DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

Month DD, YYYY

SUBJECT: Medi-Cal Fee-for-Service Member Reimbursement Form
for Transportation Expenses Cover Letter

Dear Member,

Enclosed are instructions to help you file a request for reimbursement with Medi-Cal for mileage, lodging and/or meals to and from a covered Medi-Cal service(s). Medi-Cal will reimburse you for lodging and meals when the service is not available within your local community and your provider recommended services by a provider whose location requires overnight travel. The California Department of Health Care Services (DHCS) requires pre-authorization of lodging and meals to ensure you, the member, do not incur any unnecessary or unexpected expenses and are reimbursed up to the approved DHCS daily per-diem rates. For more information, please see the Frequently Asked Questions document at https://www.dhcs.ca.gov/services/medi-cal/Pages/Transportation_Beneficiaries_FAQ.aspx

Please complete the enclosed **Medi-Cal Fee-for-Service Member Reimbursement Form for Transportation Expenses** and mail the completed form, along with all required documents, to:

Beneficiary Service Center
P.O. BOX: 138008
Sacramento, CA 95813-8008

You will receive an answer to your request via United States Postal Service (USPS) mail within 60 days after the Medi-Cal Beneficiary Service Center receives your completed form and verifies eligibility and completeness.

If you have questions, call the Beneficiary Service Center at (916) 403-2007. For TDD/TTY telephone service, please call (866) 784-2595.

Sincerely,

CA-MMIS Operations Division
Department of Health Care Services
Authority: Welfare and Institutions Code, Section 14019.3

Instructions for submitting a Medi-Cal Fee-for-Service Reimbursement Form for Transportation Expenses

What transportation expenses are eligible for reimbursement?

Mileage reimbursement is available to members with fee-for-service Medi-Cal who use their own vehicle to drive to an appointment for a Medi-Cal covered service. Members must attest in their request for reimbursement that they have an unmet transportation need and do not have another way to get to their appointment. Transportation expenses can include reimbursement for meals and lodging if certain conditions are met.

Please see the Frequently Asked Questions document for more information https://www.dhcs.ca.gov/services/medi-cal/Pages/Transportation_Beneficiaries_FAQ.aspx.

Who may file a claim?

Medi-Cal members with full-scope Medi-Cal or who are pregnant, including one year after pregnancy, who drove to the appointment with a private vehicle or who paid for lodging and/or meal expenses that were necessary to obtain covered services from an enrolled Medi-Cal provider(s). An approved representative acting on your behalf may also submit a reimbursement request for you.

If you receive Medi-Cal through a managed care plan, please contact your plan's member service department using the contact information at: https://www.dhcs.ca.gov/individuals/Pages/MMCDHealthPlanDir.aspx.

What are covered Medi-Cal services?

Services that are covered by Medi-Cal and available to members with full-scope or pregnancy-only coverage can be found on the DHCS website at https://www.dhcs.ca.gov/services/medi-cal/Pages/Benefits_services.aspx#top

How do I request reimbursement?

To request a **Medi-Cal Fee-for-Service Reimbursement Form for Transportation Expenses**

- Download the form from https://www.dhcs.ca.gov/services/medi-cal/Pages/Transportation_Beneficiaries_FAQ.aspx
- Call the Beneficiary Service Center at (916) 403-2007. For TDD/TTY telephone service, please call (866) 784-2595.

When should I submit my request for reimbursement?

DHCS recommends submitting your request within one month after your appointment. Requests that are more than one year after date of service may not be processed.

Where do I send a completed Medi-Cal Fee-for-Service Reimbursement Form for Transportation Expenses

A completed Medi-Cal Fee-for-Service Reimbursement Form for Transportation Expenses should be mailed to:

Beneficiary Service Center, P.O. Box 138008, Sacramento, CA 95813-8008.

What does a completed Medi-Cal Fee-for-Service Reimbursement Form for Transportation Expenses include?

Please use the following guide on how to complete this form and what you need to include in your submission to DHCS.

- The form must be completed using blue or black ink and must be legible.
- The form must have an original signature (copies will not be accepted, nor will DocuSign).

