក្នុងខេត្តរបស់អ្នក ។ អ្នកមានសិទ្ធិ
ទទួលការបកប្រែដោយមិនគិតថ្លៃពីស្ថាប័នរដ្ឋបាលខេត្ត ។
(Cambodian)

如果您對此份資訊或通知的內容不瞭解，請與當縣的工作人員聯繫。您有權利要求當縣所提供的免費口譯人員服務。
(Chinese)

اگر این اطلاعات یا اطلاعیه را نمیفهمید، با کارمند بخش خود تماس بگیرید. شما قانونا حق دارید از خدمات ترجمه که بطور مجانی توسط بخش فراهم میشود بهره مند شوید
(Farsi)

Yog koj tsis to taub cov ntaub ntawv lossis daim ntawv no, hu rau koj tus kws khiav ntaub ntawv nyob koj cheeb tsam. Koj muaj cai siv kev pab txhais lus pub dawb uas los ntawm cheeb tsam koj nyob ko.
(Hmong)

この情報やお知らせが理解できない時には、カウンティワーカーにご連絡下さい。あなたにはカウンティから通訳サービスを提供してもらう権利があり、料金は無料です。
(Japanese)

이 정보 또는 통지서의 내용을 잘 이해 못하시면, 카운티 담당 직원에게 연락하시기 바랍니다. 당신은 카운티로부터 통역 서비스를 무료로 받을 권리를 갖고 있습니다
(Korean)

ຫາກວ່າທ່ານບໍ່ເຂົ້າໃຈຂໍ້ມູນຫລືໃບແຈ້ງຄວາມນີ້ ໃຫ້ໂທຣໄປຫາພະນັກງານຄາວຕີ້ (county) ຂອງທ່ານ. ທ່ານມີສິດທີ່ຈະຮັບບໍລິການບາຍພາສາທີ່ຈັດໃຫ້ໂດຍຝ່າຍຄາວຕີ້ (county) ໂດຍທ່ານບໍ່ເສັງຄ່າ.
(Lao)

Se gorngv meih maiv bieqc hnyouv naaiv deix mbuox mengh fienx fai mbuox hiuv fienx nor, heuc lorz meih nyei Nquenc zaangc nyei goux sou-gorn mienh. Meih maaih leiz duqv Nquenc zaangc baeqc bun tih waac mienh tengx meih nyei oc
(Mien)

ਜੇਕਰ ਤੁਸੀ ਇਸ ਜਾਣਕਾਰੀ ਜਾਂ ਸੂਚਨਾਂ ਨੂੰ ਨਹੀ ਸਮਝਦੇ, ਤਾਂ ਆਪਣੇ ਕਾਉਂਟੀ ਵਰਕਰ ਨੂੰ ਕਾਲ ਕਰੋ। ਤੁਹਾਨੂੰ ਕਾਉਂਟੀ ਦੁਆਰਾ ਪ੍ਰਦਾਨ ਕੀਤੀ ਜਾ ਰਹੀ ਦੁਭਾਸ਼ੀ ਦੀ ਸੇਵਾਵਾਂ ਲੈਣ ਦਾ ਹੱਕ ਹੈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਦੇ ।
(Punjabi)

Если вы не понимаете эту информацию или уведомление, позвоните своему окружному работнику. Вы имеете право на услуги переводчика, которые округ окажет вам бесплатно.
(Russian)

Kung hindi ninyo na-iintidihan ang information (kabatiran) o notification (patalastas), tawagan ang county worker (manggawa) ninyo. May karapatan kayo sa serbisyo ng translator (tagasalin) na ilalaan ng county na wala kayong babayaran.
(Tagalog)

Якщо ви не розмієте цю інформацію або повідомлення, зателефонуйте своему окружному працівнику. Ви маєте право на послуги перекладача, які округ надасть вам безкоштовно.
(Ukrainian)

Nếu quý vị không hiểu thông tin hoặc thông báo này, xin vui lòng gọi cho nhân viên quận. Quý vị có quyền sử dụng các dịch vụ thông dịch miễn phí của quận
(Vietnamese)

Condado de Kern - Eligibility Services

Teléfono: (877) 410-8812

Nombre del Trabajador: Processing Team Eight
Identificación del Trabajador: [redacted]
Teléfono del Trabajador:(877) 410-8812
Fecha: 08/06/2014
Nombre del Caso: [redacted]
Número del Caso: [redacted]

Kinship
PO BOX 511
BAKERSFIELD, CA 93302-0511

[redacted]

La dirección para regresar su paquete se encuentra al reverso de esta página.

MC PE Packet

FIRST-CLASS MAIL PERMIT NO. 1531 BAKERSFIELD CA
POSTAGE WILL BE PAID BY ADDRESSEE

Kern County Dept of Human Services
PO BOX 511
BAKERSFIELD CA 93302-9985

Por favor doble la página y asegure que la dirección del condado se vea en la ventanilla del sobre.

¡Noticias importante sobre cómo mantener su Medi-Cal!

A partir de este año, la elegibilidad de Medi-Cal se determinara para la mayoría de la gente utilizando las reglas de impuestos sobre el ingreso e información de declaración personal. Medi-Cal contará el tamaño de su hogar y sus ingresos basados en su información de impuestos. Si no presenta declaración de impuestos, usted todavía puede recibir Medi-Cal.

Debido a que usted tiene Medi-Cal ahora, ya sabemos mucho acerca de usted. Lo que no sabemos es su información fiscal relacionado con los miembros del hogar. Para obtener esta información, necesitamos que usted llene los formularios que se adjuntan a esta carta.

Vamos a utilizar la información en estos formularios, junto con la información que ya sabemos acerca de usted, para ver si todavía califica para Medi-Cal. Por favor complete los formularios para usted mismo y los miembros de la familia que viven con usted o se reclaman en su declaración de impuestos. Sólo el jefe de familia (la persona que presenta declaración de impuestos) debe completar el **"Formulario Suplementario para la Solicitud de Información Fiscal de Hogares (RFTHI)"** y firmar los formularios. Sólo tiene que llenar estos formularios este año cuando lo movemos de las reglas actual de Medi-Cal a las reglas nuevas de Medi-Cal. En el futuro, vamos a tratar de volver a determinar su elegibilidad cada año basado en la información que tenemos sin pedir nada más de usted.

Ya que usaremos ahora su información de impuestos para determinar la elegibilidad de Medi-Cal, pueda ser que podamos comprobar electrónicamente la información que usted nos da para ver si todavía es elegible para Medi-Cal. Si somos en condiciones de hacerlo, es posible que no necesitemos ningunos documentos de papel adicionales distintas de los formularios incluidos. Si no podemos comprobar su información electrónicamente, le pediremos los documentos de papel. Usted sólo será pedido de enviar documentos en papel de la información que no pudimos comprobar por medios electrónicos.

Si no es elegible para Medi-Cal basado en las nuevas reglas, usted todavía puede calificar para otros programas de Medi-Cal, pero debemos comprobar primero su elegibilidad basada en información de impuestos para ver qué tipo de Medi-Cal usted es elegible a recibir.

Con el fin de ver si usted todavía es elegible para Medi-Cal, debe darnos la información en el **Formulario Suplementario RFTHI.** Usted debe darnos esta información para usted mismo y cada persona que vive con usted o se reclama en su declaración de impuestos.

Nos tiene que dar esta información por 09/02/2014 .

Hay tres maneras en que nos puede dar esta información:

Por correo:

Usted puede darnos esta información completando los formularios enviados con esta carta. Debe completar un formulario RFTHI para usted mismo y cada persona que vive con usted o se reclama en su declaración de impuestos y un RFTHI Suplementario para su hogar. Por favor use el sobre con franqueo pagado para devolver el formulario.

Por teléfono:

Usted nos puede dar esta información por teléfono llamándonos al (877) 410-8812. Cuando llame, usted debe tener su más reciente declaración de impuestos federales disponible, si usted declara impuestos.

En persona:

Usted puede darnos esta información visitándonos al

Kinship
100 E CALIFORNIA AVE
BAKERSFIELD, CA 93307-1031

Recuerde, usted de darnos esta información por 09/02/2014 **o puede perder los beneficios de Medi-Cal.**

Solicitud de Información Fiscal de Hogares(RFTHI)

Como completar esta formulario:

1. Conteste todas las preguntas en este formulario. Use tinta y letra de molde en sus respuestas. Si necesita más espacio, adjunte papel adicional a este formulario.
2. Lea la información acerca de usted y cada miembro de su hogar, incluyendo dependientes fiscales. Agregué cualquier información que falte. Si alguna información ha cambiado, edifique con la información correcta.
3. Firme y escriba la fecha en el formulario en la página 6.
4. **Regrese este formulario antes del** 09/02/2014. Use el sobre con franqueo pagado para devolver el formulario. Si no devuelve este formulario antes de esta fecha, usted perderá su cobertura de Medi-Cal.

Lo que necesitamos:

Necesitamos información acerca de cada persona que vive en su hogar o que aparece en su declaración de impuestos, incluyendo:

- Las personas que reciben Medi-Cal ahora
- Las personas que no tienen Medi-Cal pero desean aplicar, y
- Las personas que viven en el hogar y no reciben Medi-Cal pero no desean solicitarlo

Si no califica para Medi-Cal:

Si usted no califica para Medi-Cal, revisaremos si califica para otros tipos de cobertura de salud. Tal vez enviaremos su información a otro programa para que puedan determinar si usted califica.

¿Necesita ayuda?

Llame a su Agencia de Medi-Cal al (877) 410-8812
TTY: (800) 952-8349

Debe completar uno de estos formularios para cada persona en su hogar y devolverlo al condado

Número del caso (opcional)	SSN or ATIN/ITIN*
Nombre del Individuo	Fecha de nacimiento (mm/dd/aaaa)
Dirección actual, número de apartmento	Ciudad Código postal
Dirección postal, si es diferente de la anterior	Ciudad Código postal

1. Esta persona está: ☐ Empleado(a) ☐ Trabajando por cuenta propia

2. Si esta persona está empleado(a) actualmente, incluya una lista de toda la información acerca de todos los tipos de ingresos recibidos incluyendo:

Nombre del empleador: _____ Dirección del empleador: _____

Número de teléfono del empleador: _____ Promedio de horas trabajadas por semana: _____

Salarios/Propinas (antes de impuestos): _____ ☐ Por hora ☐ Dos veces al mes ☐ Bimensual ☐ Mensual ☐ Anual

3. Si esta persona trabaja por cuenta propia, conteste las siguientes preguntas:

Tipo de Trabajo: _____

¿Cuánto ingreso neto (ganancias después de gastos del negocio) recibirá este mes del trabajo por su cuenta?

_____

4. ¿Para esta persona, piensa presentar una declaración de impuestos federales sobre los ingresos el PRÓXIMO AÑO? ☐ Sí, complete a-c ☐ No, pase al c

a. ¿Va a presentar en forma conjunta con su cónyuge?

☐ No ☐ Sí, nombre de su esposo(a) _____

b. ¿Va a reclamar dependientes? ☐ No ☐ Sí, nombre de dependientes _____

c. ¿Va a ser reclamado como dependiente en la declaración de impuestos de otra persona? ☐ No ☐ Sí

Si la respuesta es sí, apunte el nombre del declarante de impuestos: _____ ¿Relación de esta persona al declarante de impuestos? _____

5. Favor de contestar la siguiente pregunta solamente si esta persona es menor de 21 años de edad y es estudiante de tiempo completo:

¿Tenía esta persona seguro de salud a través de un trabajo y lo perdió en los últimos 12 meses? ☐ Sí ☐ No

6. ¿Fueron usted o cualquier otra persona en su familia que es de 26 años de edad o menos en el cuidado de crianza temporal a la edad de 18 años? ☐ Sí ☐ No

7. ¿Ha cambiado el estado migratoria o ciudadanía de esta persona en los últimos 12 meses? ☐ Sí ☐ No

Si la respuesta es sí, favor de explicar el cambió: _____

8. Es esta persona: ☐ Hispano ☐ Latino ☐ Español ☐ Indio (indígena de los EE.UU. de América) o Nativo de Alaska

☐ Blanco ☐ Negro o Afroamericano ☐ Filipino ☐ Chino ☐ Japonés ☐ Camboyano ☐ Coreano

☐ Vietnamita ☐ Indio Asiático ☐ Laosiano ☐ Otro grupo Asiático, especifique: _____

☐ Hawaiano Nativo ☐ Guameño or Chamorro ☐ Samoano ☐ Otra o Raza Mixta

*Número de Seguro Social (SSN) o Número de Identificación del contribuyente para adopción (ATIN, por sus siglas en inglés) Número de identificación del contribuyente (ITIN, por sus siglas en inglés)

Debe completar uno de estos formularios para cada persona en su hogar y devolverlo al condado

Número del caso (opcional)	SSN or ATIN/ITIN*
Nombre del Individuo	Fecha de nacimiento (mm/dd/aaaa)
Dirección actual, número de apartmento	Ciudad Código postal
Dirección postal, si es diferente de la anterior	Ciudad Código postal

1. Esta persona está: ☐ Empleado(a) ☐ Trabajando por cuenta propia

2. Si esta persona está empleado(a) actualmente, incluya una lista de toda la información acerca de todos los tipos de ingresos recibidos incluyendo:

Nombre del empleador: _____ Dirección del empleador: _____

Número de teléfono del empleador: _____ Promedio de horas trabajadas por semana: _____

Salarios/Propinas (antes de impuestos): _____ ☐ Por hora ☐ Dos veces al mes ☐ Bimensual ☐ Mensual ☐ Anual

3. Si esta persona trabaja por cuenta propia, conteste las siguientes preguntas:

Tipo de Trabajo: _____

¿Cuánto ingreso neto (ganancias después de gastos del negocio) recibirá este mes del trabajo por su cuenta?

