Family Certification

I, ___________________________, certify that I am the ______________________, of

___________________________________and will be the family member who will be most

frequently visiting and helping with his/her personal needs;

and, if applicable,

I certify that due to the following health reasons, __________________________________

I am able to travel only to ____________________________________ nursing facility.

Signature: ______________________________ Date Signed: _________________

Original to accompany TAR
Copy to patient's medical record

Privacy Notice on Collection

This privacy notice is required by California Civil Code section 1798.17. The purpose of this form is to collect information from immediate family members responsible for the Medi-Cal member's care for purposes of admitting the member to a distinct part nursing facility (DP/NF). The personal and/or medical information collected in this form is confidential and protected by the Health Insurance Portability and Accountability Act Privacy Rule (45 C.F.R. Parts 160, 164), the Information Practices Act (California Civ. Code, § 1798 et seq.), Department of Health Care Services (Department) policy, and state policy. The information in this form is being collected by the Department's Clinical Assurance Division by the authority of Welfare and Institutions Code, section 14091.21(b)(1)(D).

All information requested in this form is required and will be submitted with the member's treatment authorization request (TAR) for admission to the DP/NF. If you do not provide the required information, the Department may defer processing the TAR and delay authorization of the service requested. The Department may share provided information with: (1) other state agencies to perform its constitutional or statutory duties where the use is compatible with a purpose for which the information was collected, (2) local, state, or federal government entities if required by state or federal law, and (3) the

DP/NF. Please do not provide any personal or medical information other than the information that is specifically requested in this form.

In most cases, individuals have a right to access information about them that is in federal and state records. For more information or access to records containing your personal information maintained by the Department, contact the following:

Department of Health Care Services
Office Technician
Clinical Assurance Division
P.O. Box 997419
Sacramento, CA 95899
(916) 552-9100

If you wish to obtain a paper copy of DHCS' privacy policy and practices, or wish to file a complaint regarding privacy practices, you may contact the Department's Data Privacy Unit by mail, email, or telephone:

Privacy Office
c/o: Data Privacy Unit
Department of Health Care Services
P.O. Box 997413, MS 4722
Sacramento, CA 95899-7413
Email: incidents@dhcs.ca.gov
Telephone: (916) 445-4646

The Department of Health Care Services' policies regarding personal information are available online in the Department's Notice of Privacy Practices and the Privacy Policy Statement. The Anthem MRMIP Privacy Policy is available at Anthem MRMIP Privacy Policy.