Section	Section Name	Action Required
I.	Member Information	Member completes
II.	Member's Benefits Identification Card (BIC)	Member provides a photocopy
III.	Member Agreement	Member signs and dates
In the case of multiple appointments, section IV is reuired for each trip in which reimbursement is requested. Additional Appointment Information forms are provided in the Medi-Cal Fee-for-Service Reimbursement for Transportation Expenses packet or on the website at packet or on the website at packet or on the website at https://www.dhcs.ca.gov/services/medi-cal/Pages/Transportation_Beneficiaries_FAQ.aspx.		
IV.	Appointment Information	Member completes applicable sections and arranges by most recent appointment to oldest appointment.
	A. Appointment Verification Form	Member completes the form and the Medi-Cal provider of services completes the form, signs, and dates.
	B. Mileage Reimbursement	Medical mileage rates for driving to and from approved FFS Medi-Cal services are established annually by the Internal Revenue Service (IRS) and can be found on the Standard Mileage Rates | Internal Revenue Service (irs.gov)
	C. Travel Related Expenses	Member completes and provides ORIGINAL itemized receipt of the incurred expense, total amount of bill, and proof of payment. For a list of approved travel related expenses, please see the Frequently Asked Questions document for more information

Section	Section Name	Action Required
		https://www.dhcs.ca.gov/services/medi-cal/Pages/Transportation_Beneficiaries_FAQ.aspx
	D. Lodging Expense Reimbursement	Member completes and provides ORIGINAL itemized receipt with name and/or address of the business, incurred expense for each expense type, total amount of bill, and proof of payment. NOTE: DHCS follows the approved DHCS daily per-diem rates, which can be found at www.calhr.ca.gov/employees/pages/travel-reimbursements.aspx Important: DHCS requires pre-authorization of lodging and meals to ensure you, the member, do not incur any unnecessary or unexpected expenses and are reimbursed up to the approved DHCS daily per-diem rates. If the schedule for your appointment does not allow you to receive pre-authorization for lodging, DHCS may still process your request.
V.	Payee Data Record STD 204 Form	Member completes, signs and dates As you complete this form, verify section 2 and 3 are completed properly as noted below: Section 2: • Mark the first box only "Sole Proprietor/Individual" • Leave all other boxes blank Section 3: Enter the member's Social Security Number or Individual Tax Identification Number (ITIN).
VI.	MC 382 Appointment of Authorized Representative	Member completes only if applicable.
VII.	DHCS General Forms and	If additional language assistance is

Section	Section Name	Action Required
	Miscellaneous Correspondence	needed, the member should refer to the Language Taglines form in Section VII for assistance.
VIII.	Non-Discrimination Notice	DHCS complies with applicable Federal and State civil rights laws. If you feel you have been discriminated against, please refer to the Nondiscrimination Notice in section VIII for assistance.

NOTE

- **Proof of payment is required for lodging and meals only** and is not required for mileage.
    - Submit ORIGINAL itemized lodging and meal receipts related to transportation expenses to obtain Medi-Cal service(s) that were provided by an enrolled FFS Medi-Cal provider(s).
    - ORIGINAL itemized receipts must show proof of payment.
    - ALL forms must be legible to be reimbursed. Forms and receipts that are illegible, faded, or damaged cannot be processed.

For additional information, refer to the DHCS Frequently Asked Questions document for more information https://www.dhcs.ca.gov/services/medi-cal/Pages/Transportation_Beneficiaries_FAQ.aspx.

Medi-Cal Fee-for-Service Reimbursement Form for Transportation Expenses

If you have any questions, please refer to the enclosed instructions or call the Beneficiary Service Center at (916) 403-2007. For TDD/TTY telephone service, please call (866) 784-2595.

I. **Member Information** - Please fill in all the information requested below in blue or black ink.

LAST NAME	FIRST NAME	MIDDLE INITIAL
HOME ADDRESS (NUMBER AND STREET)	APARTMENT/UNIT	HOME PHONE #
CITY/STATE	COUNTY ZIP CODE	WORK PHONE #
MAILING ADDRESS (IF DIFFERENT FROM ABOVE) OR P.O.BOX (If approved, payment will be mailed to this address)		MESSAGE PHONE #
CITY	STATE	ZIP CODE
SOCIAL SECURITY NUMBER (XXX-XX-XXXX)	DATE OF BIRTH (MM/DD/YYYY)	BENEFITS ID CARD NUMBER (BIC#)

II. **Beneficiary ID card –** Include a copy when you submit your transportation reimbursement form.

III. **Member Agreement**

b. Sign and date the Member Agreement. Be sure to print your name and relationship.

Member Agreement: (May include legal representative or authorized representative along with a copy of the legal documents authorizing you to represent the Member/Patient**)**

I declare under penalty of perjury under the laws of the State of California that all of the information on this claim form is true and accurate to the best of my knowledge and belief. I understand that Medi-Cal will treat all personal health information and that of all covered family members as confidential and will not disclose it for any other purpose.

I declare that all other available resources have been reasonably exhausted.