_____

4. ¿Para esta persona, piensa presentar una declaración de impuestos federales sobre los ingresos el PRÓXIMO AÑO? ☐ Sí, complete a-c ☐ No, pase al c

a. ¿Va a presentar en forma conjunta con su cónyuge?

☐ No ☐ Sí, nombre de su esposo(a) _____

b. ¿Va a reclamar dependientes? ☐ No ☐ Sí, nombre de dependientes _____

c. ¿Va a ser reclamado como dependiente en la declaración de impuestos de otra persona? ☐ No ☐ Sí

Si la respuesta es sí, apunte el nombre del declarante de impuestos: _____ ¿Relación de esta persona al declarante de impuestos?

5. Favor de contestar la siguiente pregunta solamente si esta persona es menor de 21 años de edad y es estudiante de tiempo completo:

¿Tenía esta persona seguro de salud a través de un trabajo y lo perdió en los últimos 12 meses? ☐ Sí ☐ No

6. ¿Fueron usted o cualquier otra persona en su familia que es de 26 años de edad o menos en el cuidado de crianza temporal a la edad de 18 años? ☐ Sí ☐ No

7. ¿Ha cambiado el estado migratoria o ciudadanía de esta persona en los últimos 12 meses? ☐ Sí ☐ No

Si la respuesta es sí, favor de explicar el cambió: _____

8. Es esta persona: ☐ Hispano ☐ Latino ☐ Español ☐ Indio (indígena de los EE.UU. de América) o Nativo de Alaska

☐ Blanco ☐ Negro o Afroamericano ☐ Filipino ☐ Chino ☐ Japonés ☐ Camboyano ☐ Coreano

☐ Vietnamita ☐ Indio Asiático ☐ Laosiano ☐ Otro grupo Asiático, especifique: _____

☐ Hawaiano Nativo ☐ Guameño or Chamorro ☐ Samoano ☐ Otra o Raza Mixta

*Número de Seguro Social (SSN) o Número de identificación del contribuyente para adopción (ATIN, por sus siglas en inglés) Número de identificación del contribuyente (ITIN, por sus siglas en inglés)

Debe completar uno de estos formularios para cada persona en su hogar y devolverlo al condado

Número del caso (opcional)	SSN or ATIN/ITIN*
Nombre del Individuo	Fecha de nacimiento (mm/dd/aaaa)
Dirección actual, número de apartmento	Ciudad Código postal
Dirección postal, si es diferente de la anterior	Ciudad Código postal

1. Esta persona está: ☐ Empleado(a) ☐ Trabajando por cuenta propia

2. Si esta persona está empleado(a) actualmente, incluya una lista de toda la información acerca de todos los tipos de ingresos recibidos incluyendo:

Nombre del empleador: _____ Dirección del empleador: _____

Número de teléfono del empleador: _____ Promedio de horas trabajadas por semana: _____

Salarios/Propinas (antes de impuestos): _____ ☐ Por hora ☐ Dos veces al mes ☐ Bimensual ☐ Mensual ☐ Anual

3. Si esta persona trabaja por cuenta propia, conteste las siguientes preguntas:

Tipo de Trabajo: _____

¿Cuánto ingreso neto (ganancias después de gastos del negocio) recibirá este mes del trabajo por su cuenta?

_____

4. ¿Para esta persona, piensa presentar una declaración de impuestos federales sobre los ingresos el PRÓXIMO AÑO? ☐ Sí, complete a-c ☐ No, pase al c

a. ¿Va a presentar en forma conjunta con su cónyuge?

☐ No ☐ Sí, nombre de su esposo(a) _____

b. ¿Va a reclamar dependientes? ☐ No ☐ Sí, nombre de dependientes _____

c. ¿Va a ser reclamado como dependiente en la declaración de impuestos de otra persona? ☐ No ☐ Sí

Si la respuesta es sí, apunte el nombre del declarante de impuestos: _____ ¿Relación de esta persona al declarante de impuestos?

5. Favor de contestar la siguiente pregunta solamente si esta persona es menor de 21 años de edad y es estudiante de tiempo completo:

¿Tenía esta persona seguro de salud a través de un trabajo y lo perdió en los últimos 12 meses? ☐ Sí ☐ No

6. ¿Fueron usted o cualquier otra persona en su familia que es de 26 años de edad o menos en el cuidado de crianza temporal a la edad de 18 años? ☐ Sí ☐ No

7. ¿Ha cambiado el estado migratoria o ciudadanía de esta persona en los últimos 12 meses? ☐ Sí ☐ No

Si la respuesta es sí, favor de explicar el cambió: _____

8. Es esta persona: ☐ Hispano ☐ Latino ☐ Español ☐ Indio (Indígena de los EE.UU. de América) o Nativo de Alaska

☐ Blanco ☐ Negro o Afroamericano ☐ Filipino ☐ Chino ☐ Japonés ☐ Camboyano ☐ Coreano

☐ Vietnamita ☐ Indio Asiático ☐ Laosiano ☐ Otro grupo Asiático, especifique: _____

☐ Hawaiano Nativo ☐ Guameño or Chamorro ☐ Samoano ☐ Otra o Raza Mixta

*Número de Seguro Social (SSN) o Número de identificación del contribuyente para adopción (ATIN, por sus siglas en inglés) Número de identificación del contribuyente (ITIN, por sus siglas en inglés)

9. Renovación de cobertura en los próximos años:

Para que sea más fácil determinar mi elegibilidad para obtener ayuda para solicitar la cobertura de salud en los próximos años, estoy de acuerdo en permitir que el Mercado use datos sobre los ingresos, incluyendo información de las declaraciones de impuestos. El Mercado me enviará una notificación, me permitirá hacer algún cambio, y puedo optar por no en cualquier momento.

- ☐ 5 años (la máxima cantida de años permitidos), o por menos años
- ☐ 4 años
- ☐ 3 años
- ☐ 2 años
- ☐ 1 año

☐ No use la información de las declaraciones de impuestos para renovar mi cobertura.

**Aviso: La información de ingresos/declaración de impuestos es requerido para todos los miembros del hogar. Si otros miembros en la familia están empleados o trabajan por cuenta propia, ellos también necesitan completar las preguntas 1 - 4.

Sus derechos y responsabilidades

- Estoy firmando este formulario de renovación bajo pena de perjurio. Esto quiere decir que he proporcionado respuestas verdaderas a todas las preguntas en este formulario a lo mejor de mi conocimiento, y sé que puedo ser sujeto de sanciones según la ley federal si declaro información falsa o inexacta.
- Sé que tengo que avisar a Covered California si algo cambia y si es diferente de lo que escribí en este formulario. Entiendo que un cambio en mi información podría afectar si alguien en mi hogar califica para la cobertura.
- Sé que bajo la ley federal, no se permite la discriminación por motivos de raza, color, origen nacional, sexo, edad, orientación sexual, identidad de género, o por discapacidad. Puedo presentar una queja de discriminación visitando al hhs.gov/ocr/office/file.
- Si pienso que Covered California ha cometido un error, puedo apelar la decisión. Una apelación significa decirle a alguien en Covered California que pienso que la acción es equivocada, y pedir una revisión imparcial de la acción. Si es necesario, alguien de Covered California me explicará cualquier cosa acerca de esta solicitud.
- Entiendo que si no califico para otros tipos de cobertura de salud, Covered California puede enviar mi información a otro programa para que puedan ver si califico.

Declaro, bajo pena de perjurio, conforme a las leyes del Estado de California que toda la información proporcionada en este formulario es verdadera y correcta.

Firma	Fecha

Formulario Suplementario para la Solicitud de Información Fiscal de Hogares (RFTHI)
Complete este formulario para su hogar

Por favor copie este formulario si necesita más espacio.

¿Alguien en el hogar tiene ingresos que no es de un trabajo? *Otro ingreso es el dinero que recibe de otra cosa que no sea su trabajo. No incluyen pagos de mantenimiento de hijos; pagos para veteranos, o Ingresos Suplementales de Seguridad (SSI). Vea la página 3 para información adicional.*

¿Alguien en el hogar tiene ingresos que no es de un trabajo? ☐ **Sí** ***Si la respuesta es sí,*** ¿quién? _____

Si la repuesta es sí, conteste las preguntas abajo. ☐ **No** ***Si la repuesta es no,*** vaya a *"Alguien en su hogar tiene deducciones"* en esta página.

¿De dónde viene este ingreso?	¿Con qué frecuencia recibe esta persona este ingreso? *(marque uno)*	¿Cuánto?
	☐ Por hora: ¿Cuántas horas por semana? _____ ☐ Cada dos semanas ☐ Diario: ¿Cuántas días por semana? _____ ☐ Dos veces al mes ☐ Semanalmente ☐ Mensualmente ☐ Pago por única vez	$ _____

¿Alguien en el hogar tiene ingresos que no es de un trabajo? ☐ **Sí** ***Si la respuesta es sí,*** ¿quién? _____

Si la repuesta es sí, conteste las preguntas abajo. ☐ **No** ***Si la repuesta es no,*** vaya a *"Alguien en su hogar tiene deducciones"* en esta página.

¿De dónde viene este ingreso?	¿Con qué frecuencia recibe esta persona este ingreso? *(marque uno)*	¿Cuánto?
	☐ Por hora: ¿Cuántas horas por semana? _____ ☐ Cada dos semanas ☐ Diario: ¿Cuántas días por semana? _____ ☐ Dos veces al mes ☐ Semanalmente ☐ Mensualmente ☐ Pago por única vez	$ _____

¿Alguien en su hogar tiene deducciones? *Si usted paga para ciertas cosas que se pueden deducir en la declaración de impuestos federales sobre los ingresos, diciéndonos sobre ellos puede redùcir el costo del seguro de salud. No incluya los gastos de trabajo por cuenta propia. Vea la página 3 para información adicional.*

¿Alguien en su hogar tiene deducciones? ☐ **Sí** ***Si la respuesta es sí,*** ¿quién? _____

Si la repuesta es sí, conteste las preguntas abajo. ☐ **No** ***Si la repuesta es no,*** vaya a *"Información adicional que necesitamos"* en esta página.

Tipo de deducción	¿Con qué frecuencia recibe la persona esta deducción? *(marque uno)*	¿Cuánto?
☐ Pensión alimenticia pagada ☐ Interés de préstamo estudiantil ☐ Otro _____	☐ Por hora: ¿Cuántas horas por semana? _____ ☐ Cada dos semanas ☐ Diario: ¿Cuántas días por semana? _____ ☐ Dos veces al mes ☐ Semanalmente ☐ Mensualmente ☐ Trimestral ☐ Pago por única vez ☐ Anual	$ _____

¿Alguien en su hogar tiene deducciones? ☐ **Sí** ***Si la respuesta es sí,*** ¿quién? _____

Si la repuesta es sí, conteste las preguntas abajo. ☐ **No** ***Si la repuesta es no,*** vaya a *"Información adicional que necesitamos"* en esta página.

Tipo de deducción	¿Con qué frecuencia recibe la persona esta deducción? *(marque uno)*	¿Cuánto?
☐ Pensión alimenticia pagada ☐ Interés de préstamo estudiantil ☐ Otro _____	☐ Por hora: ¿Cuántas horas por semana? _____ ☐ Cada dos semanas ☐ Diario: ¿Cuántas días por semana? _____ ☐ Dos veces al mes ☐ Semanalmente ☐ Mensualmente ☐ Trimestral ☐ Pago por única vez ☐ Anual	$ _____

Información adicional que necesitamos. *Por favor conteste las siguientes preguntas que se aplican a usted o alguien en su hogar.*

¿Alguien en su hogar tiene 19 a 20 años de edad y estudiante de tiempo completo? ☐ Sí ☐ No

Si la respuesta es sí, ¿quién? _____

¿Alguien en su hogar tiene una discapacidad física, mental, emocional, o del desarrollo? ☐ Sí ☐ No

Si la respuesta es sí, ¿quién? _____

¿Alguien en su hogar necesita ayuda con cuidado a largo plazo o servicios en el hogar y en la comunidad? ☐ Sí ☐ No

Si la respuesta es sí, ¿quién? _____

¿Alguien en su hogar está embarazada? ☐ Sí ☐ No ***Si la respuesta es sí,*** ¿quién? _____

Si la respuesta es sí, ¿cuál es la fecha de vencimiento? _____ ¿Cuántos bebés se esperan? _____

¿Alguien se ha movido en o de la casa en los últimos 12 meses? ☐ Sí ☐ No

Si su respuesta es sí, ¿quién? _____ ¿Cuál es su relación a esta persona? _____

¿En qué idioma le deberíamos escribir? _____ ¿En qué idioma desea que nosotros le hablemos? _____

Si alguien en su hogar ha cambiado su estado de ciudadanía/inmigración en los últimos 12 meses, indique el nombre(s) a continuación:

Nombre de la Persona (incluya primer nombre y apellido)	**Nueva situación migratoria o de ciudadanía**

Ejemplos de ingresos que no es de un trabajo

Use esta lista para "¿Alguien en el hogar tiene ingresos que no es de un trabajo?"

- Beneficios de desempleo
- Beneficios de Seguro Social
- Ingresos de jubilación o pensión
- Ingresos de alquileres o regalías
- Pensión alimenticia recibida
- Ingresos por inversiones
- Ganancias de capital
- Ingresos de agricultura o de la pesca
- Deudas canceladas
- Cantidad ordenada por la corte
- Pago por la obligación de servir en un jurado
- Otros ingresos no de un trabajo

Deducciones

Use esta lista para "¿Alguien en su hogar tiene deducciones?"

