State of California—Health and Human Services Agency

Department of Health Care Services

TOBY DOUGLAS
Director

EDMUND G. BROWN JR.
Governor

September 19, 2014

TO: ALL COUNTY WELFARE DIRECTORS Letter No. 14-32
ALL COUNTY ADMINISTRATIVE OFFICERS
ALL COUNTY MEDI-CAL PROGRAM PECIALISTS/LIAISONS
ALL COUNTY HEALTH EXECUTIVES
ALL COUNTY MENTAL HEALTH DIRECTORS

SUBJECT: MEDI-CAL ANNUAL REDETERMINATION PROCESS FOR MAGI BENEFICIARIES (REFERENCE ACWDL 14-18)

The Department of Health Care Services (DHCS) is providing guidance as a result of Assembly Bill (AB) x1 1, Chapter 3, Statutes of 2013, as well as guidance provided by the federal Centers for Medicare & Medicaid Services (CMS) on the Affordable Care Act of 2010 (ACA). This letter is to provide the Statewide Automated Welfare Systems (SAWS) and counties with policy guidance.

This guidance is focused on implementing annual redeterminations for 2015 and beyond for Medi-Cal beneficiaries who are eligible under Modified Adjusted Gross Income (MAGI) categories. The Department will issue separate guidance shortly to implement the annual redetermination process for 2015 and beyond for beneficiaries who are Medi-Cal eligible under non-MAGI categories.

This ACWDL provides instructions supplemental to ACWDL 14-18. The Department will be issuing additional guidance on how to process Non-MAGI Medi-Cal annual redeterminations, Medi-Cal and Covered California mixed household annual redeterminations, and Non-MAGI and MAGI annual redeterminations.

Step 1: Ex Parte Review of Available Information

The MAGI Medi-Cal annual redetermination process begins with an ex parte review of available information pursuant to Welfare and Institutions Code (W&I Code) section 14005.37(e). For beneficiaries who are up for renewal, counties must first review the most recent or last known information contained in the beneficiary's active Medi-Cal case file or other information available to the county about the beneficiary and/or the beneficiary's immediate family members, including but not limited to, information from CalWORKs, CalFresh, or Covered California as well as other state and federal data records. An ex parte review should include the review of information from cases that are either open or were closed within the last 90-days.

Medi-Cal Eligibility Division
1501 Capitol Avenue, MS 4607, P.O. Box 997417, Sacramento, CA 95899-7417
(916) 552-9430 phone, (916) 552-9477 fax
Internet Address: www.dhcs.ca.gov

Please Note: Annual redetermination forms are not being eliminated. Instead, the annual redetermination process will first start with an ex parte review to determine ongoing eligibility. If the ex parte review cannot sufficiently reconfirm eligibility, counties shall send an annual redetermination form to beneficiaries as the second step in the process. If the ex parte review is sufficient to reconfirm eligibility, a redetermination form is not required.

After the county has collected the beneficiary's most recent information that is relevant to the Medi-Cal renewal, the county shall enter the information in SAWS. The information will be sent via the electronic Health Information Transfer (e-HIT) to the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) for a MAGI Medi-Cal eligibility determination.

Example 1: No changes have been reported on the case and there are no other cases such as CalFresh or CalWORKs for the county to review, therefore the most recent information is what is already contained in the Medi-Cal case. No further review is required and the information is sent to CalHEERS for a MAGI determination.

Example 2: The most recent information on the case is an income verification that was provided for a CalFresh case that was closed 2 months ago. The county must ensure that the Medi-Cal income is updated to reflect the information reported on the CalFresh case before sending the information to CalHEERS for a MAGI eligibility determination.

If a beneficiary is not found to be eligible via the ex parte review, the county will need to send the beneficiary the pre-populated redetermination form that will be generated by the SAWS. By law, the Medi-Cal beneficiary must be given at least 60-days to provide the information requested on the form. Therefore, the ex parte review must be completed by the county and/or SAWS at least 65 days prior to the Medi-Cal annual redetermination date. As a reminder, the annual redetermination date is the last day of the renewal month. This accounts for the time needed to mail the beneficiary the renewal form should the ex parte process not establish continued eligibility.

