You may lose your Medi-Cal if you do not respond by

Medi-Cal Renewal Form

You can get this form in another language or accessible format of your choice.
To ask for help in your language, call:

Notice date:
Case number:
Case name:
Worker name:
Worker telephone number:

It's time to renew benefits for:

Name	Date of birth

Household members not on this form will get a separate letter about their Medi-Cal.

➔ **Step 1.** Read the form and answer the questions

➔ **Step 2.** Sign and date on the Declaration and Signature page

➔ **Step 3.** Send the form with proof by the due date of

Easy ways to give us your form and proof:

Online
at
or coveredca.com.

By mail
in the envelope that came with this letter.

By phone
at

In person
to

at
They are open
Monday through Friday,
a.m. to p.m.]

Questions? Call your local county office at before the due date.

Your contact information

↓ Review your information	↓ Update or add new information below
☐ This information is correct. If correct, go to page 3.	☐ I have updated my information below. Only write in new or changed information.
Name	Name (first, middle, last)
Home address	Home address Apartment #
	City State ZIP code
Mailing address	Mailing address (If different from home address or you do not have a home address)
	City State ZIP code
Phone	Phone Home _____–_____–_____ Cell _____–_____–_____ Work _____–_____–_____ Other _____–_____–_____
Email	Email (optional):
Language to write to you in	Language we should write to you in:
Language to speak to you in	Language we should speak to you in:
	Best way to contact you: ☐ Email ☐ Phone ☐ Mail

Do you need an authorized representative?

Call your local county office at
if you need to:

- Appoint an authorized representative such as a family member, friend, caretaker, attorney, or advocate to accompany, assist, or represent you with your Medi-Cal eligibility and enrollment
- Change your authorized representative

If you need to add more people or information in any of the sections, please write it on a separate sheet of paper (or you can make a copy of the page) and send it with your renewal form.

Household members

We need information about you and every member of your household.

This includes:

- Your spouse or registered domestic partner
- Your children who live with you
- All parents who live in the home with their children
- Anyone on your federal income tax return, if you file one. You don't need to file taxes to apply for health insurance.
- If you are claimed as a dependent on someone else's tax return, you must include all members of the tax filing household that claimed you, and any family members living with you.
- Anyone else who lives with you will need to file their own application if they want health insurance. (For example: a boyfriend, girlfriend or roommate)

Review your household member information.

Name	Relation to	Address	Is this correct? If **yes**, go to the next section. If **no**, update below.
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

continued on the next page »

Update or add new household member information.

Tell us about changes to your household in the last 12 months.
For example, a household member got married, had a baby, moved into or out of your home, was incarcerated, or if there was a death in the household.

Name (first, middle, last)	**Relation to**	**What changed?**
1.		
2.		
3.		

Tax information

The primary taxpayer is the person listed first on the tax return and on this table.

Review your tax information.

Name	Does this person plan to file a federal tax return?	Does this person expect to be required to file taxes?	What is this person's tax filing status?	Is this correct? If **yes**, go to the next section. If **no**, update below.
Primary Tax Filer				☐ Yes ☐ No
				☐ Yes ☐ No

Update or add new tax information.

Has your primary tax filer changed? (This is the person listed first on the tax return.)

☐ Yes ☐ No If **yes**, primary tax filer's name: _____

Name (first, middle, last)	Does this person plan to file a federal tax return?	Does this person expect to be required to file a tax return?	What is this person's tax filing status?
1.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Married filing jointly with: _____ ☐ Married filing separately ☐ Single ☐ Head of household ☐ Dependent Claimed by: _____ ☐ Non-tax filer
2.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Married filing jointly with: _____ ☐ Married filing separately ☐ Single ☐ Head of household ☐ Dependent Claimed by: _____ ☐ Non-tax filer

Income

Income is money you get from a job, self-employment, or other sources such as Social Security or pension. You must attach current proof of all incomes. For example:

- Recent pay stubs
- Benefits or award letters
- Last year's tax return

Review your income information.

Name	**Source of income**	**Income before taxes or deductions** (Federal taxable income)	**How often?** (annually, monthly, every 2 weeks, twice a month, weekly, daily, or hourly)	**Is this correct?** If **yes**, go to the next section. If **no**, give the date of the last time you got this income. Then update or add below.
		$		☐ Yes ☐ No _____ /_____ /_____
		$		☐ Yes ☐ No _____ /_____ /_____
		$		☐ Yes ☐ No _____ /_____ /_____

continued on the next page »

Update or add new income information.