Signature **(**Member/Patient, Legal Representative or Authorized Representative**)**

X: _____ Date: _____

Print Name: _____ Relationship: _____

IV. Appointment Information - Complete this section for each Medi-Cal appointment you wish to seek a reimbursement of transportation expenses for (mileage, lodging and/or meals). They can all be submitted together as one packet. Additional copies of the Section IV Appointment Information are included in this packet and are also available at https://www.dhcs.ca.gov/services/medi-cal/Pages/Transportation_Beneficiaries_FAQ.aspx.

Important: The member must have the enrolled Medi-Cal Provider they have an appointment with sign the Med-Cal Provider section of this form prior to the member submitting the completed reimbursement form to DHCS.

A. Appointment Verification Form

Trip 1: ☐ One Way Trip ☐ Round Trip

Member Information	Member Name:_____ Benefits ID# (BIC):_____ Appointment Start Date:_____ Appointment End Date:_____ Appointment Start Time:_____AM/PM Estimated Appointment End Time:_____AM/PM Member Starting Address: Street:_____ City:_____State:_____ Zip Code:_____
Medi-Cal Provider Information	Name of Medi-Cal Provider: _____ Type of Medi-Cal Provider who will provide service to member (Physician, Specialist, Dentist, Pharmacist, etc.): _____ Address of Medi-Cal Provider: City:_____State:_____ Zip Code: _____ Type of appointment (dental exam, lab tests, checkup, pharmacy):_____ See a complete list at https://www.dhcs.ca.gov/services/medi-cal/Pages/Benefits_services.aspx#top **Medi-Cal Provider Signature**: _____Date: _____

B. Mileage Reimbursement (Private vehicle ONLY)

Mileage will be calculated using the member's starting address and the shortest distance to the enrolled Medi-Cal Provider's address, as determined by an online mapping program used by DHCS. If applicable, provide additional travel information that kept you from taking the most direct route to your approved Medi-Cal appointment (road work, detours). Medical mileage reimbursement rates can be found at Standard Mileage Rates | Internal Revenue Service (irs.gov)

C. Travel Related Expenses

NOTE: Provide the ORIGINAL itemized receipt for each expense type, total amount of bill, and proof of payment. See DHCS FAQs for more information and allowable travel expenses at: https://www.dhcs.ca.gov/services/medi-cal/Pages/Transportation_Beneficiaries_FAQ.aspx.

Travel Expense Type	Description	Total Travel Expense

Request for Lodging and/or Meals Reimbursement:

DHCS follows the approved DHCS daily per-diem rates, which can be found at www.calhr.ca.gov/employees/pages/travel-reimbursements.aspx. Please be aware of the daily maximum per-diems when submitting your request for reimbursement of lodging and/or meals expenses. A member will not be reimbursed for transportation expenses above the approved DHCS daily per-diem rates.

Important: Prior authorization is necessary to receive reimbursement for lodging and meal expenses that were necessary to receive a Medi-Cal service outside a member's area and that was approved by the member's Medi-Cal Provider. The member will need to submit a ***PRE-AUTHORIZATION REQUEST for Medi-Cal Fee-for-Service Lodging and/or Meals Expense*** Form to DHCS for approval prior to requesting reimbursement. This form can be located at https://www.dhcs.ca.gov/services/medi-cal/Pages/Transportation_Beneficiaries_FAQ.aspx.

If the schedule for your appointment does not allow you to receive pre-authorization for meals, DHCS may still process your request.

D. Request for Lodging Expense Reimbursement

NOTE: Provide the ORIGINAL itemized receipt with name and/or address of the business, incurred expense for each expense type, total amount of bill, and proof of payment. See FAQs for examples			
Name of business Member stayed for lodging:	Lodging Address:	Number of nights Member stayed	Amount of Lodging expense(s):

E. Request for Meal Expense Reimbursement

NOTE: Provide the ORIGINAL itemized receipt with name and/or address of the restaurant or grocer, incurred expense for each expense type, total amount of bill, and proof of payment. See DHCS FAQs for more information at https://www.dhcs.ca.gov/services/medi-cal/Pages/Transportation_Beneficiaries_FAQ.aspx		
Meal Expense Category	Name(s) of restaurant or grocer	**Total Meal Expense**
Breakfast		
Lunch		
Dinner		
Total Estimated		

V. Instructions for Completing the Payee Data Record Form: -

PDR -STD 204 must be filled out by the member to complete the **Medi-Cal Fee-for-Service Member Reimbursement Form for Transportation Expenses**.