- Ciertos gastos del trabajo por cuenta propia
- Deducción de intereses de préstamos estudiantiles
- Costo de matrícula y cuotas
- Gastos de educador
- Contribución de cuenta individual de jubilación (IRA)
- Gastos de mudanza
- Pena en el retiro anticipado de los ahorros
- Deducción de una cuenta de ahorros para la salud
- Pensión alimenticia pagada
- Las actividades de producción doméstica deducción
- Ciertos gastos de negocios de reservistas, los artistas intérpretes y funcionarios de gobierno basado en honorarios

ESTA PÁGINA SE DEJA INTENCIONALMENTE EN BLANCO

Si no está inscrito para votar donde vive ahora, ¿quiere solicitar su inscripción para votar hoy aquí?
(Marque uno)

☐ Ya estoy inscrito. Estoy inscrito para votar en mi dirección residencial actual.

☐ Sí. Me quiero inscribir para votar. (Llene la tarjeta adjunta de inscripción para votar.)

☐ No. No me quiero inscribir para votar.

NOTA: SI NO MARCA UNA CASILLA, SE CONSIDERARÁ QUE HA DECIDIDO NO INSCRIBIRSE PARA VOTAR EN ESTE MOMENTO. PUEDE LLEVAR EL FORMULARIO DE SOLICITUD DE INSCRIPCION PARA VOTAR ADJUNTO E INSCRIBIRSE CUANDO LE SEA CONVENIENTE.

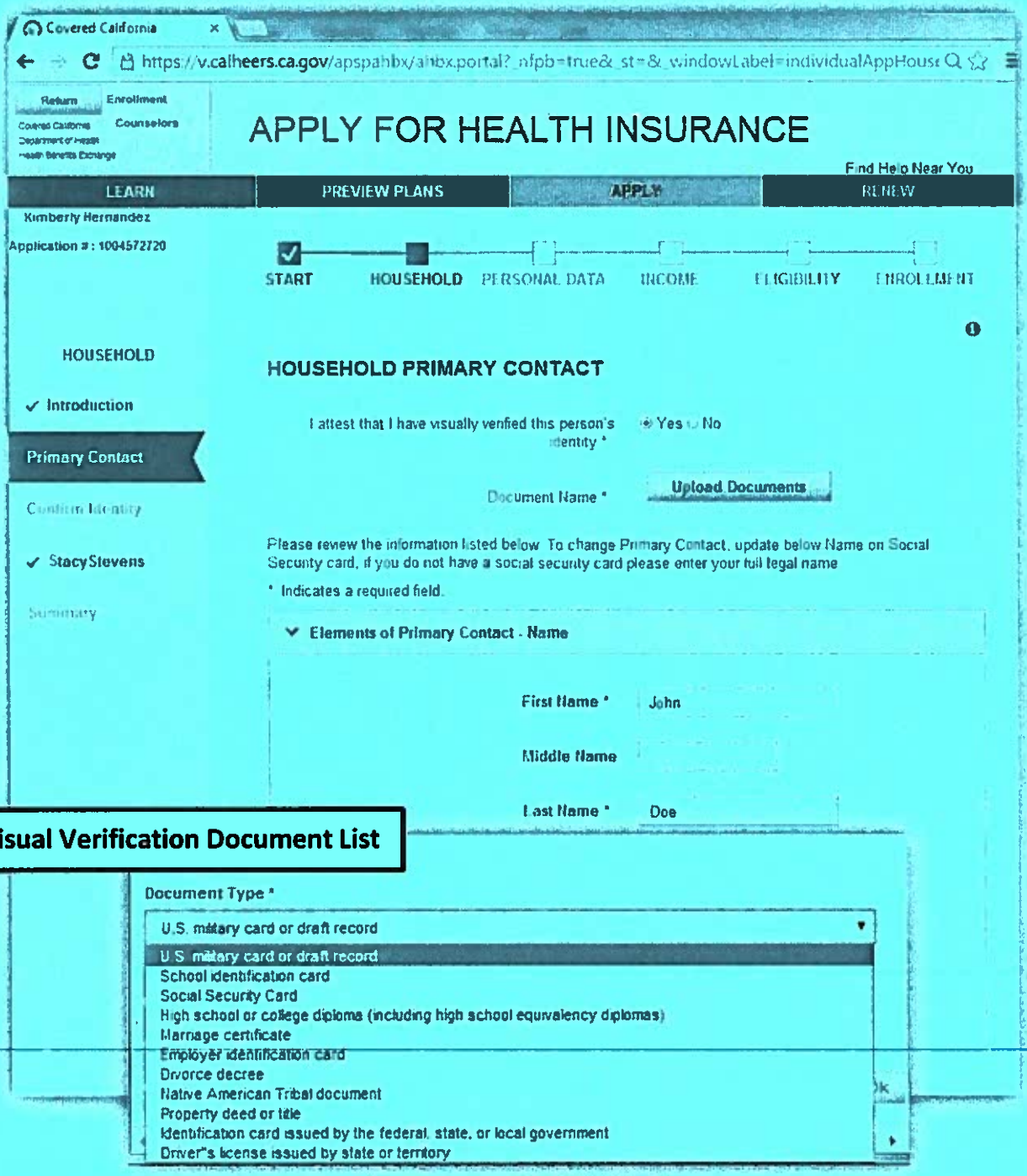
Nombre del solicitante _____ Fecha _____

Avisos importantes

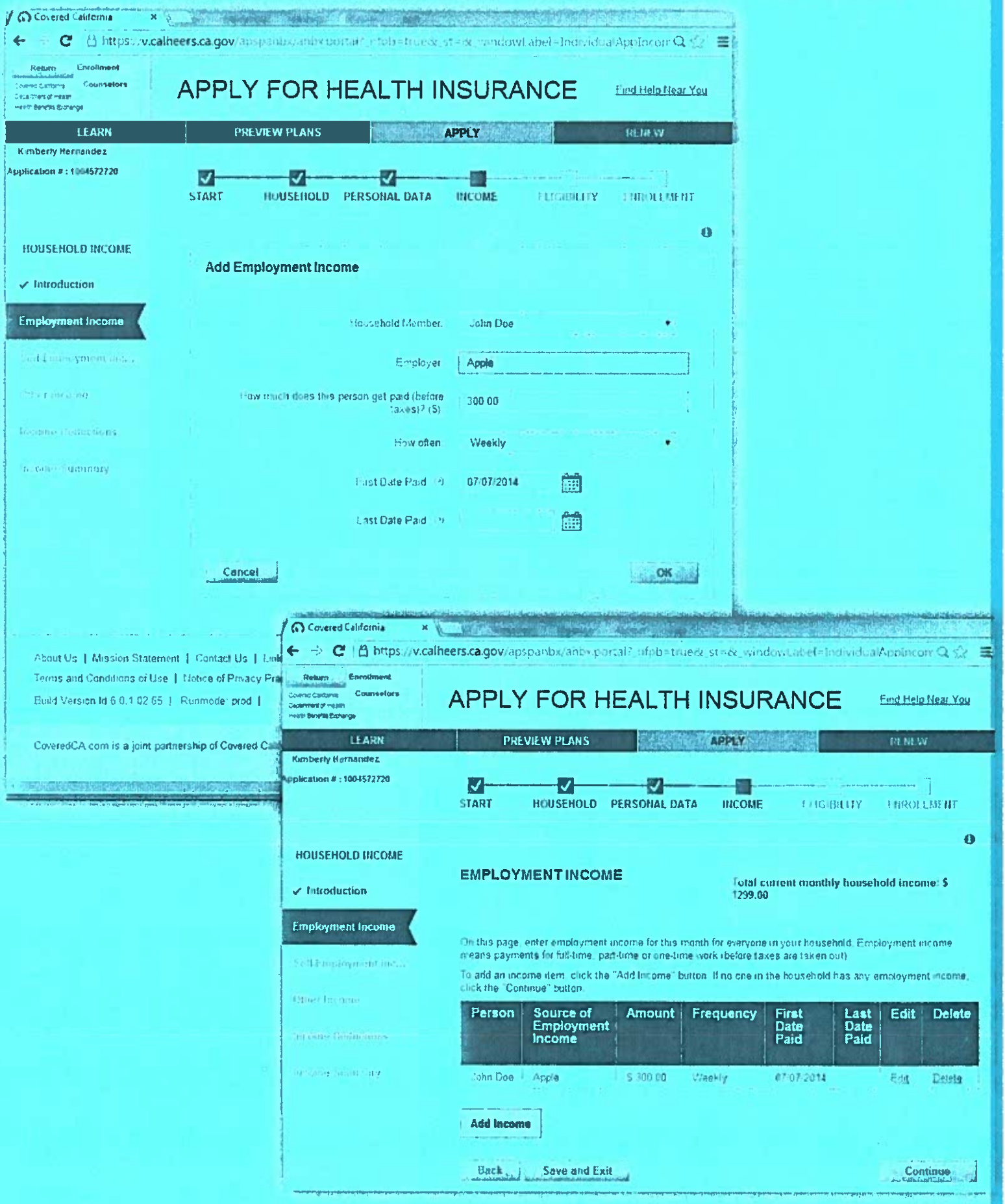
1. Si solicita su inscripción para votar, o decide no hacerlo, ello no afectará la cantidad de ayuda provista por esta agencia.
2. Si necesita ayuda para llenar el formulario de solicitud de inscripción para votar, lo ayudaremos a hacerlo. La decisión de solicitar o aceptar ayuda es sólo suya. Puede llenar el formulario de solicitud en privado.
3. Si cree que alguien interfirió con su derecho a inscribirse para votar, o a no inscribirse, su derecho a privacidad para decidir si se inscribe o solicita inscribirse para votar, o su derecho a elegir el partido político u otra preferencia política, puede presentar una queja ante el Secretario de Estado llamando sin cargo al (800) 232-VOTA (8682), o escribiendo a: Secretary of State, 1500 - 11th Street, Sacramento, CA, 95814. Para obtener más información sobre las elecciones y la votación, visite el sitio web del Secretario de Estado en www.sos.ca.gov.

MC 200 (01/13) NVRA Voter Preference Form - Spanish

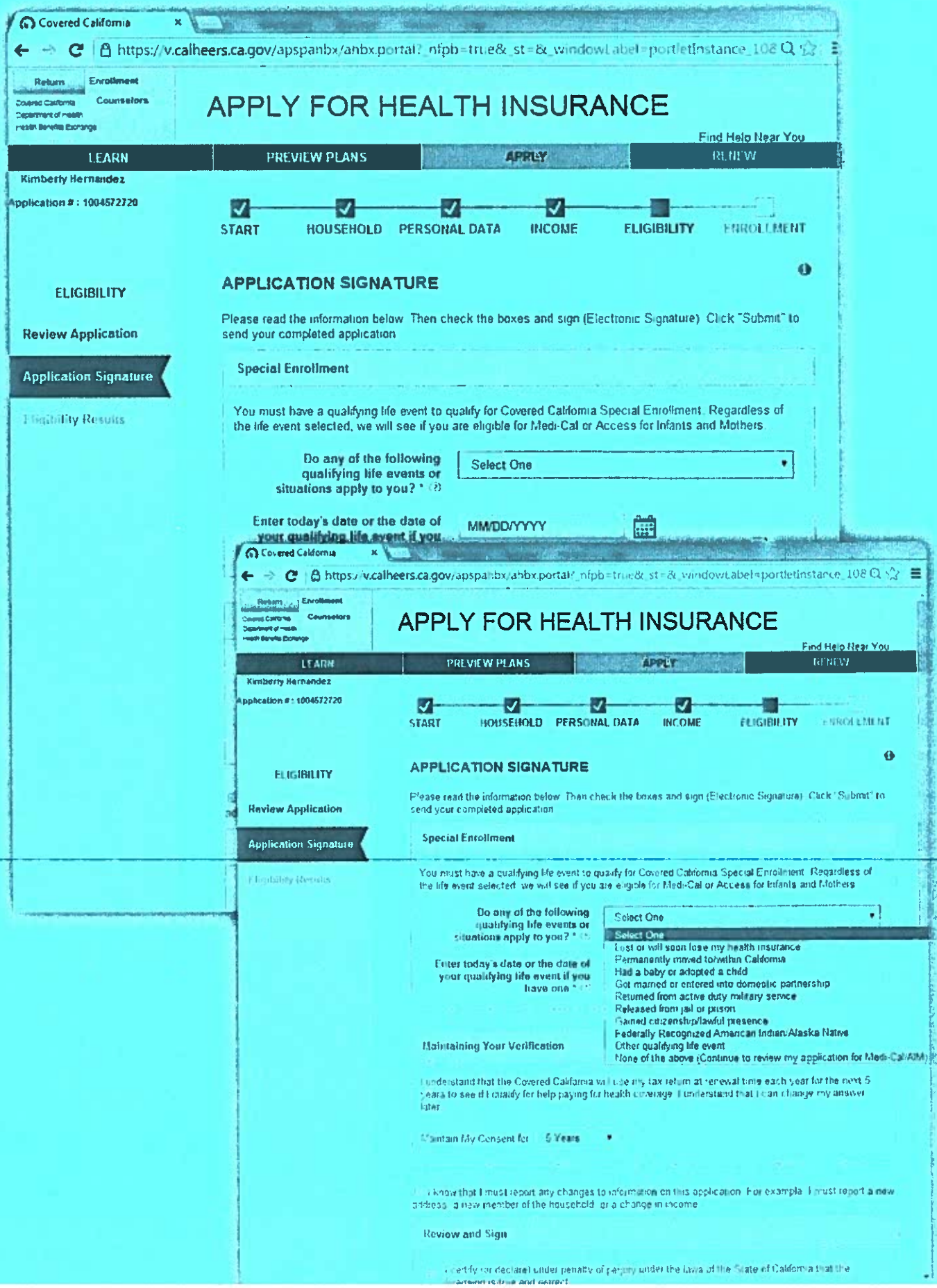
CALHEERS Updates



CALHEERS Updates



CALHEERS Updates



CALHEERS Updates

Notes for Nancy:

HOUSEHOLD PRIMARY CONTACT

I attest that I have visually verified this person's identity * ☐ Yes ☒ No

If you choose to continue with your application online, please keep in mind a few things listed below.

- Be sure that you entered your legal name, current home address, main phone number, date of birth, and email address correctly.
- Experian will use information from other agencies to help check your identity. Only you can see the information from the report. This information will never be presented to outside parties. This information will not affect your credit score. The report will be called "CMS Proofing Services" and will be taken off your Experian consumer report after 25 months.

If you choose to continue now, you will see a Terms and Conditions statement that explains how your personal information is used to make sure you are who you say you are. To go to this step, click Next. For more information and other options for this process click here

I have the consumer's consent to access their identity information through the Federal Data Services Hub Remote ID Proofing Service *

COVERED CALIFORNIA

August 1, 2014

To: Certified Enrollment Entities

From: Sarah Soto-Taylor, Deputy Director, Community Relations

RE: Letter of Instruction (LOI) 14-03: Guidelines for Processing and Preserving the Covered California Authorization for Enrollment Assistance Form

This LOI announces the Covered California Authorization for Enrollment Assistance Form (Authorization) that Certified Enrollment Entities (CEE) and/or Certified Enrollment Counselors (CEC) shall provide to and obtain from every consumer effective August 1, 2014, prior to providing enrollment assistance services.

In order to fulfill the enrollment assistance duties as described in California Code of Regulations Title 10, Chapter 12, Article 8, section 6664, CEEs and/or CECs shall:

1. Obtain the completed, signed Authorization Form from the consumer consenting to the release of his or her Personally Identifiable Information to the CEE and/or CEC;

2. Maintain for six (6) years a record of the Authorization provided in accordance with the privacy and security standards established by the California Health Benefit Exchange (Exchange) pursuant to 45 C.F.R. §155.260. Please do not mail the Authorization Form to Covered California.

The Authorization Form is attached and available on line at www.CoveredCA.com and at https://assisters.ccgrantsandassisters.org/. A Spanish version of the form will be made available in August 2014.

If you have any questions about this LOI, please contact the In-Person Assistance Program Manager Willie Walton at Willie.Walton@Covered.CA.Gov

AUTHORIZATION FOR ENROLLMENT ASSISTANCE

Certified Enrollment Entity Name

Entity Address

Entity Phone Number	Entity Email

Certified Enrollment Counselor Name and Certification Number

I, _____, give my permission, or _____, my Authorized Representative (person acting for me), gives his/her permission, to the Covered California Certified Enrollment Entity and Enrollment Counselor (together called "Counselor") named above to give me and/or my Authorized Representative information about my health coverage choices. This is to help me apply for and enroll in health coverage through a Covered California Health Insurance Plan or Medi-Cal.

I give permission for the Counselor to see or use some of my Personally Identifiable Information and to help me enroll in health coverage. My Personally Identifiable Information may include my name, home address, email address, phone number, date of birth, social security number, financial information, and employment information.

In this form, the words "me" or "my" include my Authorized Representative if I have one.

I understand that:

1. The Counselor will tell me about all coverage choices I may qualify for, including Covered California Health Plans, Medi-Cal and AIM for Pregnant Women.
2. The Counselor cannot choose or recommend a health plan for me.
3. The Counselor will make sure my Personally Identifiable Information is private and secure. This is required by law.
4. The Counselor may create, collect, give out, access, keep, store, and/or use my Personally Identifiable Information and/or my Authorized Representative's Personally Identifiable Information **only** to perform the Certified Enrollment Counselor duties. This may include giving my Personally Identifiable Information to Covered California, Covered California Health Plans, and the California Department of Health Care Services, which runs Medi-Cal. The Counselor may not use my Personally Identifiable Information for any other purposes.
5. Certified Enrollment Counselor duties also include:
   - Giving information and services in a fair, correct, and impartial way.
   - Giving information verbally and/or in writing about all coverage options for which I may qualify in my language and in a way I can understand.
   - Giving information and help in a way that persons with disabilities can access and use.
   - Helping me choose a Covered California Health Plan or Medi-Cal or AIM for Pregnant Women. If I consent, helping me apply for, enroll into, or renew coverage.
   - Referring me to agencies for help with a grievance, complaint, or question about my health plan, coverage, or a decision made by or about my plan or coverage.
6. The Counselor must also offer public education activities. The Counselor will not use my Personally Identifiable Information for this purpose.

AUTHORIZATION FOR ENROLLMENT ASSISTANCE

7. The Counselor must know the rules for Covered California Health Plans, Medi-Cal and AIM for Pregnant Women.
8. If the information I give is wrong or incomplete, the Counselor may not be able to help me make the best decisions. The Counselor's help is based only on information I or my Authorized Representative give.
9. If the Counselor can't help me, he or she will refer me to another Counselor, or to the Covered California Service Center, who can help me.
10. The Counselor will not charge me a fee. The help is free.
11. I must sign this form for the Counselor to give help. If I do not sign this form, I can still apply for and enroll in health coverage through Covered California or Medi-Cal or AIM for Pregnant Women. The Counselor will not be able to help me.
12. This authorization will expire when I communicate to the Counselor that I wish to cancel my authorization. I may cancel or limit my authorization in writing at any time. I will notify the Counselor if I choose to cancel my authorization.
13. The Counselor or Covered California must keep this form for six years.

Covered California needs your name and signature on this form to identify you. If you do not give your name and signature on this form, a Counselor will not be able to help you. These federal regulations give Covered California the right to collect and keep the information on this form: 45 C.F.R. § 155.210, 45 C.F.R. § 155.215.

Covered California must give you this Privacy Statement under CA Civil Code § 1798.17. Covered California's Notice of Privacy Practices is available at CoveredCA.com/Privacy. If you have questions about your records, you can call or write to the Privacy Officer at (800) 889-3871 or P.O. Box 1347 Sacramento, CA 95814.

Sign and date on the lines:

Signature _____ **Date**_____

For Certified Enrollment Counselor:

I affirm under penalty of perjury that:

- I am a Certified Enrollment Counselor affiliated with a Certified Enrollment Entity as defined in California Code of Regulations Title 10, Chapter 12, Article 8, section 6650.
- I gave all information in this authorization form to the applicant in a language and way he or she understands.
- I ensured all information on this form was accessible to those with disabilities by providing disability-related modifications or accommodations when necessary, including auxiliary aids, Braille, large print or other tools and services.
- I explained to the consumer what information is Personally Identifiable Information and that this will only be used to determine eligibility for health coverage.
- I obtained oral authorization from the consumer consenting to the release of his or her Personally Identifiable Information to me in order to fulfill my duties as described in California Code of Regulations Title 10, Chapter 12, Article 8, section 6664.

Signature _____ **Date**_____

September 2014
Calendar of Events

3rd — Dignity Health Screening Outreach – 9:00 to 11:00 AM
Taft Baptist Church – 220 North St. Taft, CA

Shafter Community Outreach – 8:30 AM to 4:00 PM
Shafter Healthy Start – 331 N. Shafter Ave., Shafter, CA

ACA Education Event – 3:30 to 4:30 PM
Baker Street Housing Development – 1015 Baker Street, Bakersfield, CA

4th — Dignity Health Screening Outreach – 8:30 to 11:30 AM
East Hills Mall – 3000 Mall View Dr, Bakersfield, CA

5th — Buttonwillow "Crew of the Week" Outreach – 11:00 AM to 1:30 PM
Person's Farms – Buttonwillow, CA

6th — "Dress For Success" Power Walk Outreach Event – 10:00 AM to 1:00 PM
Valley Plaza Mall – 2701 Ming Ave, Bakersfield, CA

Dignity Health Community Outreach Event – 2:00 to 5:00 PM
Mercado Latino - 2105 Edison Hwy, Bakersfield, CA

8th — ACA Education Event – 4:00 to 5:00 PM
Adelante Vista Housing Development - 1104 S. Robinson St., Bakersfield, CA

ACA Education Event – 6:00 to 7:00 PM
Rueben Blunt Migrant Camp – Arvin, CA

9th — ~~Shafter Community Outreach – 8:30 AM to 4:00 PM~~
Shafter Healthy Start - 331 N. Shafter Ave., Shafter, CA

Back to School Night Outreach – 5:00 to 6:00 PM
Bessie Owens Elementary School – 815 Potomac St., Bakersfield, CA

Back to School Night Outreach – 5:00 to 6:00 PM
Williams Elementary School – 1201 Williams St., Bakersfield, CA

Back to School Night Outreach – 5:00 to 6:00 PM
Fremont Elementary School – 607 Texas St., Bakersfield, CA

Back to School Night Outreach – 6:00 to 7:00 PM

For more information call 661.632.5018 or visit our social media to get the latest updates!!

@CHIofKernCountv @youtube.com/CHIofKernCountv getcovered

Voorhies Elementary School – 6001 Pioneer Dr., Bakersfield, CA

Back to School Night Outreach – 6:00 to 7:00 PM
Jefferson Elementary School – 1300 Baker St., Bakersfield, CA

Back to School Night Outreach – 6:00 to 7:00 PM
McKinley Elementary School – 601 4th St., Bakersfield, CA

10th Shafter Community Outreach – 8:30 AM to 4:00 PM
Shafter Healthy Start - 331 N. Shafter Ave., Shafter, CA

11th Back to School Night Outreach – 5:00 to 7:00 PM
Walter Stiern Middle School – 2551 Morning D., Bakersfield, CA

Back to School Night Outreach – 5:00 to 6:00 PM
Curran Middle School – 1116 Lymric Way., Bakersfield, CA

Back to School Night Outreach – 5:00 to 6:00 PM
Washington Middle School– 1101 Noble Ave., Bakersfield, CA

Back to School Night Outreach – 5:00 to 6:00 PM
Compton Junior High School – 3211 Pico Ave., Bakersfield, CA

Back to School Night Outreach – 6:00 to 7:00 PM
TBD- Bakersfield, CA

Back to School Night Outreach – 6:00 to 7:00 PM
TBD – Bakersfield, CA

Back to School Night Outreach – 6:00 to 7:00 PM
TBD – Bakersfield, CA

12th "Crew of the Week" Outreach – 11:00 AM to 1:30 PM
TBD – Kern County, CA

Kern County Marketplace Swap Meet Outreach – 6:30 to 8:30 PM
Kern County Marketplace Swap Meet – 1000 E. Hosking St., Bakersfield, CA

13th Bakersfield Community Health Fair Outreach – 9:30 AM to 4:00 PM
Iglesia de Dios Pentecostal Health Fair – 800 Monterey St., Bakersfield, CA

15th ACA Enrollment Event – 6:00 to 8:00 PM
Rueben Blunt Migrant Camp – Arvin, CA

16th Wasco Community ACA Education Event – 5:00 to 6:30 PM

For more information call 661.632.5018 or visit our social media to get the latest updates!!

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Homer Harrison Housing Development – 1910 Garces Hwy., Delano, CA

Bakersfield Community Outreach – 4:30 PM to 7:00 PM
Monarca Ice Cream – 1719 Wilson Rd., Bakersfield, CA

17th Shafter Community Outreach – 8:30 AM to 4:00 PM
Shafter Healthy Start - 331 N. Shafter Ave., Shafter, CA

Dignity Health Screening Outreach – 2:00 to 4:00 PM
Villa Hermosa Apartments Community Room – 1500 Poplar Ave, Wasco, CA

Greenfield Community ACA Education Event – 5:00 to 6:30 PM
Greenfield Homes Housing Development – 403 Boomerang Dr., Bakersfield, CA

18th Bakersfield Community Outreach – 3:00 to 5:00 PM
Dollar Tree – 2505 S. H St., Bakersfield, CA

Bakersfield Community Outreach – 5:00 to 7:00 PM
Wateria – 2070 White Ln., Bakersfield, CA

19th "Crew of the Week" Outreach – 11:00 AM to 1:30 PM
TBD – Kern County

23rd ACA Enrollment Event – 4:30 to 6:30 PM
Homer Harrison Housing Development – 1910 Garces Hwy., Delano, CA

24th ACA Enrollment Event – 4:30 to 6:30 PM
Greenfield Homes Housing Development – 403 Boomerang Dr., Bakersfield, CA

25th Dignity Health Screening Outreach – 2:30 to 4:30 PM
Lost Hills Paramount Park (Blue Center) – 17001 Lost Hills Rd., Lost Hills, CA

26th "Crew of the Week" Outreach – 11:00 AM to 1:30 PM
TBD – Kern County

Kern County Marketplace Swap Meet Outreach – 6:30 to 8:30 PM
Kern County Marketplace Swap Meet – 1000 E. Hosking St., Bakersfield, CA

30th Bakersfield Community Outreach – 4:30 PM to 7:00 PM
Monarca Ice Cream – 1719 Wilson Rd., Bakersfield, CA

For more information call 661.632.5018 or visit our social media to get the latest updates!!

