Your Rights and Responsibilities

- I agree to report any changes to the information on this application or renewal to Covered California or to the local county office.
- If I am found eligible for Medi-Cal, I must tell my county eligibility worker about any changes that may affect my eligibility for health insurance within 10 days of the change. These changes include, but are not limited to:
  - I moved
  - My income changed
  - My household changed (For example: marriage, divorce, pregnancy, or had a child or children)
  - I became qualified for other health insurance
- If I am enrolled in Covered California, I understand I must report changes within 30 days. I can call Covered California at 1-800-300-1506 (TTY: 1-888-889-4500) or visit CoveredCA.com to log in to my account and report any changes online.
- I understand that I must report income changes to Covered California or my local county office (if I am covered by Medi-Cal), because changes may affect my eligibility for the amount of premium assistance (tax credits) for a Covered California health plan or my eligibility for Medi-Cal benefits that I may qualify for. I also understand if I receive too much premium assistance during the benefit year, I will have to repay some or all of the extra premium assistance back to the IRS when I file my federal income taxes for the benefit year.
- I give my permission to Covered California and the Medi-Cal program to check other agencies' computer records to verify citizenship or whether I am lawfully present in the U.S., tax information, and other information related only to eligibility to see if I and other people on this application or renewal qualify for health insurance.
- I understand that as required by law, the information I provide about myself and other people on this application or renewal for Medi-Cal will be checked by computer with facts given by employers, banks, SSA, IRS, Franchise Tax Board, social services, and other agencies to see if I or other people on this application or renewal qualify for health insurance.
- I understand that Covered California and Medi-Cal may request that I provide documents to show I qualify for coverage.
- I understand that I can apply for free or low-cost health care through Medi-Cal or Covered California at any time of the year. To enroll in a health plan through Covered California, I must apply during the open enrollment period. Or I must have a qualifying life event to enroll during a special enrollment period. If I am eligible for Medi-Cal, I can enroll throughout the year.
- I understand that the Medi-Cal program must seek repayment from probated estates of certain deceased members for Medi-Cal benefits on or after their 55th birthday. Repayment includes fee-for-service and managed care premiums/capitation payments for nursing facility services, home and community-based services, and related hospital and prescription drug services received when the member was an inpatient in a nursing facility or was receiving home and community-based services. Repayment cannot exceed the value of a member's probated estate. For more information you may visit the Estate Recovery website at dhcs.ca.gov/er or call 1-916-650-0590.
- If I am eligible for the County Children's Health Initiative Program (CCHIP), I agree to contact the CCHIP Customer Service line at 1-833-912-CHIP (1-833-912-2447) about anything that changes from what I have provided on this application or renewal.
- If found eligible for the Medi-Cal Access Program (MCAP) with a premium, I agree to pay the required cost even if I cannot take full advantage of the coverage or services offered by the MCAP program.
- The full list of Medi-Cal rights and responsibilities is on the MC 219 Rights and Responsibilities form.

Your Right to Appeal

- If I think Covered California or the Medi-Cal program has made a mistake, I can appeal the decision. To appeal means to tell someone at Covered California or the Medi-Cal program that I think the decision is wrong and ask for a fair review of the action.
- I know that I can find out how to request an appeal, including an expedited appeal, by calling 1-800-300-1506 (TTY: 1-888-889-4500) for Covered California enrollees or 1-800-743-8525 (TTY: 1-800-952-8349) for the Medi-Cal program.
- I know that I must file an appeal within 90 days of the date of the decision notice.
- 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 all hearings will be conducted by telephone or video conference unless I request an in-person hearing.
- I know that if I need help, someone at Covered California, the Medi-Cal program, or the local county office can explain my case to me.
- I know that someone at Covered California or the local county office can explain the circumstances when my eligibility may be maintained or reinstated pending an appeal decision.
- I know that an appeal decision for me or other members of my household may change my eligibility or the eligibility of other members of my household. The change in eligibility may result in a redetermination of eligibility for all household members.
- I know that I can get free legal help at my local legal aid or welfare rights office. For Covered California appeals, I know that I can get free, local help with my appeal by calling the Health Consumer Alliance at 1-888-804-3536.

Declaration

- I certify (or declare) under penalty of perjury, under the laws of the State of California, that the foregoing is true and correct.
- I understood all questions on this application or renewal and gave true and correct answers to such questions to the best of my knowledge. Where I do not have personal knowledge of an answer, I made every reasonable attempt to verify (or confirm) the answer with someone who has personal knowledge of the answer.
- I know that if I do not tell the truth on this application or renewal, there may be a civil and/or criminal penalty for perjury. Under California Penal Code Section 126, perjury is punishable by imprisonment for up to 4 years.
    - I may be fined up to $25,000 if I negligently, or with intentional disregard for the rules, provide false information in my application or renewal.
    - I may be fined up to $250,000 if I knowingly lie on my application or renewal.
- I know that all information in this application or renewal will be used to determine eligibility of every person applying for health insurance on this application or renewal, to manage my ongoing health insurance, and to allow my health plan to contact me. This information will be kept private, as required by federal and California law.
- I understand that to be eligible for advance premium tax credit, I (the primary tax filer or the spouse) must agree that:
    - I will file an income tax return for the benefit year;
    - If I'm married, I will file a joint tax return for the benefit year;
    - I will claim a personal deduction on my tax return for all members of my family included on this application or renewal, including myself and my spouse; and
    - No other tax filer will be able to claim me as a tax dependent for the benefit year.
- I understand that if I have received advanced premium tax credits for health coverage through Covered California during the previous benefit year, I am required to file a federal income tax return for that benefit year.
- I agree to notify Covered California by calling 1-800-300-1506 (TTY: 1-888-889-4500) or visiting CoveredCA.com if anything changes on this application or renewal for any person applying for health insurance.