Print Form | Reset Form

STATE OF CALIFORNIA – DEPARTMENT OF FINANCE

PAYEE DATA RECORD

(Required when receiving payment from the State of California in lieu of IRS W-9 or W-7)

STD 204 (Rev. 03/2021)

Section 1 – Payee Information

NAME (This is required. Do not leave this line blank. Must match the payee's federal tax return)

BUSINESS NAME, DBA NAME or DISREGARDED SINGLE MEMBER LLC NAME (If different from above)

MAILING ADDRESS (number, street, apt. or suite no.) (See instructions on Page 2)

CITY, STATE, ZIP CODE	E-MAIL ADDRESS

Section 2 – Entity Type

Check one (1) box only that matches the entity type of the Payee listed in Section 1 above. (See instructions on page 2)

- ☐ **SOLE PROPRIETOR / INDIVIDUAL**
- ☐ **SINGLE MEMBER LLC** *Disregarded Entity owned by an individual*
- ☐ **PARTNERSHIP**
- ☐ **ESTATE OR TRUST**

CORPORATION (see instructions on page 2)

- ☐ **MEDICAL** *(e.g., dentistry, chiropractic, etc.)*
- ☐ **LEGAL** *(e.g., attorney services)*
- ☐ **EXEMPT** *(e.g., nonprofit)*
- ☐ **ALL OTHERS**

Section 3 – Tax Identification Number

Enter your Tax Identification Number (TIN) in the appropriate box. The TIN must **match** the name given in Section 1 of this form. Do not provide more than one (1) TIN. The TIN is a 9-digit number. **Note:** Payment will not be processed without a TIN.

- For **Individuals**, enter SSN.
- If you are a **Resident Alien**, and you do not have and are not eligible to get an SSN, enter your ITIN.
- Grantor Trusts (such as a Revocable Living Trust while the grantors are alive) may not have a separate FEIN. Those trusts must enter the individual grantor's SSN.
- For **Sole Proprietor or Single Member LLC (disregarded entity), in which the sole member is an individual**, enter SSN (ITIN if applicable) or FEIN (FTB prefers SSN).
- For **Single Member LLC (disregarded entity), in which the sole member is a business entity**, enter the owner entity's FEIN. Do not use the disregarded entity's FEIN.
- For all other entities including LLC that is taxed as a corporation or partnership, estates/trusts (with FEINs), enter the entity's FEIN.

Social Security Number (SSN) or Individual Tax Identification Number (ITIN)

___ ___ ___ - ___ ___ - ___ ___ ___ ___

OR

Federal Employer Identification Number (FEIN)

___ ___ - ___ ___ ___ ___ ___ ___ ___

Section 4 – Payee Residency Status (See instructions)

- ☐ **CALIFORNIA RESIDENT** – Qualified to do business in California or maintains a permanent place of business in California.
- ☐ **CALIFORNIA NONRESIDENT** – Payments to nonresidents for services may be subject to state income tax withholding.
  - ☐ No services performed in California
  - ☐ Copy of Franchise Tax Board waiver of state withholding is attached.

Section 5 – Certification

I hereby certify under penalty of perjury that the information provided on this document is true and correct. Should my residency status change, I will promptly notify the state agency below.

NAME OF AUTHORIZED PAYEE REPRESENTATIVE	TITLE	E-MAIL ADDRESS

SIGNATURE	DATE	TELEPHONE *(Include area code)*

Section 6 – Paying State Agency

Please return completed form to:

STATE AGENCY/DEPARTMENT OFFICE		UNIT/SECTION	
MAILING ADDRESS		**FAX**	**TELEPHONE** *(Include area code)*
CITY	**STATE**	**ZIP CODE**	**E-MAIL ADDRESS**

STATE OF CALIFORNIA – DEPARTMENT OF FINANCE

PAYEE DATA RECORD

(Required when receiving payment from the State of California in lieu of IRS W-9 or W-7)

STD 204 (Rev. 03/2021)

GENERAL INSTRUCTIONS

Type or print the information on the Payee Data Record, STD 204 form. Sign, date, and return to the state agency/department office address shown in Section 6. Prompt return of this fully completed form will prevent delays when processing payments.

Information provided in this form will be used by California state agencies/departments to prepare Information Returns (Form1099).
NOTE: Completion of this form is optional for Government entities, i.e. federal, state, local, and special districts.

A completed Payee Data Record, STD 204 form, is required for all payees (non-governmental entities or individuals) entering into a transaction that may lead to a payment from the state. Each state agency requires a completed, signed, and dated STD 204 on file; therefore, it is possible for you to receive this form from multiple state agencies with which you do business.