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MERCY AND MEMORIAL HOSPITALS
Department of Special Needs and Community Outreach

Verified Enrollments in Health Insurance Plans

FY 2014 Goal: 9,750 enrolled or renewed into Medi-Cal and Healthy Families
by CHI Coalition Partners

June 2014

	Enrolled			Renewed		
	0 to 5	6 to 18	0 to 18	0 to 5	6 to 18	0 to 18
Medi-Cal	-	-	-	-	-	-
Healthy Families	-	-	-	-	-	-
Multiple Programs	-	-	-	-	-	-

YTD FY 2014

	Enrolled			Renewed		
	0 to 5	6 to 18	0 to 18	0 to 5	6 to 18	0 to 18
Medi-Cal	983	1,554	2,537	952	2,076	3,028
Healthy Families	4	14	18	33	159	192
Multiple Programs	-	-	-	-	-	-

Total New Enrollments	2,555	44% Percent of YTD Total
Total Renewals	3,220	56% Percent of YTD Total
Total children enrolled	***5,775***	***100%***

Goal Achievement Year-To-Date **59.2%**

Source: SAS invoices through June 2014 invoice period. Enrollments include new enrollments, re-enrollments and verified enrollments on applications denied due to lack of stipend funding.

By month FY 14	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	YTD
Children	558	628	356	508	634	544	882	926	422	305	12	-	5,775
Applications	280	314	195	250	315	294	437	455	223	153	7	-	2,923
# agencies	12	10	9	10	10	11	10	12	6	7	2	-	
Avg. children per application	1.99	2.00	1.83	2.03	2.01	1.85	2.02	2.04	1.89	1.99	1.71		1.98
Invoice Month	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	

Total SAS New Enrollments and Renewals by Zip Code

FY 2014, through June 2014

County Region	Zip	City	0-5	%	6-18	%	0-18	%
North Central	93215	Delano	98		243		341	
	93216	Delano	-		2		2	
	93250	McFarland	156		228		384	
	93263	Shafter	11		40		51	
	93280	Wasco	9		43		52	
North Central Total			*274*	*14%*	*556*	*15%*	*830*	*14%*
West	93206	Buttonwillow	8		17		25	
	93248	Lost Hills	-		-		-	
	93249	Lost Hills	5		10		15	
	93252	Maricopa	-		-		-	
	93268	Taft	6		5		11	
West Total			*19*	*1%*	*32*	*1%*	*51*	*1%*
North East	93240	Lake Isabella	1		-		1	
	93205	Bodfish	1		1		2	
	93285	Wofford Heights	-		3		3	
	93226	Glennville	-		-		-	
	93555	Ridgecrest	-		1		1	
North East Total			*2*	*0%*	*5*	*0%*	*7*	*0%*
South East	93220	Edison	-		-		-	
	93501	Mojave	-		-		-	
	93505	California City	-		-		-	
	93518	Caliente	1		-		1	
	93523	Edwards	-		-		-	
	93560	Rosamond	-		-		-	
	93561	Tehachapi	1		-		1	
South East Total			*2*	*0%*	*-*	*0%*	*2*	*0%*
South Central	93203	Arvin	339		609		948	
	93222	Frazier Park	1		-		1	
	93224	Frazier Park	-		-		-	
	93225	Frazier Park	2		-		2	
	93241	Lamont	212		339		551	
	93243	Lebec	2		14		16	
South Central Total			*556*	*28%*	*962*	*25%*	*1,518*	*26%*
Bakersfield	93301	Bakersfield	10		20		30	
	93304	Bakersfield	162		284		446	
	93305	Bakersfield	80		123		203	
	93306	Bakersfield	130		277		407	
	93307	Bakersfield	402		835		1,237	
	93308	Bakersfield	35		53		88	
	93309	Bakersfield	103		196		299	
	93311	Bakersfield	33		73		106	
	93312	Bakersfield	27		56		83	
	93313	Bakersfield	124		300		424	
	93314	Bakersfield	13		31		44	
Bakersfield Total			*1,119*	*57%*	*2,248*	*59%*	*3,367*	*58%*
County Total			*1,972*	*100%*	*3,803*	*100%*	*5,775*	*100%*

Includes children on applications verified through the SAS program for invoice periods July 2013 through June 2014.

Total SAS New Enrollments by Zip Code

FY 2014, through June 2014

County Region	Zip	City	0-5	%	6-18	%	0-18	%
North Central	93215	Delano	48		83		131	
	93216	Delano	-		-		-	
	93250	McFarland	62		104		166	
	93263	Shafter	4		9		13	
	93280	Wasco	4		15		19	
North Central Total			*118*	*12%*	*211*	*13%*	*329*	*13%*
West	93206	Buttonwillow	4		1		5	
	93248	Lost Hills	-		-		-	
	93249	Lost Hills	3		5		8	
	93252	Maricopa	-		-		-	
	93268	Taft	3		4		7	
West Total			*10*	*1%*	*10*	*1%*	*20*	*1%*
North East	93240	Lake Isabella	1		-		1	
	93205	Bodfish	1		1		2	
	93285	Wofford Heights	-		2		2	
	93226	Glennville	-		-		-	
	93555	Ridgecrest	-		1		1	
North East Total			*2*	*0%*	*4*	*0%*	*6*	*0%*
South East	93220	Edison	-		-		-	
	93501	Mojave	-		-		-	
	93505	California City	-		-		-	
	93518	Caliente	1		-		1	
	93523	Edwards	-		-		-	
	93560	Rosamond	-		-		-	
	93561	Tehachapi	1		-		1	
South East Total			*2*	*0%*	*-*	*0%*	*2*	*0%*
South Central	93203	Arvin	107		177		284	
	93222	Frazier Park	1		-		1	
	93224	Frazier Park	-		-		-	
	93225	Frazier Park	2		-		2	
	93241	Lamont	78		113		191	
	93243	Lebec	2		14		16	
South Central Total			*190*	*19%*	*304*	*19%*	*494*	*19%*
Bakersfield	93301	Bakersfield	8		9		17	
	93304	Bakersfield	101		152		253	
	93305	Bakersfield	45		57		102	
	93306	Bakersfield	83		132		215	
	93307	Bakersfield	223		403		626	
	93308	Bakersfield	31		36		67	
	93309	Bakersfield	63		96		159	
	93311	Bakersfield	19		25		44	
	93312	Bakersfield	20		15		35	
	93313	Bakersfield	63		107		170	
	93314	Bakersfield	9		7		16	
Bakersfield Total			*665*	*67%*	*1,039*	*66%*	*1,704*	*67%*
County Total			*987*	*100%*	*1,568*	*100%*	*2,555*	*100%*

Includes children on applications verified through the SAS program for invoice periods July 2013 through June 2014

Total SAS Renewals by Zip Code

FY 2014, through June 2014

County Region	Zip	City	0-5	%	6-18	%	0-18	%
North Central	93215	Delano	50		160		210	
	93216	Delano	-		2		2	
	93250	McFarland	94		124		218	
	93263	Shafter	7		31		38	
	93280	Wasco	5		28		33	
North Central Total			*156*	*16%*	*345*	*15%*	*501*	*16%*
West	93206	Buttonwillow	4		16		20	
	93248	Lost Hills	-		-		-	
	93249	Lost Hills	2		5		7	
	93252	Maricopa	-		-		-	
	93268	Taft	3		1		4	
West Total			*9*	*1%*	*22*	*1%*	*31*	*1%*
North East	93240	Lake Isabella	-		-		-	
	93205	Bodfish	-		-		-	
	93285	Wofford Heights	-		1		1	
	93226	Glennville	-		-		-	
	93555	Ridgecrest	-		-		-	
North East Total			*-*	*0%*	*1*	*0%*	*1*	*0%*
South East	93220	Edison	-		-		-	
	93501	Mojave	-		-		-	
	93505	California City	-		-		-	
	93518	Caliente	-		-		-	
	93523	Edwards	-		-		-	
	93560	Rosamond	-		-		-	
	93561	Tehachapi	-		-		-	
South East Total			*-*	*0%*	*-*	*0%*	*-*	*0%*
South Central	93203	Arvin	232		432		664	
	93222	Frazier Park	-		-		-	
	93224	Frazier Park	-		-		-	
	93225	Frazier Park	-		-		-	
	93241	Lamont	134		226		360	
	93243	Lebec	-		-		-	
South Central Total			*366*	*37%*	*658*	*29%*	*1,024*	*32%*
Bakersfield	93301	Bakersfield	2		11		13	
	93304	Bakersfield	61		132		193	
	93305	Bakersfield	35		66		101	
	93306	Bakersfield	47		145		192	
	93307	Bakersfield	179		432		611	
	93308	Bakersfield	4		17		21	
	93309	Bakersfield	40		100		140	
	93311	Bakersfield	14		48		62	
	93312	Bakersfield	7		41		48	
	93313	Bakersfield	61		193		254	
	93314	Bakersfield	4		24		28	
Bakersfield Total			*454*	*46%*	*1,209*	*54%*	*1,663*	*52%*
County Total			*985*	*100%*	*2,235*	*100%*	*3,220*	*100%*

Includes children on applications verified through the SAS program for invoice periods July 2013 through June 2014.

SAS Database Update (8/13/2014)

HTTP://SAS.KERNCHI.ORG

As you may know, the SAS database has been moved to an upgraded system and there are some issues that have been identified and are being addressed. In the meantime we've got some workarounds that hopefully won't be too burdensome. Our recommendations are below:

Web browser compatibility

- Use Chrome or Firefox web browsers, Internet Explorer only version 11 (printing remains an issue with IE-11, see below)
- In your web browser's address bar type the following web address: http://sas.kernchi.org (always use this web address for the SAS database)
    - If you have an older shortcut or a bookmark in your favorites, please update it with this information otherwise it may direct you to the old web address and you will get an error page

Logging in to the SAS database and logging out

- Your account name is your CAA number (or CEC number if you did not have a CAA number—if you're not sure, just give me a call)
- When your password is reset, your temporary password is "password" all lower case
- After logging in you will select language, agree to the confidentiality statement, and you will be prompted to change your password. To change your password, the old password is "password". There are instructions to help you select a new password.

- **IMPORTANT!!** Please log out after every session, not just close your browser. This is especially important when changing your password, logging out finalizes the password change action, otherwise it will not save your new password. Remember the logout button is the red up-arrow that is located on the top right of the screen. 

Printing the SAS consent forms

- You may have noticed that the consent forms are now on their own separate page that must be printed individually. Note: there are only 3 pages to print now [1-the confirmation page, 2-fax cover page, and 3-the SAS consent form]
- Please use your browser's print function to print the page before pressing the **[Next]** button. Printing on Internet Explorer 11 reduces the font size to a very small size. It is still readable and acceptable; however, we recommend that if you are able to use Chrome or Firefox browsers, that you use those instead.
- Offline consent forms have been updated and are available at www.insurekernkids.org/resources. Please do not use any of the older offline consent forms.

For questions or concerns, please call Rodrigo Vazquez, Program Analyst at (661) 632-5743 or email to Rodrigo.vazquez@dignityhealth.org.

FAX

TO:	FROM:
Rodrigo Vazquez	
COMPANY:	**DATE:**
Community Health Initiative of Kern County	
FAX NUMBER:	**SENDER'S FAX:**
818-409-5392	
PHONE NUMBER:	**SENDER'S PHONE:**
661-632-5743	
RE:	**NO. OF PAGES INCLUDING COVER:**
Successful Application Stipend Program	

DOCUMENTS BEING FAXED:

- ☐ SAS confirmation page
- ☐ SAS consent form
- ☐ Other

SAS Database Input Offline Form

Applicant Information	
First Name:	
CIN (If Applicable):	
Date of Birth:	
City of Birth:	
Mother's First Name:	

Additional Applicant Information	
Last Name:	
Middle Initial:	
Email Address:	
Street Address:	
Apt. #:	
City:	
Zip Code:	
Phone No.:	
Language:	
Ethnicity:	
Is Applicant Pregnant?:	☐ YES ☐ NO

Beneficiary Information		
First Name:		
Last Name:		
Date of Birth:		
Gender:		
Relationship to Applicant:		

Successful Application Stipend (SAS)
Medi-Cal/Covered California Application or Renewal Assistance
Permission to Share Information

Case Name: _____ SS#: _____ Date: _____

DSH Worker: _____ Caseload #: _____ Phone #: _____

Permission to share information:

MEDI-CAL
I give permission to the Department of Human Services to share information concerning my application or annual eligibility renewal with Mercy Hospitals, the Certified Enrollment Counselor (CEC), the Certified Enrollment Entity (CEE) identified, and the Kern County Department of Public Health. This permission will end in one year. I certify that I had help completing this application/renewal by the listed CEC. This CEC help was free of charge to me.

COVERED CA
I give permission to the Certified Enrollment Counselor (CEC) and the Certified Enrollment Entity (CEE) identified to share information concerning my Covered California application or annual eligibility renewal with Mercy Hospitals and Kern County Department of Public Health. This permission will end in one year. I certify that I had help completing this application/renewal by the listed CEC. This CEC help was free of charge to me.

Name (Please Print): _____ DOB: _____

Signature: _____ Date: _____

Certified Enrollment Counselor Information:

(Reimbursement is subject to budget appropriations. Reimbursement will not be issued unless this section is completely filled out at the time this form is submitted.)

CEC#: _____ CEE# _____ Site: _____

CEC's Signature: _____ Phone#: _____

Email Address: _____ Fax#: _____

SAS APPLICATION ID#: _____

Forma—SAS Base de Datos

Información Del Solicitante	
Nombre:	
CIN (Si Aplica):	
Fecha de Nacimiento:	
Ciudad de Nacimiento:	
Primer Nombre de Su Mamá:	

Información Adicional Del Solicitante	
Apellido:	
Inicial del Segundo Nombre:	
Correo Electrónico:	
Dirección:	
Apt. #:	
Ciudad:	
Código Postal:	
No. de Teléfono:	
Idioma:	
Etnicidad:	
¿Está Embarazada?:	☐ **SI** ☐ **NO**

Información Del Beneficiario		
Nombre:		
Apellido:		
Fecha de Nacimiento:		
Sexo:		
Parentesco Con El Solicitante:		

Successful Application Stipend (SAS)
Verificación de Aplicación para Medi-Cal/Covered California o Asistencia para Renovación
Permiso de Compartir Información

Nombre de Caso: _____ SS#: _____ Fecha: _____

Nombre de Trabajadora: _____ No. de Caso: _____ Telefono: _____

Permiso de Compartir Información:

MEDI-CAL
Yo autorizo al Departamento de Servicios Humanos de compartir información sobre mi aplicación o renovación de elegibilidad de Medi-Cal con los Hospitales Mercy, con el Consejero de Matriculación Certificado (CEC, por sus siglas in Ingles), la Organización de Matriculación Certificada (CEE, por sus siglas en Ingles) identificada, y el Departamento de Salud Pública del Condado de Kern. Esta autorización se terminara en un año. Yo certifico que obtuve ayuda completando esta aplicación/renovación por el Consejero (CEC) indicado. Esta ayuda del CEC fue dispuesta gratuitamente.