Examples of most common income types:

- Income from your job
- Income from self-employment
- Social Security retirement, survivors, and disability benefits
- Unemployment benefits
- Spousal support received:
  Fill in the most recent date or modification date of your divorce or separation agreement (month/day/year) here:
  _____ /_____ /_____

Name (first, middle, last)	**What is the source of this income?**	**Your income before taxes or deductions** (Federal taxable income)	**Start date** (month, day, year)	**How often?** (annually, monthly, every 2 weeks, twice a month, weekly, daily, or hourly)	**Is this income expected to continue?** If **no**, give the last date you expect to get this income.
1.		$			☐ Yes ☐ No ___ /___ /___
2.		$			☐ Yes ☐ No ___ /___ /___
3.		$			☐ Yes ☐ No ___ /___ /___

Does anyone's income change from month to month?

☐ Yes ☐ No If **yes**, tell us what the total income will be for the next 12 months. This is to help get the correct annual income amount.

Name (first, middle, last)	**What is your total income expected to be for the next 12 months?**
1.	$
2.	$

Expenses and deductions

Reporting tax expenses and deductions that you pay, may lower the income Medi-Cal uses to determine your eligibility. You must attach current proof of expenses and deductions. For example:

- Profit and loss statement
- Tax return

Review your expenses and deduction information.

Name	**Type of expense or deduction**	**Amount**	**How often?** (monthly, quarterly, annually)	**Is this correct?** If **yes**, go to the next section. If **no**, update below.
		$		☐ Yes ☐ No
		$		☐ Yes ☐ No

Update or add new expenses and deductions information.

Examples of most common expenses and deductions:

- Self-employment expenses
- Student loan interest
- IRA contributions
- Alimony paid: Fill in the most recent date or modification date of your divorce or separation agreement (month/day/year) here: _____ /_____ /_____

Name (first, middle, last)	**Type of expense or deduction**	**Amount**	**How often?** (monthly, quarterly, annually)
1.		$	
2.		$	

Medicare coverage

If you are not sure which parts of Medicare you are enrolled in, call 1-800-MEDICARE (1-800-633-4227).

Review your Medicare information.

Name	**Monthly premium Part A** (Inpatient hospital)	**Monthly premium Part B** (Outpatient medical)	**Monthly premium Part C** (Medicare advantage)	**Monthly premium Part D** (Pharmacy)	**Is this correct?** If **yes**, go to the next section. If **no**, update below.
					☐ Yes ☐ No
					☐ Yes ☐ No

Update or add new Medicare information.

If you or anyone in your household is newly eligible for Medicare, or if you pay premiums for yourself or someone in your household, fill in the information below.

Name (first, middle, last)	**Medicare number**	**Monthly premium Part A** (Inpatient hospital)	**Monthly premium Part B** (Outpatient medical)	**Monthly premium Part C** (Medicare advantage)	**Monthly premium Part D** (Pharmacy)
1.		$	$	$	$
2.		$	$	$	$

Long-term care

Long-term care is a service designed to meet a person's health or personal care needs when they are unable to take care of themselves for a long period of time. For example:

- Skilled nursing home
- Assisted living home
- Hospice

Review your long-term care information.

Name of person in long-term care	Long-term care facility name	Long-term care facility address	Is this correct? If **yes**, go to the next section. If **no**, update below.
			☐ Yes ☐ No
			☐ Yes ☐ No

Update or add new long-term care information.

Person 1		
Name of person in long-term care (first, middle, last)	**Entrance date** (month/day/year) _____ /_____ /_____	**Discharge date** (month/day/year) _____ /_____ /_____
Long-term care facility name	**Long-term care facility address**	
Spouse or registered domestic partner's name (first, middle, last)	**Spouse or registered domestic partner's address** if different	

Person 2		
Name of person in long-term care (first, middle, last)	**Entrance date** (month/day/year) _____ /_____ /_____	**Discharge date** (month/day/year) _____ /_____ /_____
Long-term care facility name	**Long-term care facility address**	
Spouse or registered domestic partner's name (first, middle, last)	**Spouse or registered domestic partner's address** if different	

Other health insurance

Tell us about any health coverage that you have that is not from Medi-Cal or Medicare. For example, you may also have health insurance from Covered California or a family member's job.

If you do **not** have other health insurance, skip this section and go to the next.

Review your health insurance information.