Payees who do not wish to complete the STD 204 may elect not to do business with the state. If the payee does not complete the STD 204 and the required payee data is not otherwise provided, payment may be reduced for federal and state backup withholding. Amounts reported on Information Returns (Form 1099) are in accordance with the Internal Revenue Code (IRC) and the California Revenue and Taxation Code (R&TC).

Section 1 – Payee Information

Name – Enter the name that appears on the payee's federal tax return. The name provided shall be the tax liable party and is subject to IRS TIN matching (when applicable).

- Sole Proprietor/Individual/Revocable Trusts – enter the name shown on your federal tax return.
- Single Member Limited Liability Companies (LLCs) that is disregarded as an entity separate from its owner for federal tax purposes - enter the name of the individual or business entity that is tax liable for the business in section 1. Enter the DBA, LLC name, trade, or fictitious name under Business Name.
- Note: for the State of California tax purposes, a Single Member LLC is not disregarded from its owner, even if they may be disregarded at the Federal level.
- Partnerships, Estates/Trusts, or Corporations – enter the entity name as shown on the entity's federal tax return. The name provided in Section 1 must match to the TIN provided in section 3. Enter any DBA, trade, or fictitious business names under Business Name.

Business Name – Enter the business name, DBA name, trade or fictitious name, or disregarded LLC name.

Mailing Address – The mailing address is the address where the payee will receive information returns. Use form STD 205, Payee Data Record Supplement to provide a remittance address if different from the mailing address for information returns, or make subsequent changes to the remittance address.

Section 2 – Entity Type

If the Payee in Section 1 is a(n)...	THEN Select the Box for...
Individual • Sole Proprietorship • Grantor (Revocable Living) Trust disregarded for federal tax purposes	Sole Proprietor/Individual
Limited Liability Company (LLC) owned by an individual and is disregarded for federal tax purposes	Single Member LLC-owned by an Individual
Partnerships • Limited Liability Partnerships (LLP) • and, LLC treated as a Partnership	Partnerships
Estate • Trust (other than disregarded Grantor Trust)	Estate or Trust
Corporation that is medical in nature (e.g., medical and healthcare services, physician care, nursery care, dentistry, etc. • LLC that is to be taxed like a Corporation and is medical in nature	Corporation-Medical
Corporation that is legal in nature (e.g., services of attorneys, arbitrators, notary publics involving legal or law related matters, etc.) • LLC that is to be taxed like a Corporation and is legal in nature	Corporation-Legal
Corporation that qualifies for an Exempt status, including 501(c) 3 and domestic non-profit corporations.	Corporation-Exempt
Corporation that does not meet the qualifications of any of the other corporation types listed above • LLC that is to be taxed as a Corporation and does not meet any of the other corporation types listed above	Corporation-All Other

Section 3 – Tax Identification Number

The State of California requires that all parties entering into business transactions that may lead to payment(s) from the state provide their Taxpayer Identification Number (TIN). The TIN is required by R&TC sections 18646 and 18661 to facilitate tax compliance enforcement activities and preparation of Form 1099 and other information returns as required by the IRC section 6109(a) and R&TC section 18662 and its regulations.

Section 4 – Payee Residency Status

Are you a California resident or nonresident?

- A corporation will be defined as a "resident" if it has a permanent place of business in California or is qualified through the Secretary of State to do business in California.
- A partnership is considered a resident partnership if it has a permanent place of business in California.
- An estate is a resident if the decedent was a California resident at time of death.
- A trust is a resident if at least one trustee is a California resident.
  - For individuals and sole proprietors, the term "resident" includes every individual who is in California for other than a temporary or transitory purpose and any individual domiciled in California who is absent for a temporary or transitory purpose. Generally, an individual who comes to California for a purpose that will extend over a long or indefinite period will be considered a resident. However, an individual who comes to perform a particular contract of short duration will be considered a nonresident.

For information on Nonresident Withholding, contact the Franchise Tax Board at the numbers listed below:

Withholding Services and Compliance Section: 1-888-792-4900 E-mail address: wscs.gen@ftb.ca.gov
For hearing impaired with TDD, call: 1-800-822-6268 Website: www.ftb.ca.gov

Section 5 – Certification

Provide the name, title, email address, signature, and telephone number of individual completing this form and date completed. In the event that a SSN or ITIN is provided, the individual identified as the tax liable party must certify the form. Note: the signee may differ from the tax liable party in this situation if the signee can provide a power of attorney documented for the individual.

Section 6 – Paying State Agency

This section must be completed by the state agency/department requesting the STD 204.

Privacy Statement

Section 7(b) of the Privacy Act of 1974 (Public Law 93-579) requires that any federal, state, or local governmental agency, which requests an individual to disclose their social security account number, shall inform that individual whether that disclosure is mandatory or voluntary, by which statutory or other authority such number is solicited, and what uses will be made of it. It is mandatory to furnish the information requested. Federal law requires that payment for which the requested information is not provided is subject to federal backup withholding and state law imposes noncompliance penalties of up to $20,000. You have the right to access records containing your personal information, such as your SSN. To exercise that right, please contact the business services unit or the accounts payable unit of the state agency(ies) with which you transact that business.

All questions should be referred to the requesting state agency listed on the bottom front of this form.

VI. MC 382 Appointment of Authorized Representative

NOTE: This form is only needed when applicable.

State of California
Health and Human Services Agency

Appointment of Authorized Representative

Use this form to appoint an individual or organization as your Medi-Cal authorized representative. Your authorized representative may act for you on all duties related to your Medi-Cal eligibility and enrollment. Or, you may also limit duties. You may cancel or change this appointment at any time.

You may give this form to your local county office in person or by mail, phone or electronically.

Part A: Tell us about you:

Applicant or beneficiary name:	Phone number:	Case number (Optional):

Mailing address (number, street, city, state, ZIP code):

Part B: Tell us about the authorized representative:

Name of authorized representative (individual or organization):	Phone number:

Mailing address (number, street, city, state, ZIP code):

E-mail address:

Part C: Authorized representative duties:

Examples of authorized representative duties

- Complete and sign the application
- Complete and sign redetermination forms
- Give us information we ask for
- Report changes
- Choose a health plan
- Help with fair hearings and appeals

State of California
Health and Human Services Agency

Appointment of Authorized Representative

Tell us below if you want to limit any authorized representative duties:

_____

_____

Do you want your authorized representative to get a copy of Medi-Cal notices or other mail we send to you?

- ☐ No
- ☐ Yes, all notices and mail
- ☐ Yes, please limit to these types of notices or mail:_____

Part D: Read and sign

I. **For applicant/beneficiary:**

By signing below, I appoint the individual or organization named in Part B as my authorized representative. I agree that:

- The authorized representative may perform duties on my behalf. (See Part C.)
- This authorization starts on the date I sign this form.
- My rights and responsibilities do **not** change because I have an authorized representative.
- I must make sure that I respond to all requests for information
- The authorized representative may cancel this appointment at any time.
- I may contact the county that handles my Medi-Cal case to change or cancel this appointment at any time.

II. **For authorized representative:**

- You may cancel this appointment at any time by contacting the county that handles the applicant or beneficiary's Medi-Cal case.
- If you do not agree with your rights and responsibilities or do not want to be an authorized representative, contact the county that handles the applicant or beneficiary's Medi-Cal case.
- You agree to keep confidential any information about the applicant or beneficiary that you get from Medi-Cal.

State of California
Health and Human Services Agency

Appointment of Authorized Representative

A. For an individual appointed as an authorized representative:

- By accepting appointment as an authorized representative you agree to:
  - Give the written disclosure to the applicant or beneficiary.
  - 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.

- If you are an employee or contractor for a health care provider or facility, you must give the applicant or beneficiary a written disclosure about:
  - Your employment by or contract with the health care provider or facility.
  - Any potential conflicts of interest that may exist due to that employment or contract.

B. For an organization appointed as an authorized representative:

- The only persons who may perform duties authorized on this form are those who represent the organization and have a signed Authorized Representative Standard Agreement (MC 383) on file with the county that handles the applicant or beneficiary's Medi-Cal case.
- The organization must fully disclose in writing to the applicant or beneficiary any conflicts of interest that may result from acting as that person's authorized representative.

Medi-Cal confidentiality notice: The information given on this form is private and confidential pursuant to Welfare and Institutions Code, Section 14100.2. This information shall be disclosed only as this law allows.

By signing below, I agree to and understand my rights and responsibilities as stated above:

Signature of applicant or beneficiary (required):	Date:

Signature of individual appointed as an authorized representative (optional):	Date:

VII. Department of Health Care Services General Forms and Miscellaneous Correspondence

LANGUAGE TAGLINES

English Tagline

ATTENTION: If you need help in your language call 1-916-403-2007 (TTY: 1-916-635-6491). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 1-916-403-2007 (TTY: 1-916-635-6491). These services are free of charge.

الشعار بالعربية (Arabic)

يُرجى الانتباه: إذا احتجت إلى المساعدة بلغتك، فاتصل بـ 1-916-403-2007 (TTY: 1-916-635-6491). تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة بريل والخط الكبير. اتصل بـ 1-916-403-2007 (TTY: 1-916-635-6491). هذه الخدمات مجانية.