For example, if the Medi-Cal annual redetermination month is July 2015, the last day for the beneficiary to provide necessary information to the county will be July 31, 2015. This means that the redetermination form must be mailed to the beneficiary no later than June 1, 2015 which also means that the ex parte review must be completed prior to June 1st.

Request for Tax Household Information (RFTHI) Information for Pre-ACA Medi-Cal Beneficiaries:

As prescribed in ACWDL 14-31, counties were instructed to move Pre-ACA Medi-Cal beneficiary's annual redetermination date forward one year if the beneficiary met certain criteria. Furthermore, counties were instructed to save the RFTHI information that was provided since that information would be used during the 2015 annual redetermination to determine ongoing eligibility.

Counties shall ensure that the ex parte review, as prescribed above, is used to retrieve the RFTHI information that was provided as part of the 2014 annual redetermination process. Counties and SAWS shall also ensure that no additional forms, such as the MC 210RV, or RFTHI, are sent to these beneficiaries at this time. The annual redetermination process begins with retrieving the RFTHI information and, sending this information through the CalHEERS Business Rules Engine (BRE) in order to get a MAGI Medi-Cal eligibility determination as prescribed later in this letter.

Counties shall work with their SAWS to ensure that the RFTHI information previously collected is used to convert a Pre-ACA individual over to MAGI Medi-Cal.

Exception: If for any reason the RFTHI information was not provided and the beneficiary is up for renewal again, the county must collect the information in order to proceed with the current annual redetermination process. In this instance, it is appropriate for the county to contact the beneficiary to obtain the RFTHI information as necessary.

If the Ex Parte Review confirms Continued Medi-Cal Eligibility:

If CalHEERS confirms continued MAGI eligibility based on information from the ex parte review, the SAWS will receive an eligibility result back from CalHEERS along with a Notice of Action (NOA) confirming eligibility. The eligibility result will consist of the beneficiary's new Medi-Cal aid code for the upcoming benefit year. The county shall review and finalize the eligibility result and ensure that the beneficiary receives confirmation of eligibility.

The NOA informs the beneficiaries that their eligibility has been continued for another year, and that no additional information is needed. The NOA will also include the MAGI household size and income amount that was used to redetermine eligibility for each beneficiary in the household. If a beneficiary believes the income and household size reported on the NOA are incorrect, the beneficiary must contact the county via phone, email, in-person, or other commonly available electronic means within 90 days to provide the most current information. The NOA will also inform the beneficiary if the information is correct, and that no further action is necessary.

Please Note: This concludes the Medi-Cal annual redetermination since the appropriate information was electronically verified and continued eligibility confirmed. If the beneficiary reports a correction to the information reported on the NOA, the county shall process the corrected information as a change in circumstance, not as part of the annual renewal because the annual redetermination for the beneficiary has already been completed. If such a change in circumstance is reported by the beneficiary following the completion of a renewal, refer to ACWDL 14-22 for information on resetting renewal dates when a change in circumstance is processed.

Step 2: Pre-Populated Renewal Annual Form

If CalHEERS cannot confirm a beneficiary's continued eligibility via the ex parte review, the next step of the annual redetermination process requires the counties to send the beneficiary the MC 0216, the new Pre-Populated MAGI Medi-Cal Annual Renewal form.

The MC 0216
In the transaction from CalHEERS to SAWS, CalHEERS will tell the county which data elements could not be verified. The MC 0216 shall be populated to only ask for the information that could not otherwise be verified.

For example, if the only data element that could not be otherwise verified was income, the form would only ask for income information. Similarly, if the only information that could not be verified was incarceration status, the form would only ask for incarceration status.

SAWS shall pre-populate the information it has for the beneficiary pertaining to the unverified data element on the form. This should be the same information that the county sent to CalHEERS via the ex parte review; meaning, if income is being pre-populated, the county would pre-populate the same income data elements that it sent to CalHEERS via the ex parte review process.

Per W&I Code Section 14005.37(f), a beneficiary has 60-days to provide the information identified in the MC 0216 form by phone, e-mail, the web, in person, or through other commonly available electronic means if available in the county. The beneficiary is not required to, but may also complete, sign and return the MC 0216 form in person or by mail. The county should ensure that a beneficiary's attempt to contact them with information is recorded as an attempted contact and the case is not counted as a "failure to cooperate" and that the SAWS barcode is appropriately marked as received.

Counties must ensure that the MC 0216 is mailed to the beneficiary at least 65 days before the beneficiary's redetermination date with a return date to allow sufficient time to collect the beneficiary's information and run the information through the BRE for an eligibility determination by the last day of eligibility.

For purposes of this section, sufficient time means at least 60-days. This does not preclude the county or SAWS from sending the MC 0216 out more than 60-days before the beneficiary's redetermination date.

If the beneficiary fails to provide the needed information requested in the MC 0216 by any of the possible options to respond before 60 days of the beneficiary's redetermination date, the county shall follow the related guidance in the "Process Exceptions" section below.

County Responsibility after Sending the MC 0216:

As prescribed in W&I Code Section 14005.37(f)(2), if during the 60-day period the beneficiary has not returned the MC 0216, or has not otherwise provided all of the requested information, the county must attempt to contact the beneficiary to request the needed information at least one time after the MC 0216 is sent to request the information.

Per W&I Code section 14005.37(t), counties must contact the beneficiary using the beneficiary's preferred method of contact, if a method has been identified, to the extent possible. If no preferred method of contact was identified, counties shall use all reasonable efforts to determine the most effective method to reach the beneficiary, considering past successful efforts. All attempted contacts and the method of contact used should be documented in the case file.

As a best practice, it is recommended that the county contact the beneficiary at least 30 days after sending the MC 0216. This allows the beneficiary enough time to respond and provide ample processing time in the event that additional information needs to be verified or requested from the beneficiary. If the beneficiary responds to the request for additional information within the 60-day time period, but the information provided is incomplete or insufficient, the county shall not discontinue benefits and must work with the beneficiary to complete the information.

Eligibility is Determined:

Once the beneficiary provides the information needed by the MC 0216 and is entered into SAWS, CalHEERS will determine continued Medi-Cal eligibility.

- If MAGI Eligible – If the beneficiary is determined eligible for MAGI Medi-Cal, the beneficiary shall be sent a Notice of Action (NOA) and shall have his/her eligibility extended for a new 12-month period.
- If Not MAGI Eligible – The process and procedures for individuals found ineligible for MAGI Medi-Cal at redetermination (both annual redetermination and change in circumstance redetermination) are prescribed in ACWDL 14-18.
- Not Enough Information to Determine Eligibility – If the beneficiary provided additional information in response to the MC 0216, but it is not enough information to determine ongoing eligibility, the county shall continue to work with the client to collect the necessary information as per current policy. The county shall attempt to work with the client in the client's preferred method of contact, to the extent possible. If the county feels that the client is not making a good faith effort to provide the requested information, and the 60-days to provide the information has passed, the county shall discontinue the case for failure to provide.

Process Exceptions:

No Response to MC 0216:

If after 60-days, during which time the county has attempted to reach the beneficiary as discussed above, the beneficiary fails to provide all the requested information through any of the available means, the beneficiary shall be discontinued from Medi-Cal benefits for lack of cooperation at the end of the annual redetermination due month. In accordance with due process requirements, counties shall send the beneficiary a timely and adequate discontinuance NOA explaining the basis for termination.

Please Note: If the beneficiary provides the requested information prior to the effective date of discontinuance, the county shall rescind the discontinuance action and work the case.

