2500 Grant Road
Mountain View, CA 94040-4378
Phone: 650-940-7000
www.elcaminohospital.org

Dear Patient,

For your convenience El Camino Hospital is providing applications for Covered California/Medi-Cal as well as for California Children's Services (CCS).

Pages 2-10 of this PDF are the California Children's Services (CCS)

application. Pages 11-53 of this PDF are the Covered California/Medi-Cal

application.

Please send completed applications directly to Covered California/Medi-Cal or CCS. El Camino Hospital cannot process either of these applications.

Sincerely,

Charity Care
Patient Financial Services
EL CAMINO HOSPITAL

Information about California Children's Services

What is the California Children’s Services (CCS) Program?

CCS is a statewide program that treats children with certain physical limitations and chronic health conditions or diseases. CCS can authorize and pay for specific medical services and equipment provided by CCS approved specialists. The California Department of Health Care Services (DHCS) manages the CCS Program. Larger counties operate their own CCS programs, while smaller counties share the operation of their program with DHCS. The CCS Program is funded with state, county, and federal tax monies, along with some fees paid by parent, legal guardian, or applicant (if age 18 or older, or an emancipated minor).

What does CCS offer children?

If you or your child’s doctor think that your child might have a CCS eligible medical condition, CCS may pay for or provide a medical evaluation to find out if your child’s condition is covered.

If your child is eligible, CCS may pay for or provide:

- Treatment, such as doctor services, hospital and surgical care, physical therapy and occupational therapy, laboratory tests, X-rays, orthopedic appliances, and medical equipment.
- Medical case management to help get special doctors and care for your child when medically necessary, and referral to other agencies, including public health nursing and regional centers; or
- Medical Therapy Program (MTP), which can provide physical therapy and/or occupational therapy in a public schools for children who are medically eligible.

Who qualifies for CCS?

The CCS Program is open to anyone who:

- Is under 21 years old;
- Has or may have a medical condition that is covered by CCS;
- Is a resident of California; and
- Has a family income of less than $40,000 as reported on the adjusted gross income on the state tax form, or whose out-of-pocket medical expenses for a child who qualifies are expected to be more than 20 percent of the family income.

Family income is not a factor for children who:

- Need diagnostic services to confirm a CCS eligible medical condition; or
- Were adopted with a known CCS eligible medical condition; or
- Are applying only for services through the MTP; or
- Have Medi-Cal full scope, no share of cost.

What medical conditions does CCS cover?

Only certain conditions are covered by the CCS Program. In general, CCS covers medical conditions that are physically disabling or require medical, surgical, or rehabilitative services. There also may be certain criteria that determine if your child’s medical condition is eligible. Listed below are categories of medical conditions that may be covered and some examples of each:

- Conditions involving the heart (congenital heart disease)
- Neoplasms (cancers, tumors)
- Disorders of the blood (hemophilia, sickle cell anemia)
- Endocrine, nutritional, and metabolic diseases (thyroid problems, Phenylketonuria (PKU), diabetes)
- Disorders of the genitourinary system (serious chronic kidney problems)
- Disorders of the gastrointestinal system (chronic inflammatory disease, diseases of the liver)
- Serious birth defects (cleft lip/palate, spina bifida)
- Disorders of the sense organs (hearing loss, glaucoma, cataracts)
- Disorders of the nervous system (cerebral palsy, uncontrolled seizures)
- Disorders of the musculoskeletal system and connective tissues (rheumatoid arthritis, muscular dystrophy)
- Severe disorders of the immune system (Human immunodeficiency virus (HIV) infection)
- Disabling conditions or poisonings requiring intensive care or rehabilitation (severe head, brain, or spinal cord injuries, severe burns)
- Complications of premature birth requiring an intensive level of care
- Disorders of the skin and subcutaneous tissue (severe hemangioma)
- Medically handicapping malocclusion (severely crooked teeth)

Ask your county CCS office if you have questions.

What must the applicant or family do to qualify?

Families (or the applicant if age 18 or older, or an emancipated minor) must:

- Complete the application form beginning on page 4 and return it to their local county CCS office;
- Give CCS all of the information requested so CCS can determine if the family qualifies;
- Apply to Medi-Cal.If a family qualifies for Medi-Cal, the child is also covered by CCS. CCS approves the services; payment is made through Medi-Cal.

How is my privacy protected?

California law requires that families applying for services be given information on how CCS protects their privacy.[1]

To protect your privacy:

- CCS must keep this information confidential.[2]
- CCS may share information on the form with authorized staff from other health and welfare programs only when you have signed a consent form.

---

[1] Civil Code, Section 1798.17

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?

sectionNum=1798.17.&lawCo de=CIV

[2] In accordance with Section 41670, Title 22, California Code of Regulations and the California Public Records Act (Government Code, Sections 6250–6255)

https://www.law.cornell.edu/regulations/california/22-CCR-41670

You have the right to see your application and CCS records concerning you or your child. If you wish to see these records contact your local county CCS office. By law, the information you give CCS is kept by the CCS Program.[3]

Do I have a right to appeal a decision?

You have the right to disagree with decisions made by CCS.[4] This is called an appeal. The appeal process gives the parent/legal guardian or applicant a way to work with the CCS Program to find solutions to disagreements. For information on the appeal process, contact your local county CCS office.

Where can I get more information about CCS?

For more information about CCS, please visit the CCS home page on the DHCS website here: https://www.dhcs.ca.gov/services/ccs/Pages/default.aspx

For help in filling out this application, please contact your local county CCS office. To find your county CCS office, go to: https://www.dhcs.ca.gov/services/ccs/Pages/CountyOffices.aspx, or look in the government section of your local telephone directory under “California Children’s Services” or “county health department.”

[3] Section 123800 et. seq. of the California Health and Safety Code

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=123800.&lawCode=HSC

[4] California Code of Regulations, Title 22, Chapter 13, Sections 42702–42703

https://www.law.cornell.edu/regulations/california/22-CCR-42702

Application to Determine California Children Services Program Eligibility

This application is to be completed by the parent, legal guardian, or applicant (if age 18 or older, or an emancipated minor) in order to determine if the applicant is eligible for CCS services/benefits. The term "applicant" means the child, individual age 18 or older, or emancipated minor for whom the services are being requested. Please type or print clearly.

A. Applicant Information

1. Name of Applicant
(Last) (First) (Middle)

Name on birth certificate (if different)

Any other name the applicant is known by

2. Date of birth (month, day, year)

3. Place of birth – County State

Country, if born outside of the U.S.

4. Applicant's residence address (number, street) (do not use a P.O. Box)

City

County

Zip Code

5. Sex
Female Male

6. Sexual Orientation and Gender Identity (Optional):
If the applicant would like to tell us more about their gender, gender identity, gender expression or sexual orientation, please fill in items a, b, and c below. Section 6 is optional but is required for DHCS to ask with the passage of Assembly Bill 959 (2015 - 2016).

a. What is the applicant's gender (check the box that best describes your current gender identity)?
Female Male Transgender: Male to Female Transgender: Female to Male
Non-binary (neither male nor female) Another gender identity

b. What sex was listed on the applicant's original birth certificate?
Female Male

c. Does the applicant think of them self as:
Straight / heterosexual Gay / lesbian Bisexual Queer
Another sexual orientation Unknown

7. Race / Ethnicity	8. Social Security Number (optional)

9. What is the applicant's suspected eligible CCS condition or disability?

10. Primary Care Physician	11. Physician's phone number

B. Parent/Legal Guardian/Family Information

(Applicants age 18 or older, or emancipated minors skip items 12 and 14 below).

12.Name of parent or legal guardian	13. Mother's first name and maiden name (not identified in 12)

14. Residence address (number, street) (do not use a P.O. Box)

City	County	Zip Code

15. Mailing address (if different from 14)

City	County	Zip Code

16. Home phone number	17. Cell phone number	18. Work phone number

19. What language do you speak at home?	20. Email address

21. Number of persons in family unit	22. Other Parent Last and First Name (if not living with the applicant)

Street Address of Other Parent	City	Zip Code

C. Health Insurance Information

23. Does the applicant have Medi-Cal? Yes No	24. If yes, what is the applicant's Medi-Cal number?
25. Is there a share of cost? Yes No	26. If yes, what is the amount you pay per month?
27a. Does the applicant have other health insurance? Yes No	27b. If yes, what is the name of the insurance plan or company?

27c. Policy or Plan Number

28. Type of insurance plan or company

Preferred Provider Organization (PPO)

Health Maintenance Organization (HMO)

Other:

29. Does the applicant have dental insurance?	30. Does the applicant have vision insurance?
Yes No	Yes No

D. Certification

(Initial and sign below. Your signature authorizes the CCS Program to proceed with this application).

_______ I am applying to the CCS Program in order to determine eligibility for services/benefits.

_______ I understand that the completion of this application does not assure acceptance of applicant by the CCS Program.

_______ I give my permission to verify my residence, health information, or other circumstances required to determine eligibility for CCS services/benefits.

_______ I also certify that the information I have given on this form is true and correct.

Signature of person completing the application	Relationship to the applicant	Date
Signature of witness (only if the person signed with a mark)		Date

***See instructions on the next page.**

INSTRUCTIONS FOR COMPLETING THE CALIFORNIA CHILDREN'S SERVICES APPLICATION (DHCS 4480)

Print clearly so your application can be processed as quickly as possible.

Fill out each section completely. If you do not provide all the information, CCS will not be able to proceed with your application. If you need help filling out this form, contact your local county CCS office.

Once the application is completed, mail it to your local county CCS office. Remember to sign and date the form.

Section A: Applicant Information ("Applicant" means the child, individual age 18 or older, or emancipated minor for whom the services are being requested).

1. **Applicant's name:** Fill in the applicant's last, first, and middle name. In the next Box, write the applicant's full name as it appears on their birth certificate if different from their name. If the applicant is known by any other name, include that name in the last box.
2. **Applicant's date of birth:** Write the month, day, and year of the applicant's birth.
3. **Place of birth:** Write the county and state where the applicant was born. Include the country if the applicant was born outside the U.S.
4. **Address:** Write the street number, street name, apartment number, city, county, and ZIP code of the applicant's current residence in this space. Do not use a P.O. Box.
5. **Applicant's sex:** Mark the correct sex box for the applicant (male or female).
6. **Sexual Orientation and Gender Identity (Optional):** If the applicant would like to tell us more about their gender, gender identity, gender expression or sexual orientation, please fill in items a, b, and c. Section 6 is optional, but is required for DHCS to ask with the passage of Assembly Bill 959 (2015 - 2016).
   6a. Check the box that best describes the applicant's current gender identity.
   6b. Mark the option of the sex listed on the applicant's original birth certificate.
   6c. Check the box that best describes the applicant's sexual orientation.
7. **Race/Ethnicity:** Enter the category from the following list which best describes the applicant's primary race/ethnicity:

- Alaskan Native
- Amerasian
- American Indian
- Asian
- Asian Indian
- Black/African American
- Cambodian
- Chinese
- Filipino
- Guamanian
- Hawaiian
- Hispanic/Latino
- Japanese
- Korean
- Laotian
- Samoan
- Vietnamese
- White
- Other

8. **Applicant's social security number (optional):** Write the applicant's nine-digit social security number.
9. **Suspected CCS condition or disability:** Write the applicant's disability or special health care need that would be treated by CCS. The enclosed description of CCS eligible conditions may help you (see "What medical conditions does CCS cover" on pages 1 and 2). If you don't know, ask the applicant's doctor or leave the space blank. CCS will follow up with the applicant's physician if more information is needed.
10. **Name of applicant's primary care physician:** Write the name of the applicant's physician.
11. **Physician's phone number:** Write the phone number of the physician listed in number 10.

Section B: Parent/Legal Guardian Information (Applicants age 18 or older, or emancipated minors skip items 12 and 14).

12. **Parent/guardian name(s):** Write the name(s) of the applicant's parent(s) or the name(s) of the applicant's legal guardian(s).
13. **Mother's first name and maiden name:** Write the applicant's mother's first name and identify the mother's maiden name in the next box.
14. **Address:** Write the street number, street name, apartment number, city, county, and ZIP code of your current residence. Do not use a P.O. Box.
15. **Mailing address:** If this address is different from number 14, write the street number, street name, city, and ZIP code.
16. **Home phone number:** Write the home phone number where you can be reached.
17. **Cell phone number:** Write the cell phone number where you can be reached.
18. **Work phone number:** Write the work phone number where you can be reached.
19. **Language(s) spoken:** Write the language you speak at home.
20. **Email address:** Write the email address for the parent or legal guardian.
21. **Number of persons in family unit:** Write the number of persons living in the same household.
22. **Other Parent Name and Address if not living with the applicant:** Write the name and address for a second contact person.

Section C: Health Insurance Information

If CCS thinks you may qualify, they will ask you to apply for Medi-Cal if you are not currently receiving Medi-Cal health care benefits.

23. If the applicant does not receive Medi-Cal, mark "No" and go to number 27a. If the applicant receives Medi-Cal, mark "Yes" and fill in the applicant's Medi-Cal number.
24. If you the applicant has Medi-Cal, enter the 14-digit Medi-Cal number.
25. If you pay a portion of the cost of your Medi-Cal insurance, mark "Yes".
26. If you pay a portion of the share of cost, fill in the monthly amount paid.

27a. If the applicant does not have other health insurance, mark "No" and go to number 29. 27b. If the applicant has health insurance, fill in the name of the insurance plan or company.

27c. If the applicant has health insurance, fill in the policy or plan number.

28. If the applicant has health insurance, mark the appropriate box depending upon what type of insurance it is. Your insurance forms will tell you what type of health insurance you have. If you are not sure, call your health insurance company and ask them.

29. If the applicant has dental insurance, mark "Yes." If the applicant does not have dental insurance, mark "No."

30. If the applicant has vision insurance, mark "Yes." If the applicant does not have vision insurance, mark "No."

Section D: Certification

Be sure to sign and date in ink. If signature is signed with a mark, have a witness sign and fill in the date.

Under "Relationship to the applicant," enter father, mother, legal guardian, or self (in the case of individuals age 18 or older, or emancipated minors).

Submitting Your Application

Mail or deliver your application to your local county CCS office. To find your county CCS office, go to https://www.dhcs.ca.gov/services/ccs/Pages/CountyOffices.aspx or look in the government section of your local telephone directory under "California Children's Services" or "county health department."

Your destination for affordable health insurance, including Medi-Cal.

Medi-Cal

Application for Health Insurance

SEE INSIDE

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Covered California is the place where people can get free or low-cost health insurance, including Medi-Cal.

We will check to see if you qualify for the below programs:

- **Free or low-cost Medi-Cal**
- **Financial help through Covered California**
- **Free or low-cost health insurance for pregnant individuals**

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

You can also get this application in these languages:

Español	Русский	日本語
中文	Հայերեն	ລາວ
Tiếng Việt	فارسی	Mienh nzangc
한국어	ភាសាខ្មែរ	ਪੰਜਾਬੀ
Tagalog	العربية	ภาษาไทย
Hmoob	हिंदी	Українська

Call **1-800-300-1506** (TTY: 1-888-889-4500) to get help in other languages. You can request this application in other formats such as large print, or get information about free auxiliary aids and services.

Apply faster at CoveredCA.com!
It is easy to create an account and apply. **Have you applied for Medi-Cal or Covered California before?** If yes, please call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500) before creating an account to link your information.

About Covered California and Medi-Cal

Covered California connects Californians with health insurance from brand-name companies. When you apply for health insurance using this application, you may qualify for financial help on a health plan through Covered California, or get free or low-cost health insurance through the Medi-Cal program.

Medi-Cal is California's version of Medicaid. It is a program that offers free or low-cost health coverage for children and adults with limited income. If you qualify, you can apply for Medi-Cal year round.

Depending on your household size and income, you or your family may qualify for different programs:

- If your income is under the Medi-Cal limit and you meet certain criteria, you may qualify for Medi-Cal. Medi-Cal is free or low-cost health insurance. If you appear eligible for Medi-Cal, your information will be sent to your local county office.
- Or, if your income is over the Medi-Cal limit and you meet certain criteria, you may qualify for private health insurance through Covered California. You may also qualify for financial help that lowers your monthly health care premiums. You may qualify for cost-sharing reductions (CSR) that lower your co-pays and deductibles.
- Or, some people in your household may qualify for Medi-Cal, and others may qualify for a Covered California plan. For example, the adults may qualify for a Covered California plan and the kids may qualify for Medi-Cal.

We will tell you which health insurance you and other members qualify for.

You can apply or get help with this application in any of the following ways. This help is always FREE.

Online

CoveredCA.com

By phone

Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). You can call Monday to Friday, 8 a.m. to 6 p.m.

In person

Certified Enrollers can help you, or you can visit your local county office. Visit CoveredCA.com or call **1-800-300-1506** (TTY: 1-888-889-4500) to find local help.

If you have a disability or other need, call us if you need help with this application.

Things to know when you apply

- We keep your information private and secure, as required by law. We only use your information to see if you qualify, to manage your ongoing health insurance, and to allow your health plan to contact you.
- You may qualify for health insurance even if you are not a U.S. citizen or a U.S. national.
- If you don't have all the information needed to complete this application, please call us so we can guide you through it. Or, sign and send in your application anyway. We will help you finish your application. This help is always free.
- If you had Medi-Cal during your pregnancy and you are only applying for your baby, you do not need to fill out this application if your baby is younger than 1 year old. To make sure your baby is covered by Medi-Cal, contact your local county office.
- If you already have Medi-Cal or a Covered California plan and need to report a change, do not use this application. To report changes for Medi-Cal, contact your local county office. For Covered California, update your information at CoveredCA.com or call **1-800-300-1506** (TTY: 1-888-889-4500).
- If you were in foster care on your 18th birthday or later, you may qualify for free Medi-Cal until age 26. Your income does not matter. Go to FAQ #15 on page 41 for more information.

These items may be helpful when you apply

- ☐ Social Security numbers (SSNs) for those who have them.
- ☐ Citizenship or immigration status, and information shown on immigration documents for those who need insurance. We only use this information to see if you qualify for health insurance.
- ☐ Pay stubs or other income documents for everyone in your family.
- ☐ Your most recent tax information. If you don't file taxes, you may still qualify for free or low-cost insurance through Medi-Cal.
- ☐ Information about health insurance offered by an employer to you or any family member.

Facebook.com/
CoveredCA

X.com/
CoveredCA

Facebook.com/
DHCS.CA

X.com/
DHCS_CA

Continue to "Tell us about yourself and your family" ▶▶▶

Tell us about yourself and your family

Include these people on this application, even if they do not want to apply for health coverage:

Remember to sign your application on page 25!

- A spouse or registered domestic partner of anyone in the home
- Any children under 21 who live with you, including stepchildren
- Any parents or stepparents who live in the home with their children under 21
- Anyone on your federal income tax return, if you file one. You don't need to file taxes to apply for health insurance.
- If you are claimed as a dependent on someone else's tax return, you must include all members of the tax filing household that claimed you, and any family members living with you.

★ **Anyone else who lives with you will need to file their own application if they want health insurance.** (For example: a boyfriend, girlfriend, or roommate)

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1. Choose someone to be the Primary Contact

We need one adult in the family to contact if we need more information. The Primary Contact must be 18 years or older.

An authorized representative is different from the Primary Contact. You can tell us who you authorize to act on your behalf on **page 18.**

You must list the Primary Contact as Person 1 throughout the application.

Primary Contact information:

First name	Middle name	Last name	Suffix

What is the best way to contact you? We will ask for your phone number and address on the next pages.

☐ Phone ☐ Mail ☐ Email Email address: ____________________

Continue to "Part 2: General information" ▶▶▶

¿Preguntas? Llame a Covered California al **1-800-300-0213** (TTY: 1-888-889-4500). La llamada es gratuita. O visite CoveredCA.com. **¡Haga la solicitud más rápido en el sitio web!**

2. General information

To tell us about more than 4 people, make a copy of pages 5-14 before you fill them out. Send the added pages with your application.

Answer each question for each person. Read down the column ▼ to tell us about Persons 1, 2, 3, and 4.
Keep each person in the same column on all of the pages.

▼ Person 1 Primary Contact	▼ Person 2	▼ Person 3	▼ Person 4
Tell us the name of each person in your home.			
First name	First name	First name	First name
Middle name	Middle name	Middle name	Middle name
Last name, Suffix	Last name, Suffix	Last name, Suffix	Last name, Suffix
What is each person's relationship to each other? (For example: spouse, child, grandparent, etc.)			
Person 1 is Person 1's: Self	Person 2 is Person 1's:	Person 3 is Person 1's:	Person 4 is Person 1's:
		Person 3 is Person 2's:	Person 4 is Person 2's:
			Person 4 is Person 3's:
Primary phone number			
	☐ Check if same as Primary Contact	☐ Check if same as Primary Contact	☐ Check if same as Primary Contact
☐ Home ☐ Cell ☐ Work ( )	☐ Home ☐ Cell ☐ Work ( )	☐ Home ☐ Cell ☐ Work ( )	☐ Home ☐ Cell ☐ Work ( )
Other phone number This is optional.			
☐ Home ☐ Cell ☐ Work ( )	☐ Home ☐ Cell ☐ Work ( )	☐ Home ☐ Cell ☐ Work ( )	☐ Home ☐ Cell ☐ Work ( )

Continue on the next page ▶▶▶

Continue to answer general information questions about Persons 1, 2, 3, and 4.
Keep each person in the same column on all of the pages. Write their first name in the yellow box to keep track.

Person 1	Person 2	Person 3	Person 4
What is this person's date of birth?			
Month / Day / Year	Month / Day / Year	Month / Day / Year	Month / Day / Year
Home address (Do not list a P.O. Box.) You must give a mailing address below if you do not have a home address.			
	☐ Check if same as Primary Contact	☐ Check if same as Primary Contact	☐ Check if same as Primary Contact
Street address	Street address	Street address	Street address
City	City	City	City
State, ZIP Code	State, ZIP Code	State, ZIP Code	State, ZIP Code
Mailing address If different from Home address.			
	☐ Check if same as Primary Contact	☐ Check if same as Primary Contact	☐ Check if same as Primary Contact
Street address	Street address	Street address	Street address
City	City	City	City
State, ZIP Code	State, ZIP Code	State, ZIP Code	State, ZIP Code
Is this person homeless?			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
What is this person's gender?			
☐ Female ☐ Male Transgender: ☐ Male to female ☐ Female to male	☐ Female ☐ Male Transgender: ☐ Male to female ☐ Female to male	☐ Female ☐ Male Transgender: ☐ Male to female ☐ Female to male	☐ Female ☐ Male Transgender: ☐ Male to female ☐ Female to male

Continue on the next page ▶▶▶

¿Preguntas? Llame a Covered California al **1-800-300-0213** (TTY: 1-888-889-4500). La llamada es gratuita. O visite CoveredCA.com. **¡Haga la solicitud más rápido en el sitio web!**

Continue to answer general information questions about Persons 1, 2, 3, and 4.
Keep each person in the same column on all of the pages. Write their first name in the yellow box to keep track.

Person 1 ▼ ______	Person 2 ▼ ______	Person 3 ▼ ______	Person 4 ▼ ______
What is this person's marital status?			
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Registered domestic partner	☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Registered domestic partner	☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Registered domestic partner	☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Registered domestic partner
Is this person pregnant? We ask these questions about your household size to help you get or keep health coverage. Medi-Cal counts pregnant people as 2 or more household members.			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
▶ **If yes,** what is the estimated due date:			
Month / Day / Year	Month / Day / Year	Month / Day / Year	Month / Day / Year
▶ **If yes,** how many babies are expected?			
What language is best to write to this person? This is optional.			
☐ English ☐ Spanish ☐ Other: ______	☐ English ☐ Spanish ☐ Other: ______	☐ English ☐ Spanish ☐ Other: ______	☐ English ☐ Spanish ☐ Other: ______
What language is best to speak to this person? This is optional.			
☐ English ☐ Spanish ☐ Other: ______	☐ English ☐ Spanish ☐ Other: ______	☐ English ☐ Spanish ☐ Other: ______	☐ English ☐ Spanish ☐ Other: ______
If this person needs future written communications in an alternative format, check a box. This is optional. If you have questions, need a format not listed, or need the electronic format encrypted, please call **1-833-284-0040.**			
☐ Braille ☐ Large print ☐ Audio electronic format (not encrypted) ☐ Data electronic format (not encrypted)	☐ Braille ☐ Large print ☐ Audio electronic format (not encrypted) ☐ Data electronic format (not encrypted)	☐ Braille ☐ Large print ☐ Audio electronic format (not encrypted) ☐ Data electronic format (not encrypted)	☐ Braille ☐ Large print ☐ Audio electronic format (not encrypted) ☐ Data electronic format (not encrypted)

Continue on the next page ▶▶▶

Continue to answer general information questions about Persons 1, 2, 3, and 4.
Keep each person in the same column on all of the pages. Write their first name in the yellow box to keep track.

Person 1	Person 2	Person 3	Person 4
▼ ______________	▼ ______________	▼ ______________	▼ ______________
What is this person's race or ethnicity? This is optional. We ask this question to make sure everyone has the same access to health care. You will have a chance to provide more information on page 9.			
☐ Hispanic, Latino/a, or Spanish Origin ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander	☐ Hispanic, Latino/a, or Spanish Origin ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander	☐ Hispanic, Latino/a, or Spanish Origin ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander	☐ Hispanic, Latino/a, or Spanish Origin ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander
Has this person ever served in the United States military?			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is this person the spouse, legal partner, parent, or child of a person who is serving in or who has served in the United States military?			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Does this person have other health insurance or has this person been offered insurance through a job?			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
▶ **If yes,** fill out Attachment B on pages 30-31.			
If this person is 20 or younger, who is their primary caretaker, if they have one? The primary caretaker is the person who has the main responsibility for the daily care of a child. This can be a parent or a non-parent.			
First and last name	First and last name	First and last name	First and last name
Is this person 18 to 20 years old and a full-time student?			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is this person an American Indian or Alaska Native?			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
▶ **If yes,** fill out Attachment D on page 34.			

Continue to "Part 3: Ethnicity and race" ▶▶▶

3. Ethnicity and race

This information is optional. It will not be used to decide what health insurance each person qualifies for.

This information is confidential. We will only use it to make sure everyone has the same access to health care.

Person 1 ▼ ____	Person 2 ▼ ____	Person 3 ▼ ____	Person 4 ▼ ____
Is this person of Hispanic, Latino/a, or Spanish origin? This is optional.			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
▸ **If yes,** what is this person's origin? This is optional.			
☐ Cuban	☐ Cuban	☐ Cuban	☐ Cuban
☐ Guatemalan	☐ Guatemalan	☐ Guatemalan	☐ Guatemalan
☐ Mexican American / Mexican / Chicano	☐ Mexican American / Mexican / Chicano	☐ Mexican American / Mexican / Chicano	☐ Mexican American / Mexican / Chicano
☐ Puerto Rican	☐ Puerto Rican	☐ Puerto Rican	☐ Puerto Rican
☐ Salvadoran	☐ Salvadoran	☐ Salvadoran	☐ Salvadoran
☐ Other Hispanic, Latino/a, or Spanish origin	☐ Other Hispanic, Latino/a, or Spanish origin	☐ Other Hispanic, Latino/a, or Spanish origin	☐ Other Hispanic, Latino/a, or Spanish origin
What is this person's race? Check all that apply. This is optional.			
☐ American Indian or Alaska Native	☐ American Indian or Alaska Native	☐ American Indian or Alaska Native	☐ American Indian or Alaska Native
☐ Asian Indian	☐ Asian Indian	☐ Asian Indian	☐ Asian Indian
☐ Black or African American	☐ Black or African American	☐ Black or African American	☐ Black or African American
☐ Cambodian	☐ Cambodian	☐ Cambodian	☐ Cambodian
☐ Chinese	☐ Chinese	☐ Chinese	☐ Chinese
☐ Filipino	☐ Filipino	☐ Filipino	☐ Filipino
☐ Guamanian or Chamorro	☐ Guamanian or Chamorro	☐ Guamanian or Chamorro	☐ Guamanian or Chamorro
☐ Hmong	☐ Hmong	☐ Hmong	☐ Hmong
☐ Japanese	☐ Japanese	☐ Japanese	☐ Japanese
☐ Korean	☐ Korean	☐ Korean	☐ Korean
☐ Laotian	☐ Laotian	☐ Laotian	☐ Laotian
☐ Native Hawaiian or Other Pacific Islander	☐ Native Hawaiian or Other Pacific Islander	☐ Native Hawaiian or Other Pacific Islander	☐ Native Hawaiian or Other Pacific Islander
☐ Samoan	☐ Samoan	☐ Samoan	☐ Samoan
☐ Vietnamese	☐ Vietnamese	☐ Vietnamese	☐ Vietnamese
☐ White	☐ White	☐ White	☐ White
☐ Other ____	☐ Other ____	☐ Other ____	☐ Other ____

Continue to "Part 4: Applying for health coverage" ▶▶▶

Need help? Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free.
Or visit CoveredCA.com. **Apply faster online!**

Fill out Part 4 for anyone who wants to apply for health coverage.

4. Applying for health coverage

Person 1 ▼ ______	Person 2 ▼ ______	Person 3 ▼ ______	Person 4 ▼ ______
Is this person applying for health coverage? Check yes if this person wants to apply for Medi-Cal or Covered California.			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

▶ **If yes,** answer the rest of the questions on this page and all questions on page 11 for each person applying for coverage.

▶ **If no,** read the gray box below about your Social Security number if you are the primary tax filer. Otherwise, go to "Part 5: Citizenship / immigration information" on page 12.

Person 1	Person 2	Person 3	Person 4
Is this person currently enrolled in Medicare Part A or Part B?			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Does this person qualify for free Medicare Part A?			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

▶ **If you qualify for free Medicare Part A,** you can **not** get financial help for a Covered California plan. This is true even if you do not enroll in Medicare. But you may still qualify for Medi-Cal. To learn more, go to FAQ #19 on page 42.

Social Security number (SSN): If you are not applying for coverage for yourself, you do not have to give us your SSN. However, if you are the primary tax filer applying for financial help for members of your tax household, we need your SSN to see if they qualify for financial help with Covered California.

Tell us each person's SSN if they have one and are applying. To learn more about giving an SSN, go to FAQ #11 on page 40.

Person 1	Person 2	Person 3	Person 4
___ ___ ___-___ ___-___ ___ ___ ___	___ ___ ___-___ ___-___ ___ ___ ___	___ ___ ___-___ ___-___ ___ ___ ___	___ ___ ___-___ ___-___ ___ ___ ___
If this person does not have an SSN, please check a box.			
☐ Individual Taxpayer Identification Number: ______	☐ Individual Taxpayer Identification Number: ______	☐ Individual Taxpayer Identification Number: ______	☐ Individual Taxpayer Identification Number: ______
☐ Adoption Taxpayer Identification Number: ______	☐ Adoption Taxpayer Identification Number: ______	☐ Adoption Taxpayer Identification Number: ______	☐ Adoption Taxpayer Identification Number: ______
☐ Does not qualify for SSN, or may only be issued one for a valid non-work reason	☐ Does not qualify for SSN, or may only be issued one for a valid non-work reason	☐ Does not qualify for SSN, or may only be issued one for a valid non-work reason	☐ Does not qualify for SSN, or may only be issued one for a valid non-work reason
☐ Does not have an SSN, but has applied for one	☐ Does not have an SSN, but has applied for one	☐ Does not have an SSN, but has applied for one	☐ Does not have an SSN, but has applied for one
☐ Religious exemption	☐ Religious exemption	☐ Religious exemption	☐ Religious exemption

Continue on the next page ▶▶▶

Continue to answer health coverage questions (only if the person is applying) for Persons 1, 2, 3, and 4.
Keep each person in the same column on all of the pages. Write their first name in the yellow box to keep track.

Person 1 ▼ ______	Person 2 ▼ ______	Person 3 ▼ ______	Person 4 ▼ ______
Does this person have a physical, mental, emotional, or developmental disability? For questions about what qualifies as a disability, go to FAQ #16 on page 41.			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Does this person need help with long-term care or home and community-based services? Long-term care is inpatient care in a medical institution or nursing facility, which includes skilled nursing and intermediate care facilities.			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is this person temporarily living out of state?			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is this person involved in a lawsuit because of an injury or accident?			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If this person is 18 to 26 years old, was this person in foster care in any state on their 18th birthday or later? To learn more, go to FAQ #15 on page 41.			
☐ Yes ☐ No Which state?______	☐ Yes ☐ No Which state?______	☐ Yes ☐ No Which state?______	☐ Yes ☐ No Which state?______
Does this person want Medi-Cal to help pay for any medical expenses in the last 3 months?			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Continue to "Part 5: Citizenship / immigration information" ▶▶▶

Need help? Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free.
Or visit CoveredCA.com. **Apply faster online!**

5. Citizenship / immigration information

You only need to provide this information for people in your family who are applying for health insurance.

This information is confidential. We only use it to see if you qualify for health insurance.

Person 1 ▼ ____	Person 2 ▼ ____	Person 3 ▼ ____	Person 4 ▼ ____
Is this person a U.S. citizen or U.S. national?			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
▶ **If yes,** is this person a naturalized or derived citizen? To learn more, go to FAQ #10 on page 40.			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
▶ **If yes,** what are their Certificate Number and Alien Number, if they have them?			
Certificate Number:	Certificate Number:	Certificate Number:	Certificate Number:
Alien Number:	Alien Number:	Alien Number:	Alien Number:

▶ **If you answered yes** to either question above, skip to “Part 6: Tax information” on page 14.
▶ **If you answered no,** answer the questions on page 13.

Continue on the next page ▶ ▶ ▶

Continue to answer citizenship/immigration questions for Persons 1, 2, 3, and 4.
Keep each person in the same column on all of the pages. Write their first name in the yellow box to keep track.

Person 1 ▼ ____	Person 2 ▼ ____	Person 3 ▼ ____	Person 4 ▼ ____
Tell us about this person's immigration status and immigration document, if they have one. See "Immigration status" on page 38 for more information. Then fill in the boxes.			
Immigration status:	Immigration status:	Immigration status:	Immigration status:
Alien Number:	Alien Number:	Alien Number:	Alien Number:
Immigration document type (Example: Permanent Resident Card I-551):	Immigration document type (Example: Permanent Resident Card I-551):	Immigration document type (Example: Permanent Resident Card I-551):	Immigration document type (Example: Permanent Resident Card I-551):
Immigration document number(s) (Example: I-94 Number):	Immigration document number(s) (Example: I-94 Number):	Immigration document number(s) (Example: I-94 Number):	Immigration document number(s) (Example: I-94 Number):
Name as it appears on the document:	Name as it appears on the document:	Name as it appears on the document:	Name as it appears on the document:
Country of issuance:	Country of issuance:	Country of issuance:	Country of issuance:
Expiration date:	Expiration date:	Expiration date:	Expiration date:

- ▶ If you provided an immigration status and document for this person, answer the rest of the questions on this page.
- ▶ If you did **not** provide an immigration status and document for this person, skip to "Part 6: Tax information" on page 14.

Is this person an active duty or honorably discharged member of the United States military, or the spouse or child of a person who is?			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Has this person lived in the U.S. since August 1996?			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Continue to "Part 6: Tax information" ▶▶▶

6. Tax information

This page is required for everyone in your household even if they are not filing taxes.

Tell us how you and your household plan to file taxes.

If you don't plan to file taxes, you may still qualify for free or low-cost insurance. You must still answer the questions on this page.

Person 1 ▼ ____________	Person 2 ▼ ____________	Person 3 ▼ ____________	Person 4 ▼ ____________
Does this person plan to file taxes for the year they want health insurance? For more information, go to FAQ #12 on page 41.			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
▶ **If yes,** what will their tax filing status be? Please check only **one** box. Reminder: If you are married filing jointly, you must include your spouse on this application, beginning on page 5.			
☐ Married filing jointly with____________ ☐ Single ☐ Head of household ☐ Married filing separately	☐ Married filing jointly with____________ ☐ Single ☐ Head of household ☐ Married filing separately	☐ Married filing jointly with____________ ☐ Single ☐ Head of household ☐ Married filing separately	☐ Married filing jointly with____________ ☐ Single ☐ Head of household ☐ Married filing separately
Does this person expect to be required to file taxes for the year they want health insurance?			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Does anyone claim this person as a dependent on their taxes?			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
▶ **If yes,** who?			
First name	First name	First name	First name
Middle name	Middle name	Middle name	Middle name
Last name, Suffix	Last name, Suffix	Last name, Suffix	Last name, Suffix
☐ This person is on this application ☐ This person is **not** on this application	☐ This person is on this application ☐ This person is **not** on this application	☐ This person is on this application ☐ This person is **not** on this application	☐ This person is on this application ☐ This person is **not** on this application

Which person is the primary tax filer? This person's name is first on the tax return.
Only **one** person on this application can be the primary tax filer. Please enter their name even if they are not listed on the application. Please write "none" if you don't file taxes.

First name	Middle name	Last name	Suffix

Continue to "Part 7: Income information" ▶▶▶

7. Income information

Tell us about any current income that you get, and all income starting January 1 of this year. This can be from a job, self-employment, or any other income.

Fill out pages 15-16 for each person in your household who has income even if they aren't applying for health coverage.

Examples of income sources:

Employment: If you have a job, list the amount of income you get before taxes. This is the gross amount. This includes tips, wages, pay, salary, and bonuses. Please include any foreign earned income.

Self-employment: This is income from your own business, freelance, contract, or trade work. If you are self-employed, list your net income from self-employment. Net income means the profits after expenses are paid.

Social Security or interest income: If you get Social Security benefits or interest income, list your gross income. Gross income is what you get before taxes or pre-tax deductions (such as Medicare premiums) are taken out.

Other income: List any other type of income you get from something other than your job, such as unemployment, pension, or investment income. Do not include child support payments, Veterans Administration payments, or Supplemental Security Income (SSI)/State Supplementary Payment (SSP).

To learn more about income sources and what income to provide, go to page 37.

Does anyone on this application have income?

☐ Yes ☐ No

▶ **If yes,** tell us about all income starting on January 1 of this year, for **all** people listed on this application. Tell us about their income even if they are not applying for health coverage.

▶ **If no,** skip these questions and go to "Part 8: Deductions" on page 17.

To tell us about more than 2 incomes, make a copy of pages 15-16 before you fill them out. Send the added pages with your application.

Answer each question for each source of income. Read down the column ▼ to tell us about Incomes 1 and 2. Keep each income in the same column on this page and the next page.

▼ **Income 1**			▼ **Income 2**		
Who is the person with this income?					
First name	Middle name	Last name, Suffix	First name	Middle name	Last name, Suffix
Name this income (For example: the name of your employer or if you are an independent contractor)					
What is the source of this income? Check one.					
☐ Employment	☐ Social Security or interest		☐ Employment	☐ Social Security or interest	
☐ Self-employment	☐ Other________		☐ Self-employment	☐ Other________	

Continue on the next page ▶▶▶

Continue to answer questions about Incomes 1 and 2. Keep each income in the same column.

▼ **Income 1** (continued)	▼ **Income 2** (continued)
What is the amount of income? Read "Examples of income sources" on page 15 to learn whether to report gross or net income.	
$	$
▶ **How often do you get this income?**	
☐ Hourly: Number of hours per week?___________ ☐ Daily: Number of days per week?_____________ ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Twice a month ☐ Annually ☐ One-time payment (To learn more, go to "References" on page 37.)	☐ Hourly: Number of hours per week?___________ ☐ Daily: Number of days per week?_____________ ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Twice a month ☐ Annually ☐ One-time payment (To learn more, go to "References" on page 37.)
▶ **Did you get this income before January 1 of this year?**	
☐ Yes ☐ No **If no,** when did you first get this income? Month / Day / Year:_______________________	☐ Yes ☐ No **If no,** when did you first get this income? Month / Day / Year:_______________________
▶ **Do you still get this income?**	
☐ Yes ☐ No **If no,** when was the last time you got this income? Month / Day / Year:_______________________	☐ Yes ☐ No **If no,** when was the last time you got this income? Month / Day / Year:_______________________
▶ **Do you expect this income to end in the next 4 months?**	
☐ Yes ☐ No **If yes,** when do you expect this income to end? Month / Day / Year:_______________________	☐ Yes ☐ No **If yes,** when do you expect this income to end? Month / Day / Year:_______________________
If you get alimony, what is the date of your divorce or separation agreement? If there is more than one date, tell us the most recent date.	
Month / Day / Year: _______________________	Month / Day / Year: _______________________

Does anyone on this application have income that changes from month to month?

☐ Yes ☐ No **If yes,** answer the questions below. This is important to make sure we get your correct income.

▼ **Income that changes 1**			▼ **Income that changes 2**		
Who is the person with income that changes from month to month?					
First name	Middle name	Last name, Suffix	First name	Middle name	Last name, Suffix
▶ **What do you expect the total income to be this year for this person?**					
$			$		

Continue to "Part 8: Deductions" ▶▶▶

¿Preguntas? Llame a Covered California al **1-800-300-0213** (TTY: 1-888-889-4500). La llamada es gratuita. O visite CoveredCA.com. **¡Haga la solicitud más rápido en el sitio web!**

8. Deductions

Deductions are amounts subtracted from income on a federal tax return for certain expenses. Telling us about these deductions may lower the cost of your health insurance.

Fill out this page if anyone in your household has deductions on their taxes even if they aren't applying for health coverage.

Does anyone on this application have deductions?
For examples of deductions, go to page 37.

☐ Yes ☐ No

- **If yes,** answer the questions on this page.
- **If no,** skip these questions and go to "Part 9: Choose an authorized representative" on page 18.

Answer each question for each deduction. Read down the column ▼ to tell us about Deductions 1, 2, and 3. If you need to tell us about more than 3 deductions, make a copy of this page before you fill it out. Send the added pages with your application.

▼ Deduction 1	▼ Deduction 2	▼ Deduction 3
Who is the person with this deduction?		
First name	First name	First name
Middle name	Middle name	Middle name
Last name, Suffix	Last name, Suffix	Last name, Suffix
What is the type of deduction? For examples of deductions, go to page 37.		
How much is the deduction?		
$	$	$
▶ **How often?**		
☐ Daily: Number of days per week?_______	☐ Daily: Number of days per week?_______	☐ Daily: Number of days per week?_______
☐ Weekly	☐ Weekly	☐ Weekly
☐ Every 2 weeks	☐ Every 2 weeks	☐ Every 2 weeks
☐ Monthly	☐ Monthly	☐ Monthly
☐ Twice a month	☐ Twice a month	☐ Twice a month
☐ Annually	☐ Annually	☐ Annually
☐ One-time deduction	☐ One-time deduction	☐ One-time deduction
If you claim alimony as a deduction, what is the date of your divorce or separation agreement? If there is more than one date, tell us the most recent date.		
Month / Day / Year	Month / Day / Year	Month / Day / Year

Continue to "Part 9: Choose an authorized representative" ▶▶▶

9. Choose an authorized representative

Only fill out this page if you want to choose someone to help with your health care case.

If you choose an authorized representative, this person or organization is allowed to act on your behalf for your Covered California or Medi-Cal case. You can change or cancel your authorized representative any time. Contact your local county office or call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500).

Authorized representative contact information

Name of person or organization

Phone number ☐ Home ☐ Cell ☐ Work ( )	Email		
Mailing address	City	State	ZIP Code

Examples of authorized representative duties:	Authorized representatives must:
• Complete and sign the application and/or redetermination forms • Give us information we ask for • Report changes • Choose a health plan • Help with fair hearing / appeals process • Act on your behalf in all other matters related to your Covered California or Medi-Cal coverage	• Keep any information they get from Covered California or Medi-Cal private • Follow the laws about conflicts of interest and privacy

▶ **If you want to limit** the authorized representative's duties for Medi-Cal, tell us below:

Permission to share information

Do you want Covered California to mail notices about your case to your authorized representative?	Do you want Medi-Cal to mail notices about your case to your authorized representative?
☐ Yes ☐ No	☐ Yes ☐ No

▶ **What is the best way for us to contact your authorized representative?**

☐ Email ☐ Mail

▶ **If you want to limit** the types of notices or mail Medi-Cal sends your authorized representative, tell us below:

Sign and date below if you have chosen an authorized representative.

I authorize the person or organization above to act on my behalf regarding my Covered California or Medi-Cal case in all matters, except as specified above. I authorize Covered California or Medi-Cal to speak with this person or organization on my behalf.

Your signature	**Date**

Continue to "Part 10: Express consent to contact by autodialed or prerecorded messages" ▶▶▶

10. Express consent to contact by autodialed or prerecorded messages

Autodialed and **prerecorded** messages help Covered California and Medi-Cal contact you efficiently.

Providing your contact information gives your express consent to be contacted.

By providing your contact information on this application, you give the Department of Health Care Services, Covered California, your health plans and their business associates, your local county office, and other groups that oversee your Medi-Cal benefits express consent to contact you. The group may contact you by phone, voice message, and text message (SMS/MMS). They may use automatic dialing or messaging systems or artificial or prerecorded voices.

Your express consent allows the groups above to give you important information quickly and efficiently about your health insurance, Medi-Cal benefits and services, and other health care and wellness matters. These may include details or reminders about your Covered California or Medi-Cal annual renewal, plan enrollment, new programs that could benefit you, health plan services, help getting medical services, and more.

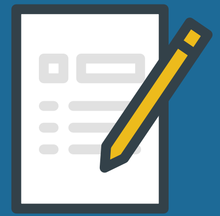
The Department of Health Care Services, your local county office, and other groups that oversee your Medi-Cal benefits will **not** use your contact information for commercial purposes or solicitations. Covered California and your health plans and their business associates **may** use your contact information for commercial purposes or solicitations. It will be kept private as required by law. For questions on privacy, go to CoveredCA.com/privacy and dhcs.ca.gov/Pages/Privacy.aspx.

You may stop autodialed or prerecorded messages at any time by opting out of messages when you are contacted. If you opt out of messages, it will not affect your ability to get Medi-Cal or enroll in a health plan.

This consent is only for autodialed and prerecorded messages. Your local county office, health plan, or the Department of Health Care Services do not need express consent to contact you directly about your Medi-Cal benefits or selected health plan by mail or live phone calls as needed.

Continue to "Please read these pages and sign the application on page 25" ▶▶▶

Please read these pages and sign the application on page 25



Nondiscrimination Policy

Covered California and the Medi-Cal program (DHCS) comply with applicable federal and state civil rights laws. We do not unlawfully discriminate on the basis of race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, sexual orientation, sex characteristics including intersex traits, sex stereotypes, or pregnancy and related conditions. Covered California and the Medi-Cal program (DHCS) do not unlawfully exclude people. We do not treat people differently because of race, color, religion, ancestry, national origin including primary language and limited English proficiency, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, or sexual orientation.

Covered California and the Medi-Cal program (DHCS) provide reasonable modifications and free accessibility aids and services to people with disabilities to communicate effectively with us. These include qualified sign language interpreters, auxiliary aids and services, and written information in other formats such as large print, audio, accessible electronic formats, and other formats. Covered California and the Medi-Cal program (DHCS) also provide free language services to people whose primary language is not English. These include qualified interpreters and information written in other languages. If you need these services, contact the Covered California Section 1557 Civil Rights Coordinator at **1-916-228-8764** or go to CoveredCA.com/accessibility. Or call the DHCS Office of Civil Rights at **1-916-440-7370** (711, CA State Relay), or email CivilRights@dhcs.ca.gov.

Filing a Discrimination Grievance

If you believe that Covered California or the Medi-Cal program (DHCS) has failed to provide these services or you have been discriminated against in another way on the basis of race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, or sexual orientation, you can file a grievance with the Covered California Section 1557 Civil Rights:

Covered California

Mail: Section 1557 Civil Rights Coordinator
P.O. Box 989725
West Sacramento, CA 95798-9725

Phone: **1-916-228-8764**

Fax: 1-916-228-8909

Email: CivilRights@covered.ca.gov

or the
Medi-Cal program's (DHCS's) Office of Civil Rights:

Mail: Office of Civil Rights
P.O. Box 997413, MS 0009
Sacramento, CA 95899-7413

Phone: 1-916-440-7370 (711, CA State Relay)

Email: CivilRights@dhcs.ca.gov

Medi-Cal complaint forms are available at dhcs.ca.gov/discrimination-grievance-procedures.

Continue on the next page ▶▶▶

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

Mail: U.S. Department of Health and Human Services
200 Independence Ave. SW, Room 509F, HHH Building
Washington, DC 20201

Phone: **1-800-368-1019** (TTY: 1-800-537-7697)

Online: Office for Civil Rights Complaint Portal at ocrportal.hhs.gov/ocr/portal/lobby.jsf.
Complaint forms are available on the U.S. Department of Health and Human Services Office for Civil Rights website at hhs.gov/ocr/office/file/index.html.

Privacy Statement

This application is to find out if you qualify for health insurance through Covered California or for benefits through the Department of Health Care Services (DHCS) (Medi-Cal). The personal and medical information you provide is private and confidential. Covered California or the DHCS needs this information 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. We will also share your information with other state and federal agencies as required by law. If we find out that you have intentionally committed fraud on this application, we will share that information with other state, federal, and local agencies.

You must answer all of the questions on this application unless they are marked “optional” or if you are directed otherwise. If your application is missing anything 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.

Full description of privacy practices

See Covered California’s Notice of Privacy Practices at CoveredCA.com/privacy.

See DHCS’s Notice of Privacy Practices at dhcs.ca.gov/NoticeofPrivacy.

Contact information if you have questions about privacy or need records

Covered California
Attn: Privacy Officer, Office of Legal Affairs
1601 Exposition Blvd.
Sacramento, CA 95815
Phone: **1-800-889-3871** (TTY: 1-888-889-4500)

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

Continue on the next page ▶▶▶

Laws that give us the right to collect and keep the information on the application

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

DHCS: CA Welfare and Institutions Code §§ 10850, 14005.36, 14011, and 14100.2.

We must give you this Privacy Statement under CA Civil Code §1798.17.

Your rights and responsibilities

- I agree to report any changes to the information on this application to Covered California or to the local county office.
- If I am found eligible for **Medi-Cal,** I must tell my county eligibility worker about any changes that may affect my eligibility for health insurance within **10** days of the change. These changes include, but are not limited to:
  - » I moved
  - » My income changed
  - » My household changed (For example: marriage, divorce, pregnancy, or had a child or children)
  - » I became qualified for other health insurance
- If I am enrolled in **Covered California,** I understand I must report changes within **30** days. I can call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500) or visit CoveredCA.com to log in to my account and report any changes online.
- I understand that I must report income changes to Covered California or my local county office (if I am covered by Medi-Cal), because changes may affect my eligibility for the amount of premium assistance (tax credits) for a Covered California health plan or my eligibility for Medi-Cal benefits that I may qualify for. I also understand if I receive too much premium assistance during the benefit year, I will have to repay some or all of 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 and the Medi-Cal program to check other agencies' computer records to verify citizenship or whether I am lawfully present in the U.S., tax information, and other information related only to eligibility to see if I and other people on this application qualify for health insurance.
- 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 cooperate with the state or county to get any health coverage that I or my family may be entitled to through an absent parent. I do not need to do this if I am currently pregnant or have good cause to not cooperate. I understand I can get more information about good cause from my local county office.
- I understand that as required by law, the information I provide about myself and other people on this application for Medi-Cal will be checked by computer with facts given by employers, banks, SSA, IRS, Franchise Tax Board, social services, and other agencies to see if I or other people on this application qualify for health insurance.

Continue on the next page ▶▶▶

- I understand that Covered California and Medi-Cal may request that I provide documents to show I qualify for coverage.
- I understand that I can apply for free or low-cost health care through Medi-Cal or Covered California at any time of the year. To enroll in a health plan through Covered California, I must apply during the open enrollment period. Or I must have a qualifying life event to enroll during a special enrollment period. If I am eligible for Medi-Cal, I can enroll throughout the year.
- I consent to the Medi-Cal program/DHCS transmitting my name, email address, mailing address, and mobile telephone number to the Department of Veterans Affairs only for the purpose of receiving additional information on veterans benefits for which I may be eligible. I understand that this consent is valid for 12 months.
- I understand that the Medi-Cal program must seek repayment from probated estates of certain deceased members for Medi-Cal benefits on or after their 55th birthday. Repayment includes fee-for-service and managed care premiums / capitation payments for nursing facility services, home and community-based services, and related hospital and prescription drug services received when the member was an inpatient in a nursing facility or was receiving home and community-based services. Repayment cannot exceed the value of a member's probated estate. For more information you may visit the Estate Recovery website at dhcs.ca.gov/er or call **1-916-650-0590.**
- If I am eligible for the County Children's Health Initiative Program (CCHIP), I agree to contact the CCHIP Customer Service line at **1-833-912-CHIP** (1-833-912-2447) about anything that changes from what I have provided on this application.
- If found eligible for the Medi-Cal Access Program (MCAP) with a premium, I agree to pay the required cost even if I cannot take full advantage of the coverage or services offered by the MCAP program.
- The full list of Medi-Cal rights and responsibilities is on the MC 219 Rights and Responsibilities form.

Your right to appeal:

- If I think Covered California or the Medi-Cal program has made a mistake, I can appeal the decision. To appeal means to tell someone at Covered California or the Medi-Cal program that I think the decision is wrong and ask for a fair review of the action.
- I know that I can find out how to request an appeal, including an expedited appeal, by calling **1-800-300-1506** (TTY: 1-888-889-4500) for Covered California enrollees or **1-800-743-8525** (TTY: 1-800-952-8349) for the Medi-Cal program.
- I know that I must file an appeal within **90 days** of the date of the decision notice.
- I know that I can represent myself or have someone else represent me in my appeal, such as an authorized representative, a friend, a relative, or a lawyer.
- I know that all hearings will be conducted by telephone or video conference unless I request an in-person hearing.
- I know that if I need help, someone at Covered California, the Medi-Cal program, or the local county office can explain my case to me.

Continue on the next page ▶▶▶

- I know that someone at Covered California or the local county office can explain the circumstances when my eligibility may be maintained or reinstated pending an appeal decision.
- I know that an appeal decision for me or other members of my household may change my eligibility or the eligibility of other members of my household. The change in eligibility may result in a redetermination of eligibility for all household members.
- I know that I can get free legal help at my local legal aid or welfare rights office. For Covered California appeals, I know that I can get free, local help with my appeal by calling the Health Consumer Alliance at **1-888-804-3536.**

Renewal of insurance:

To make it easier to keep my eligibility for advanced premium tax credits during the renewal period:

- I agree to allow Covered California to use computer sources, such as the IRS, to confirm the household income I have provided.
- If the sources match the information I provided, Covered California will automatically renew my eligibility for the following benefit year and continue my enrollment.
- I do not need to complete the renewal process unless I need to make changes.

If I do **not** allow Covered California to use computer sources to automatically renew my eligibility, I understand that:

- I must complete the renewal process each year in order to continue to get help paying for my health insurance.
- If I do not complete the renewal process, Covered California will continue my enrollment without financial help.

I agree to allow Covered California 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.

▶ **I can change my decision** at any time by contacting Covered California.

Continue to "Part 11: Declaration and signature" ▶ ▶ ▶

11. Declaration and signature. This section is required.

Remember to sign your application below!

Read and sign below.

- I certify (or declare) under penalty of perjury, under the laws of the State of California, that the foregoing is true and correct.
- I understood all questions on this application and gave true and correct answers to such questions to the best of my knowledge. Where I do not have personal knowledge of an answer, I made every reasonable attempt to verify (or confirm) the answer with someone who has personal knowledge of the answer.
- I know that if I do not tell the truth on this application, there may be a civil and/or criminal penalty for perjury. Under California Penal Code Section 126, perjury is punishable by imprisonment for up to 4 years.
  - » I may be fined up to $25,000 if I negligently, or with intentional disregard for the rules, provide false information in my application.
  - » I may be fined up to $250,000 if I knowingly lie on my application.
- I know that all information in this application will be used to determine eligibility of every person applying for health insurance on this application, to manage my ongoing health insurance, and to allow my health plan to contact me. This information will be kept private, as required by federal and California law.
- I understand that to be eligible for advance premium tax credits, I (the primary tax filer or the spouse) must agree that:
  - » I will file an income tax return for the benefit year;
  - » If I'm married, I will file a joint tax return for the benefit year;
  - » I will claim a personal deduction on my tax return for all members of my family included on this application, including myself and my spouse; and
  - » No other tax filer will be able to claim me as a tax dependent for the benefit year.
- I understand that if I have received advanced premium tax credits for health coverage through Covered California during the previous benefit year, I am required to file a federal income tax return for that benefit year.
- 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.

Signature of applicant or authorized representative:

Date

Make sure you completed all parts of your application.
Go to the checklist on page 43.

Continue to "Part 12: Certified individual, enrollment counselor, or agent" ▶▶▶

12. Certified individual, enrollment counselor, or agent

Only fill out Part 12 if you are a certified individual who helped fill out this application.

Complete this section if you are a Covered California certified individual helping someone fill out this application.
The state will not compensate the Covered California Certified Enrollment Entity unless the Certified Enrollment Counselor fills out this section completely and correctly when submitting this application.

What is your certified status? Check a box.

☐ Certified Enrollment Counselor
☐ Certified Insurance Agent
☐ Certified Medi-Cal Managed Care Plan Enroller
☐ Certified Application Counselor
☐ Certified Plan-Based Enroller
Plan: ______________________________

Name	Number

I certify that I helped the applicant complete this application and that this service was free of charge. I gave true and correct answers to all questions on this application as far as I know. I explained in easy-to-understand language the risk to the applicant of providing inaccurate information, and the applicant understood the explanation.

Sign and date below if you are the certified individual who helped fill out this application:

Date

Continue to "Other California programs that may help you and your family" ▶▶▶

Other California programs that may help you and your family

You can fill out this page if you want to tell us about other programs you might be interested in.

To apply for nutrition benefits, cash assistance, or other Medi-Cal programs, check the program boxes that you are interested in below. We will give the information you provided on this application in a referral to your local county office. Or to apply for these benefits online, visit BenefitsCal.org. To apply in person, call **1-877-847-3663** for a list of places near where you live or work.

- ☐ **CalFresh**

  CalFresh provides food benefits to help low-income households buy the food they need. To learn more, visit: cdss.ca.gov/inforesources/calfresh

- ☐ **CalWORKs**

  CalWORKs is a program that gives cash assistance and services to eligible California families. To learn more, visit: cdss.ca.gov/CalWORKS

- ☐ **Other Medi-Cal programs**

  There are other Medi-Cal programs for people 65 years old or older, people with a disability, or people with special health care needs. To learn more, visit: dhcs.ca.gov/myMedi-Cal

You can also learn more about these programs online:

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

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

Family Planning, Access, Care, Treatment (Family PACT)
A program that provides free family planning services to low-income men and women, including teens.
familypact.org

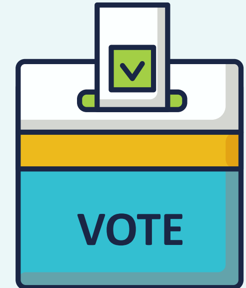
Medi-Cal for Kids & Teens
A program that provides preventive health and treatment services from birth to age 21. This includes physical, mental, and dental services needed to grow up as healthy as possible.
www.dhcs.ca.gov/services/Medi-Cal-For-Kids-and-Teens/Pages/Resources.aspx

Continue to "You can register to vote" ▶▶▶

You can register to vote

You can use this form to register to vote.

Covered California is a voter registration agency. U.S. citizens who are at least 18 years old by the next election can register to vote. U.S. citizens who are 16 or 17 years old may pre-register. If you want help, we can help you fill out the voter registration form. You may fill it out in private.



If you are not registered to vote where you live now, would you or anyone in your home like to apply to register to vote here today?

Applying to register or declining to register to vote will not affect the amount of assistance you will be provided by this agency.

- ☐ **Yes,** send me a voter registration form
- ☐ **Yes,** I will register to vote online at registertovote.ca.gov
- ☐ **No**

If you would like help in filling out the voter registration form, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration form in private.

If you do **not** check a box, you will be considered to have decided not to register to vote at this time. You may take the attached voter registration form to register at your convenience.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party preference or other political preference, you may file a complaint with California's Secretary of State.

To file a complaint:

Call: **1-800-345-VOTE (8683)**

Or write to: Secretary of State, 1500 11th Street, Sacramento, CA 95814

To learn more about elections and voting, go to the Secretary of State's website at sos.ca.gov.

Continue to "Attachment A: Special Enrollment" ▶▶▶

Attachments

Please review the directions in the following attachments to see if they apply to you or your family. If so, fill them out.

Attachment A

Special enrollment

If you qualify for Covered California, you can enroll during open enrollment or a special enrollment period. If you are applying for Medi-Cal, you do not need to complete the Special Enrollment section. You qualify for special enrollment through Covered California if one of the following events has happened to anyone in your household in the last 60 days. Members of federally recognized American Indian tribes or Alaska Native shareholders can apply any time of year.

Fill out Attachment A if anyone in your household had any qualifying life events. You do not need a qualifying life event for Medi-Cal.

To learn more about other "exceptional circumstances" that may be a qualifying life event go to CoveredCA.com.

Qualifying recent life events

1. Lost or will soon lose my health insurance
2. Permanently moved to or within California
3. Had a baby or adopted a child
4. Got married or entered into domestic partnership
5. Returned from active duty military service
6. Was released from jail or prison
7. Gained citizenship or lawful presence
8. Federally recognized American Indian or Alaska Native
9. Lost a dependent (For example: divorce or death)
10. Change in eligibility for financial help programs
11. Victim of domestic abuse or spousal abandonment, or a dependent of a victim
12. Gained or became a dependent through a child support order or other court order
13. Other qualifying life event
14. Exceptional circumstances (For example: natural disasters)
15. None of the above (Continue to review my application for Medi-Cal or MCAP.)

Person 1 ▼ ________	Person 2 ▼ ________	Person 3 ▼ ________	Person 4 ▼ ________
Tell us which person in your home had a qualifying life event.			
First name	First name	First name	First name
Middle name	Middle name	Middle name	Middle name
Last name, Suffix	Last name, Suffix	Last name, Suffix	Last name, Suffix
What was this person's life event? Write the number from the list above. (For example: write "4" for getting married)			
▶ **What date was this event?**			
Month / Day / Year	Month / Day / Year	Month / Day / Year	Month / Day / Year

▶ **If you wrote #13 "Other qualifying life event"** for any household member, describe the change briefly here:

Continue to "Attachment B: Tell us about your family's health insurance" ▶▶▶

Attachment B

Tell us about your family's health insurance

Fill out Attachment B if anyone on this application has other health insurance or an offer of other health insurance.

Answer each question for each person. Read down the column ▼ to tell us about Persons 1, 2, 3, and 4. Keep each person in the same column on all of the pages.

We use this information to see if you qualify for financial help such as advanced premium tax credits. Wrong or missing information could change the taxes that you owe at the end of the year.

We need to know if anyone applying for health insurance has minimum essential coverage now. You do not need to tell us about coverage that is not considered minimum essential coverage.

To tell us about more than 4 people, make a copy of pages 30-31 before you fill them out. Send all of the pages with your application.

Minimum essential coverage includes most government and job-based insurance and private insurance. It includes:

1. Health coverage through your job or a family member's job
2. COBRA
3. Retiree coverage
4. Medicare Part A or C (Medicare Advantage Plan)
5. Full-scope Medi-Cal coverage
6. Coverage provided to Peace Corps volunteers
7. Most TRICARE programs
8. Comprehensive Coverage for Veterans
9. Student health plans
10. Department of Defense Non-appropriated Fund Health Benefits Program

It does **not** include the Indian Health Service, a tribal health program, an urban Indian health program, flex-saving plans, health savings accounts, some supplemental insurance plans, discount plans, or insurance available in another country.

Person 1 ▼ ______	Person 2 ▼ ______	Person 3 ▼ ______	Person 4 ▼ ______
Does this person have (or has this person been offered) health insurance?			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
▶ **If yes,** write the name or corresponding number from the list above. (For example: if you have COBRA insurance, you could write "2" or "COBRA")			

Continue on the next page ▶▶▶

Continue to answer questions for Attachment B about your family's health insurance.
Keep each person in the same column.

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

☐ Yes ☐ No **If yes,** answer the rest of the questions on this page.
If no, go to Attachment C on page 32.

Tell us about health insurance you are offered through a job.

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

Person 1 ▼ ________	Person 2 ▼ ________	Person 3 ▼ ________	Person 4 ▼ ________
Is this person offered health insurance by an employer?			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
▶ **If yes,** what is the employer's name? This is optional.			
Employer name	Employer name	Employer name	Employer name
What is this person's enrollment status? Please check one.			
☐ Enrolled now ☐ Plans to enroll ☐ Is not enrolled	☐ Enrolled now ☐ Plans to enroll ☐ Is not enrolled	☐ Enrolled now ☐ Plans to enroll ☐ Is not enrolled	☐ Enrolled now ☐ Plans to enroll ☐ Is not enrolled
▶ **If this person plans to enroll,** what is the start date?			
Month / Day / Year	Month / Day / Year	Month / Day / Year	Month / Day / Year
How much is the monthly cost of the premium for the lowest cost plan offered? Only include the monthly cost for the person employed.			
$	$	$	$
Is this health insurance affordable? For more information about what qualifies as "affordable," go to FAQ #3 on page 39.			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Does this health plan meet the minimum value standard? Minimum value standard means that a plan pays at least 60% of the total cost of plan benefits provided to the employee (at least Bronze level benefits). Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986.			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Continue to "Attachment C: Choose a health plan and a dental plan" ▶▶▶

Attachment C

Choose a health plan and a dental plan

Fill out Attachment C if anyone on this application wants to choose a health or dental plan.

If you are eligible through Covered California, you can use this form to choose health insurance plans.

If you don't know if members of your household will qualify for a Covered California or Medi-Cal plan, you can wait to tell us what plan you want. After we receive your application, we will send you a notice about your eligibility. You will have an opportunity at that time to choose a health plan.

To learn more about available health insurance plans, visit CoveredCA.com to shop and compare. Or call **1-800-300-1506** (TTY: 1-888-889-4500).

To tell us about more than 4 people, or if you want to enroll members of your family in different plans, make a copy of pages 32-33 before you fill them out. Send all of the pages with your application.

Step 1: Choose your Covered California health plan

Health plan name

Choose the metal tier (coverage level)

- ☐ **Platinum:** Platinum plans have the highest premium costs, but they pay about 90% of your health care expenses.
- ☐ **Gold:** Gold plans pay about 80% of your health care expenses.
- ☐ **Silver:** Silver plans pay about 70% of your health care expenses.
- ☐ **Bronze:** Bronze plans have the lowest premium costs but pay about 60% of covered health care expenses.

Choose the plan type

- ☐ **EPO:** An Exclusive Provider Organization covers only in-network care (except for emergencies) but you do not need a referral to see a specialist.
- ☐ **HMO:** A Health Maintenance Organization covers only in-network care (except for emergencies) and you need a referral to see a specialist.
- ☐ **HDHP:** A High Deductible Health Plan allows members to open and contribute to a health savings account.
- ☐ **PPO:** A Preferred Provider Organization covers care from in-network or out-of-network providers without a referral (cost varies between in network and out of network).

Who should be enrolled in this plan?

▼ Person 1 Primary Contact	▼ Person 2	▼ Person 3	▼ Person 4
First name	First name	First name	First name
Middle name	Middle name	Middle name	Middle name
Last name, Suffix	Last name, Suffix	Last name, Suffix	Last name, Suffix

Continue on the next page ▶▶▶

Continue to answer questions for Attachment C if you are choosing a health or dental plan.

Step 2: Read and sign the Binding Arbitration Agreement

- I understand that every participating health plan has its own rules for resolving disputes or claims. This includes, but is 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 choose 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). I give up my right to a jury trial. I 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 the health plan's coverage document that is available online at CoveredCA.com for my review. Or I can call Covered California for more information at **1-800-300-1506** (TTY: 1-888-889-4500).

Signature of all individuals 18 or older who are enrolling in a health plan		
Person 1: Printed name	**Person 1:** Signature ▶	Date
Person 2: Printed name	**Person 2:** Signature ▶	Date
Person 3: Printed name	**Person 3:** Signature ▶	Date
Person 4: Printed name	**Person 4:** Signature ▶	Date

Step 3: Choose your optional family dental plan

Complete this part if you want a stand-alone family dental plan for some or all of the adults in your household. Children under the age of 19 already receive dental coverage through their health plan. They do not need a separate dental plan.

To qualify to enroll in a dental plan, you must also enroll in a health plan through Covered California. Financial help is not available for stand-alone dental plans. To learn more about optional family dental plans, visit CoveredCA.com. Or call **1-800-300-1506** (TTY: 1-888-889-4500).

Choose the dental plan	Choose the plan type
Dental plan name	☐ **DHMO:** Dental Health Maintenance Organization ☐ **DPPO:** Dental Preferred Provider Organization

Who should be enrolled in this plan?	
First and last name:	First and last name:
First and last name:	First and last name:

Continue to "Attachment D: For American Indians and Alaska Natives" ▶▶▶

Need help? Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free.
Or visit CoveredCA.com. **Apply faster online!**

Attachment D

For American Indians and Alaska Natives

Fill out Attachment D if anyone on this application is American Indian or Alaska Native.

Answer each question for each person. Read down the column ▼ to tell us about Persons 1, 2, 3, and 4. Keep each person in the same column on all of the pages.

Federally recognized American Indians and Alaska Natives may not have to pay out-of-pocket costs such as co-payments. They may get special enrollment periods. American Indians and Alaska Natives can also get services from the Indian Health Service, tribal health programs, or urban Indian health programs.

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.**

To tell us about more than 4 people, make a copy of pages 34-35 before you fill them out. Send all of the pages with your application.

Person 1 ▼ ____	Person 2 ▼ ____	Person 3 ▼ ____	Person 4 ▼ ____
Is this person a member of a federally recognized American Indian or Alaska Native (Native American) tribe?			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
▶ **If yes,** what is the name of the tribe?			
Tribe name	Tribe name	Tribe name	Tribe name
▶ **In which state** is the tribe recognized?			
State	State	State	State
Has this person ever gotten a service from the Indian Health Service, a tribal health program, an urban Indian health program, or through a referral from one of these programs?			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
▶ **If no,** is this person eligible to get services from the Indian Health Service, a tribal health program, an urban Indian health program, or through a referral from one of these programs?			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Continue on the next page ▶▶▶

Continue to answer questions about American Indians or Alaska Natives.
Keep each person in the same column on all of the pages. Write their first name in the yellow box to keep track.

Person 1 ▼ ______	Person 2 ▼ ______	Person 3 ▼ ______	Person 4 ▼ ______
Income sources: • Payments to the tribe that come from natural resources, usage rights, leases, or royalties • Payments from leases or royalties for the use of Indian trust land for natural resources, farming, ranching, or fishing • Money from selling things that have cultural value			
If this person is an American Indian or Alaska Native, do they get income from any source listed above?			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
▶ **If yes,** answer the rest of the questions on this page.			
What is the amount of income?			
$	$	$	$
▶ **How often** does this person get this income?			
☐ Daily: Number of days per week?______ ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Twice a month ☐ Annually ☐ One-time payment	☐ Daily: Number of days per week?______ ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Twice a month ☐ Annually ☐ One-time payment	☐ Daily: Number of days per week?______ ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Twice a month ☐ Annually ☐ One-time payment	☐ Daily: Number of days per week?______ ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Twice a month ☐ Annually ☐ One-time payment
Did you get this income before January 1 of this year?			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
▶ **If no,** when did you first get this income?			
Month / Day / Year	Month / Day / Year	Month / Day / Year	Month / Day / Year
Do you still get this income?			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
▶ **If no,** when was the last time you got this income?			
Month / Day / Year	Month / Day / Year	Month / Day / Year	Month / Day / Year
▶ **If you still get this income,** do you expect it to end in the next 4 months?			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
▶ **If yes,** when do you expect this income to end?			
Month / Day / Year	Month / Day / Year	Month / Day / Year	Month / Day / Year

Continue to "Attachment E: Employer contact information" ▶▶▶

Need help? Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free.
Or visit CoveredCA.com. **Apply faster online!**

Attachment E

Employer contact information

Fill out Attachment E if anyone in your household has a job. If you think you will qualify for Medi-Cal, you do not need to fill out this page.

Answer each question for each employer. Read down the column ▼ to tell us about Employers 1 and 2. Keep each employer in the same column.

To tell us about more than 2 employers, make a copy of this page before you fill it out. Send all of the pages with your application. If you are not sure whether to fill out this page, call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500).

▼ Employer 1	▼ Employer 2
Employee information	
First name Middle name Last name, Suffix	First name Middle name Last name, Suffix
Social Security number (SSN) (optional)	Social Security number (SSN) (optional)
Employer information	
Employer name	Employer name
Employer Identification Number (EIN) (optional)	Employer Identification Number (EIN) (optional)
Employer address	Employer address
City State ZIP Code	City State ZIP Code
▶ **Does this employer have a foreign mailing address?**	
☐ Yes ☐ No	☐ Yes ☐ No
▶ **If yes,** fill out the information below.	
Country name	Country name
Foreign province name	Foreign province name
Foreign postal code	Foreign postal code

Continue to "References" ▶▶▶

References

Use these lists to answer questions in the application.

Self-employment

You can subtract these items from your gross income to find your net self-employment income:

- 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
- Income from the sale of property or an investment (see IRS Form 4797)
- Rent or lease of business property and utilities
- Commissions, taxes, licenses, and fees
- Advertising
- Contract labor
- Repairs and maintenance
- Certain business travel and meals

For more information, see instructions for Schedule C at irs.gov.

Deductions

You can only include deductions that are listed above the Adjusted Gross Income (AGI) line on your federal income tax return. Examples include:

- Certain self-employment expenses, such as self-employed health insurance premiums
- Student loan interest
- Educator expenses
- IRA contribution
- Penalty on early withdrawal of savings
- Health savings account deduction
- Certain business expenses of reservists, performing artists, and fee-based government officials
- Hobby income expenses

For information about deductions, visit irs.gov.

One-time payment

One-time income payments are only allowed for:

- Gambling winnings, lottery winnings, or prizes
- Cancellation of debt
- Education scholarships
- Awards, fellowships, or grants
- Salary or wages from decedent's employer received by a surviving spouse
- Retroactive Social Security and Railroad Retirement benefits
- Gifts
- Retroactive unemployment insurance benefits

Examples of other income

Examples include:

- Federal or state government unemployment income
- Social Security retirement and survivors and disability benefits
- Railroad Retirement benefits
- State Disability Insurance (SDI) you get in place of unemployment benefits
- Income you get from retirement plans including 401k, 457, 509, Taxable IRA, and Keogh (Note: Do not enter money in retirement savings accounts that you are not using at this time.)
- Pension income
- Rent or royalty income
- Court-ordered payment after separation or divorce
- Investment income (like certain types of dividends)
- Regular income from owning stocks (see IRS Form 1099-DIV)
- Taxable refunds, credits, or offsets of state and local income taxes (see IRS Form 1099-G)
- Capital gains or losses
- Foreign-earned income
- Farming or fishing income
- Canceled debts, court awards, or jury duty pay

For more information, see instructions for Schedule D, Schedule E, and Schedule F at irs.gov.

Continue on the next page ▶▶▶

Immigration status

Even if your immigration status is not listed below, you may still qualify for health insurance and should still apply. We only use this information to see if you qualify for health insurance.

- Lawful Permanent Resident (LPR / Green Card holder)
- A non-citizen with an approved visa petition, who has a pending application for adjustment to LPR status
- A non-citizen, without a visa petition, who has a pending application for adjustment to LPR status, with Employment Authorization
- A non-citizen who has a pending application for adjustment to LPR status, without Employment Authorization
- Refugee
- Asylee
- Cuban / Haitian Entrant
- Amerasian Immigrant
- Granted withholding of deportation or removal
- Granted a stay of deportation
- Granted suspension of deportation whose departure USCIS does not contemplate enforcing
- Conditional Entrant granted before 1980
- Paroled into the United States for 1 year or more
- Paroled into the United States for less than 1 year
- Battered non-citizen, or parent or child of battered non-citizen
- Granted Deferred Action, but not under Deferred Action for Childhood Arrivals (DACA)
- Granted Deferred Action for Childhood Arrivals (DACA)
- Granted Order of Supervision, with Employment Authorization
- Granted Order of Supervision, without Employment Authorization
- An immigrant who entered and has continuously resided in the United States since before January 1, 1972, who would be eligible for an adjustment of status to lawful permanent resident (eligible as a Registry immigrant)
- Registry applicant, with Employment Authorization
- Pending application for Creation of Record of Lawful Admission for Permanent Residence, with Employment Authorization
- Granted voluntary departure and awaiting issuance of a visa
- A non-citizen on whose behalf an immediate relative petition (I-130) has been approved and who is entitled to voluntary departure
- Granted withholding of removal under the Convention against Torture (CAT)
- Granted a Victim of Trafficking visa (T visa), or spouse, child, sibling, or parent
- Pending application for a T visa, or spouse, child, sibling, or parent
- Taking steps to apply for a T visa or for certification by the Office of Refugee Resettlement
- Granted U visa
- Filed for a U visa
- Granted Student Visa (like F or M visa)
- Granted Work Visa (like H-1, J-1, O, R, or P visa)
- Granted Visitor Visa (like B visa)
- Lawful Temporary Resident (special agricultural workers or certain immigrants admitted into the U.S. before 1982)
- Granted Temporary Protected Status (TPS) or pending applicants for TPS (pending applicants must have Employment Authorization)
- Family Unity Beneficiary
- Granted Deferred Enforced Departure
- Resident of American Samoa
- Citizen of Micronesia, the Marshall Islands, or Palau
- Administrative order staying removal issued by the Department of Homeland Security
- Pending application for legalization under Immigration Reform and Control Act (IRCA), with Employment Authorization
- