The Breast and Cervical Cancer Treatment Program

MEDI-CAL Application

Please complete all of the following fields to help us process your application. Only provide the personal information specifically requested on this form and avoid including any additional details not asked for.

1. This form is to apply for immediate Medi-Cal health care services for this month and next month.
   Do you also want to use this application to get ongoing Medi-Cal coverage through the Breast and Cervical Cancer Treatment Program (BCCTP)? ☐ Yes ☐ No

***Note**: You must apply for Medi-Cal at your local county social services office to continue your BCCTP benefits. This is because you need to be evaluated for all benefits. You do not need to apply at the county if you have submitted a Medi-Cal application within the last 45 calendar days of this application date.*

2. Do you have a medical expense in the last three (3) months that you need help paying for?
   ☐ Yes ☐ No

Medi-Cal Card

3. Do you have a Medi-Cal Card also called a "Benefits Identification Card" (BIC)? ☐ Yes ☐ No

If yes, what is the number on your card?

Applicant Information

4. First name	5. Last name	6. Middle name	7. Suffix (Jr, Sr, III)

8. Social Security number

A Social Security number is not required for Medi-Cal benefits. If you do not have one now and apply for one later, you must give us the number within 60 days after you receive it.

9. Sex ☐ Male ☐ Female	10. Date of birth (MM/DD/YYYY)

11. County of birth (if in California)	12. State of birth

Home Address

13. ☐ If homeless, check the box and tell us where to send any written correspondence in "Mailing Address" below.

In Care of (C/O)

Street Address

City	State	ZIP Code	County you live in

14. Mailing address (If different from home address)

City	State	ZIP Code	County you live in

Contact Information

15. What is the best way to contact you? ☐ Mail ☐ Phone ☐ Email

Email address

Home Phone	Best time to call	Ok to leave a message? ☐ Yes ☐ No
Message Phone	Best time to call	Ok to leave a message? ☐ Yes ☐ No
Mobile Phone	Best time to call	Ok to leave a message? ☐ Yes ☐ No

Preferred spoken language	Preferred written language

Other Health Insurance Information

16. Do you have other comprehensive medical coverage including Medicare? ☐ Yes ☐ No

17. If yes, identify Health Insurance Carrier(s): Select all that apply.

- ☐ Military Benefits Comprehensive
- ☐ Medicare Part C (Advantage)
- ☐ Medicare Parolee
- ☐ PPO/PHP/HMO/EPO
- ☐ Multiple Plans Comprehensive
- ☐ Kaiser
- ☐ Any carrier outside of those listed (includes multiple coverage)

18. Do you have Medicare Part A (Inpatient)? ☐ Yes ☐ No

19. Do you have Medicare Part B (Outpatient)? ☐ Yes ☐ No

20. Do you have Medicare Part D (Prescription Drug Coverage)? ☐ Yes ☐ No

Household Information

21. Are you pregnant? ☐ Yes ☐ No If yes, how many babies are you expecting? _____

22. How many family members are in your household? _____

This includes you (BCCTP applicant), your dependent children under age 21 who live with you, and your spouse.

23. How much is your monthly household income before taxes? _____

List your household members below.

Name (First and Last)	Date of Birth	Relationship to You (i.e., spouse, child)	What is their monthly gross (before taxes) income?

Alternate Formats

24. Do you need information in an alternative format? (optional) ☐ Yes ☐ No

If yes, please select a format type.

- ☐ Large Print
- ☐ Audio Electronic Format
- ☐ Data Electronic Format
- ☐ Braille
- ☐ County Support
- ☐ Audio Electronic Format (password-protected)
- ☐ Data Electronic Format (password-protected)

Include this signed form with the application.

Applicant's Name	Tracking number

Who can sign this application?

- The applicant or their spouse. Applicants who are age 21 years and older can apply on their own. If the applicant is between ages 18 to 21 years and lives with a parent or guardian, the parent or guardian must apply for them.
- The conservator or guardian executor of the applicant who needs Medi-Cal.
- A person acting on behalf of the applicant when the person is incapable of handling their personal affairs, comatose, and has no spouse, conservator, guardian, executor, or Authorized Representative.

An individual appointed as an Authorized Representative agrees to give the written disclosure to the applicant or member and 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.

These state and federal laws give us the right to collect and keep the information on the application: 42 Code of Federal Regulations § 435.907.

The Health Insurance Portability and Accountability Act, Section 262(a), 42 U.S.C., Section 290dd-2 (42 CFR Part 2) and state law, including Civil Code, Section 56.10(b), Welfare and Institutions Code, Section 10850.

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

California Code, Welfare and Institution Code – WIC § 14011. 2

Signature and Certification

I declare under penalty of perjury under the laws of the State of California that the answers I have given in this application and the documents given are correct and true to the best of my knowledge. I declare that I have read and understand the application instructions, my rights and responsibilities, and all information printed on this application.

Signature of applicant	Date
Signature of person acting for applicant or authorized representative	Date
Relationship to applicant	Phone number

Medi-Cal Confidentiality and Disclosure Notice

The information given in this application is private and confidential under Welfare and Institutions Code 14100.2.

Any known or foreseeable disclosures which may be made of the information, including disclosures to other state agencies, the federal government, or law enforcement, including disclosures of the information which may be made pursuant to subdivision € or (f) of Civil Code 1798.24.

What are my rights when I apply for Medi-Cal?

- You have a right to fair and equal treatment regardless of race, color, national origin, religion, age, sex, sexual orientation, gender identity, marital status, political beliefs, veteran's status, or disability.
- You have a right to file a complaint if you think that the Medi-Cal program has discriminated against you or has failed to provide the reasonable accommodations required by state and federal law. You can make a complaint by calling the Department of Health Care Services (DHCS), Office of Civil Rights at 1-916-440-7370 (TTY: 1-916-440-7399) or by going online at: https://www.dhcs.ca.gov/Documents/1044-DHCS-DISCRIMINATION-COMPLAINT-FORM.pdf
- You have a right to be evaluated to see if you may be eligible for any Medi-Cal program.
- You have a right to information about the Medi-Cal program and help applying for Medi-Cal.
- You have a right to an interpreter if you need help applying for Medi-Cal, have questions, or difficulty speaking, reading, or understanding English.
- If you received health services in the three months before the month of your application, you have a right to be evaluated to see if you are eligible for Medi-Cal to pay for those services. This is called retroactive eligibility.
- You have a right to be told in writing whether you qualify for Medi-Cal or whether there are any changes to your eligibility status.
- You can ask for a hearing by
  1) contacting your nearest county social services office;
  2) calling the Department of Social Services at 1-855-795-0634 or TDD 1-800-952-8349; or
  3) making the request in writing to your county social services office. You may complete the back section on a Notice of Action (form NA Back 9) to request a hearing and send the form, or other written request, to your nearest county social services office. The form is available through your county social services office or at: https://www.cdss.ca.gov/Portals/9/Additional-Resources/Forms-and-Brochures/NABack9.pdf?ver=2022-05-16-155918-390
- You have a right to a state hearing if you are not satisfied with the decision by the local county social services office, DHCS, or Covered California, except relating to the Health Insurance Premium Payment (HIPP) program. HIPP is not an entitlement program; therefore, there are no appeal rights for HIPP.
- If you want a state hearing to appeal the decision, you must ask for it within **90 days** of the date of the Notice of Action (NOA) was given or mailed to you.
- If you do not get an NOA, you must ask for a hearing within **90 days** from the date you discovered the action or inaction you are not satisfied with unless the inaction is due to a delay in determining your application for Medi-Cal benefits.

- You have a right to review your Medi-Cal file and all Medi-Cal program rules and regulation manuals that were used to decide if you are eligible for Medi-Cal.

What are my responsibilities if I get Medi-Cal? You must inform BCCTP when any of the following changes that have occurred within 10 days of the change:

- You or a family member in your household has a change in income. This applies if the income goes up or down or starts or stops. This includes income from the Social Security Administration (SSA), loans, settlements, employment, unemployment, and any other source.
- You become physically or mentally disabled.
- You apply for or receive disability benefits with the SSA, Veterans Administration or Railroad Retirement.
- You are applying for or getting Medi-Cal and have a change in citizenship or immigration status.
- You have a change in health insurance coverage.
- If you do not give necessary information or if you give information that you know is false, your Medi-Cal benefits may be denied or stopped. Your case may also be investigated for suspected fraud.
- To read more about your privacy rights and Medi-Cal, see the Department of Health Care Services Notice of Privacy Practices Webpage. You can find it at: www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/NoticeofPrivacyPractices.aspx

You also must:

- Give proof that you are a resident of California when you are asked for it.
- Declare your citizenship or immigration status when you are applying for Medi-Cal.
- Give a Social Security Number (SSN) for anyone who is applying for Medi-Cal benefits.
  - If you are a United States (U.S.) Citizen, a U.S. national, or a person with satisfactory immigration status, you must provide an SSN. If you do not have one, you must apply for an SSN and give the number to the county social services office within 60 days of your application.
  - You can get help applying for an SSN from the county social services worker.
  - You must work with the Social Security Administration (SSA) to clear up any questions that arise or your Medi-Cal will be denied or stopped.
- Apply for Medicare if you are eligible.
- Individuals are eligible for Medicare if they are blind, disabled, have End Stage Renal Disease, or are 64 years and 9 months of age or older. You are responsible for telling your providers that you have both Medi-Cal and Medicare coverage.
- Report to the county social services office and the health care provider any health care coverage or insurance that you have or are entitled to use, including Medicare. If you willfully do not give this information, you may be billed by your provider and be guilty of a crime.
- You understand that:
- If you do not give necessary information or if you give information that you know is false, your Medi-Cal benefits may be denied or stopped. Your case may also be investigated for suspected fraud.
- If you do not report changes to your personal information right away and receive Medi-Cal benefits that you do not qualify for, you may have to repay DHCS.
- You, or any family member receiving Medi-Cal, must **not** be getting public assistance from another state.

When you apply for Medi-Cal you will be evaluated to find out if you qualify for other medical assistance programs, including the HIPP Program.

An individual has a right of access to records containing his/her personal information that are maintained by the Department of Health Care Services.

The Department of Health Care Services' policies regarding personal information are available online in the Departments' Notice of Privacy Practices Webpage: https://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/NoticeofPrivacyPractices.aspx and the Privacy Policy Statement Webpage: https://www.dhcs.ca.gov/pages/privacy.aspx

Contact your local welfare office to request your records if you are not covered by the Breast and Cervical Cancer Treatment Program.

If you are seeking access to your records within DHCS, please contact BCCTP for assistance.

Breast and Cervical Cancer Treatment Program
P.O. Box 997417, MS 4611
Sacramento, CA 95899-7417
Telephone: (800) 824-0088
Email: BCCTP@dhcs.ca.gov
Fax: (916) 440-5693

If you are requesting copies of Medi-Cal applications, please contact the county where you applied for benefits. To locate your local county office please contact Medi-Cal at 1-800-541-5554 or visit the County Offices Webpage: https://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx