State of California-Health and Human Services Agency
Department of Health Care Services
P.O. Box 989009, West Sacramento, CA 95798-9850

TOBY DOUGLAS
Director

EDMUND G. BROWN JR.
Governor

350I111E-000001-01-7-M-M
▶X- I-1111111IY-xx/xx/xx ◀

XX/XX/XXXX

Parent/Guardian of
John Sample
123 Sample Street
Sample City, CA 99999

PIN XXXXX

Good News: You Can Get Free Health Coverage From Medi-Cal!

How Do I Get Free Health Coverage?

Because you get CalFresh you can get free Medi-Cal coverage. You do not have to apply. We will use your CalFresh information to give you Medi-Cal.

What is Medi-Cal?

Medi-Cal **provides health coverage with no cost to you**. It covers services such as check-ups, hospital stays, medications, mental health, substance use treatment, and some dental care. There is no waiting list. We just need your permission to give you Medi-Cal coverage.

To get Medi-Cal coverage, just take ONE of these three steps to enroll:

- **Enroll online at http://dhcs.ca.gov/ExpressLane**. This will enroll you into Medi-Cal. Use your Personal Identification Number (PIN) in the upper right corner of this letter to log in.

  OR

- **Call Health Care Options (HCO)** Monday - Friday, 8 am - 5 pm at 1-844-212-0003, (TTY): 1-800-430-7077. Say you are calling for "Express Lane." Say you have CalFresh and want Medi-Cal.

  OR

- **Fill out and mail the form in the enclosed envelope. You must include the "Join Medi-Cal Form."**

Once we get the information back from you by one of the methods above, you will be covered by Medi-Cal and enrolled into the Medi-Cal health plan in your county. You will receive a welcome package shortly after that. You can learn more about Medi-Cal at www.dhcs.ca.gov

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Join Medi-Cal Form

The following CalFresh recipient qualifies for enrollment into Medi-Cal, without having to complete a full application at this time:

[Child's Name]

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I want to enroll my child in Medi-Cal. *I declare under penalty of perjury, I am the parent/guardian of the person named above and I have read and understood the privacy statement and rights and responsibilities that came with this letter.*

_____ _____

Parent/Guardian Signature **(Required)** Date

Please sign, date, and mail this form. Use the postage paid envelope with this letter.*

*As a reminder you can also enroll online at **http://dhcs.ca.gov/ExpressLane** or by phone at 1-844-212-0003.

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ELCO

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PRIVACY STATEMENT

This application is for benefits through the Department of Health Care Services (DHCS). The personal and medical information you provide on it is private and confidential. DHCS needs it to identify you to administer our programs.

We will share your information with other state, federal, and local agencies, contractors, health plans, and programs only to enroll you in a plan or program or to administer programs, and with other state and federal agencies as required by law.

In most cases, you have the right to see personal information about you that is in federal and state records. You can see it in an alternative format (such as large print) if you need that.

For the **Department of Health Care Services**, contact the Information Protection Unit at:

P.O. Box 997413, MS 4721
Sacramento, CA
95899-7413

Phone: 1-866-866-0602
TTY: 1-877-735-2929

These state and federal laws give us the right to collect and keep the information on the application:

DHCS: CA Welfare and Institutions Code § 14011 and Article 3, Chapters 5 and 7, Parts 2 and 3, Division 9

We must give you this Privacy Statement under CA Civil Code §1798.17. You can see DHCS's Notice of Privacy Practices at dhcs.ca.gov.

YOUR RIGHTS AND RESPONSIBILITIES

The information I gave on this application is true as far as I know. I know that I may be subject to a penalty if I do not tell the truth.

I understand that the information I give will be used only to see if I will qualify for Medi-Cal benefits.

I understand that the Medi-Cal program will keep my information private, as the law requires. For more information, or access to personal information in records maintained by the Medi-Cal program, I can contact my local social services office.

I understand that to be eligible for Medi-Cal, I am required to apply for other income or benefits to which I or any member of my household is entitled, unless he or she has good cause for not doing so. Examples of such income or benefits are pensions, government benefits, retirement income, veteran's benefits, annuities, disability benefits, Social Security benefits (also called OASDI or Old Age, Survivors, and Disability Insurance), and unemployment benefits. But such income or benefits do not include public assistance benefits, such as CalWORKs or CalFresh. If I have a question about a possible source of income for Medi-Cal, I can contact my local county social worker for help.

Any change I am required to report to CalFresh will also be reported to the Medi-Cal program. To report changes, I can contact my local county CalFresh social worker.

I know that the Medi-Cal program must not discriminate against me or anyone on this application because of race, color, national origin, religion, age, sex, sexual orientation, marital status, veteran's status, or disability. If I think the Medi-Cal program has discriminated against me, including the failure to provide reasonable accommodations as required under state and federal law, I can make a complaint by visiting **www.hhs.gov/ocr/office/file**. If I believe that the Medi-Cal program has discriminated against me or anyone else on this application in connection with a Medi-Cal eligibility determination, I can also file a complaint with the Department of Health Care Services, Office of Civil Rights by calling **1-916-440-7370** (TTY: 1-916-440-7399).

I understand that any changes in my information or information of any member(s) in the applicant's household may affect the eligibility of other members of the household.

Except for purposes of applying for Medi-Cal, I confirm that no one applying for health insurance on this application is confined, after the disposition of charges (judgment), in a jail, prison, or similar penal institution or correctional facility.

I give my permission to the Medi-Cal program to check other agencies' computer records to verify citizenship, satisfactory immigration status, tax information, and other information related only to eligibility to see if I qualify for health insurance.

If someone on the application qualifies for Medi-Cal:

I know that if Medi-Cal pays for a medical expense, any money I or anyone on this application gets from other health insurance or legal settlements related to that expense will go to Medi-Cal as payment for the expense until the expense is paid in full.

Your right to appeal:

If I think the Medi-Cal program has made a mistake, I can appeal its decision. To appeal means to tell someone at 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 my county social services office or 1-800-952-5253 (TTY: 1-800-952-8349).

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 the Medi-Cal program or the county social services office can explain my case to me.