Հայերեն պիտակ (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե Ձեզ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք 1-916-403-2007 (TTY: 1-916-635-6491): Կան նաև օժանդակ միջոցներ ու ծառայություններ հաշմանդամություն ունեցող անձանց համար, օրինակ՝ Բրայլի գրատիպով ու խոշորատառ տպագրված նյութեր: Զանգահարեք 1-916-403-2007 (TTY: 1-916-635-6491): Այդ ծառայություններն անվճար են:

ឃ្លាសម្គាល់ជាភាសាខ្មែរ (Cambodian)

ចំណាំ៖ បើអ្នក ត្រូវ ការជំនួយ ជាភាសា របស់អ្នក សូម ទូរស័ព្ទទៅលេខ 1-916-403-2007 (TTY: 916-635-6491)។ ជំនួយ និង សេវាកម្ម សម្រាប់ ជនពិការ ដូចជាឯកសារសរសេរជាអក្សរផុស សម្រាប់ជនពិការភ្នែក ឬឯកសារសរសេរជាអក្សរពុម្ពធំ ក៏អាចរកបានផងដែរ។ ទូរស័ព្ទមកលេខ 1-916-403-2007 (TTY: 1-916-635-6491)។ សេវាកម្មទាំងនេះមិនគិតថ្លៃឡើយ។

简体中文标语 (Chinese)

请注意：如果您需要以您的母语提供帮助，请致电 1-916-403-2007 (TTY: 1-916-635-6491)。另外还提供针对残疾人士的帮助和服务，例如盲文和需要较大字体阅读，也是方便取用的。请致电 1-916-403-2007 (TTY: 1-916-635-6491)。这些服务都是免费的。

مطلب به زبان فارسی (Farsi)[1]

توجه: اگر می‌خواهید به زبان خود کمک دریافت کنید، با 1-916-403-2007 (TTY: 1-916-635-6491) تماس بگیرید. کمک‌ها و خدمات مخصوص افراد دارای معلولیت، مانند نسخه‌های خط بریل و چاپ با حروف بزرگ، نیز موجود است. با 1-916-403-2007 (TTY: 1-916-635-6491) تماس بگیرید. این خدمات رایگان ارائه می‌شوند.

हिंदी टैगलाइन (Hindi)

ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो 1-916-403-2007
(TTY: 1-916-635-6491) पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में भी दस्तावेज़ उपलब्ध हैं। 1-916-403-2007 (TTY: 1-916-635-6491) पर कॉल करें। ये सेवाएं नि: शुल्क हैं।

Nqe Lus Hmoob Cob (Hmong)

CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau 1-916-403-2007 (TTY: 1-916-635-6491). Muaj cov kev pab txhawb thiab kev pab cuam rau cov neeg xiam oob qhab, xws li puav leej muaj ua cov ntawv su thiab luam tawm ua tus ntawv loj. Hu rau 1-916-403-2007 (TTY: 1-916-635-6491). Cov kev pab cuam no yog pab dawb xwb.

日本語表記 (Japanese)

注意日本語での対応が必要な場合は 1-916-403-2007 (TTY: 1-916-635-6491)へお電話ください。点字の資料や文字の拡大表示など、障がいをお持ちの方のためのサービスも用意しています。 1-916-403-2007 (TTY: 1-916-635-6491)へお電話ください。これらのサービスは無料で提供しています。

한국어 태그라인 (Korean)

유의사항: 귀하의 언어로 도움을 받고 싶으시면 1-916-403-2007 (TTY: 1-916-635-6491) 번으로 문의하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 도움과 서비스도 이용 가능합니다. 1-916-403-2007 (TTY: 1-916-635-6491) 번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다.

ແທກໄລພາສາລາວ (Laotian)

ປະກາດ: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໃຫ້ໂທຫາເບີ 1-916-403-2007 (TTY: 1-916-635-6491). ຍັງມີຄວາມຊ່ວຍເຫຼືອແລະການບໍລິການສໍາລັບຄົນພິການ
ເຊັ່ນເອກະສານທີ່ເປັນອັກສອນນູນແລະມີໂຕພິມໃຫຍ່ ໃຫ້ໂທຫາເບີ
1-916-403-2007 (TTY: 1-916-635-6491). ການບໍລິການເຫຼົ່ານີ້ບໍ່ຕ້ອງເສຍຄ່າໃຊ້ຈ່າຍໃດໆ.