COVERED CALIFORNIA
Yo autorizo al Consejero de Matriculación Certificado (CEC, por sus siglas in Ingles) y a la Organización de Matriculación Certificada (CEE, por sus siglas en Ingles) identificada de compartir información sobre mi aplicación o renovación de elegibilidad de Covered California con los Hospitales Mercy y el Departamento de Salud Pública del Condado de Kern. Esta autorización se terminara en un año. Yo certifico que obtuve ayuda completando esta aplicación/renovación por el CEC indicado. Esta ayuda del CEC fue dispuesta gratuitamente.

Nombre (Letra de Molde): _____ Fecha de Nac.: _____

Firma: _____ Fecha: _____

Certified Enrollment Counselor Information:

(Reimbursement is subject to budget appropriations. Reimbursement will not be issued unless this section is completely filled out at the time this form is submitted.)

CEC#: _____ CEE# _____ Site: _____

CEC's Signature: _____ Phone#: _____

Email Address: _____ Fax#: _____

SAS APPLICATION ID#: _____

Aguilar, Edgar - MHB

From: Covered California Information [COVEREDCAINFO@MAILLIST.DHS.CA.GOV] on behalf of Info (CoveredCA) [Info@covered.ca.gov]
Sent: Thursday, August 21, 2014 8:15 AM
To: COVEREDCAINFO@MAILLIST.DHS.CA.GOV
Subject: PRESS RELEASE: COVERED CALIFORNIA PLANS TO OFFER EXPANDED DENTAL SERVICES FOR CHILDREN AND NEW COVERAGE FOR ADULTS

Dear Colleagues and Interested Parties:

FOR IMMEDIATE RELEASE **Media Line:** (916) 205-8403
Aug. 20, 2014

COVERED CALIFORNIA PLANS TO OFFER EXPANDED DENTAL SERVICES FOR CHILDREN AND NEW COVERAGE FOR ADULTS

Pediatric Dental Care Embedded in Standard Plans for 2015; Also New in 2015 Are Optional Family Dental Plans That Will Offer Coverage for Adults

SACRAMENTO, Calif. — Covered California is offering new family dental plans to consumers who enroll in health insurance coverage in 2015. Additionally, all individual health insurance plans sold through the Covered California exchange will include pediatric dental benefits for members younger than 19.

"This is great news for families and children, because all children enrolled in Covered California will have dental coverage embedded in their comprehensive health plan," Covered California Executive Director Peter V. Lee said. "They will be getting better coverage and more for their money."

Additionally, Lee said, the family dental plan will offer adults the option of receiving dental coverage outside the general health plans at an additional cost. Some consumers also may be drawn to family dental plans if a provider they prefer for their child is not offered in their embedded coverage.

The optional stand-alone family dental plans, which offer coverage for adults, will not be available at the beginning of open enrollment, which starts Nov. 15, but are planned to be added in early 2015. Covered California will offer both dental health maintenance organization (DHMO) and dental preferred provider organization (DPPO) plans, giving consumers a choice in the type of plan that will work best for them. There is no financial assistance available for the optional adult dental benefits.

Lee emphasized that there is no requirement to enroll children in a family dental plan. The family dental plan is optional and is primarily intended to offer affordable dental coverage to adults that was not available in 2014. Families should consider that adding their children to a family dental plan will result in an extra cost for the same dental services they already receive in their standard health insurance plan. The most likely reason to enroll a child in the family dental plan is if a dental provider they prefer for their child is not offered through their embedded coverage.

Covered California is notifying enrollees to explain the availability of pediatric dental benefits in its health insurance plans, as well as to explain the newly available family dental plans that include dental benefits for adults.

Below is a list of the pediatric dental coverage embedded with Covered California's health insurance plans.

Health Insurance Plan Selected	Pediatric Dental Coverage Embedded into Health Insurance Plan
Anthem Blue Cross of California	Anthem Blue Cross
Blue Shield of California	Blue Shield of California
Chinese Community Health Plan	Delta Dental of California
Health Net	Dental Benefit Providers
Kaiser Permanente	Delta Dental of California
L.A. Care Health Plan	Liberty Dental Plan
Molina Healthcare	California Dental Network
Sharp Health Plan	Access Dental Plan
Valley Health Plan	Liberty Dental Plan
Western Health Advantage	Premier Access

Family dental plans are offered from the companies listed below.

Optional Family Dental Plans
Access Dental Plan
Anthem Blue Cross
Blue Shield of California
Delta Dental of California
Dental Health Services
Premier Access

A booklet containing more information about the new family dental plans is available online at www.CoveredCA.com/coverage-basics/plans/.

About Covered California

About Covered California's Family Dental Plans

California families will get expanded opportunities for improved dental health, through Covered California's offerings of family dental plans.

The plans offer comprehensive coverage for both children and adults. Purchase of the plans is optional, at an additional cost. Adults can choose to enroll in family dental plans without enrolling the entire family. In the individual exchange, the participating dental carriers are:

- **Access Dental Plan.**
- **Anthem Blue Cross.**
- **Blue Shield of California.**
- **Delta Dental of California.**
- **Dental Health Services.**
- **Premier Access.**

There are two different product types available, depending on where the family lives. The dental preferred provider organization (DPPO) product offers a wide variety of provider choice within a network of participating dentists, as well as coverage for some out-of-network services. The dental health maintenance organization (DHMO) limits coverage to services provided by a dentist within a network and generally requires a referral to be seen by a specialist.

Covered California family dental plans feature standard copayments, deductibles and coinsurance requirements. The children's benefit designs have an actuarial value of 85 percent. An actuarial value is the percentage of total average costs for benefits that a dental plan will cover.

These premiums are for "stand-alone" plans, dental benefit products that can be purchased by themselves to cover a specific service.

Dental plans must follow Covered California standard benefit designs. Standardizing benefits ensures that the selected plans define what the consumers get and limit the consumer's out-of-pocket costs.

Family Dental Plan Standard Benefit Designs – DPPO

ENROLLEE PAYS – DPPO

Coverage category	Adult	Child
Diagnostic and preventive*	0%	0%
Amalgam filling – one surface	20%	20%
Root canal – molar	50%	50%
Gingivectomy per quad	50%	50%
Extraction – single tooth, exposed root or erupted	50%	50%
Extraction – complete bony	50%	50%
Crown – porcelain with metal	50%	50%
Medically necessary orthodontia	not covered	50%
Enrollee costs		
Deductible *(waived for diagnostic and preventive)*	$ 50	$ 65
Annual benefit limit	$ 1,500	none
Individual out-of-pocket maximum	N/A	$ 350
Family out-of-pocket maximum *(two or more children)*	N/A	$ 700
Office copay	$ 0	$ 0
Waiting period	6 months for major services**	none

* Diagnostic and preventive services include X-rays, exams, cleanings and sealants.

** Waived with proof of prior coverage.

The listed services and the associated cost-sharing amounts represent a summary of services the plan provides. Please refer to the plan's Policy or Evidence of Coverage for a complete list of covered services provided and any exclusions and limitations on those services.

Notes on Family Dental Plan Standard Benefit Designs

Children's dental benefit notes (only applicable to the pediatric portion of the family dental plan)

1. In a coinsurance plan, each child is responsible for the individual deductible unless the family deductible has been met. Once a child's individual deductible or the family deductible is reached, cost-sharing applies until the child's out-of-pocket maximum is reached.
2. Cost-sharing payments made by each individual child for in-network services accrue to the child's out-of-pocket maximum. Once the child's individual out-of-pocket maximum has been reached, the plan pays all costs for covered services for that child.
3. In a plan with two or more children, cost-sharing payments made by each individual child for in-network services contribute to the family deductible, if applicable, as well as the family out-of-pocket maximum.
4. Only enrollees in a Covered California Platinum, Gold, Silver or Bronze health insurance plan are eligible to purchase a standalone family dental plans.

Adult dental benefit notes (only applicable to the family dental plan)

1. Each adult is responsible for an individual deductible.
2. Families that wish to purchase a family dental plan must include at least one adult who has purchased a Platinum, Gold, Silver or Bronze insurance plan through Covered California.
3. If a child is enrolled in the family dental plan, all children in the family under age 19 must be enrolled in the same family dental plan.

Family Dental Plan Standard Benefit Designs – DHMO

ENROLLEE PAYS – DHMO

Coverage category	Adult	Child
Diagnostic and preventive*	$ 0	$ 0
Amalgam filling – one surface	$ 25	$ 25
Root canal – molar	$ 300	$ 300
Gingivectomy per quad	$ 150	$ 150
Extraction – single tooth, exposed root or erupted	$ 65	$ 65
Extraction – complete bony	$ 160	$ 160
Crown – porcelain with metal	$ 300	$ 300
Medically necessary orthodontia	not covered	$ 350
Enrollee costs		
Deductible *(waived for diagnostic and preventive)*	$ 0	$ 0
Annual benefit limit	none	none
Individual out-of-pocket maximum	N/A	$ 350
Family out-of-pocket maximum *(two or more children)*	N/A	$ 700
Office copay	$ 0	$ 0
Waiting period	none	none

* Diagnostic and preventive services include X-rays, exams, cleanings and sealants.

The listed services and the associated cost-sharing amounts represent a summary of services the plan provides. Please refer to the plan's Policy or Evidence of Coverage for a complete list of covered services provided and any exclusions and limitations on those services.

Notes on Family Dental Plan Standard Benefit Designs

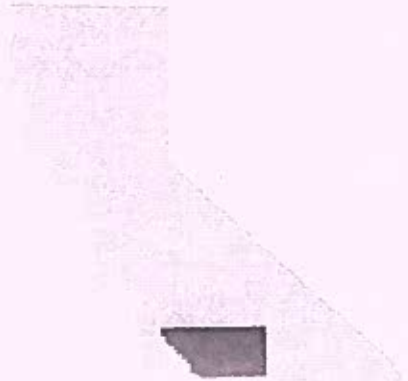
Children's dental benefit notes (only applicable to the pediatric portion of the standalone or family dental plan)

1. In a coinsurance plan, each child is responsible for the individualdeductible unless the family deductible has been met. Once a child's individual deductible or the family deductible is reached, cost-sharing applies until the child's out-of-pocket maximum is reached.
2. Cost-sharing payments made by each individual child for in-network services accrue to the child's out-of-pocket maximum. Once the child's individual out-of-pocket maximum has been reached, the plan pays all costs for covered services for that child.
3. In a plan with two or more children, cost-sharing payments made by each individual child for in-network services contribute to the family deductible, if applicable, as well as the family out-of-pocket maximum.
4. Only enrollees in a Covered California Platinum, Gold, Silver or Bronze health insurance plan are eligible to purchase a standalone family dental plans.

Adult dental benefit notes (only applicable to the family dental plan)

1. Each adult is responsible for an individual deductible.
2. Families that wish to purchase a family dental plan must include at least one adult who has purchased a Platinum, Gold, Silver or Bronze insurance plan through Covered California.
3. If a child is enrolled in the family dental plan, all children in the family under age 19 must be enrolled in the same family dental plan.

Pricing Region 14
Kern



STAND-ALONE FAMILY DENTAL RATES		
PLAN	ADULT	CHILD
Access Dental DHMO	$ 11.00	$ 14.00
Anthem DPPO	$ 48.35	$ 26.50
Blue Shield DHMO	$ 20.60	$ 17.70
Blue Shield DPPO	$ 30.10	$ 8.00
Delta Dental* DHMO	$ 12.99	$ 14.49
Delta Dental* DPPO	$ 52.99	$ 29.99
Dental Health Services DHMO	$ 12.40	$ 12.50
Premier Access DPPO	$ 40.00	$ 28.00

*Partial = not available in every ZIP code in the region.

Access Dental Plan

About the company:

Access Dental Plan was founded by a practicing dentist in 1989 in an effort to make quality dental care available at an affordable cost. In less than 25 years, the organization has grown to include multiple companies, all of which are related to promoting good oral health.

Website: www.premierlife.com

Phone: 877-702-8800

Anthem Blue Cross

About the company:

As an independent licensee of Blue Cross Blue Shield Association, Anthem Blue Cross is a major U.S. health insurance company, with more policyholders in California than any other insurer.

Website: www.anthem.com/ca

Phone: 877-702-3074

blue of california

Blue Shield of California

About the company:

As a California-based not-for-profit health plan, Blue Shield of California is driven by a single mission: to ensure all Californians have access to high quality care at an affordable price. We are offering a dental preferred provider organization (DPPO) plan and a dental health maintenance organization (DHMO) plan that gives Covered California customers a choice of high-quality dentists at an affordable price. We've been serving California for more than 70 years and have consistently been a leader in developing new and better ways of delivering dental care.

Website: www.yourdentalplan.com/bsca

Phone: 800-286-7401

DELTA DENTAL®

Delta Dental of California

About the company:

Delta Dental of California, a not-for-profit dental benefits administrator, is headquartered in San Francisco. Along with its affiliated companies, it is the state's and nation's largest dental health plan. We cover approximately 27 million people. Delta Dental of California is part of the national Delta Dental Plans Association, whose member companies collectively cover more than 63 million people in the U.S. Delta Dental of California is committed to advancing dental health and access through exceptional dental benefits service, technology and professional support.

Website: www.deltadentalins.com

Phone: DPPO: 800-471-0287

DMHO: 800-471-7583

Dental Health Services

Dental Health Services

About the company:

Founded in Long Beach, California by a practicing dentist, Dental Health Services was established in 1974 as one of the first organizations to specialize in prepaid dental plans. We have been serving the dental health needs of individuals, families, unions, groups, associations, and municipalities in California for more than 40 years. Dental Health Services members have access to an exclusive network of participating dentists, all of whom must meet our rigorous, 107-point Quality Assurance program that ensures and guarantees members receive only the highest care possible. As an independently owned and operated dental benefit solutions company, we take pride in being the only employee-owned dental plan in the country. Our employee-owners are your neighbors and friends who work, live, shop, and play right here. When you work with us, you work with real people who continuously advocate for a happier, healthier you!

Website: www.dentalhealthservices.com/CA

Phone: 800-637-6453

PREMIER ACCESS

Premier Access

About the company:

Premier Access was founded by a practicing dentist in 1989 in an effort to make quality dental care available at an affordable cost. In less than 25 years, the organization has grown to include multiple companies, all of which are related to promoting good oral health.

Website: www.premierlife.com

Phone: 877-702-8800

Out-of-Pocket Maximum
The most you pay during a policy period (a calendar year) before your health insurance plan begins to pay 100 percent of the cost of covered services. This limit never includes your premium, balance-billed charges or health care your health insurance plan doesn't cover. Some health insurance plans don't count all out-of-network payments toward this limit.

Glossary

Actuarial Value
A health insurance plan's actuarial value is the percentage of total average costs for benefits that a health insurance plan covers. These expenses are usually incurred at the point of receiving health care services — when you visit the doctor or the emergency room, for example. Dental plans come in two actuarial value options: 85 percent, which features higher premiums but lower average out-of-pocket costs; and a 70 percent value plan with lower premiums and higher average out-of-pocket costs. An actuarial value is the percentage of total average costs for benefits that a dental plan will cover.

Coinsurance
Your share of the costs of a covered health care service, calculated as a percentage (for example, 20 percent) of the allowed amount for the service, is called coinsurance. You pay coinsurance plus any deductible you may owe. For example, if the health insurance plan's allowed amount for an office visit is $100, and you have met your deductible for the year, your coinsurance payment of 20 percent would be $20. The health insurance plan pays the rest of the allowed amount. The allowed amount is the amount the doctor or hospital has agreed to accept for the care provided.

Copayment
A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Dental Preferred Provider Organization (DPPO)
A type of dental plan product that delivers dental services to members through a network of contracted dental care providers and includes limited coverage of out-of-network services.

Dental Health Maintenance Organization (DHMO)
A type of dental plan product that delivers dental services by requiring assignment to a primary dental care provider who is paid a capitated fee for providing all required dental services to the enrollee unless specialty care is needed. DMHOs require referral to specialty dental providers. These products do not include coverage of services provided by dental care providers outside the dental plan.

Qualifying Life Event	When coverage is effective	Applicable to those not currently covered?	Examples	CoveredCA.com Selection
Birth, adoption, placement for adoption, or placement in foster care	Day of event	Yes, both the new child and others in the tax household are eligible.	• An adult adopts a child. Both the adult and the child may be eligible for insurance though Covered California. • **Note:** Pregnancy is not a qualifying event.	• Had a Baby • Adopted a Child
Marriage/Domestic Partnership	The first day of the month following the plan selection month (regardless of when event and the plan selection happened during the month).	Yes	• A man who has no coverage marries a woman who has a Covered California health plan. They are both eligible to apply/re-enroll. • Two people, neither of whom have coverage, get married. Both are eligible to enroll. • A woman who has a Covered California health plan enters into a registered domestic partnership (RDP) with a woman who also has a Covered California health plan. They are eligible to re-enroll.	• Got married or entered into a domestic partnership
Becomes a citizen, national, or lawfully present individual	If enrolled by the 15th, coverage starts on the 1st of the following month. If enrolled after the 15th, coverage starts the 1st of the subsequent month thereafter.	Yes	• An individual who was previously unlawfully present becomes a permanent legal resident is eligible. • Moving between the three statuses (citizen, national, lawfully present) does not qualify.	• Gained citizenship/ lawful presence
Loss of minimum essential coverage (MEC)	The first day of the month following the plan selection month (regardless of when event and the plan selection happen during the month).	Yes	• A person who loses their employer-sponsored coverage (either through job loss or reduction of benefits). • A person who loses their Medi-Cal coverage. • A 26-year-old dependent who ages out of coverage or a 19-year-old in a child-only plan who ages out of coverage. • A divorce that results in loss of coverage (previously covered on spouse's plan). • See Notes on COBRA	• Lost my health insurance including Medi-Cal

Qualifying Life Event	When coverage is effective	Applicable to those not currently covered?	Examples	CoveredCA.com Selection
Newly eligible or ineligible for Advance Premium Tax Credit/Cost-Sharing Reduction (APTC/CSR)	If enrolled by the 15th, coverage starts on the 1st of the following month. If enrolled after the 15th, coverage starts the 1st of the subsequent month thereafter.	No, only those already enrolled in Covered California are eligible.	• Income increases or decreases across the 138%, 250%, or 400% Federal Poverty Level (FPL) threshold. • An enrollee whose income drops from 400% to 240% FPL is eligible to change health plans. • Someone who currently has APTC and CSR becomes ineligible for CSR is eligible to change coverage.	• Other qualifying life event
Permanently moves and gains access to a new Covered California health plan	If enrolled by the 15th, coverage starts on the 1st of the following month. If enrolled after the 15th, coverage starts the 1st of the subsequent month thereafter.	Yes	• Someone moves from out of state with the intention of permanently residing in California for the benefit year. • Someone who currently has a Covered California health plan moves to a different rating region and gains access to at least one new QHP that was not available in the previous rating region is eligible • Release from incarceration (considered a move).	• Permenently moved to/within California • Released from incarceration • Returned from active duty military service
American Indian and Alaskan Native	If enrolled by the 15th, coverage starts on the 1st of the following month. If enrolled after the 15th, coverage starts the 1st of the subsequent month thereafter.	Yes	• Someone who is a member of a federally-recognized Indian tribe can change plans at least, but no more than, once per month.	• American Indian / Alaskan Native
Other exceptional circumstances	If enrolled by the 15th, coverage starts on the 1st of the following month. If enrolled after the 15th, coverage starts the 1st of the subsequent month thereafter. Covered California may grant an earlier effective date based on the specific circumstances of each case.	Yes	• Covered California will determine on a case-by-case basis. • Exceptional circumstances that occur on or around plan selection deadlines could include natural disasters, medical emergencies and planned system outages.	• Other qualifying life event

Qualifying Life Event	When coverage is effective	Applicable to those not currently covered?	Examples	CoveredCA.com Selection
Misrepresentation or erroneous enrollment	If enrolled by the 15th, coverage starts on the 1st of the following month. If enrolled after the 15th, coverage starts the 1st of the subsequent month thereafter.Covered California may grant an earlier effective date based on the specific circumstances of each case.	Yes	• Consumers who applied in open enrollment and were initially found Medi-Cal eligible, but later found Medi-Cal ineligible, are eligible to enroll in Covered California. • Issuer (health plan) did not receive a consumer's information due to technical issues. • A CEC entered the wrong date, birthday, income, etc. on life changing event.	• Other qualifying life event
Misconduct on the part of a non-Exchange entity providing enrollment assistance or conducting enrollment activities	If enrolled by the 15th, coverage starts on the 1st of the following month. If enrolled after the 15th, coverage starts the 1st of the subsequent month thereafter. Covered California may grant an earlier effective date based on the specific circumstances of each case.	Yes	• A CEC enrolled a consumer in a plan that the consumer did not want to enroll in or failed to enroll the consumer in any plan. • Other situations in which misconduct by those conducting formal enrollment assistance results in the consumer not receiving APTC/CSR for which they are eligible.	• Other qualifying life event
Qualified Health Plan (QHP) violated its contract	Based on the specific circumstances of each case, Covered California will grant an effective date that is either the date of the event or the regular effective date based on the date of plan selection.	No, only those already enrolled in Covered California are eligible.	• Someone who has a QHP that violates its contract is eligible to change issuers.	• Other qualifying life event

Notes:

- A consumer or representative can apply for coverage at any time even if there is no qualifying life event, as the consumer may be eligible for other programs such as Medi-Cal. In the absence of a life event, **None of the above** should be selected from the dropdown list.
- **The date** of the life event is very important because consumers have a limited amount of time to report these events and still qualify for special enrollment. Consumers must report a life event to Covered California within 60 days. If this deadline is missed, the consumer must wait until the next Open Enrollment period to enroll in health coverage. A consumer must report a change in circumstances (i.e. income) within 30 days.
- When COBRA benefits have been exhausted, an individual is then eligible to enroll in Covered California. Individuals are eligible to enroll if they opt out of COBRA when it is intially offered. Not paying one's COBRA premium or volunteeraly canceling once participating in COBRA is **not** a qualifying event, and the individual would not be eligible to enroll in Covered California.

Covered California
PO Box 989725
West Sacramento, CA 95798-9725

COVERED CALIFORNIA

Your destination for affordable healthcare, including Medi-Cal

Sally Smith
456 ABC Street
Apt. 300
Sacramento, CA 95833

Important news about your application for health insurance

November 9, 2013{2} Case Number: 91234567{1}

Dear Sally{3} Smith{4},

Thank you for your interest in Covered California!

Your application has been entered in the **CoveredCA.com** system. We have created an access code for you so you can link your application to an online account. This will allow you to view your application online. You will also be able to update your account information.

Your access code is: **123ABC**{11}

What you have to do...

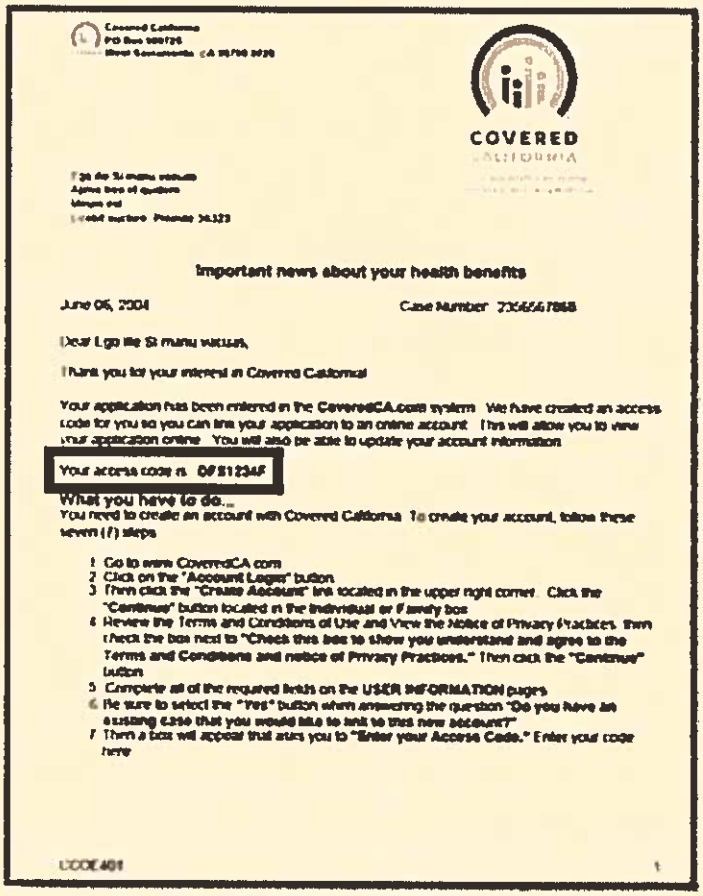
You need to create an account with Covered California. To create your account, follow these seven (7) steps:

1. Go to www.CoveredCA.com
2. Click on the "**Account Login**" button.
3. Then click the **"Create Account"** link located in the upper right corner. Click the "**Continue**" button located in the **Individual or Family** box
4. Review the Terms and Conditions of Use and View the Notice of Privacy Practices, then check the box next to "**Check this box to show you understand and agree to the Terms and Conditions and Notice of Privacy Practices.**" Then click the "**Continue**" button.
5. Complete all of the required fields on the **USER INFORMATION** pages.
6. Be sure to select the ***"Yes"*** button when answering the question "**Do you have an existing case that you would like to link to this new account?**"
7. Then a box will appear that asks you to "**Enter your Access Code.**" Enter your code here.

How to Link an Existing Case to an Account

Starting the week of **July 28, 2014** many of the consumers you helped apply for health insurance will receive this notice. This notice gives the consumers an access code. It explains how the consumer can use the code to link their application to an online account. This will allow the consumer to make changes, such as update their address and income, to their accounts on their own.

The consumers that you helped in the past may ask you for help with linking their application to an account. This document will help you guide them through the process.



COVERED CALIFORNIA

Important news about your health benefits

June 06, 2014 Case Number 7356667868

Dear Ligo Ile Si manu vakuin,

Thank you for your interest in Covered California!

Your application has been entered in the CoveredCA.com system. We have created an access code for you so you can link your application to an online account. This will allow you to view your application online. You will also be able to update your account information.