Name	**Insurance company**	**Type of Insurance** (such as health, dental, vision, pharmacy)	**Premium amount you pay**	**How often** (monthly, quarterly, annually)	**Is this correct?** If **yes**, go to the next section. If **no**, update below.
			$		☐ Yes ☐ No
			$		☐ Yes ☐ No

Update or add new health insurance information.

Name (first, middle, last)	**Insurance company**	**Type of Insurance** (such as health, dental, vision, pharmacy)	**Premium amount you pay**	**How often** (monthly, quarterly, annually)
1.			$	
2.			$	

Household changes

Fill-in the information below if you answer yes to any of the following questions.

Medi-Cal

Does anyone in your household who is not on Medi-Cal want to apply? If **yes**, fill in below.

Name (first, middle, last)	**Date of birth** (month/day/year)	**Social Security number,** if they have one, of the person who wants Medi-Cal ___ ___ ___–___ ___–___ ___ ___ ___

Pregnant

Is anyone in your household pregnant? If **yes**, fill in below.

Name (first, middle, last)	**Due date** (month/day/year) _____ /_____ /_____	**How many babies are expected?**

Former foster youth

If anyone in your household is between 18 and 26 years old, were they in foster care in any state on or after their 18th birthday? If **yes**, fill in below.

Name (first, middle, last)	**State** (example: California)

Immigration or citizenship (This information is only used to determine health coverage.)

Has anyone in your household who now has Medi-Cal had a change in their immigration or citizenship status in the past 12 months? If **yes**, fill in below.

Name (first, middle, last)	**New status number**

Disability

Does anyone in your household have a physical, mental, emotional, or developmental disability? If **yes**, fill in below.

Name (first, middle, last)	**Is the disability a result of an injury?** ☐ Yes ☐ No

Student

Is anyone in your household 19 or 20 years old and a full-time student? If **yes**, fill in below.
Name (first, middle, last)

Medicare

Does anyone in your household have Medicare? If **yes**, fill in below.		
Name (first, middle, last)	**Medicare number**	**Monthly premium you pay** $

Long-term care

Is anyone in your household in long-term care? If yes, fill in below.		
Name of person in long-term care (first, middle, last)	**Entrance date** (month/day/year) _____ /_____ /_____	**Discharge date** (month/day/year) _____ /_____ /_____
Long-term care facility name	**Long-term care facility address**	
Spouse or registered domestic partner's name (first, middle, last)	**Spouse or registered domestic partner's address** if different	

Information reported to the county

Our reports say this person is currently incarcerated (jail or prison).	
Name	**Is this person incarcerated?** ☐ Yes ☐ No If **no**, fill in the release date ____/____/____

Our reports say this person is deceased (died or passed away).	
Name	**Is this person deceased?** ☐ Yes ☐ No

Health program information and referrals

This section is optional. You can choose not to answer, but your answers help us refer you to available services.

1. Do you want information on the no-cost health program for children under 21 (Child Health and Disability Prevention Program, also known as CHDP)?

☐ Yes ☐ No

2. Do you want information on the no-cost supplemental food program for people who are pregnant or breastfeeding and children under 5 (Women, Infants, and Children Program, called WIC)?

☐ Yes ☐ No

3. Is any household member living in the home receiving kidney dialysis-related services?

☒ Yes ☐ No If **yes**, who:_____

4. Has any household member living in the home received an organ transplant within the last 2 years?

☒ Yes ☐ No If **yes**, who:_____

5. Do you want information on the Personal Care Services Program, an in-home care program for aged, blind, or disabled persons (also called In-Home Supportive Services)?

☒ Yes ☐ No

6. Does anyone in your household need help with long-term care or home and community-based services?

☒ Yes ☐ No If **yes**, who:_____

Declaration and signature

- 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 have read or had read to me the privacy statement, rights, and responsibilities on the following pages.
- 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.
- If anything changes on this renewal form for any person applying for health insurance, I agree to notify the Medi-Cal program or contact my local county office within 10 days of any change. If I have insurance through Covered California, I agree to report any changes within 30 days.

Sign and date below.

Signature of applicant/beneficiary or authorized representative ▶	Date (month/day/year)

Remember to attach all current proof if required, and all additional copies or extra pages.

Keep for your records

These pages contain important information about privacy statement, rights and responsibilities, right to appeal, and nondiscrimination policy, and filing a discrimination grievance.

