Step 3: Please read and sign this application *(continued)*

Your rights and responsibilities *(continued)*

Your right to appeal:

- If I think Covered California or the Medi-Cal program has made a mistake, I can appeal its decision. To appeal means to tell someone at Covered California or the Medi-Cal program that I think its decision is wrong and ask for a fair review of the action.
- I know that I can find out how to appeal by calling **1-800-300-1506** (TTY: 1-888-889-4500).
- I know that I must file an appeal within 90 days of the decision.
- I know that I can represent myself or have someone else represent me in my appeal, such as an authorized representative, a friend, a relative, or a lawyer.
- I know that if I need help, someone at Covered California, the Medi-Cal program, or the county social services office can explain my case to me.

Renewal of insurance

To make it easier to continue to get health insurance in future years, I agree to allow Covered California to use computer sources, such as the IRS, to check my income. If the sources show I am still eligible, my insurance coverage can be renewed for another 12 months and I won't have to fill out a renewal form or send other paperwork.

I understand that if I choose not to allow Covered California to use computer sources, I must complete a renewal packet every 12 months in order to continue my health insurance.

I agree to allow Covered California or the Medi-Cal program to check my information for:

☐ 5 years ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year

OR

☐ I do not want Covered California to check my tax returns at renewal.

Declaration and signature *This is required.*

I declare under penalty of perjury that what I say below is true and correct.

- I understood all questions on this application and gave true and correct answers as far as I know. Where I did not know the answer myself, I made every reasonable attempt to confirm the answer with someone who did know.
- I know that if I do not tell the truth on this application, there may be a civil or criminal penalty for perjury that may include up to four years in jail. (See California Penal Code Section 126.)
- I know that the information in this application will be used to decide if the people who are applying qualify for health insurance. Covered California will keep the information private, as required by federal and California law.
- I agree to notify Covered California by calling **1-800-300-1506** (TTY: 1-888-889-4500) or visiting **CoveredCA.com** if anything changes on this application for any person applying for health insurance.
- If I am selecting a health plan by filling out and submitting Attachment D, and if I am determined eligible by Covered California to enroll in the plan I selected in Attachment D:
    - I understand that by signing here I am entering into a contract with the issuer of that plan.
    - I am at least 18 years of age or I am an emancipated minor, and I am mentally competent to sign a contract.

Signature of applicant or authorized representative	Date

***Step 3** continued on next page*

APPOINTMENT OF REPRESENTATIVE

SECTION I. TO BE COMPLETED BY APPLICANT/BENEFICIARY

Name	Case number *(optional)*	Date

I appoint this individual ______________________ / ______________________
Name of individual ***Name of organization***

Complete address Telephone number

as my authorized representative to accompany, assist, and represent me in my application for, or redetermination of, Medi-Cal benefits.

THIS AUTHORIZATION ENABLES THE ABOVE NAMED INDIVIDUAL TO:

- submit requested verifications to the county welfare department;
- accompany me to any required face-to-face interview(s);
- obtain information from the county welfare department and from the State Department of Social Services, Disability Evaluation Division, regarding the status of my application;
- provide medical records and other information regarding my medical problems and limitations to the county welfare department or the State Department of Social Services, Disability Evaluation Division;
- accompany and assist me in the fair hearing process; and
- receive one copy of a specific notice of action from the county welfare department, at the request of the applicant/beneficiary.

I UNDERSTAND THAT I HAVE THE RESPONSIBILITY TO:

- complete and sign the Statement of Facts;
- attend and participate in any required face-to-face interview(s);
- sign MC 220 (Authorization for Release of Medical Information);
- provide all requested verifications before my Medi-Cal eligibility can be determined; and
- accept any consequences of the authorized representative's actions as I would my own.

I UNDERSTAND THAT I HAVE THE RIGHT TO:

- choose anyone that I wish to be my authorized representative;
- revoke this appointment at any time by notifying my Eligibility Worker; and
- request a fair hearing at any time if I am not satisfied with an action taken by the county welfare department.

Applicant/Beneficiary's signature	Date
➤	

Address

SECTION II. TO BE COMPLETED BY THE AUTHORIZED REPRESENTATIVE NAMED. *LAW FIRMS, ORGANIZATIONS, AND GROUPS MAY REPRESENT THE APPLICANT/BENEFICIARY BUT AN INDIVIDUAL MUST BE DESIGNATED AS THE CONTACT PERSON TO ACT ON THE APPLICANTS/BENEFICIARIES BEHALF.*

I HEREBY ACCEPT THE ABOVE APPOINTMENT AND UNDERSTAND THAT:

- the applicant/beneficiary may revoke this authorization at any time and appoint another individual(s) to act as his/her authorized representative;
- I have no other power to act on behalf of the applicant/recipient, except as stated above;
- I may not act in lieu of the applicant/beneficiary; and
- I may not transfer or reassign my appointment without a new Appointment of Representative form being completed by the applicant/recipient.

I CERTIFY THAT:

- I have not been suspended or prohibited from practice before the Social Security Administration
- I am not, as a current or former officer or employee of the United States, disqualified from acting as the applicant's representative; and
- I am known to be of good character.

This authorization is recognized for one year from the date signed by the applicant unless revoked earlier as described in Section 1 above.

Authorized representative's signature	Employed by	Date	Telephone number
➤ Dignity Health - CHI			661-632-5018

COUNTY USE ONLY

Date verbal request to revoke received ______ Date written request to revoke received ______ Request received from: ______

EW name: ______________________ Telephone number: ______________

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: Dignity Health

CEC's Signature: ______________________________________ Phone#: ____________

Email Address: _______________________________________ Fax#: ____________

KCDHS 724-Gen (10/08) SAS APPLICATION ID#: ________________

KERN COUNTY

KERN COUNTY INTERAGENCY

DEPARTMENT OF HUMAN SERVICES

CONSENT AND AUTHORIZATION TO RELEASE AND EXCHANGE INFORMATION

(Please type/print all information)

Name ____________ Relationship ____________ SSN # ____________

Name ____________ Relationship ____________ SSN # ____________

Name ____________ Relationship ____________ SSN # ____________

Name ____________ Relationship ____________ SSN # ____________

Name ____________ Relationship ____________ SSN # ____________

Name ____________ Relationship ____________ SSN # ____________

I authorize the agencies listed below to exchange or obtain records/information obtained during the course of my CalWORKs/CalFresh/Health Care eligibility, case and/or service plan. I understand that the sharing of information is deemed necessary to plan or provide needed services to establish eligibility or continuing eligibility. This authorization includes all individuals listed above for whom services are provided.

Community Connection for Child Care
Department of Rehabilitation
Employment Development Department
Employer's Training Resource
Housing Authority of the County of Kern
Kern County Department of Human Services
Kern County Child Support Services
Kern County Aging & Adult Services Department
Kern County Mental Health Department
KC Department of Mental Health: Children's System of Care
KC Superintendent of Schools/District School of Attendance
Kern County Department of Public Health
The Work Number Services
Kern Medical Center
Kern County Probation Department
Kern Community College District
Other Dignity Health - Community Health Initiative

Restrictions of Records or Information: [x] No [ ] Yes ____________

CONSENT

I understand that this Consent for Release of Exchange of Records and Information is effective until such time as consent is withdrawn by the undersigned or one year. I have read this consent carefully.

Print your name ____________

Signature ____________ Date ____________
(Participant, Parent/Caretaker, Relative/Guardian)

Print your name ____________

Signature ____________ Date ____________
(Participant, Parent/Caretaker, Relative/Guardian)

AGENCY REPRESENTATIVE/WITNESS

Print Agency Representative Name Dignity Health- Community Health Initiative of Kern County
(Eligibility technician, Social Services Worker)

Signature ____________ Date ____________

Original: Case Record
Copy: Social Service Worker
Copy: Client Copy

Obtain at application, redetermination, and when adding additional persons
KCDHS 694-Gen (9/14)

Appointment of Authorized Representative

A. For an individual appointed as an authorized representative:

- By accepting appointment as an authorized representative you agree to:
  - Give the written disclosure to the applicant or beneficiary.
  - Obey all state and federal laws governing authorized representatives. These include, but are not limited to, laws about privacy of information, rules against reassigning provider claims, and conflicts of interest.

- If you are an employee or contractor for a health care provider or facility, you must give the applicant or beneficiary a written disclosure about:
  - Your employment by or contract with the health care provider or facility.
  - Any potential conflicts of interest that may exist due to that employment or contract.

B. For an organization appointed as an authorized representative:

- The only persons who may perform duties authorized on this form are those who represent the organization and have a signed Authorized Representative Standard Agreement (MC 383) on file with the county that handles the applicant or beneficiary's Medi-Cal case.
- The organization must fully disclose in writing to the applicant or beneficiary any conflicts of interest that may result from acting as that person's authorized representative.

Medi-Cal confidentiality notice: The information given on this form is private and confidential pursuant to Welfare and Institutions Code, Section 14100.2. This information shall be disclosed only as this law allows.

By signing below, I agree to and understand my rights and responsibilities as stated above:

Signature of applicant or beneficiary (required):	Date:

Signature of individual appointed as an authorized representative (optional):	Date:
Dignity Health- Community Health Initiative	

- Referring me to resources for tax preparation and tax advice if I have any tax-related questions about health insurance, financial assistance to pay for health insurance, and any legal requirements pertaining to health insurance.

6. The Counselor must also offer public education activities. The Counselor will not use my Personally Identifiable Information for this purpose.
7. The Counselor is knowledgeable about the rules for enrollment into Covered California Health Plans, Medi-Cal, and the Medi-Cal Access Program.
8. If I give incorrect information to the Counselor, he or she may not be able to help me make the best decision regarding health insurance. The Counselor can only rely on the information that either my Authorized Representative or I provide.
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 cannot charge me any fees. This assistance is free.
11. I must sign this form in order to authorize the Counselor to help me. If I do not sign this form, I can still apply for and enroll in health insurance through Covered California, Medi-Cal, or the Medi-Cal Access Program.
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 Certified Enrollment Entity must keep this form for ten (10) 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.

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 1601 Exposition Blvd., Sacramento, CA 95815.

Signature	Date
Print Name	
Application No.	Case No.

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 conveyed all information in this form to the applicant in a language and manner which 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 applicant the meaning of Personally Identifiable Information and its purpose in applying for insurance. I stated that Personally Identifiable Information will only be used to determine eligibility for health coverage.
- I obtained oral or written 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

Dignity Health
Mercy & Memorial Hospitals

Memorial Hospital
420 34th St.
Bakersfield, CA 93301

Mercy Hospital Downtown
2215 Truxtun Ave.
Bakersfield, CA 93301

Mercy Hospital Southwest
400 Old River Rd.
Bakersfield, CA 93311

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

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 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**

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 *(Hospital, Foundation, etc.)* _ Mercy & 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):_Enrollment Assistance______________________________Date__________________
(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 person/owner named above (if different), our heirs, agents, legal representatives, and assigns. If the person to be photographed or recorded is a minor, I confirm that I am his/her parent or legal guardian and I am legally authorized to give this consent for such minor.

ACCEPTED AND AGREED TO

______________________________ ______________________________
Signature of person to be photographed or owner named above (if subject is an unemancipated minor, signature of parent or legal guardian) | Date

______________________________ ______________________________
Print name of signatory | Signatory's relationship to the person to be photographed *(If signatory is not the subject)*

Mail form back to: California Department of Health Care Services
P.O. Box 989009 • W. Sacramento, CA 95798-9850

Medi-Cal Choice Form

Highly Confidential

Use this form to join or change plans. For help, call 1-800-430-4263.
Please print. Fill in the ovals ⬬ to indicate your choice.

1) Head of Household Name (First Name) ____________ 2) Last Name ____________

3) Home Address (House Number, Street Name, Apartment Number) ____________

4) City ____________ 5) Zip Code ______ 6) Area Code & Phone Number ___-___-____

7) E-mail Address ____________

Choose a plan from the list below. See the provider directory for Doctor/Clinic Codes.

8) Applicant's Name (First Name) ____________ 9) Last Name ____________

10) Sex ⬭ Male ⬭ Female

11) Due Date (If Pregnant) __/__/____

12) Birth Year ______

13) Social Security Number ___-__-____

14) **I wish to JOIN or change my plan to:**

- ⬭ **366** **Kaiser Permanente**
- ⬭ **303** **Kern Family Health Care**
- ⬭ **379** **Anthem Blue Cross Partnership**
- ⬭ **000** **Regular Medi-Cal (FFS)**

15) Doctor/Clinic Code ____________ Internal Use ____________

16) Fill in the oval next to the reason for changing your plan.

- ⬭ I could not choose the doctor I wanted
- ⬭ The plan did not meet my needs
- ⬭ My doctor did not meet my needs
- ⬭ Too far to go
- ⬭ I did not choose this plan
- ⬭ Moving out of the county
- ⬭ Indian Health Program Exemption
- ⬭ Exempt from a plan
- ⬭ Other

17) **Program of All-Inclusive Care for the Elderly (PACE):** You may qualify for PACE (see instructions). If you want to enroll with a PACE plan, fill out this option **in addition to section 14**. If you do not qualify for PACE, you will get your care through the plan selected in Section 14.

- ⬭ **043** **IIH-Bakersfield PACE (Kern)**

Choice Statement: I/We have made written choice to receive Medi-Cal benefits through the plans as I/we have indicated on this form. I/We have read and understand the conditions of this agreement on **both sides**. I/We understand that in order to change my/our current Medi-Cal plan, I/we must complete this form.

____________________ Head of Household or Authorized Representative Signature ________ Date

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