Mien Tagline (Mien)

LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiemx longc mienh tengx faan benx meih nyei waac nor douc waac daaih lorx taux 1-916-403-2007
(TTY: 1-916-635-6491). Liouh lorx jauv-louc tengx aengx caux nzie gong bun taux ninh mbuo wuaaic fangx mienh, beiv taux longc benx nzangc-pokc bun hluo mbiutc aengx caux aamz mborqv benx domh sou se mbenc nzoih bun longc. Douc waac daaih lorx 1-916-403-2007 (TTY: 1-916-635-6491). Naaiv deix nzie weih gong-bou jauv-louc se benx wang-henh tengx mv zuqc cuotv nyaanh oc.

ਪੰਜਾਬੀ ਟੈਗਲਾਈਨ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਾਲ ਕਰੋ 1-916-403-2007
(TTY: 1-916-635-6491). ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਮੋਟੀ ਛਪਾਈ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ| ਕਾਲ ਕਰੋ 1-916-403-2007(TTY: 1-916-635-6491).

Русский слоган (Russian)

ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру 1-916-403-2007(линия TTY: 1-916-635-6491). Также предоставляются средства и услуги ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру 1-916-403-2007(линия TTY: 1-916-635-6491). Также предоставляются средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру 1-916-403-2007(линия TTY: 1-916-635-6491). Такие услуги предоставляются бесплатно.

Mensaje en español (Spanish)

ATENCIÓN: si necesita ayuda en su idioma, llame al 1-916-403-2007 (TTY: 1-916-635-6491). También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al 1-916-403-2007 (TTY: 1-916-635-6491). Estos servicios son gratuitos.

Tagalog Tagline (Tagalog)

ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa 1-916-403-2007 (TTY: 1-916-635-6491). Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan,tulad ng mga dokumento sa braille at malaking print. Tumawag sa 1-916-403-2007 (TTY: 1-916-635-6491). Libre ang mga serbisyong ito.

แท็กไลน์ภาษาไทย (Thai)

โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข 1-916-403-2007 (TTY: 1-916-635-6491) นอกจากนี้ ยังพร้อมให้ความช่วยเหลือและบริการต่าง ๆ สำหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศัพท์ไปที่หมายเลข 1-916-403-2007 (TTY: 1-916-635-*6491) ไม่มีค่าใช้จ่ายสำหรับบริการเหล่านี้

Примітка українською (Ukrainian)

УВАГА! Якщо вам потрібна допомога вашою рідною мовою, телефонуйте на номер 1-916-403-2007 (TTY: 1-916-635-6491). Люди з обмеженими можливостями також можуть скористатися допоміжними засобами та послугами, наприклад, отримати документи, надруковані шрифтом Брайля та великим шрифтом. Телефонуйте на номер 1-916-403-2007 (TTY: 1-916-635-6491). Ці послуги безкоштовні.

Khẩu hiệu tiếng Việt (Vietnamese)

CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số 1-916-403-2007 (TTY: 1-916-635-6491). Chúng tôi cũng hỗ trợ và cung cấp các dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và chữ khổ lớn (chữ hoa). Vui lòng gọi số 1-916-403-2007 (TTY: 1-916-635-6491). Các dịch vụ này đều miễn phí.

VIII. Non-Discrimination notice

State of California – Health and Human Services Agency - Department of Health Care Services

NONDISCRIMINATION NOTICE

The Department of Health Care Services (DHCS) complies with applicable Federal and State civil rights laws. DHCS does not unlawfully discriminate against, exclude, or treat people differently on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation.

DHCS:

- Provides free aids and services to people with disabilities to communicate effectively with DHCS, such as:
  - Qualified sign language interpreters
  - Written information in other formats such as large print, braille, audio or accessible electronic formats
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call the Office of Civil Rights, at **1-916-440-7370**, 711 (California State Relay) or email CivilRights@dhcs.ca.gov. Upon request, this document can be made available to you in braille, large print, audio or accessible electronic formats.

If you believe DHCS has failed to provide these services or you have been discriminated against in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation, you can file a grievance with the Office of Civil Rights.

Department of Health Care Services
Office of Civil Rights
PO Box 997413, MS 0009
Sacramento, CA 95899-7413
(916) 440-7370, 711 (California State Relay)
Email: CivilRights@dhcs.ca.gov

If you need help filing a grievance, the Office of Civil Rights can help you. Complaint forms are available at https://www.dhcs.ca.gov/discrimination-grievance-procedures

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. You can file electronically through the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or you can file by mail or phone at:

US Department of Health and Human Services
2000 Independence Avene SW Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, TTY 1-800-537-7697

You can get a complaint form at: http://www.hhs.gov/ocr/office/file/index.html