CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

Month, DD, YYYY

**SUBJECT: Pre-Authorization Request Medi-Cal Fee-for-Service Lodging and/or Meals Expense**

Dear Member,

Enclosed are instructions to help you file a ***PRE-AUTHORIZATION REQUEST for* Medi-Cal Fee-for-Service Lodging and/or Meals Expense Form.**

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 (refunded) up to the approved DHCS daily per-diem rates. If the schedule of your appointment does not allow you to submit your request for pre-authorization prior to attending your appointment, DHCS may still consider your request. Please complete the enclosed ***PRE-AUTHORIZATION REQUEST for* Medi-Cal Fee-for-Service Lodging and/or Meals Expense Form** and mail the completed form 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 three (3) business days after the Medi-Cal Beneficiary Service Center receives your completed form and verifies eligibility and completeness. Response delivery time for USPS requests is dependent on the USPS delivery schedule.

Upon approval of your pre-authorized expenses, the Business Service Center will send you an approval letter along with a claim form to request reimbursement for lodging and meals after you have attended your Medi-Cal appointment. You will need to include Itemized receipts with the claim form.

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 (FFS) 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 DHCS Frequently Asked Questions 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

## What are the Pre-Authorization Requirements?

For reimbursement of lodging and meal expenses, pre-authorization is required for all Medi-Cal approved appointments. The member will need to complete and submit a completed ***PRE-AUTHORIZATION REQUEST for*** **Medi-Cal Fee-for-Service Lodging and/or Meals Expense Form** for each appointment they are planning to request reimbursement of travel expenses.

## How do I request a Pre-Authorization form?

To request a **Medi-Cal Fee-for-Service Pre-Authorization Form**

- Download the form from https://www.dhcs.ca.gov/services/medi-cal/Pages/Transportation_Beneficiaries_FAQ.aspx or
- 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 prior authorization request as soon as possible and well in advance of your Medi-Cal appointment so it can be reviewed and approved prior to the date of service(s).

## Where Do I Send Pre-Authorization Forms?

A completed ***PRE-AUTHORIZATION REQUEST for*** **Medi-Cal Fee-for-Service Lodging and/or Meals Expense Form** can be mailed to:

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

**What does a completed Medi-Cal Fee-for-Service Pre-Authorization Form 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; and
- 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.** | Beneficiary Identification Card (BIC) | Member provides a photocopy |
| **III.** | Member Agreement | Member signs and dates |
| In the case of multiple appointments, section IV is required for pre-authorization of each trip in whi reimbursement of lodging and meal expenses is requested. Additional Appointment Information forms are included in the ***PRE-AUTHORIZATION REQUEST for*** **Medi-Cal Fee-for-Service Lodging and/or Meals Expense Form** or on the website at https://www.dhcs.ca.gov/services/me cal/Pages/Transportation_Beneficiaries_FAQ.aspx. | | |
| **IV.** | Appointment Information | Member completes applicable sections and arranges by earliest appointment date. |
| | A. Appointment Verification Form | Member completes the form. |
| | B. Pre-Authorization Request for Lodging Expense | Member provides lodging details and estimated expenses.<br><br>NOTE: DHCS follows the approved DHCS daily per-diem rates, which can be found at: www.calhr.ca.gov/employees/pages/travel-reimbursements.aspx<br><br>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 maximum DHCS daily per-diem rates. |

| Section | Section Name | Action Required |
|---|---|---|
| | | See DHCS Transportation Reimbursement FAQ's https://www.dhcs.ca.gov/services/medi-cal/Pages/Transportation_Beneficiaries_FAQ.aspx. |
| | C. Pre-Authorization Request for Meal Expense | Member provides estimated meal expenses.<br><br>NOTE: DHCS follows the approved DHCS daily per-diem rates, which can be found at www.calhr.ca.gov/employees/pages/travel-reimbursements.aspx<br><br>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 maximum DHCS daily per-diem rates.<br><br>See DHCS FFS NMT/NEMT Transportation Reimbursement FAQ's https://www.dhcs.ca.gov/services/medi-cal/Pages/Transportation_Beneficiaries_FAQ.aspx. |
| **V.** | MC 382 Appointment of Authorized Representative | Member completes only if applicable. |
| **VI.** | DHCS General Forms and Miscellaneous Correspondence | These forms are for information only and do not need to be returned. If additional language assistance is needed, the member should refer to the Language Taglines form in Section VI for assistance. |
| **VII.** | Non-Discrimination Notice | This notice is for information only and does not need to be returned. 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 VII for assistance. |

# PRE-AUTHORIZATION REQUEST for Medi-Cal Fee-for-Service Lodging and/or Meals Expense

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**

a. Include a copy when you submit your PRE-AUTHORIZATION REQUEST for Medi-Cal Fee-for-Service Lodging and/or Meals Expense form.

**III. Member Agreement**

**a.** 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 pre-authorization of travel expenses for (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.

### A. Appointment Verification Form

**Trip 1:** ☐ One Way Trip ☐ Round Trip

**Member Information**

Member Name:_____

Benefits ID# (BIC):_____

Appointment Start Date:_____

Appointment End Date:_____

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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

## B. Pre-Authorization Request for Lodging Expense

DHCS follows the approved 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 allowance when submitting your Pre-Auth Request for Lodging Expenses.

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

| Name and address of business Member plans to stay for lodging | Number of nights Member expects to stay | Estimated Amount of Lodging expense(s): |
|---|---|---|
| | | |
| | | |

## C. Pre-Authorization Request for Meal Expense

DHCS follows the approved 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 allowance when requesting reimbursement for meal expenses.

See DHCS Frequently Asked Questions for more information https://www.dhcs.ca.gov/services/medi-cal/Pages/Transportation_Beneficiaries_FAQ.aspx.

| Meals Expense Category | Total Estimated # | Total Estimated Meal Expense(s) |
|---|---|---|
| Breakfast | | |
| Lunch | | |
| Dinner | | |
| Total Estimated | | |
| | | |

## V. 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

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.

## 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: |
|---|---|
| | |

## VI. 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)**
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 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.

## VII. 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:

**U.S. Department of Health and Human Services**
**200 Independence Avenue 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