Privacy statement

This renewal form is for renewing Medi-Cal 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. DHCS or Covered California 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 marked "optional" or if you are directed otherwise. 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:

The Department of Health Care Services
Attn: Information Protection Unit
P.O. Box 997413, MS 4721
Sacramento, CA 95899-7413
Phone: 1-866-866-0602
TTY: 1-877-735-2929

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

DHCS shall comply with the requirements of 45 C.F.R. Parts 160 and 164, California Civil Code §§ 1798 – 1798.78, CA Welfare and Institutions Code (WIC) Section 14005.37, CA WIC Section 14011 and Article 3, Chapters 5 and 7, Parts 2 and 3, Division 9, and other applicable laws in the storage, use, and release of the information provided in this form.

Covered CA: 42 U.S.C. § 18031; CA Government Code §§ 100502(k) and 100503(a).

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 the Medi-Cal program and Covered California 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 local county 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 local county office or Covered California at **1-800-300-1506** (TTY: 1-888-889-4500) for help.
- 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 to my local county office. These changes include, but are not limited to:
  - » I move
  - » my income changes
  - » my household changes (for example, marriage/divorce, become pregnant, or have a child(ren))
  - » I become 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**.
- I understand that I must report income changes to my local county office because it may affect the eligibility for Medi-Cal benefits or Covered California for the amount of state and federal financial help that I may be eligible to receive. I also understand if I receive too much financial help during the benefit year, I will have to repay the extra premium assistance or state subsidy back to the IRS or California Franchise Tax Board when I file my federal and state 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 renewal qualify for health insurance.
- I understand that as required by law, the information I provide about myself and other people on this renewal for Medi-Cal will be checked by computer with facts given by employers, banks, SSA, Internal Revenue Service, Franchise Tax Board, social services and other agencies to see if I or other people on this renewal qualify for health insurance.

- I know that if Medi-Cal pays for a medical expense, any money I or anyone on this renewal form 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.
- 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.

Right to Appeal

If I think the Medi-Cal program or Covered California has made a mistake, I can appeal its decision. To appeal means to tell someone at the Medi-Cal program or Covered California that I think its decision is wrong and ask for a fair review of the action.

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, Covered California, or the local county office can explain my case to me.

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 9-17-37
Sacramento, California 94244-2430
Fax: 1-833-281-0905
Toll free: 1-855-795-0634 or
Public Inquiry and Response toll free: 1-800-952-5253 or TDD 1-800-952-8349

Nondiscrimination Policy

The Medi-Cal program (DHCS) and Covered California comply with applicable federal and state civil rights laws and do not unlawfully discriminate on the basis of race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, sex, gender, gender identity, or sexual orientation.

The Medi-Cal program (DHCS) and Covered California do not unlawfully exclude people or treat them differently because of race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, sex, gender, gender identity, or sexual orientation.

The Medi-Cal program (DHCS) and Covered California provide free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, and other formats).

The Medi-Cal program (DHCS) and Covered California also provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other

languages. If you need these services, contact the DHCS Office of Civil Rights at **1-916-440-7370**, (Ext. 711, California State Relay) or email CivilRights@dhcs.ca.gov, or contact Covered California at **1-800-300-1506** (TTY: 1-888-889-4500).

Filing a Discrimination Grievance

If you believe that the Medi-Cal program (DHCS) or Covered California has failed to provide these services or you have been discriminated against in another way on the basis of race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, sex, gender, gender identity, or sexual orientation, you can file a grievance with the Medi-Cal program's (DHCS's) Office of Civil Rights or the Covered California Civil Rights Coordinator:

Medi-Cal Program (DHCS)
Office of Civil Rights
P.O. Box 997413, MS 0009
Sacramento, CA 95899-7413
Phone: 1-916-440-7370
(Ext. 711, CA State Relay)
Email: CivilRights@dhcs.ca.gov
Medi-Cal complaint forms are available at:
www.dhcs.ca.gov/Pages/Language_Access.aspx

Covered California
Civil Rights Coordinator
P.O. Box 989725
West Sacramento, CA 95798-9725
Phone: 1-916-228-8764
Fax: 1-916-228-8909
Email: CivilRights@covered.ca.gov

You can also file a separate civil rights complaint with the federal Office for Civil Rights at the U.S. Department of Health and Human Services. You can do this if you believe you have been discriminated against on the basis of race, color, national origin, age, disability, or sex:

U.S. Department of Health and Human Services
Mail: 200 Independence Ave. SW Room 509F
HHH Building, Washington, DC 20201
Phone: 1-800-368-1019 (TTY: 1-800-537-7697)
Online Complaint Portal Assistant: **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**
Online Complaint forms: **https://ocrportal.hhs.gov/ocr/cp/wizard_cp.jsf**