MEDI-CAL TO HEALTHY FAMILIES BRIDGING CONSENT FORM

County Return Address Box

Medi-Cal Recipient Address Box

Notice date: _____
Case number: _____
Worker name: _____
Worker number: _____
Worker telephone number: _____
Office hours: _____
Notice for: _____

Your child(ren) listed above may be eligible for low-cost health coverage through the Healthy Families Program (HFP). They will receive no share of cost Medi-Cal for one calendar month in order to give you time to apply for the HFP. If you give us consent, we will forward your case file information to the HFP and you will not have to file a new application with the HFP.

The benefits in the HFP include:

- Choice of health, dental and vision insurance plans.
- Low monthly premiums from $4 per child per month to a maximum of $45 per family per month.
- No co-payment for preventive services (such as immunizations).
- $5 co-payment for other office visits and prescriptions.

If you consent to our sending your case file information to the HFP, HFP will accept your Medi-Cal information as your application for the HFP. If you consent, you will not have to complete a new HFP application. The HFP will then contact you to let you know what different information they need to enroll your child(ren).

If you wish to give consent to forward your information to the HFP, you must check the box that shows, "I give my consent to forward my Medi-Cal case file information to the HFP." You must sign and date this form and return it to the county address above. You may also call your Medi-Cal worker to tell him/her that you wish to give consent.

If you do not wish to give consent, do NOT return this form. If you do not return this form, consent is NOT given. Your Medi-Cal case file information will not be sent to the HFP and your child(ren) will not get HFP health care coverage unless you apply.

You can request an HFP/Medi-Cal application by calling 1 (800) 880-5305.

☐ **I give my consent to forward my Medi-Cal case file information to the HFP.**

Sign: _____ **Date:** _____ **Phone:** _____

(Return this form or call-in your response within five days.)

If you have any questions or need additional information, please contact your Medi-Cal worker listed on the top right corner of this notice. Please call (800) 880-5305 if you want additional information about the HFP.