Exhibit D
Billing 340B Drugs to the Medi-Cal Fee-for-Service Program and County Organized Health Systems (Policy)

[*See attached*.]

POLICY

CEDARS-SINAI

Effective Date: 08/14/2017
Last Review Date: 08/14/2017

Title: Billing 340B Drugs to the Medi-Cal Fee-for-Service Program and County Organized Health Systems

Home Department: Patient Financial Services

I. Policy Statement(s)

It is the policy of Cedars-Sinai Medical Center to submit outpatient claims to the Medi-Cal Program 340B drug line items to (1) the Medi-Cal Program in Fee-for-Service ("FFS") Program and (2) County Organized Health System ("COHS") in accordance with Health Resources and Services Administration ("HRSA") and Medi-Cal Program guidelines and recommendations.

A. When submitting an outpatient claim to the Medi-Cal FFS Program which includes 340B drugs, the 340B drug line item(s) will be appended with a UD modifier and will be billed at the 340B acquisition cost plus the dispensing fee (in place at that time).

B. When submitting an inpatient claim to the Medi-Cal FFS Program, which includes 340B drugs that were dispensed to the patient while in an outpatient status, the charge associated with the 340B price will be the 340B acquisition cost plus the dispensing fee, **not the default price** in the Charge Master.

C. When submitting an outpatient claim to a County Organized Health System which includes 340B drugs, the 340B drug line item(s) will be appended with a UD modifier and will be billed at the 340B acquisition cost plus the dispensing fee (in place at that time).

D. When submitting an inpatient claim to a County Organized Health System which includes 340B drugs that were dispensed to the patient while in an outpatient status, the charge associated with the 340B price will be the 340B acquisition cost plus the dispensing fee, **not the default price** in the Charge Master.

E. As of this approval date, **there is no State of California requirement** to submit an outpatient claim which includes 340B drugs at the 340B acquisition cost plus the dispensing fee (in place at that time) to a Medi-Cal Managed Care Plan.

II. Purpose

The purpose of this policy is to ensure billing compliance with HRSA and Medi-Cal regulations and guidance so as not to invalidate any 340B reporting prepared and submitted by CSMC's Pharmacy.

Title: Billing 340B Drugs to the Medi-Cal Fee-for-Service Program and County Organized Health Systems

Home Department: Patient Financial Services

III. Definitions of Key Terms and Concepts

Term / Concept	Definition
340B	340B Drug Discount Program is a US federal government program created in 1992 that requires drug manufacturers to provide outpatient drugs to eligible health care organizations and covered entities at significantly reduced prices. Section 340B(a)(4) of the Public Health Services Act specifies which covered entities are eligible to participate.
Health Resources and Services Administration ("HRSA")	The 340B Drug Discount Program is administered by the Office of Pharmacy Affairs ("OPA"), located within the Health Resources and Services Administration of the Department of Health and Human Services.
Apexus	
Conduent	The Fiscal Intermediary for the Medi-Cal Program (formerly Xerox).

IV. Policy Implementation and Compliance Measures

This policy was implemented years ago. This document formalizes the policy.

Responsible Party (Functional Title)	Steps to Implement Measures to Promote Compliance
Associate Director, Pharmacy Services	Communicates new 340B information to the Associate Director of Revenue Management, the Manager of Government Billing and Follow-Up, the Senior Consultant, CRI, and others as appropriate. Escalates issues as appropriate.
Associate Director, Revenue Management	Communicates 340B information to RMD staff and others as appropriate. Escalates issues as appropriate.
Manager, Government Billing and Follow-Up	Communicates 340B information to Government Billing staff and others are appropriate. Escalates issues as appropriate.

V. Related Documents

List of County Organized Health Systems:
http://cshsppmweb.csmc.edu/dotNet/documents/?docid=45238&mode=edit&PropertiesActiveStepNumber=2

VI. References

Jason Atlas, Manager, Apexus, (469) 299-7310.
Advised on July 31, 2017 that Apexus does not provide any guidance on billing/claim submission. Recommended we contact the Medi-Cal Program for specific billing instructions.

Mari Gonzalez, Outreach and Education Manager, Conduent. Mari.Gonzalez@conduent.com.

Bonnie Kinkade, Chief, Department of Health Care Services. bkinkade@dhcs.ca.gov.

Exhibit E
Cedars-Sinai's Financial Assistance Policy

[*See attached*.]

POLICY

CEDARS-SINAI **Effective Date: July 1, 2016**

Title: Full and Partial Financial Assistance for Financially Qualified Patients Policy (Fair Pricing Policies)

Home Department: Patient Financial Services

PURPOSE:

The purpose of this policy (the "Policy") is to define Cedars-Sinai Medical Center's and Cedars-Sinai Medical Care Foundation's policy for eligibility determination and the processing of Full and Partial Financial Assistance for Financially Qualified Patients as described below. Collectively, both of these nonprofit entities will be referred to as Cedars-Sinai. Recognizing their charitable mission, it is the policy of Cedars-Sinai to provide a reasonable amount of services without charge, or at significantly discounted prices, to Eligible Patients who cannot afford to pay for all or a portion of their care.

POLICY:

It is Cedars-Sinai's policy to be fully compliant with applicable State Law, Federal Law and industry practices, and to apply the general guidelines for Full and Partial Financial Assistance for Financially Qualified Patients to patients who do not have or cannot obtain adequate financial resources and who demonstrate material financial need through the financial screening process. Additional means of funding to cover the cost of services will be explored in the manner provided in this Policy and other Cedars-Sinai policies. This Policy applies to all emergency and other medically necessary care provided by Cedars-Sinai.

NOTICES, SUMMARIES AND WRITTEN COMMUNICATIONS:

Cedars-Sinai provides the following notices regarding Full and Partial Financial Assistance for the Financially Qualified Patients:

a. **Posted Signage.** Notice of this Policy is posted in the following locations: the Emergency Department, the Admitting Department, centralized and decentralized registration areas and other outpatient settings as deemed appropriate.

b. **Notices Hand-Delivered to Patients.** During the registration or admission process (or otherwise prior to discharge), patients shall be provided a Plain Language Summary of this Policy and Cedars-Sinai's other financial assistance programs in the form of the Summary of Financial Assistance Policy and Other Programs (Attachment A). Patients will be asked to acknowledge receipt of Attachment A via an electronic signature. The notice to a specific Patient will be considered continually in effect until a revision to the form is required (and a new acknowledgement obtained) or three years from the date of the original acknowledgement.

c. **Patient Statement Notices.** Cedars-Sinai will print a notice on the side of the last page of the patient billing statements that will describe its financial assistance programs and that will inform patients how to apply for Financial Assistance under this Policy and other assistance programs (Attachment F).

d. **Other Written Communications.** In order to administer the requirements of this Policy, Cedars-Sinai may provide Patients with additional written communications. Standard letters and notices to Patients in this regard are included in the Attachments to this Policy.

Cedars-Sinai may print any written notice or communication described in this Policy, including any Plain Language Summary of the Policy, on a billing statement or along with other descriptive or explanatory matter, provided that the required information is conspicuously placed and of sufficient size to be clearly readable.

Cedars-Sinai may provide electronically any written notice or communication described in this Policy to any Patient who indicates he or she prefers to receive the written notice or communication electronically.

TRANSLATIONS:

Patient communications shall comply with the requirements of Cedars-Sinai's Language Assistance Plan. Without limiting the foregoing, notices, formal communications and Cedars-Sinai signage under this Policy shall be in English and in the additional languages required by California Health and Safety Code §1259, California Health and Safety Code §12693.30, California Health and Safety Code §127410(a) and Title VI of the Civil Rights Act (42 USC §200d). As of January 1, 2015, those additional languages are Farsi, Russian, and Spanish.

PUBLICIZING THE POLICY:

Cedars-Sinai shall take various efforts to widely publicize its financial assistance programs. These efforts will change from time to time and will generally include the distribution of information to targeted community organizations, among a variety of other means of alerting the Cedars-Sinai community to the availability of Cedars-Sinai financial assistance programs.

This Policy, the Application Form and the Plain Language Summary shall be available on the Cedars-Sinai website.

DEFINITIONS:

Amounts Generally Billed ("AGB") means the amounts generally billed for emergency or other medically necessary care to Patients who have insurance covering such care, determined in accordance with 26 C.F.R. §1.501(r)-5(b). Cedars-Sinai will use the Look-Back Method for determining the maximum amount that would be billed to an eligible inpatient using the average Medicare inpatient reimbursement rate of 12% of gross charges. To further benefit an eligible inpatient, Cedars-Sinai will use the lower of 12% of gross charges or the Medicare MS-DRG reimbursement amount for this episode of care in determining an eligible patient's liability. Cedars-Sinai will use the Look-Back Method in determining the maximum amount that would be billed to an eligible outpatient using the average Medicare outpatient reimbursement rate of 9% of gross charges. Inpatient and outpatient reimbursement rates are calculated at least annually using the most recently closed Medicare accounts from the past 12 months.

Application means Cedars-Sinai's Application for Financial Assistance attached to this Policy at Attachment C.

Application Period means the period during which Cedars-Sinai must accept an Application for financial assistance under this Policy. Cedars-Sinai may accept and process a Patient's Application submitted outside of the Application Period. The Application Period begins on the date the care is provided and ends on the later of the 240th day after the date that the first post-discharge billing statement for the care, unless another period is provided by this Policy.

Assets mean only "monetary assets." This includes assets that are readily convertible to cash, such as bank accounts and publicly traded stocks. Retirement plans, deferred compensation plans (both qualified and nonqualified under the IRS code) will not be considered.

Eligible means that a Patient meets the requirements for Full or Partial Financial Assistance under this Policy.

Essential Living Expenses are expenses for any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

Extraordinary Collection Actions refers to collection activities that Cedars-Sinai will not undertake before making reasonable efforts to determine whether a Patient is eligible for financial assistance under this Policy. Extraordinary Collection Actions are specifically described later in this Policy.

Federal Poverty Level (FPL) is defined as a measurement used to determine poverty in the United States and is published yearly by the Department of Health and Human Services ("DHHS") on their website, http://www.dhhs.gov.

Financially Qualified Patient is a Patient who has requested financial assistance from Cedars-Sinai, has completed and submitted an Application, and review of the Application shows that the Patient is eligible for either Full or Partial financial assistance and the Application is approved in accordance with this Policy.

Full Financial Assistance are arrangements under this Policy for health care services to be provided at no charge to the patient.

Guarantor is the individual financially responsible for payment of hospital services received by the Patient.

High Medical Costs are the annual out-of-pocket costs of a Patient whose family income does not exceed 450% of the Federal Poverty Level that are in excess of 10% of the Patient's Family income in the prior twelve (12) months. To calculate the costs, they must either be provided at Cedars-Sinai or the Patient must provide sufficient documentation of the expenses paid by the Patient or the Patient's Family.

Income Testing means the process for measuring a Patient's income for the purposes of determining a Patient's eligibility for financial assistance as set forth below.

Medical Indigency refers to a patient/guarantor who is unable to pay for services due to unexpected high-cost care but who does not qualify for Full or Partial Financial Assistance under this Policy.

Monetary Assets mean Assets as defined above.

Partial Financial Assistance are arrangements under this Policy for health care services to be provided at a reduced charge, and generally pursuant to a Payment Plan.

Patient means an existing or prospective patient.

Patient's Family is defined as the following: (1) For persons 18 years of age and older, spouse, domestic partner and dependent children under 26 years of age, whether living at home or not, (2) For persons under 18 years of age, parent, caretaker relatives and other children under 26 years of age of the parent or caretaker relative.

Payment Plan is a written agreement between Cedars-Sinai and the Patient, whereby Cedars-Sinai has offered and the Patient has accepted the opportunity to pay off their liability in monthly payments not exceeding 10% of the Patient's Family income for a month, excluding deductions for Essential Living Expenses.

Plain Language Summary is a clear, concise, and easy to understand document that notifies Patients and other individuals that Cedars-Sinai offers financial assistance under this Policy. The Plain Language Summary shall be drafted in a manner that sets out relevant information including the information required by state and Federal law such as the eligibility requirements and assistance offered under this Policy, a brief summary of how to apply for assistance under this Policy, and information for obtaining additional information and assistance, including copies in other languages.

Provided means, in the context of Patient communications, when a document is delivered to a Patient. For materials sent by regular U.S. mail, the materials shall be deemed "provided" three business days after mailing. For materials sent by overnight mail or messenger, the materials shall be deemed "provided" when delivered to the Patient's address. For hand-delivered and emailed notices (if the Patient accepts emailed communications), the materials shall be deemed "provided" when given (i.e., immediately).

Reasonable Efforts refer to the steps Cedars-Sinai must take prior to undertaking any Extraordinary Collection Actions. These efforts are specifically described later in this Policy.

Self-Pay/Automatic Discounts represents the discounts provided to all self-pay patients (with no third-party coverage) pursuant to Cedars-Sinai programs distinct from the financial assistance provided under this Policy. Self-Pay/Automatic Discounts are provided by Cedars-Sinai Medical Center and Cedars-Sinai faculty physicians in their capacity as faculty. For other physicians, Patients should ask their physician for information on any discounts that may be provided by the

physician's practice. The following percentage discounts apply for Cedars-Sinai Medical Center and its faculty:

i. Inpatients receive a seventy-five percent (75%) discount from total charges.
ii. Emergency Room patients receive a sixty-five percent (65%) discount from total charges.
iii. Outpatients receive a forty percent (40%) discount from total charges.

CLINICAL DETERMINATION:

The evaluation of the necessity for medical treatment of any Patient will be based upon clinical judgment, regardless of insurance or financial status. In cases where an emergency medical condition exists, any evaluation of financial arrangements will occur only after an appropriate medical screening examination has occurred and necessary stabilizing services have been provided in accordance with all applicable State and Federal laws and regulations. All Cedars-Sinai staff should be aware that federal law prohibits making financial inquiries of a Patient with an unstabilized emergency medical condition. For further guidance, please refer to Cedars-Sinai Policy on "Emergency Medical Condition: Scope of Services Provided to Patients with Emergency Medical Conditions Policy: Clinical Administrative."

EXCLUSIONS AND LIMITATIONS ON ELECTIVE PROCEDURES:

The mission of Cedars-Sinai includes providing financial assistance to the Cedars-Sinai community for Cedars-Sinai services. Financial assistance as described in this Policy will be made available to all patients receiving emergency and other medically necessary care. Financial assistance for elective procedures and for follow-up care following discharge is limited to patients who live in the Cedars-Sinai service area or as otherwise approved by an officer of Cedars-Sinai.

Cedars-Sinai retains the right to prospectively not grant financial assistance in connection with a patient's proposed non-emergency and other non-medically necessary care, based on Cedars-Sinai's need to judiciously allocate its financial and clinical resources.

POLICY ONLY APPLIES TO CEDARS-SINAI SERVICES AND PARTICIPATING PHYSICIANS:

Only services provided by Cedars-Sinai will be covered by this Policy. These services will include professional services if provided at Cedars-Sinai by Cedars-Sinai affiliated physicians as follows: Cedars-Sinai's emergency department physicians of Community Urgent Care Medical Group, Inc., Cedars-Sinai faculty physicians in their capacity as faculty, or physicians employed by Cedars-Sinai Medical Care Foundation or by medical groups which have an exclusive Professional Agreement with Cedars-Sinai Medical Care Foundation.

Other members of the Medical Staff of Cedars-Sinai Medical Center may make financial assistance available to their patients. Cedars-Sinai will make available a list of information it has regarding these physicians. The list will be available at the Cedars-Sinai website. The list will indicate whether a Physician agrees that the Physicians, and any of Physician's billing or collection agents will: (i) provide equivalent discounts from Physicians' professional fees to low-income uninsured patients as Cedars-Sinai provides, based on the criteria set forth in the Policy; (ii) accept Cedars-Sinai's determination of a Patient's Eligibility for financial assistance; and (iii) comply with all applicable federal, state and local laws, regulations, ordinances and orders with respect to the collection of consumer debt accounts. Cedars-Sinai will not be responsible for such Physicians' administration of financial assistance programs or their billing practices.

ELIGIBILITY:

a. **Additional Financial Resources Available to Patients – Cooperation Required from Patients.** Alternative means of funding (i.e., external agency or foundation) to cover the cost of services for Patients will be explored before Full or Partial Financial Assistance under this Policy is approved. Patients approved for assistance under this Policy agree to continuously cooperate in the process needed to obtain reimbursement for Cedars-Sinai's

services from third party sources such as the California Victims of Crime funds, the County Trauma Program, the Medi-Cal program, and health plans that offer coverage through the California Health Benefit Exchange. A Patient's Application for third party coverage for the Patient's health care costs shall not preclude Eligibility for assistance under this Policy. A Patient shall, as a condition to Full or Partial Financial Assistance,

apply for coverage under Medi-Cal, Healthy Families, and the County Trauma Program as applicable and, where appropriate, coverage under the Exchange. The foregoing shall also apply to Patients residing out of state and their application for Medicaid within their State.

Cedars-Sinai will make appropriate referrals to local county agencies including Healthy Families, Covered California, Medi-Cal or other programs to determine potential eligibility.

Cedars-Sinai shall be entitled to bill any third party insurer providing coverage to a Patient. Health insurers and health plans are prohibited from reducing their reimbursement of a claim to Cedars-Sinai even if Cedars-Sinai has waived all or a portion of a Patient's bill pursuant to this Policy.

b. **Full Financial Assistance.** Full Financial Assistance (no charge to Patient) will be made available to Patients whose income and Assets are at or below 200% of the current year's Federal Poverty Level. The Patient's Family income will be considered in determining eligibility.

c. **Partial Financial Assistance.** Partial Financial Assistance will be made available to Patients whose income is in the range of 201% - 450% of the current year's Federal Poverty Level. The Patient's Family income will be considered in determining eligibility. Assets will not be considered. Refer to Attachment G (Income Sliding Scale) for additional guidelines**.**

d. **Patients with Limited Information for Application.** The absence of patient financial data available to Cedars-Sinai does not preclude eligibility for financial assistance. In evaluating all factors pertaining to a Patient's clinical, personal and demographic situation, and alternative documentation (including information that may be provided by other charitable organizations), Cedars-Sinai may determine a Patient is eligible for Full or Partial Financial Assistance by making reasonable assumptions regarding the Patient's income.

e. **Pre-Service Patients (Elective/Non-Emergent Care).** Patients scheduled as elective inpatients or scheduled as non-emergent outpatients require prior approval for financial

assistance by the Vice President of Patient Financial Services ("PFS") or his or her designee. Only medically necessary procedures are eligible for approval. Financial assistance for elective procedures and for follow-up care following discharge is limited to patients who live in the Cedars-Sinai service area or as otherwise approved by an officer of Cedars-Sinai.

f. **Medically Indigent Patients (Not Otherwise Eligible).** Patients who are Medically Indigent but who are not otherwise eligible for financial assistance under this Policy may still request financial assistance in accordance with the process set forth in this Policy. The request for financial assistance due to Medical Indigency must be approved by the Vice-President of Patient Financial Services or his or her designee, in their discretion.

TERM:

The initial Full and Partial Financial Assistance For Financially Qualified Patients approval is valid for a period of six (6) months, from the date the Application was complete. Eligibility may be reassessed, upon Patient request, at the end of the initial approval period. At Cedars-Sinai's election, a new six (6) month approval period may be authorized without a new Application. After twelve (12) months, a new Application must be completed by the Patient. Starting with the date the final Application is approved, open, qualified accounts will be written-off to financial assistance. On a go-forward basis, qualified accounts for the next six (6) months would be eligible for financial assistance write-off.

QUALIFIED COUNTY TRAUMA CASES:

Patients whose services at Cedars-Sinai are eligible for payment under the County Trauma Program (formerly known as Prop 99) shall be automatically approved for Full Financial Assistance under this Policy as needed to cover portions of the services that will not be paid by the County Trauma Program based on its funding processes. Such Patients will not receive a Financial Assistance Approval Letter. All other procedures identified in this Policy will be followed for eligible County Trauma patients.

SABAN CLINIC REFERRALS:

Cedars-Sinai has reviewed the Saban Clinic's financial screening process. Patients the Saban Clinic has determined are eligible for financial assistance in accordance with its sliding fee discount policy and for whom Saban has provided a referral letter to Cedars-Sinai will be Eligible under this Policy and not need to submit an Application provided a Patient's income does not exceed 200% of the current Federal Poverty Level. If a patient's income exceeds 200%

of the current Federal Poverty Level, the patient must complete an Application in order to be considered for Full or Partial Financial Assistance under this Policy.

Cedars-Sinai will consider these Patients' eligibility to be good for a period of one (1) year from the date the Patient was referred by Saban to Cedars-Sinai. Saban Patients eligible for Full Financial Assistance under this Policy will not receive a Financial Assistance Approval letter. All other procedures identified in this Policy will be followed for Eligible Saban Clinic patients.

FINANCIAL ASSISTANCE PROGRAM:

A. **Initiating the Financial Assistance Application**
The Application process can be initiated by Admitting/Registration, the Patient, the Patient's authorized representative, a Patient Accounting or PFS Customer Service representative or a Patient Financial Advocate.
This process includes the following:
1. Patients are provided with the Application, including a cover letter, a Medi-Cal Application and information on Credit Counseling. [Refer to Attachments B, C, D and E]
2. Applicants are offered assistance in completing the forms in the Emergency Department, Main Admitting South Tower and in the Primary Adult Clinic.
3. Patient Financial Advocates will assist in-house patients.

