MASS MAILER REQUEST

The purpose of this form is to obtain the required information for the Department of Health Care Services (DHCS) to coordinate a mass mailing project. Health plans must complete Part A and include three original copies (photo copy finish) of the mailer information to be sent out. Please allow at least 45 days for DHCS to process the mailer request. Please send completed form to:

Department of Health Care Services
Long-Term Care Division
PACE/SCAN Unit
1501 Capitol Avenue, MS 0018
Suite 71.3052
P.O. Box 997413
Sacramento, CA 95899-7413

Note: All marketing material must be preapproved by DHCS and CMS before it will be mailed out.

PART A—TO BE COMPLETED BY AUTHORIZED HEALTH PLAN REPRESENTATIVE	Today's date

Health plan name

Health plan address (number, street)	City	State	ZIP code

Contact person's name	Email address	Telephone number

Brief explanation of the purpose for the mailer and any special instructions

Target group

☐ Head of household only ☐ Each individual recipient in household ☐ Specific age group (specify:)

Month of Eligibility (MOE)

☐ Most current/recent

Other criteria

Eligible target population

☐ Plan members (enrolled in requesting plan only)

☐ Medi-Cal fee-for-service (FFS) only (all Medi-Cal eligible excluding plan members)

☐ All Medi-Cal eligible including plan members and FFS

☐ Others (explain):

Please list targeted geographic area ZIP codes or countywide (list county code) for health plan in ***alphanumeric*** order.

Are beneficiary counts required? ☐ Yes ☐ No Beneficiary count by ZIP code required? ☐ Yes ☐ No

Please list aid codes of targeted population.

Date to be mailed out *(service period)*

Please check who will reproduce pre-approved material:

☐ PLAN ☐ Department General Services, Office of State Publishing

Please check specifications:		
Envelopes required? ☐ Yes ☐ No	Envelope Size	Self-addressed by PLAN ☐ Yes ☐ No
Material inserted and sealed by PLAN? ☐ Yes ☐ No	If yes, weight of one envelope with mailer	
Size of Mailer (Material) (Width First):	Number of Parts:	☐ One-Sided ☐ Two-Sided
Number of Folds:	Paper Color ☐ White	☐ Other Color (*specify*)

The Provider named above certifies that the instructions on this form are correct. Provider agrees to reimburse DHCS within ten days of the invoice date for all costs incurred in fulfilling this request which may include, but are not limited to, reproduction of materials, paper, envelopes, postage, and handling. The Provider guarantees that all mailed material will be delivered in satisfactory condition.

Authorized Health Plan Representative's signature	Date
DHCS Program Staff signature	Date
DHCS Program Chief signature	Date

PART B – TO BE COMPLETED BY LONG-TERM CARE DIVISION STAFF

Program:	Health Plan Code:	ITSD Project Number:
Account Project Number:	Index Code:	PCA Code:

PART C – TO BE COMPLETED BY LONG-TERM CARE DIVISION STAFF

ITSD staff must code the amount below to CALSTARS.
ITSD costs:
(formula for developing costs)

Project No.: _____

Total: $ _____ Initials: _____ Date: _____

Department of General Services
Office of State Publishing
(Reproduction/Addressing-Mass Mailing/ Packaging/Handling/Postage Costs)

Job No.: _____

Total: $ _____ Initials: _____ Date: _____

Grand total CAB/CALSTARS system charges to be posted to the Index and PCA codes as listed above and invoiced to the Health Plan: $ _____