Application for Coverage of Coronavirus (COVID-19) Testing Costs

Complete this application to get help paying for certain coronavirus (COVID-19) testing, testing-related, and treatment costs.

The health coverage you will get if you are found eligible using this application will only pay for medical tests for coronavirus.

To see if you are eligible for other health care benefits and services through Medi-Cal or Covered California, you should complete a full application at www.coveredca.com.

1. First Name	2. Middle Name	3. Last Name	4. Suffix (if applicable)
5. Gender: ☐ Male ☐ Female		6. Date of Birth (MM/DD/YYYY):	
7. Living in California? ☐ Yes ☐ No		8. County Living in?	
9. ☐ If homeless, check the box and tell us where we can reach you in the mailing address field below			
10. Home Address (Number & Street)			Apt. #
City		State	Zip
11. Mailing Address (if different from home address)			Apt. #
City		State	Zip
12. Best Contact Number	13. Other Phone Number	14. Email Address	
15. What language do you speak best?		16. What language do you read best?	

17. Social Security Number (SSN): _____

If you have a Social Security Number (SSN) you must provide it when you are applying for health coverage for yourself. We use Social Security Numbers (SSNs) to check your income and other information to see if you are eligible to get help paying for health coverage. If you are applying for coverage and do not have a SSN and would like help getting one, visit www.ssa.gov. you may be eligible for some coverage even if you do not have an SSN. For more information call the Medi-Cal helpline, at (800) 541-5555.

18. Are you a US Citizen or National? If yes, go to 19. If No, skip to 20. ☐ Yes ☐ No

19. Are you a naturalized or derived citizen? If Yes, complete a or b and skip to 21. If No, skip to 21. ☐ Yes ☐ No

a. Alien Number/USCIS Number:	b. Naturalization/Citizenship Number:

20. If you are not a US Citizen or National, do you have an eligible immigration status? ☐ Yes ☐ No If yes, enter document type and any of the information below that applies to you.	
a. Immigration Document Type:	b. Immigration Status (Optional):
c. Name as it appears on your Immigration Document:	
d. Alien Number/USCIS Number:	e. I-94 Number:
f. Passport Number:	g. Country of Issuance:
h. SEVIS ID:	i. Other (Card Number or Visa Number):
21. Do you currently have Medicare? ☐ Yes ☐ No	22. Do you currently have other health insurance? ☐ Yes ☐ No

YOUR RIGHTS AND RESPONSIBLITIES

- I know that under federal law, DHCS does not unlawfully discriminate 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, sexual orientation, or any other basis protected by federal or State civil rights laws.
- Complaints may be filed by calling the Office of Civil Rights, Department of Health Care Services at (916) 440-7370 or by written correspondence to P.O. Box 997413, MS 0009, Sacramento, CA 95899-7413, or by email addressed to CivilRights@dhcs.ca.gov.
- I know that information on this form will be used to determine eligibility for health coverage, help paying for coverage, and for lawful purposes of programs that help pay for coverage.
- If anyone on this application is eligible for Medi-Cal, I grant to the California Department of Health Care Services our rights to pursues and get any money from other health insurance, legal settlements, or other third parties.
- We need the information on this application to check your eligibility for help paying for coverage of COVID-19 testing, testing-related, and treatment costs. We'll check your answers using information in our electronic databases and databases from Social Security, and the Department of Homeland Security. If the information doesn't match, we may ask you to send us more information.
- I have the right to know how my protected health information may be used and disclosed, and what my privacy rights are. The Notice of Privacy Practices (NPP) provides this information and is available at https://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/NoticeofPrivacyPractices.aspx

PRIVACY STATEMENT

- This application is for the COVID-19 Uninsured Group program administered by the Department of Health Care Services (DHCS). The personal and medical information you provide on it is private and confidential. DHCS needs it to identify you and to administer the COVID-19 Uninured Group program.
- 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 as described in the Notice of Privacy Practices.
- You must answer all of the questions on this application unless they are marked "optional." If your application 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 application. You may have to submit a new application, or your application for COVID-19 Uninsured Group benefits may be denied.
- For more information or to see Department of Health Care Services records, contact the Information Protection Unit at P.O. Box 997413, MS 4721 Sacramento, CA 95899-7413 Phone: 1-866-866-0602 TTY: 1-877-735-2929.
- These state and federal laws give us the right to collect and keep the information on the application: DHCS: CA Welfare and Institutions. Code § 14011 and Article 3, Chapters 5 and 7, Parts 2 and 3, Division 9, Covered CA: 42 U.S.C § 18031; CA Government Code §§ 100502(k) and 100503(a).

WHAT SHOULD I DO IF I THINK MY ELIGIBILITY NOTICE IS WRONG?

- If I think the Medi-Cal program has made a mistake, I can appeal the decision. To appeal means to tell someone at 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 1-800-743-8525 (TTY: 1-800-952-8349) for the Medi-Cal program.
- I know that I must file an appeal within 90 days of the 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 the Medi-Cal program can explain my case to me.
- I know that someone at the Medi-Cal program can explain the circumstances when my eligibility may be maintained or reinstated pending an appeal decision.

SIGNATURE

By signing, I declare that what I say below is true, complete, and correct.

- I have read and understand this application
- I understand that this application is only to get help paying for certain coronavirus (COVID-19) testing, testing-related, and treatment costs. To see if I am eligible for other health care benefits and services through Medi-Cal or Covered California, I should complete a full application at www.coveredca.com.

Signature	Date