B. **Guidelines for Reviewing Financial Assistance Applications**

i. **Determination**
1. The Eligibility guidelines and rates of discount are noted on Attachment G.
2. The guidelines are calculated using 450% of the then current Federal Poverty Level as the highest measure of Eligibility.

ii. **Assets**
The consideration of Assets in determining Eligibility is limited to Assets, as defined above.
1. The first $10,000 of a Patient's Assets will not be considered, and 50% of a Patient's Monetary Assets above $10,000 will not be considered for Full Financial Assistance.
2. Assets are not factored in the determination of eligibility for Partial Financial Assistance.

iii. **Income**
Income for partial periods shall be included in worksheets using annualized data.

iv. **Deductions**
Other financial obligations including living expenses and other items of reasonable and necessary nature will be considered.

v. **Patient Maximum Out-of-Pocket Expense**

Any payment from a Patient for services covered by this Policy shall be limited to no greater than the Amounts Generally Billed.

vi. **Reevaluation**
Eligibility may be reevaluated by Cedars-Sinai if any of the following occur:

a. Patient income change.
b. Patient Family size change.
c. A determination is made that any part of the Financial Assistance Application is false or misleading in which case the initial Financial Assistance may be retroactively denied.

C. **Required Documents from Patients**

Cedars-Sinai requests various documents from Patients applying for Full Financial Assistance or Partial Financial Assistance in order to substantiate their eligibility. The documents may include, but are not limited to, the following:

1. Completed Application.
2. Income documents may include:
   a. Current period payroll check stub, or
   b. Prior year's tax return, or
   c. Written explanation
3. Asset documents may include:
   a. Copies of prior month's bank statement (all pages)
   b. Money Market account statements
   c. Stocks
   d. Bonds
   e. Certificate of Deposits
   f. Brokerage accounts
   [No documents pertaining to retirement plans, deferred compensation plans (both qualified and nonqualified under the IRS code) are to be requested or reviewed.]
4. Unemployment, Social Security or Disability stub.

D. **Complete Applications**

If a Patient submits a complete Application during the Application Period, Cedars-Sinai shall:

i. Immediately suspend any Extraordinary Collection Actions to obtain payment for the care.

ii. Within a reasonable time make a determination as to whether the Patient is Eligible or that the Application is incomplete.

iii. Notify the Patient in writing of the eligibility determination (including, if applicable, the assistance for which the Patient is Eligible) and the basis for this determination within 35 days of the submission of the Application.

Eligibility not Met
If the Patient is not Eligible, no further steps are required.
Eligibility for Full or Partial Financial Assistance Determined

iv. If the Patient is Eligible for Full Financial Assistance, no further steps are required other than refunding amounts paid as provided at Subparagraph (c) below.

v. If Cedars-Sinai determines a Patient is Eligible for Partial Financial Assistance, Cedars-Sinai shall, in addition to the information and steps set out, above, provide the Patient with a billing statement that indicates the amount the Patient owes for the care as an Eligible Patient and how that amount was determined and that states, or describes

how the Patient can get information regarding, the AGB for the care.

vi. Cedars-Sinai shall refund to the Patient any amount he or she has paid for the care (whether to Cedars-Sinai or any other party to whom it has referred or sold the Patient's debt for the care) that exceeds the amount he or she is determined to be personally responsible for paying as an Eligible Patient, unless such excess amount is less than $5 (or such other amount set by notice or other guidance published in the Internal Revenue Bulletin).

vii. Cedars-Sinai shall take all reasonably available measures to reverse any Extraordinary Collection Actions taken against the Patient to obtain payment for the care. Such reasonably available measures generally include, but are not limited to, measures to vacate any judgment against the Patient, lift any levy or lien on the Patient's property, and remove from the Patient's credit report any adverse information that was reported to a consumer reporting agency or credit bureau.

COLLECTIONS AND REASONABLE REVIEW EFFORTS AND CONTACTS REQUIRED PRIOR TO COLLECTIONS:

A. **Suspending Extraordinary Collection Actions while an Application is Pending**
With respect to any care provided by Cedars-Sinai to a Patient, if the Patient has submitted an Application during the Application Period, Cedars-Sinai shall suspend all Extraordinary Collection Actions until the Application process is complete.

B. **Extraordinary Collection Actions**
The following actions against a Patient related to obtaining payment of a bill for care covered under this Policy are Extraordinary Collection Actions:

(i) Selling a debt to another party (other than debt sales described below).

(ii) Reporting adverse information to consumer credit reporting agencies or credit bureaus.

(iii) Deferring or denying, or requiring a payment before providing, medically necessary care because of the Patient's nonpayment of one or more bills for previously provided care covered under this Policy (which is considered an Extraordinary Collection Action to obtain payment for the previously provided care, not the care being potentially deferred or denied). If Cedars-Sinai requires a payment before providing medically necessary care to a Patient with one or more outstanding bills for previously provided care, such a requirement for payment will be presumed to be because of the Patient's nonpayment of such bill(s) unless Cedars-Sinai can demonstrate that it required the payment from the Patient based on factors other than, and without regard to, the Patient's nonpayment of past bills.

(iv) Actions that require a legal or judicial process, including but not limited to —

(A) Placing a lien on a Patient's property (other than a lien specifically permitted by this Policy);
(B) Foreclosing on a Patient's real property;
(C) Attaching or seizing a Patient's bank account or any other personal property;
(D) Commencing a civil action against a Patient;
(E) Causing a Patient's arrest;
(F) Causing a Patient to be subject to a writ of body attachment; and
(G) Garnishing a Patient's wages.

C. **Reasonable Steps Needed to Determine Eligibility of All Patients**
Prior to initiating any Extraordinary Collection Actions, Cedars-Sinai shall have taken the following steps as applicable:

(i) **Presumptive Eligibility for Full Financial Assistance.** Cedars-Sinai has determined that the Patient is Eligible for Full Financial Assistance for the current services based on information it has obtained or assessed without looking to the Patient to provide all information required by the usual Application process. Cedars-Sinai's determination may include reliance on a prior determination by Cedars-Sinai, information provided by another provider of the Patient, or a general assessment of information available to Cedars-Sinai staff.

(ii) **Presumptive Eligibility for Partial Financial Assistance.** Cedars-Sinai has determined that the Patient is Eligible for Partial Financial Assistance for the current services based on information it has obtained or assessed without looking to the Patient to provide all information required by the usual Application process. Cedars-Sinai's determination may include reliance on a prior determination by Cedars-Sinai, information provided by another provider of the Patient, or a general assessment of information available to Cedars-Sinai staff.

In such cases, Cedars-Sinai shall (a) notify the Patient of the basis for the presumptive eligibility determination and the manner in which the Patient may apply for more generous assistance available under the Policy; (b) give the Patient 240 days to apply for more generous assistance; and if the Patient submits a complete Application seeking more generous assistance, determines whether the Patient is Eligible for a more generous discount and takes the other steps required by this Policy with regard to complete Applications.

(iii) **Reasonable Efforts Based on Billing Statement Notification and Amounts Not Eligible.** Cedars-Sinai shall notify Patients of its financial assistance programs

before initiating any Extraordinary Collection Actions to obtain payment for the care and refrain from initiating such Extraordinary Collection Actions for at least 120 days from the date Cedars-Sinai provides the billing statement for the care if the Patient has not submitted an Application or Cedars-Sinai has determined the Patient is not Eligible for financial assistance for the amounts sought to be collected

based on the Patient's Application.

(iv) **Notifications to Patients 30 Days Before Actions.** In addition to the foregoing, at least 30 days before first initiating any Extraordinary Collection Actions, Cedars-Sinai shall have provided the Patient with a written notice that indicates financial assistance is available as described in this Policy, identify all the Extraordinary Collection Action(ies) that Cedars-Sinai intends to initiate to obtain payment for the care, and that state a deadline after which such Extraordinary Collection Actions may be initiated (which date shall be no earlier than 30 days after the date that the written notice is provided). The notice shall include the Plain Language Summary of Cedars-Sinai's financial assistance programs (Attachment A).

(v) **Additional Oral Notice Before Actions.** In addition to all written notices, prior to initiating any Extraordinary Collection Actions, Cedars-Sinai shall make a reasonable effort to orally notify the Patient about Cedars-Sinai's financial assistance programs and about how the Patient may obtain assistance with the Application process.

(vi) **Notification Before Actions in the Event of Multiple Episodes of Care.** Cedars-Sinai may satisfy the notification requirements described above for multiple episodes of care and notify the Patient of its planned Extraordinary Collection Actions in notices that cover multiple billing statements. However, if it aggregates outstanding bills for multiple episodes of care it must refrain from initiating Extraordinary Collection Actions on all the episodes of care until 120 days after it provided the first post-discharge billing statement for the most recent episode of care included in the aggregation.

(vii) **Notification before Deferring or Denying Care Due to Nonpayment for Prior Care.** In cases where Cedars-Sinai proposes to defer or deny services, or require a payment before providing, medically necessary care because of the Patient's nonpayment of one or more bills for previously provided care covered under this Policy (which is considered an Extraordinary Collection Action to obtain payment for the previously provided care, not the care being potentially deferred or denied), Cedars-Sinai shall notify the Patient about this Policy and the Cedars-Sinai financial assistance programs less than 30 days before initiating the Extraordinary Collection Action, provided that it provides the notices required by subparagraphs (iv) (Notifications to Patients 30 Days Before Actions) and (v) (Additional Oral Notice Before Actions) above. In addition to such notices, Cedars-Sinai may

provide the Patient with an Application form and stating the deadline, if any, after which Cedars-Sinai will no longer accept and process an Application submitted (or, if applicable, completed) by Patient for the previously provided care at issue. This deadline must be no earlier than the later of 30 days after the date that the written notice is provided or 240 days after the date that the first post-discharge billing statement for the previously provided care was provided. If the Patient submits an Application for the previously provided care on or before the deadline described above (or at any time, if Cedars-Sinai didn't provide any such deadline to the Patient), processes the Application on an expedited basis.

(viii) **Incomplete Applications.** If a Patient submits an incomplete Application during the Application Period, Cedars-Sinai shall notify the Patient about how to complete the Application and give the Patient through the expiration of the Application Period to complete the Application (or such longer period of time as elected by Cedars-Sinai. During this period, Cedars-Sinai shall suspend all Extraordinary Collection Actions to obtain payment for the care and provide the Patient with a written notice that describes the additional information and/or documentation required for the Application and include the Cedars-Sinai contact information for Application processing.

(ix) **Incomplete Application Completed.** If a Patient who has submitted an incomplete Application during the Application Period subsequently completes the Application during the Application Period (or, if later, within a reasonable timeframe given to respond to requests for additional information and/or documentation), the Patient will be considered to have submitted a complete Application during the Application Period, and Cedars-Sinai will have made reasonable efforts to determine whether the Patient is Eligible only if it and takes the other steps required by this Policy with regard to complete Applications.

(x) **Anti-Abuse Rule for Complete Applications – Questionable Information.** Cedars-Sinai shall not make determinations that a Patient is not Eligible for financial assistance based on information it has reason to believe is unreliable or incorrect or on information obtained from the Patient under duress or through the use of coercive practices. A coercive practice includes delaying or denying emergency medical care to a Patient until the Patient has provided information requested to determine whether the Patient is Eligible for financial assistance for the care being delayed or denied.

D. **Reasonable Efforts Must Be Taken with Guarantors**
Extraordinary Collection Actions include steps taken adversely not only with regard to a Patient but with regard to any Guarantor of a Patient account.

E. **Patient Waivers Do Not Relieve Cedars-Sinai of Reasonable Efforts Obligations**
Obtaining a verbal or written waiver from a Patient, such as a signed statement that the Patient does not wish to apply for assistance under the Policy or receive the information to be provided Patients under this Policy, will not itself constitute a determination that the Patient is not Eligible and will not satisfy the requirement to make reasonable efforts to determine whether the Patient is Eligible before engaging in Extraordinary Collection Actions against the Patient.

F. **Collection Agencies and Sales of Debt**
Cedars-Sinai shall ensure that all parties who provide services as collection agencies or who have acquired the debt of a Patient shall comply with the requirements of this Policy of not engaging in any Extraordinary Collection Actions unless reasonable steps have been taken by Cedars-Sinai or the applicable third party to determine if the Patient is Eligible for assistance under this Policy.

Cedars-Sinai's sale of a Patient's debt for care provided will not be considered an Extraordinary Collection Action if, prior to the sale, Cedars-Sinai enters into a legally binding written agreement with the purchaser of the debt pursuant to which —

(i) The purchaser is prohibited from engaging in any Extraordinary Collection Actions to obtain payment for the care;

(ii) The purchaser is prohibited from charging interest on the debt in excess of the rate in effect under Internal Revenue Code Section 6621(a)(2) at the time the debt is sold (or such other interest rate set by notice or other guidance published in the Internal Revenue Bulletin);

(iii) The debt is returnable to or recallable by Cedars-Sinai upon a determination by it or the purchaser that the Patient is Eligible;

(iv) If the Patient is Eligible and the debt is not returned to or recalled by Cedars-Sinai, the purchaser is required to adhere to procedures specified in the agreement

that ensure that the Patient does not pay, and has no obligation to pay, the purchaser and Cedars-Sinai together more than he or she is personally responsible for paying as an Eligible Patient;

(v) If the Patient submits an Application after the referral or sale of the debt but before the end of the Application Period, the party will suspend Extraordinary Collection Actions to obtain payment for the care;

(vi) If the Patient submits an Application after the referral or sale of the debt but before the end of the Application Period and is determined to be Eligible for the

care, the party will do the following in a timely manner:

a. Adhere to procedures specified in the agreement that ensure that the Patient does not pay, and has no obligation to pay, the party and Cedars-Sinai together more than he or she is required to pay for the care as an Eligible Patient.

b. If applicable and if the party (rather than Cedars-Sinai) has the authority to do so, take all reasonably available measures to reverse any Extraordinary Collection Action taken against the Patient; and

(vii) If the party refers or sells the debt to yet another party during the Application Period, the party will obtain a written agreement from that other party including all of the elements described in above.

G. **Liens on Certain Judgments, Settlements, or Compromises**
Any lien that Cedars-Sinai is entitled to assert under state law on the proceeds of a judgment, settlement, or compromise owed to a Patient (or his or her representative) as a result of personal injuries for which Cedars-Sinai provided care is not an Extraordinary Collection Action.

H. **Collection Procedures and Payment Plans**

(i) Collection requirements with regard to any amounts payable by a Patient under this Policy are set forth in the policy Debt Collections Policy: Patient Accounting**.**

(ii) Cedars-Sinai shall reasonably consider and enter into Payment Plans with patients

who will have a financial obligation under this Policy. Cedars-Sinai will not charge interest on amounts owed by a Patient pursuant to this Policy including, without limitation, amounts owed under a Payment Plan.

a. A Payment Plan may be cancelled, at Cedars-Sinai's discretion, after the Patient fails to make all consecutive payments due during any one hundred twenty (120) day period.

b. Prior to cancelling a Payment Plan, Cedars-Sinai collection agency or assignee will make a reasonable attempt to notify the Patient, by phone at the last known phone number and in writing at the last known address, that the Payment Plan may be cancelled and there might be an opportunity to renegotiate.

c. Cedars-Sinai, its collection agencies or assignees, in good faith, will attempt to renegotiate the terms of the defaulted Payment Plan if requested by the Patient. Cedars-Sinai is, however, not required by law to compromise further solely on the basis of the Patient's default.

d. If the Patient fails to make all consecutive payments of a Payment Plan and fails to renegotiate a Payment Plan, then nothing limits or alters the Patient's obligation to make payments from the first date due on the obligation owing to the hospital pursuant to any contract or applicable statute.

e. Cedars-Sinai, its collection agencies or assignees, will not report adverse information to a consumer credit reporting agency or commence a civil action against the patient or responsible party for nonpayment prior to effective date of the cancellation of the Payment Plan.

(iii) The following provisions address the timing and under whose authority Patient debt is advanced for collection. Any collection activity shall only be conducted by Cedars-Sinai's Patient Financial Services or Physician Billing Services Departments or Cedars-Sinai's external collection agency(ies).

a. Cedars-Sinai will not initiate any Extraordinary Collection Action except in accordance with this Policy.

b. Each external collection agency shall agree in writing that it will adhere to Cedars-Sinai's standards and scope of practices with regard to collection activities, including, without limitation, the Payment Plan provisions of this Policy.

c. In determining the amount of a debt Cedars-Sinai may seek to recover from patients who are Eligible under this Policy, Cedars-Sinai shall consider only income and Monetary Assets as defined and limited by the Policy.

d. At time of billing, Cedars-Sinai shall provide a written summary of the services and charges including the same information concerning services and charges provided to all other patients who receive care at Cedars-Sinai.

e. If a Patient attempting to qualify for eligibility under this Policy is attempting in good faith to settle an outstanding bill with Cedars-Sinai by negotiating a Payment Plan or by making regular partial payments of a reasonable amount, Cedars-Sinai shall not send the unpaid bill to any collection agency or other assignee, unless that entity has agreed to comply with this article.

f. Cedars-Sinai and its agents shall not, in dealing with patients Eligible under this Policy use wage garnishments or liens on primary residences as a means of collecting unpaid Cedars-Sinai bills.

g. Cedars-Sinai collection agencies or other assignees shall not, in dealing with any Patient use as a means of collecting unpaid Cedars-Sinai bills, any of the following:

- A wage garnishment, except by order of the court upon noticed motion, supported by a declaration filed by the movant identifying the basis for which it believes that the Patient has the ability to make payments on the judgment under the wage garnishment, which the court shall consider in light of the size of the judgment and additional information provided by the Patient prior to, or at, the hearing concerning the Patient's ability to pay, including information about probable future medical expenses based on the current condition of the Patient and other obligations of the Patient.

- Notice or conduct a sale of the Patient's primary residence during the life of the Patient or his or her spouse, or during the period a child of the Patient is a minor, or a child of the Patient who has attained the age of majority is unable to take care of himself or herself and resides in the dwelling as his or her primary residence. In the event a person protected by this paragraph owns more than one dwelling, the primary residence shall be the dwelling that is the Patient's current homestead, as defined in Section 704.710 of the California Code of Civil Procedure, or was the Patient's homestead at the time of the death of a person other than the Patient who is asserting the protections of this paragraph.

h. Cedars-Sinai and its agents shall not report adverse information to a consumer credit reporting agency or commence a civil action against a patient or responsible party for nonpayment prior to the time a Payment Plan is declared to be no longer operative.

CONFIDENTIALITY OF APPLICATION INFORMATION:

Cedars-Sinai shall maintain all information received from Patients requesting eligibility under this Policy as confidential information. Information concerning Assets obtained as part of the Application and approval process shall be maintained in a file that is separate from information that may be used to collect amounts owed Cedars-Sinai. Such file (and all information that should be in such file) shall not be available to the personnel involved in debt collection. However, nothing prohibits the use of information obtained by Cedars-Sinai, its collection agencies or assignees independently from the Application process.

REFUNDS:

Cedars-Sinai will reimburse patients for amounts they paid in excess of the amount due pursuant to this Policy, including any interest paid, at the rate of seven percent (7%) per annum.

i. If the amount due to the Patient is less than $5.00, Cedars-Sinai is not required to reimburse the Patient or pay interest. It will give the patient a credit for the applicable amount for at least 60 days from the date the amount is due.

ii. This is applicable to patients applying for Financial Assistance or Partial Financial Assistance on or after January 1, 2007.

Interest will accrue starting from the date the Patient's payment was deposited.

OSHPD REPORTING:

Cedars-Sinai will submit its Financial Assistance and Partial Financial Assistance Policy to the Office of Statewide Health Planning and Development (OSHPD) by January 1st of each calendar year, when a significant change occurs. If no significant change has been made to this Policy, Cedars-Sinai will notify OSHPD of same to meet the reporting requirements.

RELEVANT LAWS:

California Health and Safety Code, Fair Pricing Policies, Sections 127400 et seq.

Internal Revenue Code Section 501(r).

26 CFR Parts 1, 53 and 602.

RELATED POLICIES:

Debt Collections Policy: Patient Accounting.

Emergency Medical Conditions: Scope of Services Provided to Patients with Emergency Medical Conditions Policy: Clinical Administrative.

CONTACTS:

Questions regarding this Policy and Procedure should be addressed to any of the following individuals:

i.	Manager, PFS Customer Service	(323) 866-8953
ii.	Supervisor, PFS Customer Service	(323) 866-8635
iii.	Senior Consultant, CRI	(323) 866-8563

ATTACHMENTS:

Attachment A	Summary of Financial Assistance Policy and Other Programs (Described in this Policy as the "Plain Language Summary")
Attachment B	Medi-Cal Application
Attachment C	Financial Assistance Application
Attachment D	Cover Letter for Financial Assistance Application
Attachment E	Consumer Credit Counseling Letter
Attachment F	Statement of Hospital and Physician Services Template
Attachment G	Income Sliding Scale
Attachment H	Request for Additional Information Letter
Attachment I1	Letter Template: Unable to Grant Financial Assistance (based on assets)
Attachment I2	Letter Template: Unable to Grant Financial Assistance (based on income)
Attachment I3	Letter Template: Unable to Grant Financial Assistance (based on lack of requested documentation)
Attachment J	Financial Assistance Worksheet
Attachment K	Letter Template: Financial Assistance Approval Letter
Attachment K1	Letter Template: Financial Assistance Approval Presumptive Eligibility Letter

Attachment L	Letter Template: Financial Assistance Unable to Honor After Appeal Letter

HISTORY:

ORIGINAL ISSUE: 05/01/03

LAST REVIEW DATES: 05/23/16, 12/30/14, 02/14/11, 09/01/10, 12/28/09, 09/30/09, 12/01/07, 12/12/06, 06/21/06, 01/11/06, 11/10/05, 08/29/05

APPROVALS:

APPROVED BY:	Patricia E. Kittell, Vice President, Patient Financial Services
REVIEWED BY:	Gretchen Case, Director, Compliance and Revenue Integrity Hank Smither, Director, Patient Financial Services

Document ID: 28707719

SUMMARY OF FINANCIAL ASSISTANCE POLICY AND OTHER PROGRAMS

This document is the "in plain language summary" of the Full and Partial Financial Assistance for Financially Qualified Patients Policy (the "Policy) of Cedars-Sinai Medical Center and Cedars-Sinai Medical Care Foundation (together "Cedars-Sinai"). It is also a description of other financial assistance programs Cedars-Sinai makes available to Patients.

As part of our mission, Cedars-Sinai is committed to providing access to quality health care for the community and treating all of our Patients with dignity, compassion and respect. This includes providing services without charge, or at significantly discounted prices, to eligible Patients who cannot afford to pay for part or all of their care as provided by the Policy. In addition, we offer our Patients a variety of payment plans and options to meet their financial needs even if they do not qualify for assistance under the Policy.

A. Cedars-Sinai program for low-income patients – the Policy.

As provided in detail in the Policy, Cedars-Sinai makes free or discounted care available to Patients whose limited income is within the parameters of the Policy.

1. Eligibility requirements and assistance offered under the Policy.

Full Financial Assistance (no charge to Patient) will be made available to Patients whose income and monetary assets (together "income") are at or below 200 percent of the current year's Federal Poverty Level. Partial Financial Assistance will be made available to Patients whose income is in the range of 201 percent to 450 percent of the current year's Federal Poverty Level. Discounts available to Patients will be on a sliding scale based on family size and income level. Examples: (a) a Patient in a family of four with no insurance and an annual family income of $71,000 could be eligible for a 90 percent discount from amounts generally billed and (b) a Patient in a family of two with insurance that is not sufficient to pay for the services and an annual family income of $55,000 could be eligible for a 70 percent discount from amounts generally billed. Patients who are not able to verify their income status may also be eligible for assistance under the Policy. As the Federal Poverty Level is updated on an annual basis, these examples are subject to change each year.

Patients seeking elective services to be covered by the Policy arrangements will require prior approval for Financial Assistance by the Vice President of Patient Financial Services or his or her designee. Only medically necessary procedures are eligible for approval. Financial assistance for elective procedures and for follow-up care following discharge is limited to Patients who live in the Cedars-Sinai service area or as otherwise approved by an officer of Cedars-Sinai.

If a Patient does not qualify for free services but is eligible for a discount under the Policy, the Patient will not be charged more than "amounts generally billed" by Cedars-Sinai for emergency or other medically necessary care. How we calculate "amounts generally billed" is set out in the Policy, but is an approximate of our Medicare reimbursement.

2. Physicians covered by the Policy.

The Policy only applies to services provided by Cedars-Sinai. These services will include physician services if provided at Cedars-Sinai by Cedars-Sinai's emergency department physicians of Community Urgent Care Medical Group, Inc., Cedars-Sinai faculty physicians in their capacity as faculty or physicians employed by Cedars-Sinai Medical Care Foundation or by medical groups which have an exclusive Professional Services Agreement with Cedars-Sinai Medical Care Foundation.

3. How to apply for assistance under the Policy.

Patients seeking free or discounted care under the Policy will need to complete an Application that will be reviewed by Cedars-Sinai. In addition to asking representatives at Cedars-Sinai registration and admission desks, Patients can obtain the Application form and assistance with the Application process by contacting us as provided below.

4. How to obtain copies of the Policy and the Application form including translations.

You may obtain free copies of the Policy and Application in various ways:

- On our website: cedars-sinai.edu type "Financial Assistance Policy" in the search box and follow the instructions. You may also go to the State website oshpd.ca.gov and type "Hospital Fair Pricing Policies" in the search bar and follow the instructions.
- For patients who are currently admitted to the hospital, contact Patient Financial Advocates at 310-423-5071. Their office is in the hospital building on the street level of the South Tower, Room 1740.
- If you are not an inpatient, you may contact Patient Financial Services Customer Service at 323-866-8600. The physical address is 6500 Wilshire Blvd, Suite 800, Los Angeles, CA, 90048.
- By telephone: 323-866-8600.
- By Mail: 6500 Wilshire Blvd, Suite 800, Los Angeles, CA, 90048.

Translations of the Policy, the Application form and this Plain Language Summary are also available by reaching out to us by any of the means listed above. The available Translations are in Farsi, Russian and Spanish.

B. How to contact us with questions, for additional information about the Policy or for assistance with the Application and Application process as well as other assistance programs.

For additional information including questions on how to apply for Financial Assistance or to request copies of the Financial Assistance Policy, you may contact our Patient Financial Services Customer Service office at 323-866-8600. They are located at 6500 Wilshire Boulevard,

Suite 800, Los Angeles, CA 90048.

For patients with questions regarding government insurance (Medi-Cal, Victims of Crime, etc.) you may contact the Patient Financial Advocates office at 310-423-5071. They are located in the hospital building South Tower, Room 1740.

For patients with questions regarding other insurance, please call 800-233-2771 or e-mail insurance@cshs.org.

C. Governmental programs for low income and certain other patients.

Cedars-Sinai participates in several government assistance programs that are not part of the arrangements under the Policy. These include Medi-Cal, the California Healthy Families Program and the California Victims of Crime Compensation Program. Patients may be eligible for subsidized coverage through the California Health Benefit Exchange (Covered California). See above for our contact information.

D. Arrangements with Patients who pay directly (self-pay).

Patients who do not qualify for free or discounted care under the Policy may find other Cedars-Sinai programs helpful. Patients who lack insurance may receive substantial discounts, similar to the discounts we provide to managed-care insurance plans. Eligible services include outpatient, emergency, and inpatient services. Additionally, Patients who lack insurance or who do not wish to use their commercial insurance are eligible at their request for cash package pricing for selected services. Cash packages generally cover the hospital and anesthesiologist fees for outpatient procedures.

E. Regulatory notice regarding collection activities.

We do refer some delinquent accounts to third-party debt collection agencies. State and federal law require debt collectors to treat you fairly and prohibit debt collectors from making false statements or threats of violence, using obscene or profane language and making improper communications with third parties, including your employer. Except under unusual circumstances, debt collectors may not contact you before 8 a.m. or after 9 p.m. In general, a debt collector may not give information about your debt to another person, other than your attorney or spouse. A debt collector may contact another person to confirm your location or to enforce a judgment. For more information about debt collection activities, you may contact the Federal Trade Commission by telephone at 877-FTC-HELP (877-382-4357) or online at ftc.gov/os/statutes/fdcpajump.shtm. Additionally, in the event your account is referred to a collection agency and you have problems with that agency, please contact us immediately at 323-866-8600.

Cedars-Sinai

Please acknowledge receipt of the SUMMARY OF FINANCIAL ASSISTANCE POLICY AND OTHER PROGRAMS by signing below.

I acknowledge I have read the Summary of Financial Assistance Policy and Other Programs of Cedars-Sinai.

Patient/Patient Representative:

_____

(Please print)

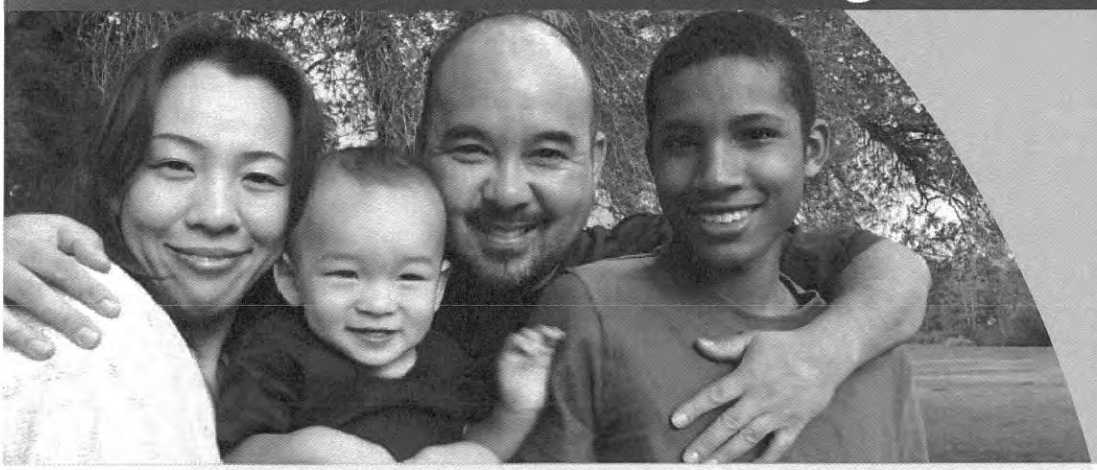
Signature/Initials: Date:

Attachment B

Application for Health Insurance

COVERED CALIFORNIA

Your destination for affordable health insurance, including Medi-Cal



See Inside

Covered California is the place where individuals and families can get affordable health insurance. With just one application, you'll find out if you qualify for free or low-cost health insurance, including Medi-Cal.

The state of California created Covered California™ to help you and your family get health insurance.

Having health insurance can give you peace of mind and help make it possible for you to stay healthy. With insurance, you'll know you and your family can get health care when you need it.

Use this application to see what insurance choices you qualify for:

- Free or low-cost insurance from Medi-Cal
- Low-cost insurance for pregnant women through Access for Infants and Mothers (AIM)
- Affordable private health insurance plans
- Help paying for your health insurance

➡ You may qualify for a free or low-cost program even if you earn as much as $94,000 a year for a family of 4.

➡ You can use this application to apply for anyone in your family, even if they already have insurance now.

Apply faster through Covered California at CoveredCA.com

Or call: 1-800-300-1506 (TTY: 1-888-889-4500)
You can call Monday to Friday, 8 a.m. to 8 p.m., and Saturday, 8 a.m. to 6 p.m.

You can get this application in other languages

Español	1-800-300-0213
繁體字	1-800-300-1533
Tiếng Việt	1-800-652-9528
한국어	1-800-738-9116
Tagalog	1-800-983-8816
Русский	1-800-778-7695
Հայերեն	1-800-996-1009
فارسی	1-800-921-8879
ភាសាខ្មែរ	1-800-906-8528
Hmoob	1-800-771-2156
العربية	1-800-826-6317

Call 1-800-300-1506 to get this application in other formats, such as large print.

Things to know

What you need to know when you apply

- Social Security numbers for applicants who are U.S. citizens, or document information for immigrants with satisfactory status who need insurance. Proof of citizenship or immigration status is required only for applicants.
- Employer and income information for everyone in your family.
- Your federal tax information. For example, the person who files taxes as head of household and the dependents claimed on your taxes.
- Information about health insurance that you or any family member gets through a job.

➡ We ask about income and other information to make sure you and your family get the most benefits possible.

➡ **We keep your information private and secure, as required by law.** We'll use your information only to see if you qualify for health insurance.

➡ Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying for your eligible child won't affect your immigration status or chances of becoming a permanent resident or citizen.

➡ If you don't file taxes, you can still qualify for free or low-cost insurance through Medi-Cal.

➡ If you are a federally recognized American Indian or Alaska Native who is getting services from the Indian Health Services, tribal health programs, or urban Indian health programs, you may still qualify for health insurance through Covered California.

Apply faster online

Apply online at **CoveredCA.com**. It's safe, secure, and fast – and you will get results sooner!

When you're done

Send your completed and signed application to:

Covered California
P.O. Box 989725
West Sacramento, CA 95798-9725

➡ **If you don't have all the information we ask for, sign and send in your application anyway.** We can call you to help you finish your application.

➡ **Do not send your health insurance plan enrollment payment with this application.** Your plan will send you an invoice for the amount you owe.

Get help with this application

We're here to help you! You can get help at no cost.

- **Online: CoveredCA.com**
- **Phone:** Call our Customer Service Center at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 8 p.m., and Saturday, 8 a.m. to 6 p.m.
- **In person:** We have trained Certified Enrollment Counselors and Certified Insurance Agents who can help you. For a list of Certified Enrollment Counselors and Certified Insurance Agents near where you live or work, or a list of county social services offices near you, visit **CoveredCA.com** or call **1-800-300-1506** (TTY: 1-888-889-4500). This help is free!
- If you have a disability or other need, we can provide assistance with completing this application at no cost to you. You can go to your local county social services office in person or call our Customer Service Center at **1-800-300-1506** (TTY: 1-888-889-4500).

Need help? Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 8 p.m., and Saturday, 8 a.m. to 6 p.m. Or visit **CoveredCA.com**.

CCFRM604 (11/13) EN

Start application here *(use blue or black ink only)*

Step 1: Tell us about the adult who will be our main contact for this application

First name | Middle name | Last name | Suffix *(examples: Sr., Jr., III, IV)*

Home address | Apartment #

City *(home address)* | State | ZIP code | County

☐ Check here if you do not have a home address. You must give us a mailing address below.

☐ Check here if your mailing address is the same as your home address.
If it is not the same, you must give us your mailing address below:

Mailing address or P.O. box *(if different from home address)* | Apartment #

City *(mailing address)* | State | ZIP code | County

Best phone number to reach you ☐ Home ☐ Cell ☐ Work
Number: ( ) –

Other phone number ☐ Home ☐ Cell ☐ Work
Number: ( ) –

What language should we write to you in?

What language do you want us to speak to you in?

How would you like to get information about this application?

☐ Phone ☐ Mail ☐ Email Email address: _____

Are you applying for a child less than 1 year old?

Infants less than one year old are eligible for Medi-Cal if their mother was on Medi-Cal or AIM at the time of delivery. You do not need to fill out an application to get Medi-Cal for an infant born to a mother with Medi-Cal or AIM at the time of delivery. Call your county social services office when your baby is born to make sure your baby is covered. Or fill out the information below.

Optional: If the following information is provided, the infant may be automatically eligible for Medi-Cal. You do not have to fill out Step 2 of this application for the infant.

Are you applying for a child less than 1 year old? ☐ Yes ☐ No

If yes, did the child's mother have Medi-Cal or AIM when the child was born? ☐ Yes ☐ No

If yes, will the child's mother be listed on this application? ☐ Yes ☐ No

If yes, the mother is Person #_____ on this application

If no, what is the mother's first and last name? _____

Please provide the mother's Medi-Cal number, AIM number, or SSN_____

Step 2: Tell us about yourself and your family

Your income and family size help us decide what programs you qualify for. With this information, we can make sure everyone gets the best coverage possible.

You must include these people on this application:

- Your spouse
- Your children who live with you
- All parents living in the home with their child
- 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 – for example, a boyfriend, girlfriend, or roommate – will need to file his or her **own** application if they want health insurance.

Complete Step 2 for each person in your family. Start with yourself!

- To apply for more than four people on this application, **make a copy of pages 6–8** for each additional person.
- We'll keep all your information private, as required by law. We'll use personal information only to see if you qualify for health insurance. You do not need to provide the immigration status or Social Security number (SSN) for those in your family who are not applying for health insurance.

Person 1 *Tell us about yourself.*

First name	Middle name	Last name	Suffix *(examples: Sr., Jr., III, IV)*	Relationship to you **Self**

Are you: ☐ Male ☐ Female

Are you: ☐ Single ☐ Never married ☐ Married ☐ Divorced ☐ Registered domestic partner ☐ Widowed

Date of birth *(month / day / year)*

Are you pregnant? ☐ Yes ☐ No ***If yes,*** how many babies are expected? _____

What is the expected delivery date? _____

Applying for health insurance *Even if you have insurance now, you might find better coverage or lower costs.*

▶ Are you applying for health insurance for yourself?

☐ Yes ***If yes,*** answer the questions below and complete pages 4 and 5.

☐ No If you are **not** applying for yourself but you are applying for a dependent, be sure to fill in page 5.

☐ No If you are **not** applying for yourself or for a dependent, go to page 6.

★ Social Security number (SSN)

_ _ _ – _ _ – _ _ _ _

If you do not have an SSN, what is the reason?

☐ Adoption Taxpayer Identification Number (ATIN) _____

☐ Individual Taxpayer Identification Number (ITIN) _____

☐ Religious exemption ☐ I do not qualify for an SSN

★ You must provide a Social Security number (SSN) if you wish to apply for health insurance. We use Social Security numbers (SSNs) to check income and other information. Even if you are not applying, giving your SSN will help us review your application faster. Be sure to provide your SSN if you are not applying for yourself but you file taxes and are applying for someone in your tax household.

If someone who is applying does not have an SSN and would like help getting one, call **1-800-300-1506** (TTY: 1-888-889-4500) or visit **CoveredCA.com**.

***Person 1** continued on next page*

Need help? Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 8 p.m., and Saturday, 8 a.m. to 6 p.m. Or visit **CoveredCA.com**.

Step 2: Person 1 *(continued)*

Federal income tax information *If you don't file taxes, you can still qualify for free or low-cost insurance through Medi-Cal. We will keep your information private. We will use your information only to decide if you qualify for health insurance.*

Are you the primary tax filer (your name was first on the tax return)? ☐ Yes ☐ No
Only one person on this application can be the primary tax filer.

Are you going to file taxes for the **benefit** year?
☐ Yes ☐ No
If yes, how will you file?
☐ Head of household ☐ Single
☐ Married filing jointly ☐ Married filing separately

Does anyone claim you as a dependent on their taxes? ☐ Yes ☐ No
If yes, who?
☐ Person #_____ on this application
☐ This person is a parent without custody
☐ This person is a parent without custody who is not listed on this application

Do you have other health insurance or are you offered insurance through a job? ☐ Yes ☐ No
If yes, fill out Attachment B on pages 22 and 23.

Do you have a physical, mental, emotional, or developmental disability?
☐ Yes ☐ No *See FAQ #27 for more information on what it means to have a disability.*

Do you need help with long-term care or home and community-based services? ☐ Yes ☐ No

Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No
If you are **not** a U.S. citizen or U.S. national, answer these questions:
Do you have satisfactory immigration status? ☐ Yes ***To see if you have satisfactory status,*** *go to Attachment E on page 27 for a list.*
Then write the document information here. In most cases your document ID number will be your Alien Registration Number.

Document type: _____ ID number: _____
Country of issuance: _____ Expiration date: _____
Name as it appears on the document: _____

Have you lived in the U.S. since 1996?
☐ Yes ☐ No

Are you, your spouse, or an unmarried dependent child an honorably discharged veteran or active-duty member of the U.S. armed forces? ☐ Yes ☐ No

Do you receive Medicare benefits?
☐ Yes ☐ No

Did you have a medical expense in the last 3 months that you need help paying for?
☐ Yes ☐ No

Do you live with any children under the age of 19? ☐ Yes ☐ No
If yes, do you take care of the child or children? ☐ Yes ☐ No

Are you 18 to 20 years old and a full-time student? ☐ Yes ☐ No
Are you 18 to 26 years old? ☐ Yes ☐ No ***If yes,*** were you in foster care in any state on your 18th birthday? ☐ Yes ☐ No
Are you 18 years old or younger? ☐ Yes ☐ No How many parents live with you? _____

Are you temporarily living out of state? ☐ Yes ☐ No

If you would like to choose a health insurance plan now, check here ☐ and fill out Attachment D on page 25.

Tell us about your race *This information is confidential and will only be used to make sure that everyone has the same access to health care. It will not be used to decide what health insurance you qualify for.*

What is your race? *(optional; check all that apply)*

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Cambodian
☐ Chinese
☐ Filipino
☐ Hmong
☐ Japanese
☐ Korean
☐ Laotian
☐ Vietnamese
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other _____

Are you of Hispanic, Latino, or Spanish origin? *(optional)* ☐ Yes ☐ No
If yes, check which ones:
☐ Mexican, Mexican American, Chicano
☐ Salvadoran ☐ Guatemalan
☐ Cuban ☐ Puerto Rican
☐ Other Hispanic, Latino, or Spanish origin: _____

★ ☐ Check here if you are an American Indian or Alaska Native, and fill out Attachment A on pages 20 and 21.

Person 1 *continued on next page*

Step 2: Person 1 *(continued)*

Tell us about your current job and how you get money *Attach an extra page if you need more space.*

Do you work now? ☐ **Yes** *If yes,* answer the questions below. ☐ **No** *If no,* go to other income on this page.

▶ **Where do you work now?** *If you have more jobs, attach another sheet of paper.*

JOB 1:
How do you get paid?

☐ Hourly: How many hours per week?_____ ☐ Daily: How many days per week?_____
☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly
☐ Every six months ☐ Yearly ☐ One-time payment *(See FAQ #33 on page 33.)*

Employer name *(optional)*

How much do you get paid (before taxes)? $_____

JOB 2:
How do you get paid?

☐ Hourly: How many hours per week?_____ ☐ Daily: How many days per week?_____
☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly
☐ Every six months ☐ Yearly ☐ One-time payment *(See FAQ #33 on page 33.)*

Employer name *(optional)*

How much do you get paid (before taxes)? $_____

▶ **Are you self-employed?**

JOB 1: Are you self-employed? ☐ **Yes** *If yes,* answer the questions below. ☐ **No** *If no,* go to other income on this page.

Type of work

How much *net income* will you get from self-employment this month? $_____
Net income means the profits left over after expenses are paid. *Attachment E on page 27 lists what could be counted.*

JOB 2: Are you self-employed? ☐ **Yes** *If yes,* answer the questions below. ☐ **No** *If no,* go to other income on this page.

Type of work

How much *net income* will you get from self-employment this month? $_____
Net income means the profits left over after expenses are paid. *Attachment E on page 27 lists what could be counted.*

▶ **Do you have other income?** *Other income is money you get from something other than your job. Do not include child support payments, veteran's payments, or Supplemental Security Income (SSI). Go to Attachment E on page 27 to see examples of other income.*

Do you have other income? ☐ **Yes** *If yes,* answer the questions below. ☐ **No** *If no,* go to income change on this page.

Where does this income come from?	**How often do you get paid?** *(check one)*	**How much?**
	☐ Hourly: How many hours per week?_____ ☐ Daily: How many days per week?_____ ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Every six months ☐ Yearly ☐ One-time payment *(See FAQ #33 on page 33.)*	$
	☐ Hourly: How many hours per week?_____ ☐ Daily: How many days per week?_____ ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Every six months ☐ Yearly ☐ One-time payment *(See FAQ #33 on page 33.)*	$

▶ **Does your income change from month to month?** *If it does, answer the two questions below.*

What do you expect your total income to be **this** year? *(optional)* $_____

If you expect your income to change **next** year, what will the new total income be? *(optional)* $_____

▶ **Do you have deductions?** *If you pay for certain things that can be deducted on a federal income tax return, telling us about them may lower the cost of health insurance. Do not include self-employment expenses. Attachment E on page 27 lists other types of deductions.*

Do you have deductions? ☐ **Yes** *If yes,* answer the questions below. ☐ **No** *If no,* go to the next page.

Type of deduction	**How often do you get or pay for this deduction?** *(check one)*	**How much?**
☐ Alimony paid ☐ Student loan interest ☐ Other	☐ Hourly: How many hours per week?_____ ☐ Daily: How many days per week?_____ ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Every six months ☐ Yearly ☐ One-time payment *(See FAQ #33 on page 33.)*	$
☐ Alimony paid ☐ Student loan interest ☐ Other	☐ Hourly: How many hours per week?_____ ☐ Daily: How many days per week?_____ ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Every six months ☐ Yearly ☐ One-time payment *(See FAQ #33 on page 33.)*	$

Need help? Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 8 p.m., and Saturday, 8 a.m. to 6 p.m. Or visit **CoveredCA.com**.

Step 2:

Person 2 *Tell us about **the next person** living in your home.*

***If you have more than four people** on this application, make a copy of pages 6–8 for each additional person.*

First name	Middle name	Last name	Suffix *(examples: Sr., Jr., III, IV)*	Relationship to you

☐ Check here if this person's home address is the same as the main contact's home address.
If it is not the same, you must give us this person's home address below:

Home address | Apartment #

City *(home address)*	State	ZIP code	County

☐ Check here if this person does not have a home address. You must give us a mailing address below.

☐ Check here if this person's mailing address is the same as the main contact's mailing address.
If it is not the same, you must give us this person's mailing address below:

Mailing address or P.O. box *(if different from home address)* | Apartment #

City *(mailing address)*	State	ZIP code	County

Best phone number to reach this person ☐ Home ☐ Cell ☐ Work
Number: ( ) –

Other phone number ☐ Home ☐ Cell ☐ Work
Number: ( ) –

Email address:

What language should we write to this person in?	What language does this person want us to speak to him or her in?

Is this person: ☐ Male ☐ Female

Is this person: ☐ Single ☐ Never married ☐ Married ☐ Divorced ☐ Registered domestic partner ☐ Widowed

Date of birth *(month / day / year)*

Is this person pregnant? ☐ Yes ☐ No ***If yes,*** how many babies are expected? _____
What is the expected delivery date? _____

Applying for health insurance *Even if this person has insurance now, you might find better coverage or lower costs.*

▶ Is this person applying for health insurance? ☐ **Yes** ***If yes,*** answer the questions below. ☐ **No** ***If no,*** SSN information is optional.

★ Social Security number (SSN)
— — — – — — – — — — —

If this person does not have an SSN, what is the reason?
☐ Adoption Taxpayer Identification Number (ATIN) _____
☐ Individual Taxpayer Identification Number (ITIN) _____
☐ Religious exemption ☐ Does not qualify for an SSN

Federal income tax information *If this person didn't file taxes, he or she can still qualify for free or low-cost insurance through Medi-Cal. We will keep the information private and use it only to decide if the person qualifies for health insurance.*

Is this person the primary tax filer (his or her name was first on the tax return)? ☐ Yes ☐ No
Only one person on this application can be the primary tax filer.

Is this person going to file taxes for the **benefit** year?
☐ Yes ☐ No ***If yes,*** how will he or she file?
☐ Head of household ☐ Single ☐ Dependent
☐ Married filing jointly ☐ Married filing separately

Does anyone claim this person as a dependent on their taxes? ☐ Yes ☐ No
If yes, who?
☐ Person # _____ on this application
☐ This person is a parent without custody
☐ This person is a parent without custody who is not listed on this application

***Person 2** continued on next page*

Step 2: Person 2 *(continued)*

Does this person have other health insurance or is this person offered insurance through a job? ☐ Yes ☐ No
If yes, fill out Attachment B on pages 22 and 23.

Does this person have a physical, mental, emotional, or developmental disability? ☐ Yes ☐ No
See FAQ #27 for more information on what it means to have a disability.

Does this person need help with long-term care or home and community-based services? ☐ Yes ☐ No

Is this person a U.S. citizen or U.S. national? ☐ Yes ☐ No

If this person is **not** a U.S. citizen or U.S. national, answer these questions:

Does this person have satisfactory immigration status? ☐ Yes ***To see if this person has satisfactory status,*** *go to Attachment E on page 27. for a list. Then write the document information here. In most cases the document ID number will be the Alien Registration Number.*

Document type: _____ ID number: _____

Country of issuance: _____ Expiration date: _____

Name as it appears on the document: _____

Has this person lived in the U.S. since 1996? ☐ Yes ☐ No

Is this person, this person's spouse, or an unmarried dependent child an honorably discharged veteran or active-duty member of the U.S. armed forces? ☐ Yes ☐ No

Does this person receive Medicare benefits? ☐ Yes ☐ No

Did this person have a medical expense in the last 3 months that he or she needs help paying for? ☐ Yes ☐ No

Does this person live with any children under the age of 19? ☐ Yes ☐ No
If yes, does this person take care of the child or children? ☐ Yes ☐ No

Is this person 18 to 20 years old and a full-time student? ☐ Yes ☐ No

Is this person 18 to 26 years old? ☐ Yes ☐ No

If yes, was this person in foster care in any state on his or her 18th birthday? ☐ Yes ☐ No

Is this person 18 years old or younger? ☐ Yes ☐ No How many parents live with this person? _____

Is this person temporarily living out of state? ☐ Yes ☐ No

Tell us about this person's race *This information is confidential and will only be used to make sure that everyone has the same access to health care. It will not be used to decide what health insurance program this person qualifies for.*

What is this person's race? *(optional; check all that apply)*

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Vietnamese
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other _____

Is this person of Hispanic, Latino, or Spanish origin? *(optional)* ☐ Yes ☐ No

If yes, check which ones:

- ☐ Mexican, Mexican American, Chicano
- ☐ Salvadoran ☐ Guatemalan
- ☐ Cuban ☐ Puerto Rican
- ☐ Other Hispanic, Latino, or Spanish origin: _____

★ ☐ Check here if this person is an American Indian or Alaska Native, and fill out Attachment A on pages 20 and 21.

Person 2 *continued on next page*

Step 2: Person 2 *(continued)*

Tell us about this person's current job and how he or she gets money *Attach an extra page if you need more space.*

Does this person work now? ☐ **Yes** *If yes,* answer the questions below. ☐ **No** *If no,* go to other income on this page.

▶ Where does this person work now? *If he or she has more jobs, attach another sheet of paper.*

JOB 1: How does this person get paid?

☐ Hourly: How many hours per week?_____ ☐ Daily: How many days per week?_____
☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly
☐ Every six months ☐ Yearly ☐ One-time payment *(See FAQ #33 on page 33.)*

Employer name *(optional)*

How much does this person get paid (before taxes)? $_____

JOB 2: How does this person get paid?

☐ Hourly: How many hours per week?_____ ☐ Daily: How many days per week?_____
☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly
☐ Every six months ☐ Yearly ☐ One-time payment *(See FAQ #33 on page 33.)*

Employer name *(optional)*

How much does this person get paid (before taxes)? $_____

▶ Is this person self-employed?

JOB 1: Is this person self-employed? ☐ **Yes** *If yes,* answer the questions below. ☐ **No** *If no,* go to other income on this page.

Type of work

How much *net income* will this person get from self-employment this month? $_____
Net income means the profits left over after expenses are paid. *Attachment E on page 27 lists what could be counted.*

JOB 2: Is this person self-employed? ☐ **Yes** *If yes,* answer the questions below. ☐ **No** *If no,* go to other income on this page.

Type of work

How much *net income* will this person get from self-employment this month? $_____
Net income means the profits left over after expenses are paid. *Attachment E on page 27 lists what could be counted.*

▶ Does this person have other income? *Other income is money you get from something other than your job. Go to Attachment E on page 27 to see examples of other income. Do not include child support payments, veteran's payments, or Supplemental Security Income (SSI).*

Does this person have other income? ☐ **Yes** *If yes,* answer the questions below. ☐ **No** *If no,* go to income change on this page.

Where does this income come from?	**How often does this person get paid?** *(check one)*	**How much?**
	☐ Hourly: How many hours per week?_____ ☐ Daily: How many days per week?_____ ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Every six months ☐ Yearly ☐ One-time payment *(See FAQ #33 on page 33.)*	$
	☐ Hourly: How many hours per week?_____ ☐ Daily: How many days per week?_____ ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Every six months ☐ Yearly ☐ One-time payment *(See FAQ #33 on page 33.)*	$

▶ Does this person's income change from month to month? *If it does, answer the two questions below.*

What does this person expect this person's total income to be **this** year? *(optional)* $_____

If you expect this person's income to change **next** year, what will the new total income be? *(optional)* $_____

▶ Does this person have deductions? *If this person pays for certain things that can be deducted on a federal income tax return, telling us about them may lower the cost of health insurance. Do not include self-employment expenses. Attachment E on page 27 lists other types of deductions.*

Does this person have deductions? ☐ **Yes** *If yes,* answer the questions below. ☐ **No** *If no,* go to the next page.

Type of deduction	**How often does this person get or pay for this deduction?** *(check one)*	**How much?**
☐ Alimony paid ☐ Student loan interest ☐ Other	☐ Hourly: How many hours per week?_____ ☐ Daily: How many days per week?_____ ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Every six months ☐ Yearly ☐ One-time payment *(See FAQ #33 on page 33.)*	$
☐ Alimony paid ☐ Student loan interest ☐ Other	☐ Hourly: How many hours per week?_____ ☐ Daily: How many days per week?_____ ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Every six months ☐ Yearly ☐ One-time payment *(See FAQ #33 on page 33.)*	$

Step 2: Person 3 *Tell us about **the next person** living in your home.*

First name | Middle name | Last name | Suffix *(examples: Sr., Jr., III, IV)* | Relationship to you

☐ Check here if this person's home address is the same as the main contact's home address.
If it is not the same, you must give us this person's home address below:

Home address | Apartment #

City *(home address)* | State | ZIP code | County

☐ Check here if this person does not have a home address. You must give us a mailing address below.

☐ Check here if this person's mailing address is the same as the main contact's mailing address.
If it is not the same, you must give us this person's mailing address below:

Mailing address or P.O. box *(if different from home address)* | Apartment #

City *(mailing address)* | State | ZIP code | County

Best phone number to reach this person ☐ Home ☐ Cell ☐ Work
Number: ( ) –

Other phone number ☐ Home ☐ Cell ☐ Work
Number: ( ) –

Email address:

What language should we write to this person in?

What language does this person want us to speak to him or her in?

Is this person: ☐ Male ☐ Female

Is this person: ☐ Single ☐ Never married ☐ Married ☐ Divorced ☐ Registered domestic partner ☐ Widowed

Date of birth *(month / day / year)*

Is this person pregnant? ☐ Yes ☐ No ***If yes,*** how many babies are expected?_____
What is the expected delivery date? _____

Applying for health insurance *Even if this person has insurance now, you might find better coverage or lower costs.*

▶ Is this person applying for health insurance? ☐ **Yes** ***If yes,*** answer the questions below. ☐ **No** ***If no,*** SSN information is optional.

★ Social Security number (SSN)
— — — – — — – — — — —

If this person does not have an SSN, what is the reason?
☐ Adoption Taxpayer Identification Number (ATIN) _____
☐ Individual Taxpayer Identification Number (ITIN) _____
☐ Religious exemption ☐ Does not qualify for an SSN

Federal income tax information *If this person didn't file taxes, he or she can still qualify for free or low-cost insurance through Medi-Cal. We will keep the information private and use it only to decide if the person qualifies for health insurance.*

Is this person the primary tax filer (his or her name was first on the tax return)? ☐ Yes ☐ No
Only one person on this application can be the primary tax filer.

Is this person going to file taxes for the **benefit** year?
☐ Yes ☐ No ***If yes,*** how will he or she file?
☐ Head of household ☐ Single ☐ Dependent
☐ Married filing jointly ☐ Married filing separately

Does anyone claim this person as a dependent on their taxes? ☐ Yes ☐ No
If yes, who?
☐ Person #_____ on this application
☐ This person is a parent without custody
☐ This person is a parent without custody who is not listed on this application

***Person 3** continued on next page*

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Step 2: Person 3 *(continued)*

Does this person have other health insurance or is this person offered insurance through a job? ☐ Yes ☐ No
If yes, fill out Attachment B on pages 22 and 23.

Does this person have a physical, mental, emotional, or developmental disability? ☐ Yes ☐ No
See FAQ #27 for more information on what it means to have a disability.

Does this person need help with long-term care or home and community-based services? ☐ Yes ☐ No

Is this person a U.S. citizen or U.S. national? ☐ Yes ☐ No

If this person is **not** a U.S. citizen or U.S. national, answer these questions:

Does this person have satisfactory immigration status? ☐ Yes ***To see if this person has satisfactory status,*** *go to Attachment E on page 27. for a list. Then write the document information here. In most cases the document ID number will be the Alien Registration Number.*

Document type: _____ ID number: _____

Country of issuance: _____ Expiration date: _____

Name as it appears on the document: _____

Has this person lived in the U.S. since 1996? ☐ Yes ☐ No

Is this person, this person's spouse, or an unmarried dependent child an honorably discharged veteran or active-duty member of the U.S. armed forces? ☐ Yes ☐ No

Does this person receive Medicare benefits? ☐ Yes ☐ No

Did this person have a medical expense in the last 3 months that he or she needs help paying for? ☐ Yes ☐ No

Does this person live with any children under the age of 19? ☐ Yes ☐ No
If yes, does this person take care of the child or children? ☐ Yes ☐ No

Is this person 18 to 20 years old and a full-time student? ☐ Yes ☐ No

Is this person 18 to 26 years old? ☐ Yes ☐ No

If yes, was this person in foster care in any state on his or her 18th birthday? ☐ Yes ☐ No

Is this person 18 years old or younger? ☐ Yes ☐ No How many parents live with this person? _____

Is this person temporarily living out of state? ☐ Yes ☐ No

Tell us about this person's race *This information is confidential and will only be used to make sure that everyone has the same access to health care. It will not be used to decide what health insurance program this person qualifies for.*

What is this person's race? *(optional; check all that apply)*

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Vietnamese
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other _____

Is this person of Hispanic, Latino, or Spanish origin? *(optional)* ☐ Yes ☐ No

If yes, check which ones:

- ☐ Mexican, Mexican American, Chicano
- ☐ Salvadoran ☐ Guatemalan
- ☐ Cuban ☐ Puerto Rican
- ☐ Other Hispanic, Latino, or Spanish origin: _____

★ ☐ Check here if this person is an American Indian or Alaska Native, and fill out Attachment A on pages 20 and 21.

Person 3 *continued on next page*

Step 2: Person 3 *(continued)*

Tell us about this person's current job and how he or she gets money *Attach an extra page if you need more space.*

Does this person work now? ☐ **Yes** *If yes,* answer the questions below. ☐ **No** *If no,* go to other income on this page.

▶ Where does this person work now? *If he or she has more jobs, attach another sheet of paper.*

JOB 1: How does this person get paid?

☐ Hourly: How many hours per week?_____ ☐ Daily: How many days per week?_____
☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly
☐ Every six months ☐ Yearly ☐ One-time payment *(See FAQ #33 on page 33.)*

Employer name *(optional)*

How much does this person get paid (before taxes)? $_____

JOB 2: How does this person get paid?

☐ Hourly: How many hours per week?_____ ☐ Daily: How many days per week?_____
☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly
☐ Every six months ☐ Yearly ☐ One-time payment *(See FAQ #33 on page 33.)*

Employer name *(optional)*

How much does this person get paid (before taxes)? $_____

▶ Is this person self-employed?

JOB 1: Is this person self-employed? ☐ **Yes** *If yes,* answer the questions below. ☐ **No** *If no,* go to other income on this page.

Type of work

How much *net income* will this person get from self-employment this month? $_____
Net income means the profits left over after expenses are paid. *Attachment E on page 27 lists what could be counted.*

JOB 2: Is this person self-employed? ☐ **Yes** *If yes,* answer the questions below. ☐ **No** *If no,* go to other income on this page.

Type of work

How much *net income* will this person get from self-employment this month? $_____
Net income means the profits left over after expenses are paid. *Attachment E on page 27 lists what could be counted.*

▶ Does this person have other income? *Other income is money you get from something other than your job. Go to Attachment E on page 27 to see examples of other income. Do not include child support payments, veteran's payments, or Supplemental Security Income (SSI).*

Does this person have other income? ☐ **Yes** *If yes,* answer the questions below. ☐ **No** *If no,* go to income change on this page.

Where does this income come from?	**How often does this person get paid?** *(check one)*	**How much?**
	☐ Hourly: How many hours per week?_____ ☐ Daily: How many days per week?_____ ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Every six months ☐ Yearly ☐ One-time payment *(See FAQ #33 on page 33.)*	$
	☐ Hourly: How many hours per week?_____ ☐ Daily: How many days per week?_____ ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Every six months ☐ Yearly ☐ One-time payment *(See FAQ #33 on page 33.)*	$

▶ Does this person's income change from month to month? *If it does, answer the two questions below.*

What does this person expect this person's total income to be **this** year? *(optional)* $_____

If you expect this person's income to change **next** year, what will the new total income be? *(optional)* $_____

▶ Does this person have deductions? *If this person pays for certain things that can be deducted on a federal income tax return, telling us about them may lower the cost of health insurance. Do not include self-employment expenses. Attachment E on page 27 lists other types of deductions.*

Does this person have deductions? ☐ **Yes** *If yes,* answer the questions below. ☐ **No** *If no,* go to the next page.

Type of deduction	**How often does this person get or pay for this deduction?** *(check one)*	**How much?**
☐ Alimony paid ☐ Student loan interest ☐ Other	☐ Hourly: How many hours per week?_____ ☐ Daily: How many days per week?_____ ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Every six months ☐ Yearly ☐ One-time payment *(See FAQ #33 on page 33.)*	$
☐ Alimony paid ☐ Student loan interest ☐ Other	☐ Hourly: How many hours per week?_____ ☐ Daily: How many days per week?_____ ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Every six months ☐ Yearly ☐ One-time payment *(See FAQ #33 on page 33.)*	$

Need help? Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 8 p.m., and Saturday, 8 a.m. to 6 p.m. Or visit **CoveredCA.com**.

Step 2: Person 4 *Tell us about **the next person** living in your home.*

First name	Middle name	Last name	Suffix *(examples: Sr., Jr., III, IV)*	Relationship to you

☐ Check here if this person's home address is the same as the main contact's home address.
If it is not the same, you must give us this person's home address below:

Home address | Apartment #

City *(home address)*	State	ZIP code	County

☐ Check here if this person does not have a home address. You must give us a mailing address below.

☐ Check here if this person's mailing address is the same as the main contact's mailing address.
If it is not the same, you must give us this person's mailing address below:

Mailing address or P.O. box *(if different from home address)* | Apartment #

City *(mailing address)*	State	ZIP code	County

Best phone number to reach this person ☐ Home ☐ Cell ☐ Work
Number: ( ) –

Other phone number ☐ Home ☐ Cell ☐ Work
Number: ( ) –

Email address:

What language should we write to this person in?

What language does this person want us to speak to him or her in?

Is this person: ☐ Male ☐ Female

Is this person: ☐ Single ☐ Never married ☐ Married ☐ Divorced ☐ Registered domestic partner ☐ Widowed

Date of birth *(month / day / year)*

Is this person pregnant? ☐ Yes ☐ No ***If yes,*** how many babies are expected?_____
What is the expected delivery date? _____

Applying for health insurance *Even if this person has insurance now, you might find better coverage or lower costs.*

▶ Is this person applying for health insurance? ☐ **Yes** ***If yes,*** answer the questions below. ☐ **No** ***If no,*** SSN information is optional.

★ Social Security number (SSN)
— — — – — — – — — — —

If this person does not have an SSN, what is the reason?
☐ Adoption Taxpayer Identification Number (ATIN) _____
☐ Individual Taxpayer Identification Number (ITIN) _____
☐ Religious exemption ☐ Does not qualify for an SSN

Federal income tax information *If this person didn't file taxes, he or she can still qualify for free or low-cost insurance through Medi-Cal. We will keep the information private and use it only to decide if the person qualifies for health insurance.*

Is this person the primary tax filer (his or her name was first on the tax return)? ☐ Yes ☐ No
Only one person on this application can be the primary tax filer.

Is this person going to file taxes for the **benefit** year?
☐ Yes ☐ No ***If yes,*** how will he or she file?
☐ Head of household ☐ Single ☐ Dependent
☐ Married filing jointly ☐ Married filing separately

Does anyone claim this person as a dependent on their taxes? ☐ Yes ☐ No
If yes, who?
☐ Person # _____ on this application
☐ This person is a parent without custody
☐ This person is a parent without custody who is not listed on this application

***Person 4** continued on next page*

Step 2: Person 4 *(continued)*

Does this person have other health insurance or is this person offered insurance through a job? ☐ Yes ☐ No
If yes, fill out Attachment B on pages 22 and 23.

Does this person have a physical, mental, emotional, or developmental disability? ☐ Yes ☐ No
See FAQ #27 for more information on what it means to have a disability.

Does this person need help with long-term care or home and community-based services? ☐ Yes ☐ No

Is this person a U.S. citizen or U.S. national? ☐ Yes ☐ No

If this person is **not** a U.S. citizen or U.S. national, answer these questions:

Does this person have satisfactory immigration status? ☐ Yes ***To see if this person has satisfactory status,*** *go to Attachment E on page 27. for a list. Then write the document information here. In most cases the document ID number will be the Alien Registration Number.*

Document type: _____ ID number: _____

Country of issuance: _____ Expiration date: _____

Name as it appears on the document: _____

Has this person lived in the U.S. since 1996? ☐ Yes ☐ No

Is this person, this person's spouse, or an unmarried dependent child an honorably discharged veteran or active-duty member of the U.S. armed forces? ☐ Yes ☐ No

Does this person receive Medicare benefits? ☐ Yes ☐ No

Did this person have a medical expense in the last 3 months that he or she needs help paying for? ☐ Yes ☐ No

Does this person live with any children under the age of 19? ☐ Yes ☐ No

If yes, does this person take care of the child or children? ☐ Yes ☐ No

Is this person 18 to 20 years old and a full-time student? ☐ Yes ☐ No

Is this person 18 to 26 years old? ☐ Yes ☐ No

If yes, was this person in foster care in any state on his or her 18th birthday? ☐ Yes ☐ No

Is this person 18 years old or younger? ☐ Yes ☐ No How many parents live with this person? _____

Is this person temporarily living out of state? ☐ Yes ☐ No

Tell us about this person's race *This information is confidential and will only be used to make sure that everyone has the same access to health care. It will not be used to decide what health insurance program this person qualifies for.*

What is this person's race? *(optional; check all that apply)*

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Vietnamese
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other _____

Is this person of Hispanic, Latino, or Spanish origin? *(optional)* ☐ Yes ☐ No

If yes, check which ones:

- ☐ Mexican, Mexican American, Chicano
- ☐ Salvadoran ☐ Guatemalan
- ☐ Cuban ☐ Puerto Rican
- ☐ Other Hispanic, Latino, or Spanish origin: _____

★ ☐ Check here if this person is an American Indian or Alaska Native, and fill out Attachment A on pages 20 and 21.

Person 4 *continued on next page*

Need help? Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 8 p.m., and Saturday, 8 a.m. to 6 p.m. Or visit **CoveredCA.com**.

Step 2: Person 4 *(continued)*

Tell us about this person's current job and how he or she gets money *Attach an extra page if you need more space.*

Does this person work now? ☐ **Yes** *If yes,* answer the questions below. ☐ **No** *If no,* go to other income on this page.

▶ Where does this person work now? *If he or she has more jobs, attach another sheet of paper.*

JOB 1: How does this person get paid?

☐ Hourly: How many hours per week?_____ ☐ Daily: How many days per week?_____
☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly
☐ Every six months ☐ Yearly ☐ One-time payment *(See FAQ #33 on page 33.)*

Employer name *(optional)*

How much does this person get paid (before taxes)? $_____

JOB 2: How does this person get paid?

☐ Hourly: How many hours per week?_____ ☐ Daily: How many days per week?_____
☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly
☐ Every six months ☐ Yearly ☐ One-time payment *(See FAQ #33 on page 33.)*

Employer name *(optional)*

How much does this person get paid (before taxes)? $_____

▶ Is this person self-employed?

JOB 1: Is this person self-employed? ☐ **Yes** *If yes,* answer the questions below. ☐ **No** *If no,* go to other income on this page.

Type of work

How much *net income* will this person get from self-employment this month? $_____
Net income means the profits left over after expenses are paid. *Attachment E on page 27 lists what could be counted.*

JOB 2: Is this person self-employed? ☐ **Yes** *If yes,* answer the questions below. ☐ **No** *If no,* go to other income on this page.

Type of work

How much *net income* will this person get from self-employment this month? $_____
Net income means the profits left over after expenses are paid. *Attachment E on page 27 lists what could be counted.*

▶ Does this person have other income? *Other income is money you get from something other than your job. Go to Attachment E on page 27 to see examples of other income. Do not include child support payments, veteran's payments, or Supplemental Security Income (SSI).*

Does this person have other income? ☐ **Yes** *If yes,* answer the questions below. ☐ **No** *If no,* go to income change on this page.

Where does this income come from?	**How often does this person get paid?** *(check one)*	**How much?**
	☐ Hourly: How many hours per week?_____ ☐ Daily: How many days per week?_____ ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Every six months ☐ Yearly ☐ One-time payment *(See FAQ #33 on page 33.)*	$
	☐ Hourly: How many hours per week?_____ ☐ Daily: How many days per week?_____ ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Every six months ☐ Yearly ☐ One-time payment *(See FAQ #33 on page 33.)*	$

▶ Does this person's income change from month to month? *If it does, answer the two questions below.*

What does this person expect this person's total income to be **this** year? *(optional)* $_____

If you expect this person's income to change **next** year, what will the new total income be? *(optional)* $_____

▶ Does this person have deductions? *If this person pays for certain things that can be deducted on a federal income tax return, telling us about them may lower the cost of health insurance. Do not include self-employment expenses. Attachment E on page 27 lists other types of deductions.*

Does this person have deductions? ☐ **Yes** *If yes,* answer the questions below. ☐ **No** *If no,* go to the next page.

Type of deduction	**How often does this person get or pay for this deduction?** *(check one)*	**How much?**
☐ Alimony paid ☐ Student loan interest ☐ Other	☐ Hourly: How many hours per week?_____ ☐ Daily: How many days per week?_____ ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Every six months ☐ Yearly ☐ One-time payment *(See FAQ #33 on page 33.)*	$
☐ Alimony paid ☐ Student loan interest ☐ Other	☐ Hourly: How many hours per week?_____ ☐ Daily: How many days per week?_____ ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Every six months ☐ Yearly ☐ One-time payment *(See FAQ #33 on page 33.)*	$

Step 3: Please read and sign this application

You can choose an authorized representative

★ You can choose someone to be your "authorized representative." An authorized representative is a person you allow to see your application and talk with us about it now and in the future.

Name of authorized representative

Address | Apartment #

City	State	ZIP code	County

By signing, you allow this person to sign your application, to get official information about this application, and to act for you on all future matters with this agency.

Your signature ▶	Date

Privacy statement

This application is for health insurance through Covered California or for benefits through the Department of Health Care Services (DHCS). The personal and medical information you provide on it is private and confidential. Covered California or the DHCS needs it to identify you and the other people on this application 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 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 you may not be able to get health insurance through Covered California, or your application for benefits 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:

Covered California
Attn: Privacy Officer
P.O. Box 989725
West Sacramento, CA 95798-9725

Phone: 1-800-300-1506
TTY: 1-888-889-4500

For the **Department of Health Care Services**, 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:

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

DHCS: CA Welfare and Institutions. Code § 14011 and Article 3, Chapters 5 and 7, Parts 2 and 3, Division 9

We must give you this Privacy Statement under CA Civil Code § 1798.17. You can see Covered California's Privacy Policy at CoveredCA.com. See DHCS's Notice of Privacy Practices at dhcs.ca.gov.

Step 3 *continued on next page*

Step 3: Please read and sign this application *(continued)*

Your rights and responsibilities

- The information I gave on this application 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 for health insurance will qualify.
- I understand that Covered California and the Medi-Cal program will keep my information private, as the law requires. For more information, or access to personal information in records maintained by Covered California and the Medi-Cal program, I can contact the 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 Covered California at **1-800-300-1506** (TTY: 1-888-889-4500) for help.
- I know that I must tell Covered California or my county social services office about changes to anything I wrote on this application. To report changes, I can call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500) or visit **CoveredCA.com**. Or I can call my county social services office.
- I know that Covered California must not discriminate against me or anyone on this application because of race, color, national origin, religion, age, sex, sexual orientation, marital status, veteran's status, or disability. If I think Covered California has discriminated against me, including the failure to provide reasonable accommodations as required under state and federal law, I can make a complaint by visiting **www.hhs.gov/ocr/office/file or http://oag.ca.gov/contact/general-comment-question-or-complaint-form**. If I believe that Covered California has discriminated against me or anyone else on this application in connection with a Medi-Cal eligibility determination, I can also file a complaint with the Department of Health Care Services, Office of Civil Rights by calling **1-916-440-7370** (TTY: 1-916-440-7399).
- I understand that any changes in my information or information of any member(s) in the applicant's household may affect the eligibility of other members of the household.
- Except for purposes of applying for Medi-Cal, I confirm that no one applying for health insurance on this application is confined, after the disposition of charges (judgment), in a jail, prison, or similar penal institution or correctional facility.
- I understand that I must report income changes to Covered California because it may affect the amount of premium assistance (or tax credits) that I may be eligible to receive. I also understand if I receive too much premium assistance (or tax credits) during the benefit year, I will have to repay the extra premium assistance back to the IRS when I file my federal income taxes for the benefit year.
- I give my permission to Covered California to check other agencies' computer records to verify citizenship, satisfactory immigration status, tax information, and other information related only to eligibility to see if I and other people on this application qualify for health insurance.

If someone on the application qualifies for Medi-Cal:

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

Your rights and responsibilities *continued on next page*

Step 3: Please read and sign this application *(continued)*

Your rights and responsibilities *(continued)*

Your right to appeal:

- If I think Covered California or the Medi-Cal program has made a mistake, I can appeal its decision. To appeal means to tell someone at Covered California or the Medi-Cal program that I think its decision is wrong and ask for a fair review of the action.
- I know that I can find out how to appeal by calling **1-800-300-1506** (TTY: 1-888-889-4500).
- 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 Covered California, the Medi-Cal program, or the county social services office can explain my case to me.

Renewal of insurance

To make it easier to continue to get health insurance in future years, I agree to allow Covered California to use computer sources, such as the IRS, to check my income. If the sources show I am still eligible, my insurance coverage can be renewed for another 12 months and I won't have to fill out a renewal form or send other paperwork.

I understand that if I choose not to allow Covered California to use computer sources, I must complete a renewal packet every 12 months in order to continue my health insurance.

I agree to allow Covered California or the Medi-Cal program to check my information for:

☐ 5 years ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year

OR

☐ I do not want Covered California to check my tax returns at renewal.

Declaration and signature *This is required.*

I declare under penalty of perjury that what I say below is true and correct.

- I understood all questions on this application 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 know that if I do not tell the truth on this application, 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 application will be used to decide if the people who are applying qualify for health insurance. Covered California will keep the information private, as required by federal and California law.
- I agree to notify Covered California by calling **1-800-300-1506** (TTY: 1-888-889-4500) or visiting **CoveredCA.com** if anything changes on this application for any person applying for health insurance.
- If I am selecting a health plan by filling out and submitting Attachment D, and if I am determined eligible by Covered California to enroll in the plan I selected in Attachment D:
  - I understand that by signing here I am entering into a contract with the issuer of that plan.
  - I am at least 18 years of age or I am an emancipated minor, and I am mentally competent to sign a contract.

Signature of applicant or authorized representative ▶	Date

***Step 3** continued on next page*

Need help? Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 8 p.m., and Saturday, 8 a.m. to 6 p.m. Or visit **CoveredCA.com**.

Step 3: Please read and sign this application *(continued)*

Complete this section if you are a Covered California certified individual helping someone fill out this application.

I certify that as a Certified Enrollment Counselor, Certified Insurance Agent, or Certified Plan-Based Enroller, I helped the applicant complete this application and that this service was free of charge. I also certify that I gave true and correct answers to all questions on this application as far as I know. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information, and the applicant understood the explanation.

☐ Certified Enrollment Counselor Name:	CEC number
Certified Enrollment Entity Name:	CEE number
☐ Certified Insurance Agent Name:	License number
☐ Certified Plan-Based Enroller Plan:_____ Name:	Certification number
Certified individual's signature ▶	Date

The state will not compensate the Covered California Certified Enrollment Entity unless the Certified Enrollment Counselor fills out this section completely and correctly when the application is submitted.

Step 4: Mailing information and checklist

Mail your signed application to:

Covered California
P.O. Box 989725
West Sacramento, CA 95798-9725

Did you remember to:

- Tell us about everyone in your family and household, even if they don't need insurance? See page 3 for the list of whom to include.
- Ask your employer about any job-related insurance you may qualify for?
- **Sign** this application on **page 17**? If you chose an authorized representative, also sign page 15.

A few more questions *(optional)*

1. **Would you like to be considered for all Medi-Cal programs?** ☐ Yes ☐ No
   There are other Medi-Cal programs for people 65 years old or older, people with a disability, or people with special health care needs.

   If you check yes, we will contact you to get information about your property and assets.

2. **Have you had any recent changes in your life that made you want to apply for health insurance?**
   If yes, check all that apply.

   ☐ Moved to California
   ☐ Gained citizenship or lawful presence
   ☐ Loss of health insurance
   ☐ Gained dependent (by birth, marriage, or adoption)
   ☐ Other
   ☐ No longer incarcerated
   ☐ Newly eligible for premium assistance
   ☐ Applying for Medi-Cal
   ☐ American Indian or Alaska Native

   When did this life event occur? *(month / day / year)* _____

***Step 4** continued on next page*

Step 4: Mailing information and checklist *(continued)*

How did you hear about Covered California?

Check all that apply.

☐ Outreach and education program ☐ TV ad ☐ Radio ad ☐ Online ad ☐ Email
☐ Magazine or newspaper ad ☐ Mailer ☐ Internet search ☐ News program or story
☐ Social media (e.g., Facebook, Twitter, etc.) ☐ Mobile app ☐ Community organization or event
☐ Billboard ☐ Sign in retail store ☐ Friend or family ☐ Brochure
☐ Certified Insurance Agent ☐ Certified Enrollment Counselor ☐ Employer ☐ Church
☐ **CoveredCA.com** website ☐ Pharmacy ☐ Provider or hospital ☐ Government office
☐ Word of mouth ☐ Other _____

Need more information about other programs?

Beginning January 1, 2014, would you and your household like to share the information you just provided in a referral to your local Health and Human Services Agency for other programs? Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying for your eligible child won't affect your immigration status or chances of becoming a permanent resident or citizen.

To apply for nutrition or cash assistance before January 1, 2014, visit **benefitscal.org.** Or to apply in person, call **1-877-847-3663** for a list of places near where you live or work.

For benefits after January 1, 2014, check which programs you want a referral for:

☐ **CalFresh** *A program that helps people pay for food. Benefits are renewed monthly on a debit card that can be used to buy most foods at many markets and stores. It is also known as the Supplemental Nutrition Assistance Program (SNAP). Visit* ***www.calfresh.ca.gov*** *for more information.*

☐ **CalWORKs** *A program that gives cash assistance and support services to low-income families with children to help pay for housing, food, and other necessary expenses.*

You may also find more information about these programs online:

Access for Infants and Mothers (AIM)
A program that helps pregnant women get health care
aim.ca.gov

Child Health and Disability Prevention (CHDP)
A preventive program that delivers periodic health assessments and services to low-income children
www.dhcs.ca.gov/services/chdp

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
A Medi-Cal program for children and young adults under the age of 21 – it allows for regular checkups to identify health care needs, followed by diagnosis and treatment when necessary
www.dhcs.ca.gov/services/Pages/EPSDT.aspx

Family Planning, Access, Care, Treatment (Family PACT)
A program that provides no-cost family planning services to low-income men and women, including teens
familypact.org

In-Home Supportive Services Program (IHSS)
A program that will help pay for services provided to you so that you can remain safely in your own home
www.cdss.ca.gov/agedblinddisabled/pg1296.htm

Women, Infants, and Children (WIC)
A nutrition program for pregnant women, new mothers, and children under the age of 5
www.wicworks.ca.gov

Need help? Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 8 p.m., and Saturday, 8 a.m. to 6 p.m. Or visit **CoveredCA.com**.

Attachment A: For American Indians or Alaska Natives

★ **Complete this if you or a family member is American Indian or Alaska Native.**

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. Federally recognized American Indians and Alaska Natives also may not have to pay out-of-pocket costs (such as copayments) and may get special enrollment periods. Be sure to complete this form and send it in with your application and your proof of American Indian or Alaska Native heritage. You may send a document from a federally recognized Indian tribe that shows you are a member of the tribe or affiliated with the tribe. Documents may include a tribal enrollment card or certificate of degree of Indian blood (CDIB) from the Bureau of Indian Affairs. If you think you qualify for Medi-Cal, you do not have to send proof. See Attachment F to see if you can qualify for Medi-Cal.

If you need to tell us about more than four people who are American Indians or Alaska Natives, **make a copy of this page**, and be sure to send it with your application.

Person 1: First name | Middle name | Last name | Suffix *(examples: Sr., Jr., III, IV)*

Is this person a member of a federally recognized American Indian or Alaska Native tribe? ☐ Yes ☐ No

If yes, write the name of the tribe: _____ *and the state of the tribe:* _____

Has this person ever gotten a service from the Indian Health Service, a tribal health program, or an urban Indian health program or through a referral from one of these programs? ☐ Yes ☐ No

If no, is this person eligible to get services from the Indian Health Service, a tribal health program, or an urban Indian health program or through a referral from one of these programs? ☐ Yes ☐ No

Does this person get income from any of the sources below? ☐ Yes ***If yes,*** fill in the amount and frequency below.
☐ No ***If no,*** continue the application.

▶ Payments to the tribe that come from natural resources, usage rights, leases, or royalties
Amount **$** _____ ☐ Weekly ☐ Every two weeks ☐ Monthly ☐ Other _____

▶ Payments from leases or royalties for the use of Indian trust land for natural resources, farming, ranching, or fishing
Amount **$** _____ ☐ Weekly ☐ Every two weeks ☐ Monthly ☐ Other _____

▶ Money from selling things that have cultural value
Amount **$** _____ ☐ Weekly ☐ Every two weeks ☐ Monthly ☐ Other _____

Person 2: First name | Middle name | Last name | Suffix *(examples: Sr., Jr., III, IV)*

Is this person a member of a federally recognized American Indian or Alaska Native tribe? ☐ Yes ☐ No

If yes, write the name of the tribe: _____ *and the state of the tribe:* _____

Has this person ever gotten a service from the Indian Health Service, a tribal health program, or an urban Indian health program or through a referral from one of these programs? ☐ Yes ☐ No

If no, is this person eligible to get services from the Indian Health Service, a tribal health program, or an urban Indian health program or through a referral from one of these programs? ☐ Yes ☐ No

Does this person get income from any of the sources below? ☐ Yes ***If yes,*** fill in the amount and frequency below.
☐ No ***If no,*** continue the application.

▶ Payments to the tribe that come from natural resources, usage rights, leases, or royalties
Amount **$** _____ ☐ Weekly ☐ Every two weeks ☐ Monthly ☐ Other _____

▶ Payments from leases or royalties for the use of Indian trust land for natural resources, farming, ranching, or fishing
Amount **$** _____ ☐ Weekly ☐ Every two weeks ☐ Monthly ☐ Other _____

▶ Money from selling things that have cultural value
Amount **$** _____ ☐ Weekly ☐ Every two weeks ☐ Monthly ☐ Other _____

Attachment A: For American Indians or Alaska Natives *(continued)*

Person 3: First name | Middle name | Last name | Suffix *(examples: Sr., Jr., III, IV)*

Is this person a member of a federally recognized American Indian or Alaska Native tribe? ☐ Yes ☐ No

If yes, write the name of the tribe: _____ *and the state of the tribe:* _____

Has this person ever gotten a service from the Indian Health Service, a tribal health program, or an urban Indian health program or through a referral from one of these programs? ☐ Yes ☐ No

If no, is this person eligible to get services from the Indian Health Service, a tribal health program, or an urban Indian health program or through a referral from one of these programs? ☐ Yes ☐ No

Does this person get income from any of the sources below? ☐ Yes ***If yes,*** fill in the amount and frequency below.
☐ No ***If no,*** continue the application.

▶ Payments to the tribe that come from natural resources, usage rights, leases, or royalties
Amount **$** _____ ☐ Weekly ☐ Every two weeks ☐ Monthly ☐ Other _____

▶ Payments from leases or royalties for the use of Indian trust land for natural resources, farming, ranching, or fishing
Amount **$** _____ ☐ Weekly ☐ Every two weeks ☐ Monthly ☐ Other _____

▶ Money from selling things that have cultural value
Amount **$** _____ ☐ Weekly ☐ Every two weeks ☐ Monthly ☐ Other _____

Person 4: First name | Middle name | Last name | Suffix *(examples: Sr., Jr., III, IV)*

Is this person a member of a federally recognized American Indian or Alaska Native tribe? ☐ Yes ☐ No

If yes, write the name of the tribe: _____ *and the state of the tribe:* _____

Has this person ever gotten a service from the Indian Health Service, a tribal health program, or an urban Indian health program or through a referral from one of these programs? ☐ Yes ☐ No

If no, is this person eligible to get services from the Indian Health Service, a tribal health program, or an urban Indian health program or through a referral from one of these programs? ☐ Yes ☐ No

Does this person get income from any of the sources below? ☐ Yes ***If yes,*** fill in the amount and frequency below.
☐ No ***If no,*** continue the application.

▶ Payments to the tribe that come from natural resources, usage rights, leases, or royalties
Amount **$** _____ ☐ Weekly ☐ Every two weeks ☐ Monthly ☐ Other _____

▶ Payments from leases or royalties for the use of Indian trust land for natural resources, farming, ranching, or fishing
Amount **$** _____ ☐ Weekly ☐ Every two weeks ☐ Monthly ☐ Other _____

▶ Money from selling things that have cultural value
Amount **$** _____ ☐ Weekly ☐ Every two weeks ☐ Monthly ☐ Other _____

Attachment B: Tell us about your family's health insurance

★ If you need to tell us about more than four people who have other health insurance, **make a copy of this page**, and be sure to send it with your application.

Tell us about the health insurance you have now

Answer these questions for everyone who needs help paying for health insurance.

We need to know if anyone applying for health insurance has coverage now. You do not have to tell us about coverage that is not considered minimum essential coverage. Examples of the types of plans you don't have to tell us about are: Indian Health Service, tribal health program, urban Indian health program, flex savings plans, health savings accounts, or insurance available in another country.

We do need to know if anyone has any of the following health insurances now: COBRA, employer-sponsored insurance, Peace Corps, retiree health plan, TRICARE/CHAMPUS, veterans health program, or other health insurance. Does anyone have any of these insurances?

☐ **Yes** ***If yes,*** fill in this page. If you need more space, attach another sheet of paper.
☐ **No** ***If no,*** go to page 23.

Note: If you have private health insurance you bought on your own, check the box for "Other health insurance" under "What type?" in the table below.

Name *First, middle, last, suffix (for example, Jr., Sr., III, IV)*	**What type?** *(choose one)*
Person 1: _____ Has this person been offered affordable full-coverage health insurance for January 2014? ☐ Yes ☐ No	☐ COBRA ☐ Employer-sponsored insurance ☐ Peace Corps ☐ Other health insurance ☐ Veteran's health program ☐ Retiree health plan ☐ TRICARE/CHAMPUS
Person 2: _____ Has this person been offered affordable full-coverage health insurance for January 2014? ☐ Yes ☐ No	☐ COBRA ☐ Employer-sponsored insurance ☐ Peace Corps ☐ Other health insurance ☐ Veteran's health program ☐ Retiree health plan ☐ TRICARE/CHAMPUS
Person 3: _____ Has this person been offered affordable full-coverage health insurance for January 2014? ☐ Yes ☐ No	☐ COBRA ☐ Employer-sponsored insurance ☐ Peace Corps ☐ Other health insurance ☐ Veteran's health program ☐ Retiree health plan ☐ TRICARE/CHAMPUS
Person 4: _____ Has this person been offered affordable full-coverage health insurance for January 2014? ☐ Yes ☐ No	☐ COBRA ☐ Employer-sponsored insurance ☐ Peace Corps ☐ Other health insurance ☐ Veteran's health program ☐ Retiree health plan ☐ TRICARE/CHAMPUS

Attachment B *continued on next page* ⏩

Attachment B: Tell us about your family's health insurance *(cont'd)*

Employer health insurance *Answer these questions for everyone who needs help paying for health insurance.*

★ We need to know about any health insurance you could get through someone's job. You can use Attachment C, Employer Insurance Form, on page 24 to help you complete this section. Answer these questions or use Attachment C **only** if someone in the household qualifies for health insurance from someone's job.

Is anyone on this application offered health insurance by an employer?

*This could be someone else's job, such as a parent's or a spouse's. It could also include COBRA, TRICARE, federal or state employer, private employer, or Peace Corps plans. You may have additional health insurance that you do **not** have to report to us. The following are **examples** of additional coverage (not considered minimum essential coverage) you do not have to tell us about: flex savings plans, health savings accounts, disability insurance, or insurance available in another country.*

☐ **Yes** *If yes,* answer these questions. If you need more space, attach another sheet of paper.
☐ **No** *If no,* go back to the application to continue.

Name *First, middle, last, suffix (for example, Jr., Sr., III, IV)*	**Employer name** *(optional)*	**This person:**	**How much does this person pay in monthly premiums?**	**Does this health plan meet the *minimum value standard**?**
Person 1:		☐ Is enrolled now ☐ Plans to enroll *Start date* _____ ☐ Is not enrolled	**$**	☐ Yes ☐ No ☐ I don't know
Person 2:		☐ Is enrolled now ☐ Plans to enroll *Start date* _____ ☐ Is not enrolled	**$**	☐ Yes ☐ No ☐ I don't know
Person 3:		☐ Is enrolled now ☐ Plans to enroll *Start date* _____ ☐ Is not enrolled	**$**	☐ Yes ☐ No ☐ I don't know
Person 4:		☐ Is enrolled now ☐ Plans to enroll *Start date* _____ ☐ Is not enrolled	**$**	☐ Yes ☐ No ☐ I don't know

What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage.

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the **minimum value standard.*** (Premium should reflect the discount for wellness programs.)

How much will the employee have to pay in premiums for that plan? **$** _____

How often?

☐ Weekly ☐ Every 2 weeks ☐ Quarterly
☐ Monthly ☐ Twice a month ☐ Yearly

Date of change _____

***Minimum value standard** means that a plan pays at least 60% of the total cost of plan benefits provided to the employee. (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Attachment C: Employer Insurance Form

COVERED CALIFORNIA

This form is only necessary for those who qualify for health insurance through a job. It is not necessary for some health insurance programs offered through Covered California, including Medi-Cal. If you are not sure whether or not to use this form, call Covered California to ask: **1-800-300-1506** (TTY: 1-888-889-4500). If you think you qualify for Medi-Cal, you do not need to fill out this form. To see if you qualify for Medi-Cal or premium assistance, see Attachment F on page 28.

If more than one job offers health coverage, use a separate form for each employer.

▶ Employee information *You need to fill out this section.*

★ Fill in your name and Social Security number (SSN) *(optional)*. Then make a copy of this page or take the application to your employer. Ask your employer to fill in the rest of the page. If you copy the page, be sure to send it with your application.

Employee: First name	Middle name	Last name	Suffix	Social Security number (SSN) *(optional)*
				_ _ _ – _ _ – _ _ _ _

▶ Employer information *Ask your employer for this information.*

★ **Note for employer:** To complete the Covered California application, we need to know about health insurance that your employee or their dependents might be able to get from you. Please complete the information below, even if your company does not offer health insurance.

Employer name:		Employer Identification Number (EIN) _ _ – _ _ _ _ _ _ _
Employer address		Employer phone number
City	State	ZIP code

Whom can we contact about employee health coverage at this job?

Phone number	Email address

☐ We do not offer health insurance. ☐ This employee does not qualify for coverage under our plan.

☐ The employee qualifies for coverage under our plan beginning on _____ *(start date)*.

What's the name of the lowest-cost, self-only health plan this employee could enroll in at this job? Consider only those plans that meet the **minimum value standard*** set by the Federal Patient Protection and Affordable Care Act of 2010. If you're not sure, ask your health insurance issuer.

Name: _____

☐ No plans meet the **minimum value standard.***

How much would the employee have to pay in premiums for the lowest cost? **$** _____

How often?

☐ Weekly ☐ Every 2 weeks ☐ Quarterly
☐ Monthly ☐ Twice a month ☐ Yearly
☐ Other _____

What change will you make for the new plan year (if known)?

☐ We won't offer health coverage.

☐ We will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the **minimum value standard.*** (Premium should reflect the discount for wellness programs.)

How much will the employee have to pay in premiums for that plan? **$** _____

How often?

☐ Weekly ☐ Every 2 weeks ☐ Quarterly
☐ Monthly ☐ Twice a month ☐ Yearly

Date of change _____

***Minimum value standard** means that a plan pays at least 60% of the total cost of plan benefits provided to the employee. (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

¿Preguntas? Llame a Covered California al **1-800-300-1506** (TTY: 1-888-889-4500). La llamada es gratuita. Usted puede llamar de lunes a viernes de 8 a.m. a 8 p.m. y los sábados de 8 a.m. a 6 p.m. O visite **CoveredCA.com**.

Attachment D: Choose your pediatric dental plan and your health insurance plan

★ If you need to tell us about more than four people who would like to choose a pediatric dental plan or health insurance plan, **make a copy of this page and the next page,** and be sure to send them with your application.

If you think you qualify for premium assistance, write the name or metal tier of the pediatric dental plans or health insurance plans you want below. To learn more about private plans provided by Covered California, visit **CoveredCA.com** or call **1-800-300-1506** (TTY: 1-888-889-4500).

If you think you qualify for Medi-Cal, write the name of the health insurance plan you want below. To learn more about available Medi-Cal plans in your county, or to change your plan once you are enrolled, call Health Care Options at **1-800-430-4263** (TTY: 1-800-430-7077), or visit **healthcareoptions.dhcs.ca.gov.**

To see if you qualify for Medi-Cal or premium assistance, look at Attachment F.

▶ Choose your Covered California pediatric dental plan *for children 18 or younger only*

Name *First, middle, last, suffix (for example, Jr., Sr., III, IV)*	**Pediatric dental plan name**	**Coverage level**	**Plan type**
Child 1:		☐ High ☐ Low	☐ DEPO ☐ DPPO ☐ DHMO
Child 2:		☐ High ☐ Low	☐ DEPO ☐ DPPO ☐ DHMO
Child 3:		☐ High ☐ Low	☐ DEPO ☐ DPPO ☐ DHMO
Child 4:		☐ High ☐ Low	☐ DEPO ☐ DPPO ☐ DHMO

DEPO–Dental Exclusive Provider Organization; DHMO–Dental Health Maintenance Organization; DPPO–Dental Preferred Provider Organization

▶ Choose your health insurance plan

Medi-Cal and Covered California plans		Covered California plans only		
Name *First, middle, last, suffix (for example, Jr., Sr., III, IV)*	**Health plan name**	**Metal tier**	**Metal number**	**Plan type**
Person 1:		☐ Platinum ☐ Gold ☐ Silver ☐ Bronze ☐ Minimum coverage plan		☐ EPO ☐ HMO ☐ HSA ☐ PPO
Person 2:		☐ Platinum ☐ Gold ☐ Silver ☐ Bronze ☐ Minimum coverage plan		☐ EPO ☐ HMO ☐ HSA ☐ PPO
Person 3:		☐ Platinum ☐ Gold ☐ Silver ☐ Bronze ☐ Minimum coverage plan		☐ EPO ☐ HMO ☐ HSA ☐ PPO
Person 4:		☐ Platinum ☐ Gold ☐ Silver ☐ Bronze ☐ Minimum coverage plan		☐ EPO ☐ HMO ☐ HSA ☐ PPO

EPO–Exclusive Provider Organization; HMO–Health Maintenance Organization; HSA–Health Savings Account (this plan type allows members to open and contribute to a Health Savings Account); PPO–Preferred Provider Organization

To complete plan selection, all individuals age 18 or older who are selecting a health insurance plan must agree to and sign the arbitration agreement on the next page.

***Attachment D** continued on next page*

Need help? Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 8 p.m., and Saturday, 8 a.m. to 6 p.m. Or visit **CoveredCA.com**.

Attachment D: Choose your Covered California plans *(continued)*

Agreement for Binding Arbitration

▶ For each person who selects a Covered California plan:

I understand that every participating health plan has its own rules for resolving disputes or claims, including, but not limited to, any claim asserted by me, my enrolled dependents, heirs, or authorized representatives against a health plan, any contracted health care providers, administrators, or other associated parties, about the membership in the health plan, the coverage for, or the delivery of, services or items, medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), or premises liability.

I understand that, if I select a health plan that requires binding arbitration to resolve disputes, I accept, and agree to, the use of binding arbitration to resolve disputes or claims (except for Small Claims Court cases and claims that cannot be subject to binding arbitration under governing law) and give up my right to a jury trial and cannot have the dispute decided in court, except as applicable law provides for judicial review of arbitration proceedings. I understand that the full arbitration provision for each participating health plan, if they have one, is in the health plan's coverage document, which is available online at **CoveredCA.com** for my review, or, I can call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500) for more information.

▶ For each person who selects a Kaiser Medi-Cal health plan:

Notice of binding arbitration: I have read the plan description. I understand that Kaiser requires the use of binding neutral arbitration to resolve certain disputes. This includes disputes about whether the right medical treatment was provided (called medical malpractice) and other disputes relating to benefits or the delivery of services, including whether any medical services provided were unnecessary or unauthorized, or were improperly, negligently, or incompetently rendered. If I pick Kaiser as my Medi-Cal health plan, I give up my constitutional right to a jury or court trial for those certain disputes. I also agree to use binding neutral arbitration to resolve those certain disputes. I do not give up my right to a state hearing of any issue, which is subject to the state hearing process.

▶ Signatures of enrollees for <u>all</u> plans

Signature of **Person 1**, or responsible party, or authorized representative for Person 1, if at least 18 years old ▶	Date
Signature of **Person 2**, or responsible party, or authorized representative for Person 2, if at least 18 years old ▶	Date
Signature of **Person 3**, or responsible party, or authorized representative for Person 3, if at least 18 years old ▶	Date
Signature of **Person 4**, or responsible party, or authorized representative for Person 4, if at least 18 years old ▶	Date

Attachment E: Step 2 references *Use these lists to answer the questions in Step 2.*

Immigration status

Use this list for "Applying for health insurance"

If you have one of these immigration statuses, you ***may qualify for health insurance***:

- Lawful Permanent Resident (LPR, or Greencard holder)
- Lawful Temporary Resident (LTR)
- Asylee
- Refugee
- Cuban/Haitian entrant
- Paroled into the U.S.
- Conditional entrant granted before 1980
- Battered spouse, child, or parent
- Victim of trafficking and his or her spouse, child, sibling, or parent
- Individual with non-immigrant status (includes worker visas, student visas, and citizens of Micronesia, the Marshall Islands, and Palau)
- Temporary Protected Status (TPS) or applicant for Temporary Protected Status (TPS)
- Deferred Enforced Departure (DED)
- Deferred action status *Note: If you are an individual with deferred action status under the Department of Homeland Security's deferred action for childhood arrivals in process (DACA), you are not considered to be lawfully present.*
- Granted withholding of deportation or withholding of removal, under the immigration laws or under the Convention against Torture (CAT)
- Applicant for withholding of deportation or withholding of removal, under the immigration laws or under the Convention against Torture (CAT)
- Applicant for special immigrant juvenile status
- Applicant for adjustment to LPR status, with approved visa petition
- Applicant for asylum
- Registry applicants with Employment Authorization Document (EAD)
- Order of supervision (with EAD)
- Applicant for cancellation of removal or suspension of deportation (with EAD)

If your immigration status is not listed above, you may still qualify for health insurance and should still apply.

Self-employment

Use this list for "Are you self-employed?"

You can subtract these items from your gross income to find your net self-employment income. See "Instructions for Schedule C" at **irs.gov** for more information.

- Car and truck expenses (workday travel, not commuting)
- Depreciation
- Employee wages and fringe benefits
- Property, liability, or business interruption insurance
- Interest (for example, mortgage interest paid to banks)
- Legal and professional services
- Rent or lease of business property and utilities
- Commissions, taxes, licenses, and fees
- Advertising
- Contract labor
- Repairs and maintenance
- Certain business travel and meals

Examples of other income

Use this list for "Do you have other income?"

- Unemployment benefits
- Social Security benefits
- Retirement or pension income
- Rent or royalty income
- Alimony received
- Investment income
- Capital gains
- Farming or fishing income
- Canceled debts
- Court awards
- Jury duty pay
- Miscellaneous

Deductions

Use this list for "Do you have deductions?"

- Certain self-employment expenses
- Student loan interest deduction
- Tuition and fees
- Educator expenses
- IRA contribution
- Moving expenses
- Penalty on early withdrawal of savings
- Health savings account deduction
- Alimony paid
- Domestic production activities deduction
- Certain business expenses of reservists, performing artists, and fee-basis government officials

Need help? Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 8 p.m., and Saturday, 8 a.m. to 6 p.m. Or visit **CoveredCA.com**.

Attachment F: Federal Poverty Guidelines

▶ **Estimate what type of health insurance you may be eligible for in 2014.**

Number of people in your household	If your annual household income is less than:	If your annual household income is between:
1	$15,860*	$15,860 – $45,960
2	$21,400	$21,400 – $62,040
3	$26,950	$26,950 – $78,120
4	$32,500	$32,500 – $94,200
5	$38,050	$38,050 – $110,280
	⬇	⬇
	You may be eligilble for Medi-Cal.	**You may be eligible for insurance with financial help through Covered California.**

**These annual household income amounts are approximate only and based on 2013 income data.*

If you already have affordable insurance from your employer or a government program like Medicare or Medicaid, you will not be eligible for Covered California health insurance plans.

★ If you have children or are pregnant, you can have higher income and still qualify for free or low-cost insurance through Medi-Cal or AIM. If you are pregnant, you and your expected baby (or babies) are counted as separate persons to qualify for Medi-Cal and as one person for financial help through Covered California.

Frequently Asked Questions (FAQ)

Getting help through Covered California

1. What is Covered California?

Covered California is the new marketplace that makes it possible for individuals and families to get free or low-cost health insurance through Medi-Cal, or to get help paying for private health insurance available through Covered California.

Our goal is to make it simple and affordable for Californians to get health insurance. Covered California is a partnership of the California Health Benefit Exchange and the California Department of Health Care Services.

2. What is Medi-Cal?

Medi-Cal is California's version of the federal Medicaid program. It is free or low-cost health insurance for California residents who qualify.

3. What is Access for Infants and Mothers (AIM)?

AIM is a low-cost health insurance program for pregnant women who don't have health insurance and whose income is too high for no-cost Medi-Cal. AIM is also available to women who have private health insurance plans with a maternity-only deductible or copayment greater than $500.

4. How can Covered California help me?

Covered California can help you choose a private insurance plan that meets your health needs and budget. We offer some of the state's best-known health plans, and some regional or local plans too.

We can explain the costs and benefits of health insurance plans clearly, so you can compare the different choices available to you. You will know exactly what you're getting and how much you have to pay before you choose your plan.

5. Can I get health insurance even if my income is too high?

Yes. Any Californian who qualifies can purchase private health insurance through Covered California regardless of income. We use your income to help us find the health insurance that is most affordable for your family.

6. What health insurance is offered through Covered California?

You will have a wide variety of health plans to choose from. Health insurance companies **cannot refuse to cover you** because you have been sick before or could not get coverage.

Covered California offers four groups of private health insurance plans: platinum, gold, silver, and bronze, plus a minimum-coverage plan.

Each group offers a different level of coverage, from high to low. Health insurance plans that cover more of your medical expenses will usually have a higher premium but allow you to pay less when you receive medical care.

Platinum plans have the highest premium, but they pay roughly 90% of your health care expenses. Gold plans pay roughly 80%, and silver plans pay roughly 70% of your health care expenses. Bronze plans have the lowest premium but pay roughly 60% of covered health expenses. To learn more about the full benefit packages available, please visit **CoveredCA.com** and review the plan documents, such as the plan's Evidence of Coverage, or the plan's insurance policy. Or call us at **1-800-300-1506** (TTY: 1-888-889-4500).

If you qualify for Medi-Cal, the coverage and costs are different and may be free for you.

7. Can I get health insurance through Covered California?

Any Californian can get health insurance through Covered California if he or she is a state resident and meets other requirements.

Applicants may qualify for a free or low-cost health plan, or for financial help that can lower the cost of premiums and copayments. The amount of financial help is based on household size and family income. Applicants qualify if their income meets the income limits.

8. How much does it cost?

The cost depends on what health insurance programs and financial assistance you qualify for, as well as which plan you choose. You can use the cost calculator at **CoveredCA.com** to find the cost and see if you qualify for help paying insurance.

Frequently Asked Questions *continued on next page*

Need help? Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 8 p.m., and Saturday, 8 a.m. to 6 p.m. Or visit **CoveredCA.com**.

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Getting help through Covered California *(continued)*

9. Should I include my first premium payment with this application?

No, do not send your first payment with this application. Your plan will send you an invoice for the amount you owe.

10. How do I apply?

You can apply for health insurance through Covered California in the following ways:

- **Online:** Visit **CoveredCA.com**. We provide information about each health insurance plan, explained in clear and simple terms.
- **By phone:** Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). You can call Monday through Friday, 8 a.m. to 8 p.m., and Saturday, 8 a.m. to 6 p.m. The call is free!
- **By fax:** Fax your application to **1-888-329-3700.**
- **By mail:** Mail the Covered California application to:

  Covered California
  P.O. Box 989725
  West Sacramento, CA 95798-9725
- **In person:** We have trained Certified Enrollment Counselors or Certified Insurance Agents who can help you. Or you can visit your county social services office. This help is free! For a list of places near where you live or work, visit **CoveredCA.com** or call **1-800-300-1506** (TTY: 1-888-889-4500).

11. I am currently enrolled in Medi-Cal. Can I get health insurance through Covered California?

If your income changes during the year or at your annual renewal, you may qualify for other health insurance and premium assistance through Covered California.

12. What if I already have health insurance?

If you already have affordable health insurance from your employer, you do not need to do anything. But you can still apply anyway to find out if you or your family members qualify for free or low-cost health insurance.

If you apply, be sure to complete Attachment B and send it in with your application.

13. Do I need health insurance now that health reform has started?

Starting in January 2014, most people, including children, will be required to have health insurance or pay a tax penalty. Coverage may include insurance through your job, coverage you buy on your own, Medicare, or Medi-Cal.

But some people are exempt from having health insurance. Those people include, but are not limited to, members of federally recognized religious sects or divisions whose religious beliefs are opposed to accepting benefits from a health insurance plan, people who are incarcerated, people who are members of a federally recognized American Indian or Alaska Native tribe, and those people who have to pay more than 8% of their income for health insurance, after taking into account any employer contributions or premium assistance.

In 2014, the penalty will be 1% of your yearly income or $95, whichever is higher. The penalty will go up each year. By 2016, the penalty will be 2.5% of your yearly income or $695, whichever is higher. After 2016, the tax penalty will increase each year based on a cost-of-living adjustment.

For more information about penalties, visit **CoveredCA.com** or call your local county social services office or Covered California.

14. I don't have all the information I need to answer the questions on the application. What should I do?

If you don't have all the information, sign and submit your application anyway. We will call you to tell you what to do within 10 to 15 calendar days after we get your application. If you don't hear from us, please call us at **1-800-300-1506** (TTY: 1-888-889-4500).

15. What will happen after I apply?

We will send you a letter within 45 days to tell you which program you and your family members qualify for. If you don't hear from us, please call us at **1-800-300-1506** (TTY: 1-888-889-4500).

Frequently Asked Questions *continued on next page*

Getting help through Covered California *(continued)*

16. Can I get help with my application or with choosing a plan?

Yes! Help is free. Certified Enrollment Counselors and Certified Insurance Agents are available in communities across the state to give you information about new health insurance choices and help you apply. You can also get help by visiting your county social services office. You can get help in many different languages.

Get help with your application or with choosing a plan:

- **Online:** Visit **CoveredCA.com**. We provide information about each health insurance plan, explained in clear and simple terms.
- **By phone:** Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). You can call Monday through Friday, 8 a.m. to 8 p.m., and Saturday, 8 a.m. to 6 p.m. The call is free!
- **In person:** We have trained Certified Enrollment Counselors and Certified Insurance Agents who can help you. Or you can visit your county social services office. This help is free! For a list of places near where you live or work, visit **CoveredCA.com** or call **1-800-300-1506** (TTY: 1-888-889-4500).

17. How can I choose a health insurance plan?

If you qualify for private health insurance plans through Covered California, you can visit **CoveredCA.com** to easily shop and compare health insurance plans. Covered California health plan brochures are also available for you.

Covered California will offer choices of private health insurance plans and Medi-Cal plans. You can choose the level of coverage that best meets your health needs and budget.

- You can choose to pay a higher monthly cost (called a premium) so that you pay less out of pocket when you need medical care.
- ***Or,*** you can choose to pay a lower monthly cost but pay more out of pocket when you need care.

If you qualify for Medi-Cal, the coverage and costs are different, and they may even be free. To learn more about available Medi-Cal plans in your county, call Health Care Options at **1-800-430-4263** (TTY: 1-800-430-7077). Or, visit www.**healthcareoptions.dhcs.ca.gov**.

Financial assistance

18. I don't make a lot of money. What programs are available to help me get health insurance?

Starting on January 1, 2014, people who need health insurance may be able to get help in one of these ways:

A. Assistance with monthly premiums. Premium assistance is available to help make health insurance affordable. People who qualify for premium assistance can get the assistance in advance (before they file taxes) to make their monthly premiums lower. Or they can get the assistance at the end of the year and pay less in taxes.

The amount of assistance for monthly premiums depends upon your household size and family income.

B. Medi-Cal: Medi-Cal is California's Medicaid program, paid for with federal and state taxes. It's health insurance for low-income California residents who meet certain requirements.

If your income is within the Medi-Cal limits for your family size, you will receive Medi-Cal coverage at no cost to you.

19. If my income changes, will my premium assistance change immediately?

No, your premium assistance will not change immediately. We will process any new information we have. And, we will tell you if the amount of your premium assistance changes.

20. If my income changes, how will the change affect me when I file my taxes?

It is important to report income changes to Covered California that affect the amount of premium assistance (or tax credits) that you receive. If your income decreases, you may qualify to receive a higher amount of premium assistance and reduce your out-of-pocket expenses even more. However, if your income increases, you may receive too much premium assistance and may be required to repay some of it back when you file your taxes for the benefit year.

Frequently Asked Questions *continued on next page*

Frequently Asked Questions *(continued)*

Financial assistance *(continued)*

21. What if I didn't file taxes last year?

If you didn't file taxes last year, you can still apply for health insurance and get premium assistance. We will use your income to help us find the health insurance that is most affordable for you and your family.

If you qualify for premium assistance, you must file taxes for the benefit year.

22. What if my income changes after I apply?

If your income changes, it may change what kind of health insurance you qualify for.

If you have private health insurance through Covered California, call to report any change in your income that may affect your eligibility within 30 days.

If you have Medi-Cal and your income changes, contact your county social services office within 10 days.

Other questions

23. Does everyone on the application have to be a U.S. citizen or U.S. national?

No. You may qualify for health insurance through Medi-Cal even if you are not a U.S. citizen or a U.S. national.

24. Will my family and I qualify for the same program?

Depending on your household size or family income, you or your family may qualify for different programs. For example, you may qualify for affordable private health insurance available through Covered California. However, your child may qualify for free Medi-Cal. We will tell you which health insurance you and other members qualify for.

25. This application asks for a lot of personal information. Will Covered California share my personal and financial information?

No. The information you provide is private and secure, as required by federal and state law. We use your information only to see if you qualify for health insurance.

26. Will I be able to use my new Covered California health insurance plan right away?

If you are applying between October and December, 2013, health plans start providing services as early as January 1, 2014. If you are applying after January 1, 2014, your health plan may be able to start providing services as soon as the month after you apply.

27. What do you mean by "disability"?

You may have a disability and qualify for Medi-Cal if:

- You are deaf or have a serious hearing loss.
- You are blind or have a serious vision loss, even when wearing glasses.
- You have an intellectual or cognitive disability and have difficulty remembering, concentrating, or making decisions.
- You have an ambulatory condition and have difficulty walking or climbing the stairs.
- You have difficulty bathing or dressing or doing similar daily activities.
- You have a physical, mental, or emotional condition and have difficulty doing errands (such as shopping or visiting a doctor's office) without help.

You do **not** have to be receiving special assistance services in your home or living in any kind of nursing facility or assisted living facility.

28. I have a pre-existing condition or disability. Can I get health insurance through Covered California?

Yes, you can get health insurance regardless of any current or past health conditions or disability.

Starting in 2014, most health insurance plans can't refuse to cover you or charge you more just because you have a pre-existing health condition or disability.

29. I just found out I am pregnant. Can I apply for health insurance that will cover me during my pregnancy?

Yes. Make sure to answer yes to the application question "Are you pregnant?" or tell the person helping you to fill out your application. You can apply for health insurance that can cover prenatal care, labor and delivery, and postpartum care. Health insurance plans can no longer deny you health insurance if you are pregnant.

Frequently Asked Questions *continued on next page*

Other questions *(continued)*

30. I just had a new baby. What should I do about health insurance?

If you did not have Medi-Cal or Access for Infants and Mothers (AIM) at the time of delivery, fill out this application for your newborn.

If you did have Medi-Cal or AIM during your pregnancy, you do not need to fill out this application.

- Include the mother's information on page 2 of this application.
- If you had Medi-Cal, call your county social services office to make sure your baby is covered from birth, or fill out a newborn referral form. Print the form at www.**dhcs.ca.gov/formsandpubs/forms/Forms/mc330.pdf**.
- If you had AIM, call **1-800-433-2611**, or go to **aim.ca.gov** to register your baby.

31. Will I qualify for health insurance if I am not a citizen or do not have satisfactory immigration status?

Anyone who lives in California can apply for health insurance using this application. Only people who are applying must provide Social Security numbers or information about immigration status.

But you may qualify for certain health insurance programs regardless of your immigration status and even if you do not have a Social Security number.

We keep your information private and only share information with other government agencies to see which programs you qualify for.

32. Were you in foster care on your 18th birthday?

If you were in foster care and getting Medicaid in any state when you turned 18, and you are now between the ages of 18 and 26, you may qualify for Medi-Cal. After we verify that you are a California resident, we will enroll you in Medi-Cal for free. Then we will verify that you were in foster care and Medicaid before.

33. What constitutes a one-time payment?

One-time payments are only allowed for gambling winnings, prizes, cancellation of debt, salary or wages from decedents' employer received by a surviving spouse, retroactive social security and railroad retirement benefits, lottery winnings, gifts, and retroactive unemployment insurance benefits.

34. What does "self-employed" mean?

People who are self-employed earn a living directly from their own business or services. They do not earn money from a company that pays them.

35. Where can I get information about becoming registered to vote?

If you are not registered to vote where you live now and would like to apply to register to vote today, please visit **registertovote.ca.gov**. Or, call 1-800-345-VOTE (8683).

36. I am an American Indian or an Alaska Native. How can Covered California help me?

If you are a federally recognized American Indian or Alaska Native, or if you qualify in another way for services from the Indian Health Services, tribal health programs, or urban Indian health programs, you may qualify for free or low cost Medi-Cal. Or you may qualify for other cost savings, such as assistance paying premiums or no copayments. You may also have special monthly enrollment times.

- Complete Attachment A and send it with proof that you are an American Indian or Alaska Native. You can use a tribal enrollment card or Certificate of Degree of Indian Blood (CDIB) from the Bureau of Indian Affairs.
- If you qualify for Medi-Cal, you do **not** need to send proof of your American Indian or Alaska Native heritage. To see if you qualify for Medi-Cal, see Attachment F.

37. What if I don't agree with the decision Covered California makes?

You can file an appeal. To appeal a decision you don't agree with, contact Covered California in one of these ways:

- **Online:** Visit **CoveredCA.com**.
- **By phone:** Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). You can call Monday through Friday, 8 a.m. to 8 p.m., and Saturday, 8 a.m. to 6 p.m. The call is free!
- **By fax:** Fax the appeal to **1-888-329-3700**.
- **By mail:** Mail the appeal to:
  Covered California – Appeals
  P.O. box 989725
  West Sacramento, CA 95798-9725
- **In person:** We have trained Certified Enrollment Counselors and Certified Insurance Agents who can help you. Or you can visit your county social services office. This help is free!

  For a list of Certified Enrollment Counselors and Certified Insurance Agents near where you live or work, or a list of county social services offices near you, visit **CoveredCA.com** or call **1-800-300-1506** (TTY: 1-888-889-4500).

Extra help may be available

CalFresh

Do you need help buying food for you and your family? CalFresh may be able to help!

In California, the federal Supplemental Nutrition Assistance Program (SNAP) is known as CalFresh. CalFresh helps you pay for nutritious fruits, vegetables, and other healthy foods.

To see if you quality for CalFresh, call **1-877-847-3663** or visit **www.calfresh.ca.gov**, or apply online at **benefitscal.org**.

Welltopia by DHCS

Visit Welltopia by the Department of Health Care Services (DHCS), the place of wellness, on Facebook and Twitter! You'll find tips to lower stress, eat healthier food, enjoy physical activity, quit smoking, and more.

Welltopia by DHCS has:

- Free, fun health apps
- Cool videos
- Links to:
  - Tasty and easy recipes
  - Farmers' market locations
  - CalFresh
- Fun places and activities for you and your kids
- Education, job placement, and other services to make your life a little easier

"Like" Welltopia by DHCS on Facebook!
Go to: facebook.com/DHCSWelltopia

Follow us! @WelltopiaDHCS

Earned Income Tax Credit (EITC)

EITC is a benefit for working people who have low to moderate income. This tax credit reduces the amount of tax you owe and may also result in a refund.

www.eitc.ca.gov

Child Tax Credit

This tax credit that may be worth as much as $1,000 per qualifying child, depending on your income.

www.childtaxcredit.ca.gov

Getting help in other languages

You can get help with this application in other languages. Call 1-800-300-1506.

Podemos ayudarle en español a llenar esta solicitud. Llame al 1-800-300-0213.

SPANISH

您可以透過其他語言
獲得此申請的幫助。
請致電 1-800-300-1533.

TRADITIONAL CHINESE

Quý vị có thể được trợ giúp về đơn đăng ký này bằng tiếng Việt. Hãy gọi 1-800-652-9528.

VIETNAMESE

이 응용 프로그램에 대한 한국어 지원을 받으실 수 있습니다.
전화: 1-800-738-9116.

KOREAN

Maaari kang kumuha ng tulong para sa aplikasyong ito sa Tagalog. Tumawag sa 1-800-983-8816.

TAGALOG

Koj txais tau kev pab nrog kev tso npe no ua lus Hmoob. Hu 1-800-771-2156.

HMONG

Вы можете получить помощь в оформлении этой заявки на русском языке. Звоните по телефону 1-800-778-7695.

RUSSIAN

Դուք կարող եք հայերենով օգնություն ստանալ այս դիմումի ձևը լրացնելու հարցում: Զանգահարեք 1-800-996-1009.

ARMENIAN

می توانید در ارتباط با این فرم تقاضا به زبان های دیگر کمک دریافت کنید. با شماره 1-800-921-8879 تماس بگیرید.

FARSI

អ្នកអាចទទួលបានជំនួយចំពោះ
ពាក្យសុំនេះជាភាសាខ្មែរ។
សូមទូរស័ព្ទមកលេខ 1-800-906-8528.

KHMER

يمكنك الحصول على مساعدة
خاصة بهذا التطبيق باللغة العربية.
اتصل بـ 1-800-826-6317.

ARABIC

"Like" Covered California on Facebook!
Go to: Facebook.com/CoveredCA

Follow us! @CoveredCA

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Attachment C

APPLICATION FOR FINANCIAL ASSISTANCE

Patient Name:_____

Patient Account or Medical Record Number:_____

Date of Birth:_____ Last 4 Digits of SS#: XXX-XX-_____

Best Daytime Telephone Number: ( )_____-_____

Address:_____

City:_____State:_____ Zip:_____

Spouse's Name:_____Last 4 Digits of SS#: XXX-XX-_____

Are you a U.S. Citizen? Yes No

If not, a resident alien? Yes No

If not, a non-resident alien? Yes No

Family Status: List all dependents that you support (if more than 4 use separate page)

Name	Age	Relationship

Employment and Occupation

Employer:_____Position:_____

If self-employed, name of business:_____

Employer address:_____

Phone: ( )_____-_____ How long employed:_____

Spouse's Employer:_____Position:_____

If self-employed, name of business:_____

Current Monthly Income	**Patient**	**Spouse**	**Total**
Gross Pay (Salary)	$	$	$
Net Self-Employed Income	$	$	$
Interest and Dividends	$	$	$
Real Estate or Rental Property	$	$	$
Social Security/Retirement/Disability	$	$	$
Alimony, Support Payments	$	$	$
Other	$	$	$
Total Monthly Income	$	$	$

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APPLICATION FOR FINANCIAL ASSISTANCE

Essential Living Expenses	Patient	Spouse	Total
Rent or Mortgage	$	$	$
Real Estate Taxes	$	$	$
Utilities and Telephone	$	$	$
Alimony, Support Payment	$	$	$
Auto Loan/Lease Payment	$	$	$
Education	$	$	$
School/Childcare (Minor Dependents)	$	$	$
Food	$	$	$
Insurance (Home/Auto)	$	$	$
Other Expenses	$	$	$
Total Monthly Expenses	$	$	$

Current Medical Debt	Patient	Spouse	Total
Outstanding Medical Debt (**Cedars-Sinai**)	$	$	$
Other Medical Debt	$	$	$
Total Medical Debt	$	$	$

Assets (Exclude Retirement Accounts)	Patient	Spouse	Total
Stocks and Bonds	$	$	$
Money Market/Brokerage Accounts	$	$	$
Certificates of Deposit	$	$	$
Total Assets	$	$	$

By signing this application, I agree to allow Cedars-Sinai to check my employment and request a credit history.

_____ _____

(Signature of Patient) (Date)

_____ _____

(Signature of Spouse) (Date)

CEDARS-SINAI®

Cedars-Sinai Medical Center
Financial Assistance Processing Unit
P.O. Box 48954
Los Angeles, CA 90048

Business Hours: 8 a.m. – 6 p.m., weekdays
Phone Number: 323-866-8600
24-Hour Access by Fax: 323-866-3077
Email: Patient.Billing@cshs.org

It is possible the services you received may be eligible for coverage under Cedars-Sinai's Financial Assistance Policy. In order to properly assess your ability to pay all or part of the hospital bill(s) under the Cedars-Sinai Financial Assistance Policy, however, additional documentation is required.

Attached for your review is a policy summary. To assist us in our evaluation, please submit the following documentation no later than 15 days from the date of this letter. Please note that it is imperative to include all requested documents or provide a signed statement explaining why any of the items **below** do not pertain to your situation. Please return your information by the mail, fax or email information noted at the top of this letter. **We ask that you send copies of the documents referenced below as they will not be returned to you:**

(1) Fully completed application (enclosed with this letter).
- A copy of your current Federal Tax Return (example, Form 1040) or prior year's filings along with the attached 4506-T form, signed and dated. Do not send your state tax return. If a Federal Tax Return is not available, include a copy of your most recent pay stub(s) from all employment during the last six (6) months (patient and spouse) and let us know if there is a significant change in your prior year's income.
- Please note that this includes public assistance, for example, Unemployment, Disability Payments, Social Security, etc.
- If you are not receiving any income that would be reflected in the documents listed above, please prepare a brief statement stating your current financial situation. Be sure to sign and date the statement.
- If you are receiving financial assistance from someone, please have that person submit a written statement stating the amount and frequency of financial assistance being provided to you.

(2) Rent or Mortgage verification (coupon, rental receipt, canceled check)
- If you are living with someone, please have that person submit a written statement explaining the financial terms of the arrangement.

(3) Copy of your prior two (2) month's checking and savings bank statements (all pages for patient and for the spouse).

(4) Copy of Money Market/Brokerage account statements, Stock & Bond certificates and Certificate of Deposits, if applicable.

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Retirement accounts such as 401(k) and 403(b) statements and pension plans are excluded and should not be provided.

Please also understand that submission of a complete application does not mean that your services will qualify under the Cedars-Sinai Financial Assistance Policy. There are a number of considerations involved in our review. Once the review process is complete, you will be notified by mail of the outcome of your application.

Cedars-Sinai's Financial Assistance Policy provides assistance for patients whose family income does not exceed 450 percent of the Federal Poverty Level. There are a number of other federal, state, local and private sources available to fund care to low-income individuals. We can help you identify funding sources that would apply to your situation.

Should you have any questions, please contact the Customer Service Representatives at 323-866-8600 for assistance.

Sincerely,

CSMC Department of Patient Financial Services

Attachments:
- Plain Language Summary
- Application for Financial Assistance

(Rev. 1/16)

CEDARS-SINAI®

Dear Patient:

State law requires us to inform you that there are several local consumer assistance centers available in the Los Angeles area. Two are:

- Neighborhood Legal Services of Los Angeles County
  - Telephone: 1-800-896-3202
  - Website: nlsla.org

- Health Consumer Alliance
  - Telephone: 1-888-804-3546
  - Website: healthconsumer.org

Should you have any questions, please contact Patient Financial Services Customer Service at 323-866-8600.

Sincerely,

Cedars-Sinai Department of Patient Financial Services

Language for Statement:

Financial Assistance

Cedars-Sinai Medical Center provides some services without charge to eligible patients who cannot afford to pay for part or all of their care. We also offer patients other discounts, payment plans and options. These programs may also apply to physician services if provided by Cedars-Sinai's emergency department physicians, faculty physicians or physicians affiliated with Cedars-Sinai Medical Care Foundation.

Cedars-Sinai also participates in several government assistance programs including Medi-Cal, the California Healthy Families Program and the California Victims of Crime Compensation Program. Patients may also be eligible for subsidized coverage through the California Health Benefit Exchange (Covered California).

You may obtain further information including applications for financial assistance programs in various ways:

- At our Web site address: www.cedars-sinai.edu.
- By Email: Patient.Billing@cshs.org.
- By contacting Patient Financial Services Customer Service at (323) 866-8600 or 6500 Wilshire Blvd, Suite 800, Los Angeles, CA. 90048.
- Having information mailed to you: (323) 866-8600.

Translations are also in Farsi, Russian and Spanish.

Physician Services

Your Cedars-Sinai statement may include services provided by physicians who are part of the Cedars-Sinai Emergency Dept., Pathology Dept., Faculty Physicians at Cedars-Sinai and Physicians affiliated with the Cedars-Sinai Medical Care Foundation. For a complete list please visit: www.cedars-sinai.edu. Other physicians will bill you separately. Please be aware that these physicians may or may not be part of your insurance company's network of providers. For your reference, contact information for some of these physician groups appears below.

- **Cedars-Sinai Health Associates**
- Tel (800) 773-2742
- **General Anesthesia Specialists Partnership**
  Tel (213) 637-3700 Fax (213) 639-0790
- **Cedars-Sinai Imaging & MRI**
  Tel (800) 303-3044 Fax (818) 879-8272

CEDARS-SINAI®

FULL AND PARTIAL FINANCIAL ASSISTANCE DISCOUNT

Column A		Full Column B	Partial Column C	Partial Column D	Partial Column E	Partial Column F
	Uninsured Discount*	100%	95%	90%	85%	85%
	Underinsured Discount	100%	90%	80%	70%	60%

Size of Family	**2017 FPL Annual Salary**					
1	$12,060	$24,120	$30,150	$36,180	$42,210	$54,270
2	$16,240	$32,480	$40,600	$48,720	$56,840	$73,080
3	$20,420	$40,840	$51,050	$61,260	$71,470	$91,890
4	$24,600	$49,200	$61,500	$73,800	$86,100	$110,700
5	$28,780	$57,560	$71,950	$86,340	$100,730	$129,510
6	$32,960	$65,920	$82,400	$98,880	$115,360	$148,320
7	$37,140	$74,280	$92,850	$111,420	$129,990	$167,130
8	$41,320	$82,640	$103,300	$123,960	$144,620	$185,940
For each additional person add	$4,180					
		200%	250%	300%	350%	450%

* The difference between the Uninsured and Underinsured Discount rates is based on the following: (1) the Underinsured amount has already been discounted; (2) the Underinsured patient generally has a maximum limit on their annual out of pocket expenses and (3) the amount due from an Underinsured patient is normally less than an amount due by an "Uninsured" patient.

(Note: FPL= Federal Poverty Level)

Column B shows qualifying salaries at the 200 percent of the FPL. Column C at 250 percent of the FPL, Column D at 300 percent, Column E at 350 percent and Column F at 450 percent.

To calculate potential eligibility, select the size of the Family (number of immediate members in the household), then find the annual income in Column B, C, D, E or F. This will identify the potential percent Financial Assistance Discount you may be eligible for once all documentation is verified.

Examples: If the family size is three (3) and the annual income is $42,000, look at the number in Column B. The income of $42,000 is greater than the $40,320 (Column B) and less than $50,400 (Column C), so you would qualify for potential discounts in Column C. Next, look at the Uninsured Discount percent

line in Column C. It is 95 percent. The discount for an Underinsured patient in Column C is 90 percent.

If the family size is one (1) and the annual income is $45,000, look at the Annual Income in Column E. $45,000 is greater than $41,580 (Column E) and less than $53,460 (Column F), so you would qualify for potential discounts in Column F. Next, look at the Uninsured Discount percentage in Column F for the family size of one. It is 85 percent. The potential discount for an Underinsured patient in Column F is 60 percent.

For each additional member, of a unit of eight (8), add $4,160 to each annual salary number.

Uninsured Inpatient Maximum: Patients treated on an inpatient basis and that qualify for a Financial Assistance discount of less than 100 percent will not be financially responsible for more than the amount that would be paid under Medicare Diagnosis Related Group (DRG) payment system.

Underinsured Outpatient Maximum: Patients treated on an outpatient basis and who qualify for a Financial Assistance discount of less than 100 percent will not be financially responsible for more than our average outpatient Medicare reimbursement rate of nine percent (see note below).

Income levels are based upon the published Federal Poverty Guidelines in effect at the time of Cedars-Sinai's receipt of the Financial Assistance Application. Applicants who earn 200 percent of the published minimum level or less may qualify for full assistance. Each level represents the maximum family income to qualify.

Note: The average outpatient Medicare reimbursement rate is calculated by the Manager of the Reimbursement, Department of Finance, Cedars-Sinai. The number comes from the monthly contractual adjustment. This is based on a closed account analysis. Accounts are reviewed to determine the total adjustments (the amounts that remain after the Medicare payment and the patient's share of cost, if any). When subtracted from 100 percent, this number yields the outpatient Medicare reimbursement rate.

CEDARS-SINAI®

January 1, 2016

RE: Application for Financial Assistance
Medical Record #
Total Charges: $

Dear ,

We have received your Cedars-Sinai Financial Assistance Application. In order to complete our review, we need the following information from you:

- ☐ Prior year **(1040)** Federal Income Tax Return or current period pay stub
- ☐ Unemployment, Social Security, or Disability stub
- ☐ Prior two (2) month's bank statements (all pages)
- ☐ Rent verification or Mortgage statement

Other: _____

Unless we receive this information within the next 10 days, your Financial Assistance application will be determined ineligible, and you will be fully responsible for the balance owed above.

If you are unable to provide any of the requested items, submit a written statement explaining why you are unable to do so. If you are receiving financial assistance or living with someone who is providing you with financial support, please have them submit a written explanation as to the amount and frequency of benefits provided to you. The document must be signed and dated.

We appreciate your timely attention to this matter. If you have any questions, please call us at 323-866-8600.

Sincerely,

Cedars-Sinai Department of Patient Financial Services

(Rev. 1/16)

CEDARS-SINAI®

January 1, 2016

Name
Address
City, State, Zip

Re: Application for Financial Assistance
Medical Record Number: #123456789

Thank you for submitting your application for Financial Assistance. Our goal is to make our quality healthcare services accessible and affordable for you by providing significant discounts or offering adjustments based on financial need.

Unfortunately, after careful review of your application, **your request for Financial Assistance has been determined ineligible because your property/assets exceed Cedars-Sinai's guidelines.** However, please note that we have provided a significant discount – similar to the discounts we offer our contracted insurance companies – for your healthcare services .

We encourage you to contact us at 323-866-8600 to discuss payment options, which include personal check, credit card or a monthly payment schedule.

You may appeal this determination by submitting documents, which were not part of the initial consideration, that support your inability to pay. If you wish to appeal, please submit the additional documents within 15 working days from the date of this letter or contact us. If your appeal is not received, the decision will be final and the balance of $500 will be due within 30 days.

Sincerely,

Cedars-Sinai Patient Financial Services

Online Billing Manager: cedars-sinai.edu/business
A simple way to access your updated account information and pay your accounts online.

To speak to a customer service representative, please call 323-866-8600
8 a.m. to 6 p.m., weekdays

- **Automated account information?**
  Call 323-866-8600
  24 hours a day, 7 days a week
- **Itemized bill request?**
  Call 323-866-8600
- **Written request or inquiry?**
  Patient Communication
  File 1688
  1801 W. Olympic Blvd.
  Pasadena, CA, 91199-1688

CEDARS-SINAI®

January 1, 2016

Name
Address
City, State, Zip

Re: Application for Financial Assistance
Medical Record Number: #123456789

Thank you for submitting your application for Financial Assistance. Our goal is to make our quality healthcare services accessible and affordable for you by providing significant discounts or adjustments based on financial need.

Unfortunately, after careful review of your application, **your request for Financial Assistance has been determined ineligible because your income level exceeds Cedars-Sinai's guidelines.** However, please note that we have provided a significant discount – similar to the discounts we offer our contracted insurance companies – for your healthcare services..

We encourage you to contact us at 323-866-8600 to discuss our payment options, which include personal check, credit card or a monthly payment schedule.

You may appeal this determination by submitting documents, which were not part of the initial consideration, to support your inability to pay. If you wish to appeal, please submit the additional documents within 15 working days from the date of this letter or contact us. If your appeal is not received, the decision will be final and the balance of $500.00 will be due within 30 days.

Sincerely,

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January 1, 2016

Name
Address
City, State, Zip

Re: Application for Financial Assistance
Medical Record Number: #123456789

Thank you for submitting your application for Financial Assistance. Our goal is to make our quality healthcare services accessible and affordable for you by providing significant discounts or offering adjustments based on financial need.

Unfortunately, after careful review of your application, **your request for Financial Assistance has been determined ineligible because you have not provided the requested information necessary to determine your eligibility.** However, please note that we have provided a significant discount – similar to the discounts we offer our contracted insurance companies – for your healthcare services.

We encourage you to contact us at 323-866-8600 to discuss payment options, which include personal check, credit card or a monthly payment schedule.

You may appeal this determination by submitting documents, which were not part of the initial consideration, to support your inability to pay. If you wish to appeal, please submit the additional documents within 15 working days from the date of this letter or contact us. If your appeal is not received, the decision will be final and the balance of $500.00 will be due within 30 days.

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Attachment J

Financial Assistance Worksheet

Medical Record Number: ☐

Fill Patient Name

Patient First Name: ☐ Last Name: ☐ Middle Name: ☐

Family Size: ☐ Monthly Income: ☐ Yearly Income:

Recommendation/Comments: ☐

Determination Based on Financial Assistance Guidelines

☐ 100% ☐ 95% ☐ 90% ☐ 85%
☐ 80% ☐ 70% ☐ 60% ☐ Ineligible

Approvals

Financial Specialist:	Electronically signed by	☐	Date:	☐
Supervisor:	Electronically signed by	☐	Date:	☐
Manager:	Electronically signed by	☐	Date:	☐
Director:	Electronically signed by	☐	Date:	☐
Vice President:	Electronically signed by	☐	Date:	☐

Financial Assistance **2017** Federal Poverty Guidelines

Uninsured Discount	100%	95%	90%	85%	85%
Underinsured Discount	100%	90%	80%	70%	60%

Size of Family Unit	**2017 FPL Annual Salary**					
1	$12,060	$ 24,120	$ 30,700	$ 36,180	$ 42,210	$ 54,270
2	$16,240	$ 32,480	$ 40,600	$ 48,720	$ 56,840	$ 73,080
3	$20,420	$ 40,840	$ 51,050	$ 61,260	$ 71,740	$ 91,890
4	$24,600	$ 49,200	$ 61,500	$ 73,800	$ 86,100	$ 110,700
5	$28,780	$ 57,560	$ 71,950	$ 86,340	$ 100,730	$ 129,510
6	$32,960	$ 65,920	$ 82,400	$ 98,880	$ 115,360	$ 148,320
7	$37,140	$ 74,280	$ 92,850	$ 111,420	$ 129,990	$ 167,130
8	$41,320	$ 82,640	$ 103,300	$ 123,960	$ 144,620	$ 185,940
For each additional per person add	$4,160					
FPL Level		200%	250%	300%	350%	450%

OP cap 15%, IP cap DRG rates

Attachment J

Save Cancel

E-form release version: 02/04/2016

CEDARS-SINAI®

January 1, 2016

Name
Address
City, State, Zip

RE: Application for Financial Assistance
Patient Name: Name
Medical Record No: 123456789

Dear Name,

We have reviewed and approved your request for Financial Assistance under the Cedars-Sinai's Financial Assistance Policy. Your Financial Assistance is valid for the period of XX/XX/XX through XX/XX/XX. We want you to know that we value you as a patient and appreciate the opportunity to provide services to you. There are various accounting rules and laws that direct Cedars-Sinai to run its Financial Assistance program in a relatively formal manner. Please understand that it remains your responsibility to secure a treating physician.

This approval has several limitations attached to it. They are as follows:

(a) Based upon the information you submitted, you are eligible for a discount of 100 percent. Accordingly, you will owe a balance of $0.00 to Cedars-Sinai for outstanding account balances with service dates prior to the date of this letter. The same percentage discount will apply to outstanding faculty physician accounts with service dates prior to the date of this letter.

(b) Services rendered by other private, attending physicians (who are not providing services to you as a member of the Cedars-Sinai's faculty) must be paid by you, unless other arrangements have been made with them.

(c) If you need additional services for this specific injury or illness, Cedars-Sinai, in its sole discretion, may determine to provide such services and will, at that time, determine the appropriate discount. Any future discount will need to be agreed to by Cedars-Sinai in writing and may require that you re-confirm your family's financial condition or complete a new Financial Assistance application if required.

(d) If you access additional services approved in (c) above at Cedars-Sinai, please bring this letter with you and show it to the registration representative.

(e) Because Cedars-Sinai may be entitled to reimbursement for the services it provides to you from other sources, we will require that you continue to cooperate in the application for funding from such sources. Funding sources may include Victim of Crime, Queens Care, Medi-Cal, Proposition 99, etc.

CEDARS-SINAI®

(f) Established patients of Cedars-Sinai's Primary Adult Care Center (PAC) are eligible for a discounted pharmacy price for their prescriptions. To qualify for this discount, please bring this letter with you.

(g) Cedars-Sinai reserves the right to retroactively cancel this determination of Financial Assistance eligibility in the event Cedars-Sinai discovers your application was not truthful or was materially misleading.

(h) Should your financial situation change, you must notify the Cedars-Sinai of those changes. Changes may be a material, financial and/or family size change that could impact your financial assistance status with the Cedars-Sinai.

Sincerely,

Cedars-Sinai Department of Patient Financial Services
323-866-8600

(Rev. 1/16)

CEDARS-SINAI®

January 1, 2016

Name
Address
City, State, Zip

RE: Application for Financial Assistance
Patient Name: Name
Medical Record No: 123456789

Dear Name,

In accordance with Treasury Regulation 501(r), Marina Del Rey Hospital has presumptively determined your eligibility for assistance under its Financial Assistance Policy. What this means is that we have approved a discount of XX percent off of the bills noted below based on information provided to us from an outside vendor.

When you do not apply for Financial Assistance or when you submit an application that is not complete, we use a third-party vendor to help us figure out if you are eligible for assistance. This vendor determines your eligibility based on public and private data sources in combination with predictive models and algorithms.

Presumptive Eligibility is only good for the medical expenses noted below. It does not apply towards any future services. If your discount is less than 100 percent, you are eligible to apply for additional assistance under the Marina Del Rey Hospital Financial Assistance Program. To obtain a more generous discount you will need to submit a complete Marina Del Rey Hospital Financial Assistance Application. For an account to be considered, the application needs to be submitted no later than 240 days from the first post-discharge bill for each account listed. Please let us know if you have any questions about these dates or if you need any help completing your application.

Approved accounts for past expenses are identified below:

Account No.	Date of Service	Amount	Amount Due after Discount
_____	_____	$_____	$_____
_____	_____	$_____	$_____
_____	_____	$_____	$_____

We value you as a patient and appreciate the opportunity to provide services to you.

Sincerely,

Cedars-Sinai Department of Patient Financial Services
(323) 866-8600

CEDARS-SINAI®

January 1, 2016

Name
Address
City, State, Zip

Re: Application for Financial Assistance
Medical Record Number: #123456789

RE: Financial Assistance Ineligibility Determination After Appeal
Patient Name: Name
Medical Record No: 123456789
Account Number(s): 00001, 00002, 00003
Patient Liability: $500.00

Dear Name,

We have received your appeal to our initial ineligibility determination for Financial Assistance. After review of your appeal submission, we have upheld our original ineligibility determination based on the following reason(s):

_____

_____.

You are responsible to pay the remaining amount of $500.00 within 30 days of the date of this letter. If you are unable to pay this amount, we encourage you to contact us at 323-866-8600 to discuss payment options, which include personal check, credit card or an interest free monthly payment schedule.

Sincerely,

Cedars-Sinai Department of Patient Financial Services

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  Pasadena, CA, 91199-1688

Exhibit F

List of Cedars-Sinai's Child-Sites Registered to Participate in 340B Drug Pricing Program

[*See attached*.]

340B ID	Participation Date	Entity Sub-Division Name	Address 1	Address 2	City	State	Zip
DSH050625	4/1/2005		8700 BEVERLY BOULEVARD		LOS ANGELES	CA	90048
DSH050625AA	7/1/2012	Center for Minimally Invasive Surgery (Bariatric)/General Surgery	8635 W. Third St.	Rm 795W	Los Angeles	CA	90048
DSH050625AC	7/1/2012	Comprehensive Transplant Center - Liver	8900 Beverly Blvd.		Los Angeles	CA	90048
DSH050625AD	7/1/2012	Comprehensive Transplant Center - Lung	8900 Beverly Blvd.		Los Angeles	CA	90048
DSH050625AE	7/1/2012	Pulmonary Rehab	8631 W. Third St.	Rm 740E	Los Angeles	CA	90048
DSH050625AF	7/1/2012	Cardiac Rehab	8631 W. Third St.	Rm 740E	Los Angeles	CA	90048
DSH050625AG	7/1/2012	MOT O/P Radiology	8631 W. Third St.	Rm 120E	Los Angeles	CA	90048
DSH050625AH	7/1/2012	Center for Minimally Invasive Gynecologic Surgery	444 San Vicente Blvd.	Rm 1003	Los Angeles	CA	90048
DSH050625AJ	7/1/2012	310 Surgery Center	310 San Vicente Blvd.		Los Angeles	CA	90048
DSH050625AK	7/1/2012	Cancer Center	8700 Beverly Blvd		Los Angeles	CA	90048
DSH050625E	7/1/2012	Primary Adult Care - PAC	8723 Alden Drive	Rm 290	Los Angeles	CA	90048
DSH050625H	7/1/2012	Pediatric Children's Health Center	8723 Alden Drive	Rm 240	Los Angeles	CA	90048
DSH050625J	7/1/2012	ENDO-CDCS DOTEC / RHEUMATOLOGY	8723 Alden Drive	Rm 250	Los Angeles	CA	90048
DSH050625L	7/1/2012	Spine Injury Inst (Spine Center)	444 San Vicente Blvd.	Rm 800 and Rm 900/901	Los Angeles	CA	90048
DSH050625M	7/1/2012	Orthopedic Center	444 San Vicente Blvd.	Rm 600/603	Los Angeles	CA	90048
DSH050625N	7/1/2012	Reproductive Medicine Center	444 San Vicente Blvd	Rm 1002	Los Angeles	CA	90048
DSH050625P	7/1/2012	Minimally Invasive Urology Institute (MIUI)	8635 W. Third St.	Rm 1070W	Los Angeles	CA	90048
DSH050625T	7/1/2012	Ellis Eye Center (Eye Lab)	8723 Alden Drive	Rm 250-260	Los Angeles	CA	90048
DSH050625U	7/1/2012	Prenatal Diagnostic Center	444 San Vicente Blvd.	suite 1001	Los Angeles	CA	90048
DSH050625V	7/1/2012	Pain Center	444 San Vicente Blvd.	Rm 1101	Los Angeles	CA	90048
DSH050625W	7/1/2012	MGB O/P Radiology (MRI)	444 San Vicente Blvd.	Rm 106	Los Angeles	CA	90048
DSH050625X	7/1/2012	Physical Therapy O/P	444 San Vicente Blvd.	Rm 701/103	Los Angeles	CA	90048
DSH050625Y	7/1/2012	Speech Therapy O/P (Voice Clinic)	8635 W. Third Street	Rm 975W	Los Angeles	CA	90048
DSH050625Z	7/1/2012	Occupational Therapy O/P	444 San Vicente Blvd.	Rm 700	Los Angeles	CA	90048
DSH050625AL	4/1/2013	DIGESTIVE DISEASE CENTER	8730 ALDEN DR	2nd FL EAST THALIANS BLDG	LOS ANGELES	CA	90048
DSH050625AS	4/1/2013	THORACIC SURGERY CLINIC	8631 W. THIRD ST	RM 240E	LOS ANGELES	CA	90048
DSH050625AT	4/1/2014	CEDARS-SINAI TOWER HEMATOLOGY AND ONCOLOGY (THO)	9090 Wilshire Blvd.	Suite 200	Beverly Hills	CA	90211
DSH050625AV	7/1/2014	Comprehensive Transplant Center - Kidney	8900 Beverly Blvd.		Los Angeles	CA	90048
DSH050625AW	7/1/2014	Comprehensive Transplant Center - Pancreas	8900 Beverly Blvd.		Los Angeles	CA	90048
DSH050625BA	4/1/2015	OT OP HAND	8635 W THIRD ST	ROOM 975W	LOS ANGELES	CA	90048
DSH050625BD	7/1/2015	Advanced Health Sciences Pavilion / AHSP HB Heart	127 S. San Vicente Blvd.	Level 6	Los Angeles	CA	90048
DSH050625BE	7/1/2015	Advanced Health Sciences Pavilion / AHSP Women's Heart Ctr	127 S. San Vicente Blvd.	Level 3	Los Angeles	CA	90048
DSH050625BF	7/1/2015	Advanced Health Sciences Pavilion / AHSP Heart Inst. Ambulatory	127 S. San Vicente Blvd.	Level 3	Los Angeles	CA	90048
DSH050625BG	7/1/2015	Advanced Health Sciences Pavilion / AHSP Pituitary Center	127 S. San Vicente Blvd.	Level 6	Los Angeles	CA	90048
DSH050625BH	7/1/2015	Advanced Health Sciences Pavilion / AHSP Neuro Onc (brain tumor)	127 S. San Vicente Blvd.	Level 6	Los Angeles	CA	90048
DSH050625BJ	7/1/2015	Advanced Health Sciences Pavilion / AHSP Neurosurgery	127 S. San Vicente Blvd.	Level 6	Los Angeles	CA	90048
DSH050625BK	7/1/2015	Advanced Health Sciences Pavilion / AHSP Neurology Clinics	127 S. San Vicente Blvd.	Level 6	Los Angeles	CA	90048
DSH050625BL	7/1/2015	Advanced Health Sciences Pavilion / AHSP Electromyography	127 S. San Vicente Blvd.	Level 6	Los Angeles	CA	90048
DSH050625BM	7/1/2015	Advanced Health Sciences Pavilion / AHSP EEG	127 S. San Vicente Blvd.	Level 6	Los Angeles	CA	90048
DSH050625BN	7/1/2015	Advanced Health Sciences Pavilion / AHSP EKG	127 S. San Vicente Blvd.	Level 3	Los Angeles	CA	90048
DSH050625BP	7/1/2015	Advanced Health Sciences Pavilion / AHSP CARD CATH LAB	127 S. San Vicente Blvd.	Level 5	Los Angeles	CA	90048
DSH050625BQ	7/1/2015	Advanced Health Sciences Pavilion / AHSP Diagnostic Imaging Center	127 S. San Vicente Blvd.	Level 2	Los Angeles	CA	90048
DSH050625BR	7/1/2015	Advanced Health Sciences Pavilion / AHSP IR	127 S. San Vicente Blvd.	Level 5	Los Angeles	CA	90048
DSH050625BS	7/1/2015	Advanced Health Sciences Pavilion / AHSP PreOp PACU	127 S. San Vicente Blvd.	Level 5	Los Angeles	CA	90048
DSH050625BT	7/1/2015	Advanced Health Sciences Pavilion / AHSP OR	127 S. San Vicente Blvd.	Level 5	Los Angeles	CA	90048
DSH050625BU	7/1/2015	Advanced Health Sciences Pavilion / AHSP APEC	127 S. San Vicente Blvd.	Level 2	Los Angeles	CA	90048
DSH050625BV	1/1/2016	Advanced Health Sciences Pavilion / AHSP ECHOCARDIOLOGY	127 S. San Vicente Blvd.	Level 3	Los Angeles	CA	90048
DSH050625BW	4/1/2016	310 Breast Center	310 San Vicente Blvd	Level 3	Los Angeles	CA	90048
DSH050625BX	4/1/2016	Advanced Health Sciences Pavilion / AHSP Cardiology Center - MCS	127 S. San Vicente Blvd.	Level 6	Los Angeles	CA	90048
DSH050625BY	4/1/2016	Comprehensive Transplant Clinic - Heart Operations	127 S. San Vicente Blvd.	Level 6	Los Angeles	CA	90048
DSH050625BZ	4/1/2016	Procedure Center	8700 Beverly Blvd.	Level 5	Los Angeles	CA	90048
DSH050625CA	4/1/2017	Lung Center - Advanced Lung Disease	8723 Alden Drive	Room 260	Los Angeles	CA	90048