Your access code is: 0F512345

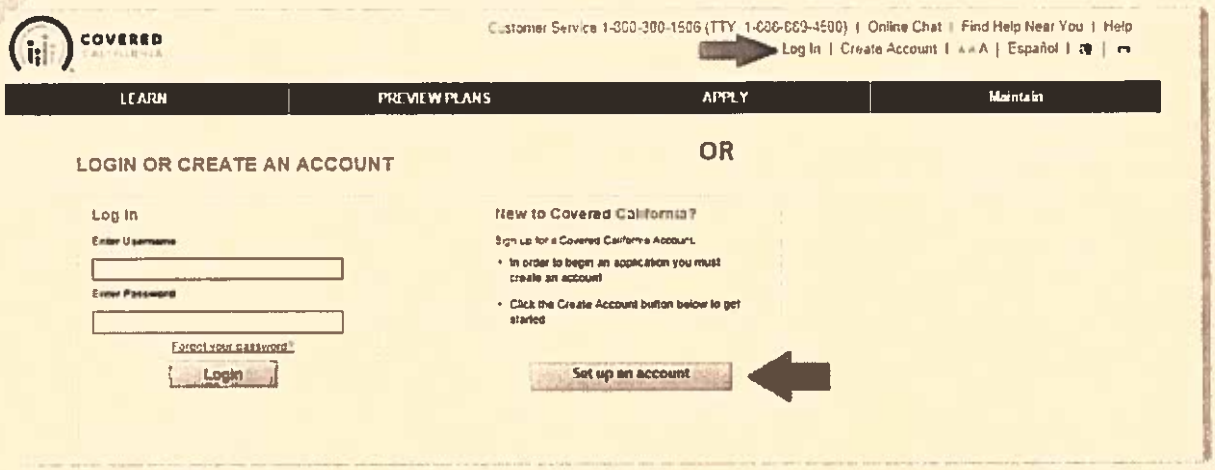
What you have to do...

You need to create an account with Covered California. To create your account, follow these seven (7) steps:

1. Go to www.CoveredCA.com
2. Click on the "Account Login" button
3. Then click the "Create Account" link located in the upper right corner. Click the "Continue" button located in the Individual or Family box
4. Review the Terms and Conditions of Use and View the Notice of Privacy Practices. Then check the box next to "Check this box to show you understand and agree to the Terms and Conditions and notice of Privacy Practices." Then click the "Continue" button
5. Complete all of the required fields on the USER INFORMATION pages
6. Be sure to select the "Yes" button when answering the question "Do you have an existing case that you would like to link to this new account?"
7. Then a box will appear that asks you to "Enter your Access Code." Enter your code here

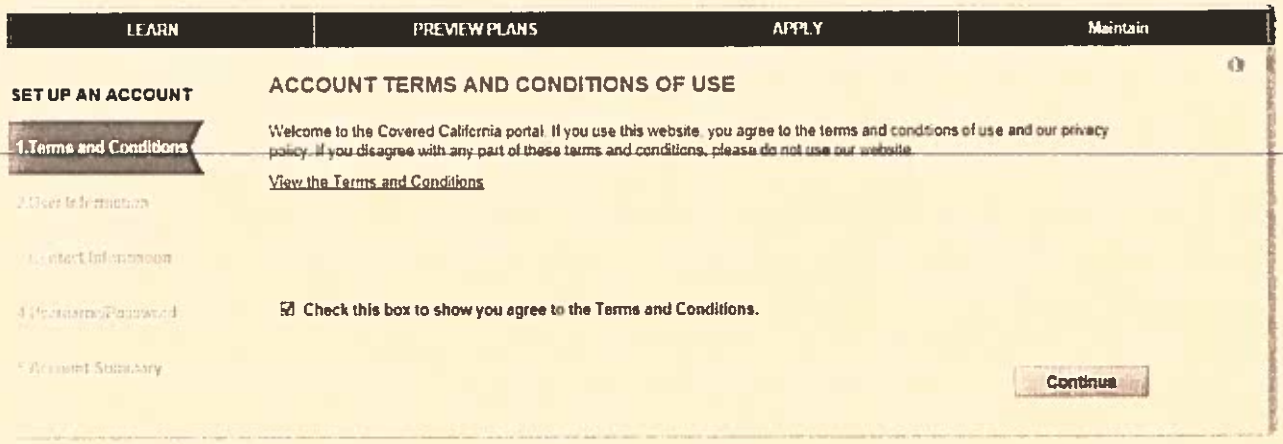
LCOE401 1

1. From the CoveredCA.com home page, Click on Account login:

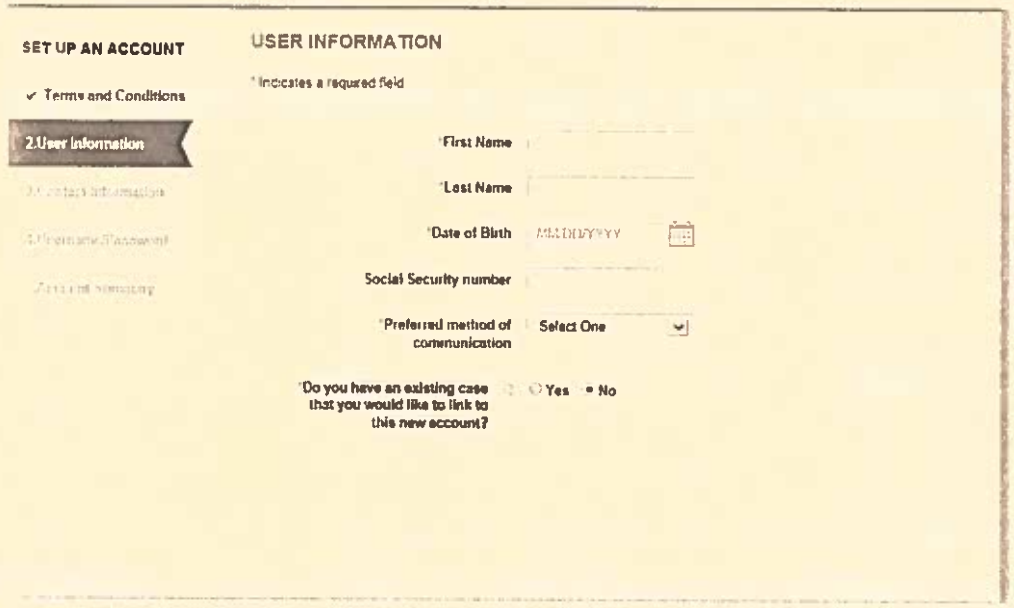


2. Click "Set up an account" or "Create Account"

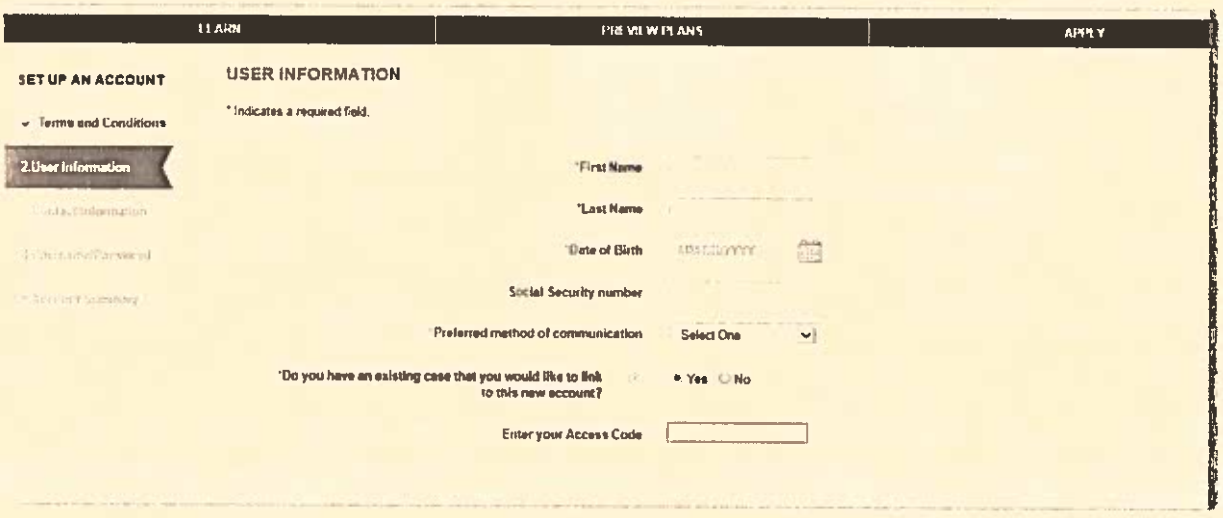
3. Click on the continue button located with the Individual or Family box.



4. Check the box indicating that you agree to the Terms and Conditions of Use. The click continue



5. Complete all of the required fields on the USER INFORMATION pages.



6. Be sure to select the ***"Yes"*** button when answering the question "**Do you have an existing case that you would like to link to this new account?**"
7. Then a box will appear that asks you to "Enter your Access Code." Enter your code here.

Once the account is created, the consumer can then access their account. So at any time, they will be able to:

- **Review and update their application information,**
- **View their notices, or**
- **Upload documents that we've requested.**

Mercy & Memorial Hospitals
Dignity Health Members

CONSENT TO PHOTOGRAPHY, RECORDING AND/OR PUBLISHING

Official Use Only:

Use this form if the subject to be photographed or recorded is NOT a patient and the product does not involve protected health information. DO NOT USE THIS FORM IF THE SUBJECT OF THE PHOTOGRAPHY OR RECORDING IS A PATIENT. If the subject of the photography or recording is a Patient, use either Form No. PF-1 or PF-2, as appropriate.

Print Name (person to be photographed/recorded or owner of product/premises photographed)

Print Address

Telephone **Email**

In consideration of the engagement as a model or actor and for other good and valuable consideration, the receipt of which is hereby acknowledged, I hereby permit Mercy and Memorial Hospitals hereinafter referred to as **"you"** or **"your"** and the persons designated by you, to photograph, and/or make audio and/ or visual recordings, or create images in the likeness of *(name of subject, e.g., employee, model, actor, product, premises, etc.)* _____.

Description of event(s):_____ Date FY2014

(check one) ☐ One time event ☑ Series of events

I grant to you and/or your affiliates, successors, or other persons acting under your permission and authority, the irrevocable, perpetual, unrestricted, royalty-free right, license and permission to copyright in your own name, and to use, re-use, publish, reproduce and distribute, such audio and/or visual recordings, pictures, composites, or other reproductions thereof, distorted or modified in form or character, without restriction as to changes or alterations, whether in conjunction with the subject's true or fictitious name or in conjunction with other photographs or printed matter, made through any medium, including website publishing, for illustration, education, promotion, art, editorial, advertising, trade, or any purpose whatsoever, in such manner as you deem appropriate for such purposes. I understand that if such picture or image, or recording is published on the web, it may be downloaded by any computer user. You agree not to use the photograph/ recording/ image in any derogatory manner.

I waive the right to inspect or approve the finished product(s) and/or the advertising copy or other matter used in connection with the product or the use for which it may be applied. I further waive any claims to royalties or monetary compensation connected with such recordings, creations or photographs, or the publication or distribution thereof.

My signature below confirms that I have the legal right to grant this license to you. I hereby release, discharge and agree to hold you and/or your affiliates, successors, or those acting under your authority or permission, harmless from any liability whatsoever connected with the photography, recording, or creation, or the use, re-use or publication of such images or recordings, including any blurring, distortion, alteration, cropping, or use in composite form, intentional or otherwise, that may occur or be produced in the processing of such products. This consent shall be binding upon me and the subject of this photography or recording (if different), my heirs, agents, legal representatives, and assigns.

ACCEPTED AND AGREED TO

Signature Date

Print name Signatory's relationship to the subject *(If signatory is not the subject)*

Mercy & Memorial Hospitals.
Dignity Health Members

Form No. PF-3 – Media Matrix
(For Non-Patients)

CONSENTIMIENTO PARA TOMAR FOTOGRAFÍAS, GRABAR O PUBLICAR

Official Use Only:

Use this form if the subject to be photographed or recorded is NOT a patient and the product does not involve protected health information. DO NOT USE THIS FORM IF THE SUBJECT OF THE PHOTOGRAPH OR RECORDING IS A PATIENT. If the subject of the photography or recording is a Patient, use either Form No. PF-1 or PF-2, as appropriate.

_____

Print Name (person to be photographed/recorded or owner of product/premises photographed)

_____

Print Address

_____ _____

Telephone **Email**

En consideración al compromiso como modelo o actor y por otras consideraciones válidas y efectivas, las cuales aquí se reconocen como recibidas, por medio del presente documento acepto que *(Mercy and Memorial Hospitals)* _____ _____(denominado de aquí en adelante **"usted"** o **"su"**) y las personas que usted designe, fotografíen o hagan grabaciones de sonido o visuales, o creen imágenes a semejanza de *(nombre del sujeto, por ejemplo, empleado, modelo, actor, producto, instalaciones, etc.)*_____.

Descripción del evento:_____ Fecha FY2014

(marque uno) ☐ Un evento ☑ Serie de eventos

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ACEPTADO Y ACORDADO PARA

_____ _____

Firma Fecha

_____ _____

Nombre en letra de imprenta Relación de quien firma con el sujeto *(si no es el sujeto)*

Workshop Evaluation Sheet

CEC Quarterly Network Meeting
Mercy Hospital – September 4, 2014

1. Were your expectations of the session met?

1 2 3 4 5
Low High

Why or why not?

2. Did you learn new ideas, techniques or was new information presented?

1 2 3 4 5
Low High

3. Do you feel that this training has provided you with information and/or methods you'll be able to use when working with families?

1 2 3 4 5
Low High

4. What were the strengths of this session?

5. What topics would you like covered in future workshops?