90-Day Cure Period:

The beneficiary has an additional 90 days after the date of termination to provide the additional information needed for redetermination. If the beneficiary provides the requested information on the MC 0216 within the 90-day cure period, the county shall treat the information as if it were received timely. The county shall immediately enter the information into the SAWS system, and run the information through the CalHEERS BRE as prescribed above to determine continued eligibility.

If the beneficiary is redetermined for continued eligibility during the 90-day cure period, the county shall grant benefits back to the date of discontinuance, retain the application and annual redetermination dates, and notify the beneficiary that their Medi-Cal benefits will be restored back to date of discontinuance. As a reminder, counties should ensure that the good cause regulations are followed if a client presents outside of the 90-day cure period with good cause for not providing information timely.

Please Note: As prescribed in W&I Code Section 14005.37(i), the submission of the MC 0216, or the otherwise providing of the requested information, does not constitute a finding of Medi-Cal eligibility. The discontinuance action shall not be overturned until the information is processed (i.e., run through the CalHEERS BRE and verified against the federal hub) and eligibility is found. However, the county must promptly act to process the information provided by the beneficiary during the 90-day cure period.

If the beneficiary is no longer eligible under a MAGI category, the county must first check all available sources to see if the beneficiary is a newborn who is deemed eligible or a former foster youth. If not, the county shall screen the beneficiary for other programs by following the steps outlined in ACWDL 14-18 for beneficiaries discontinued from MAGI Medi-Cal.

Loss of Contact:

If the MC 0216 is returned to the county with a “return to sender” or “no forwarding address,” before proceeding with the steps to discontinue the beneficiary, the county shall first check all available sources to see if the beneficiary is a deemed infant or former foster youth. The county shall then attempt to contact the beneficiary as required in W&I Code Section 14005.37(c). This shall include first, an ex parte review of information available to the county about the beneficiary or his or her family members, such as from a CalFresh file with more current contact information for the beneficiary, and then, if necessary, by attempting to contact the beneficiary via e-mail, by telephone, or by other means available to the county according to the beneficiary’s preferred method of contact if a method has been identified. For beneficiaries other than deemed infants or former foster youth, if all required attempts at contact fail, the county shall send a notice of discontinuance and document the inability to make appropriate contact in the case file.

Former Foster Youth up to Age 26:

As required by W&I Code Section 14005.28(a)(3), the annual renewal process for former foster youth is simplified and former foster youth should not receive the MC 0216 unless they are part of a household where other household members must complete a MAGI Medi-Cal evaluation to continue to receive Medi-Cal benefits.

Former foster youth up to age 26 shall not be discontinued due to a loss of contact or for not responding to county contact at renewal. As discussed above, if the county receives an MC 0216 as return to sender or otherwise undeliverable, before proceeding with the steps to discontinue, the county shall check all available sources to see if the beneficiary is a former foster youth. If a beneficiary is found to be a former foster youth for which the county has lost contact, the beneficiary should be placed into fee-for-service Medi-Cal until such time as contact is re-established or information is received that would require a discontinuance

(such as death, loss of California residency, or aging out of the program). The Department will issue additional guidance on this policy in the near future.

If you have any questions, please contract Braden Oparowski by phone at (916) 552-9570 or by email at Braden.Oparowski@dhcs.ca.gov.

Sincerely,

Original Signed By:

Tara Naisbitt, Chief
Medi-Cal Eligibility Division

Attachment

You can get this notification in another language or in large print or another way that's best for you. Call 1-800-XXX-XXXX (TTY: 1-888-XXX-XXXX).

Medi-Cal Renewal Form

Respond By:

Case Number:

Date
Name
Address Line 1
Address Line 2

It is time to renew your Medi-Cal coverage.

We need some information from you to help you keep your Medi-Cal for the next year.

You can renew your Medi-Cal in any one of these ways:	• By mail: Complete this form and mail it to: [Medicaid Agency] [100 State Street] [Any city, State] • In person: Visit our office at [Medicaid Agency] [100 State Street] [Any city, State]. Office hours are [8:30 a.m. to 5 p.m. Monday to Friday]. • Online: Renewing online is quick and easy. Go to www.coveredca.com or [SAWS online portal] to upload your documents.
How to complete this form:	To make sure you or your family continue to have Medi-Cal coverage, you must let us know if there are any changes or not to the information on this form. 1. Please review the information about you and members of your household and let us know about any changes. 2. Send us or upload copies of documents that show your most current information for information even if your information has not changed. 3. Return this form or provide this information online by _________________. 4. If you return this form by mail, please make sure to sign the form on page 10.
Whose information we need:	We need the most current information about every member of your household who is living with you or is listed on your tax return, if you file taxes. We need information from: • People in your household who currently have Medi-Cal, • People in your household who would like to apply. • We may need some information about people in your household who live with you or are listed on your tax return, who do not have Medi-Cal and who do not want to apply for Medi-Cal. Their information will be kept private and used only to help those in your household who want to keep or apply for Medi-Cal. You do not need to file a tax return to apply for or renew your Medi-Cal.
What happens if my information is different:	If anyone in your household does not qualify for Medi-Cal because the information on this form has changed, we will use your new information to check to see if you or other people in your household qualify for other affordable health coverage, including Covered California. Your information will be kept private and will be used only to see if you or your family qualifies for affordable health coverage. We may need more information from you to find you the most affordable health coverage.

1 Your current household

Please check the information below and tell us if there are any changes.

Is the address below correct? ❑ Yes If correct, go to Section 2.	❑ No. If not, please write the correct information below.
Ernie Roberts **Home address:** 1234 America Ave. Apt. 1A Anywhere, ST 12345 **Mailing address:** 5678 Broad St. P.O. Box 6789 Anywhere, ST 12345 **Phone:** Home: 111-222-3333 Other:	Name *(first, middle, last & suffix)* **Home** address — Apartment # City *(home)* — State — ZIP code **Mailing** address, only if different from above. — Apartment # City *(mailing)* — State — ZIP code What number can we call to contact you: ☐Home ☐Cell ☐Work Number: What is the best time to reach you at this number? (Optional) Is there another number we can use to call you? ☐Home ☐Cell ☐Work Number:

(Optional) What email address can we contact you?

2 Who is in your household

Please check the information below about people in your household who want to renew Medi-Cal. Please tell us if there are any changes to the information we have about people living with you or who are listed on your federal tax return.

Name	Tax Filing Status (e.g., primary tax filer, dependent)	How is this person related to the primary tax filer or head of household	Who claims this person as a dependent?	Correct Information?
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No

If the information above is not correct, please write the correct information into the space provided below. If there are other members of your household, please write their information in below.

Name	Tax Filing Status	Relationship to Tax Filer	Who claims this person as a dependent?

3 Income and Expenses

We were not able to renew your Medi-Cal using the income below that we have for you or your household members from electronic data sources. Please let us know if the information below is correct or not. We need paper documentation showing us what your most current income is. Please attach any of the following that show income before taxes or deductions: recent pay stubs, benefits or award letters, checks received or signed statement from employer, or last year's tax return. If income is from self-employment, send a copy of your most recent tax return or profit and loss statement.

The income information below is only for individuals within your household we could not otherwise verify. If you have members of your household not listed below it is because we were able to verify their income and no other income information is needed for the individual.

Pre-Populated Name:

Our records show that this individual's monthly income is: __________.

This estimate includes the income sources and amounts below. Please let us know if this information is correct or has changed. If this information has changed, please tell us the correct information.

Income 1 _____________ How often received __________________

Is this correct? ❑ Yes ❑ No If no, enter correct information _____________

Income 2 ______________ How often received: ___________________

Is this correct? ❑ Yes ❑ No If no, enter correct information _____________

Income 3 ______________ How often received: __________________

Is this correct? ❑ Yes ❑ No If no, enter correct information _____________

Please enter below any additional income you expect that is not shown above?

Source of Income	Amount	How often received

Fluctuating Income

You told us that your income changes from month to month and gave us an estimate of what you thought your income would be for the past 12 months. Last year, you told us your income would be _________________

What do you think your income will be for the next 12 months? ________________

Expenses/Tax Deductions

Our records show that this individual had the following tax expenses (deductions) last year. Please let us know if this will be the same for next year or not:

Tax Deduction 1 ______________ How often paid? __________________

Is this correct? ❑ Yes ❑ No If no, enter correct information ______________

Tax Deduction 2 ______________ How often paid? ___________________

Is this correct? ❑ Yes ❑ No If no, enter correct information _____________

Tax Deduction 3 ______________ How often paid?__________________

Is this correct? ❑ Yes ❑ No If no, enter correct information _____________

Pre-Populated Name:

Our records show that this individual's monthly income is: ___________.

This estimate includes the income sources and amounts below. Please let us know if this information is correct or has changed. If this information has changed, please tell us the correct information.

Income 1 ______________ How often received __________________

Is this correct? ❑ Yes ❑ No If no, enter correct information ______________

Income 2 _____________ How often received: ___________________

Is this correct? ❑ Yes ❑ No If no, enter correct information ____________

Income 3 _____________ How often received: __________________

Is this correct? ❑ Yes ❑ No If no, enter correct information ____________

Please enter below any additional income you expect that is not shown above?

Source of Income	Amount	How often received

Fluctuating Income

You told us that your income changes from month to month and gave us an estimate of what you thought your income would be for the past 12 months. Last year, you told us your income would be ________________

What do you think your income will be for the next 12 months? _______________

Expenses/Tax Deductions

Our records show that this individual had the following tax expenses (deductions) last year. Please let us know if this will be the same for next year or not:

Tax Deduction 1 _____________ How often paid? __________________

Is this correct? ❑ Yes ❑ No If no, enter correct information _____________

Tax Deduction 2 _____________ How often paid? ___________________

Is this correct? ❑ Yes ❑ No If no, enter correct information ____________

Tax Deduction 3 _____________ How often paid?__________________

Is this correct? ❑ Yes ❑ No If no, enter correct information ____________

4 Other Health Insurance

Please let us know if the information below is still correct. If someone in your family now has other health insurance not listed below, please write it in below.

Name	Type of Insurance	Do you still have this coverage?
		❑ Yes ❑ No
		❑ Yes ❑ No

5 Incarceration

Our information shows that one or more people in your household is incarcerated. Is this information correct?

Name	Is this individual incarcerated?
	❑ Yes ❑ No
	❑ Yes ❑ No

6 Deceased

Our information shows that one or more in your household has died. Is this information correct?

Name	Is this individual deceased?
	❑ Yes ❑ No
	❑ Yes ❑ No

7 Other Household Changes

Is anyone in your household between the ages of 18 and 26 years old and was either in foster care, in any state, on his or her 18th birthday or who lost foster care assistance, in any state, due to having reached the maximum age limit?

☐Yes ☐No ***If yes,*** who? ____

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

If yes, who? ____

Questions? Call [state agency] at **1-800-XXX-XXXX**. The call is free. (TTY: 1-888-XXX-XXXX). You can call [days and hours of operation].

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? ____

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 her expected due date? _________________

How many babies are expected? ___________________

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

If yes, who _______________________

What is your relationship to this person? ____________________________

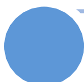
If yes, who _______________________

What is your relationship to this person? ____________________________

Do any of these individuals want to apply for Medi-Cal? ☐Yes ☐No
If yes, who? ____

If anyone in your household who currently has Medi-Cal recently gained lawful immigration or citizenship status in the past 12 months, list the name(s) below:

Name of Person (include first and last name)	New Status



8 Signature

PRIVACY STATEMENT

This renewal form is for renewing benefits through the Department of Health Care Services (DHCS) and determining eligibility for health insurance through Covered California. The personal and medical information you provide on it is private and confidential. Covered California or DHCS needs it to identify you and the other people on this renewal form and 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.

You must answer all of the questions on this renewal form unless they are marked "optional." If your renewal form is missing anything that we require, we will contact you to get it. If you do not provide it, we will not be able to make a decision on your renewal. You may have to submit a new application, or you may not be able to get health insurance through Covered California, or your application for benefits renewal may be denied.

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 more information or to see Covered California records, contact the Privacy Officer at:

Covered California
Attn: Privacy Officer
P.O. Box 989725
West Sacramento, CA 95798-9725
Phone: 1-800-300-1506
TTY: 1-888-889-4500

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 renewal form: Covered CA: 42 U.S.C. § 18031; CA Government Code §§ 100502(k) and 100503(a) 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 find the Notices of Privacy Practices for the Medi-Cal program at www.dhcs.ca.gov and for Covered California at www.CoveredCA.com.

RIGHTS AND RESPONSIBILITIES

The information I gave on this renewal form 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 those in my family who are applying to renew health insurance will qualify.

I understand that Covered California and 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 and Covered California, I can contact my county social services office or I can contact the Covered California Privacy Officer at 1-800-300-1506 (TTY: 1-888-889-4500).

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, I can call my county social services office or Covered California at 1-800-300-1506 (TTY: 1-888-889-4500) for help.

I know that I must tell Covered California or my Medi-Cal county social services office about changes to anything I stated in this renewal form. To report changes, I can call my county social services office. Or I can call Covered California at 1-800-300-1506 (TTY: 1-888-889-4500) or visit CoveredCA.com.

I know that Covered California or the Medi-Cal program must not discriminate against me or anyone on this renewal form because of race, color, national origin, religion, age, sex, sexual orientation, marital status, veteran's status, or disability. If I think Covered California or 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 contacting the U.S. Department of Health & Human Services at www.hhs.gov/ocr/office/file or the California Office of the Attorney General at http://oag.ca.gov/contact/general-comment-question-or-complaint-form.

If I believe that Covered California or the Medi-Cal program has discriminated against me or anyone else on this renewal form 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.

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

I understand that I must report income changes to my Medi-Cal county social services office or Covered California because it may affect the eligibility for Medi-Cal benefits or the amount of premium assistance (or tax credits) that I may be eligible to receive. I also understand if I receive too much premium assistance (or tax credits) during the benefit year, I will have to repay the extra premium assistance back to the IRS when I file my federal income taxes for the benefit year.

I give my permission to the Medi-Cal program or Covered California 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 and other people on this renewal form qualify for health insurance. If someone on the renewal form qualifies for Medi-Cal:

I know that if Medi-Cal pays for a medical expense, any money I or anyone on this renewal form get 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. For parents whose child or children qualify for Medi-Cal:

I know I will be asked to help the agency that collects medical support from any parent on this renewal form who does not live with the child and does not send support for the child. If I think that helping will harm me or my children, I can tell the Medi-Cal program and I will not have to help.

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 1-855-795-0634 (TTY: 1-800-952-8349) for the Medi-Cal program or calling
1-800-300-1506 (TTY: 1-888-889-4500) for Covered California enrollees.

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.

DECLARATION
I declare under penalty of perjury under the laws of the State of California that what I say below is true and correct.

I understood all questions on this renewal form 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 renewal form, 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 renewal form will be used to decide if the people who are applying qualify for health insurance. The Medi-Cal program and Covered California will keep the information private, as required by federal and California law.

I agree to notify the Medi-Cal program or my Medi-Cal county social services offices or Covered California by calling 1-800-300-1506 (TTY: 1-888-889-4500) or visiting CoveredCA.com if anything changes on this renewal form for any person applying for health insurance.

Signature of Applicant or Authorized Representative

Date and Place: ____

Signature: ____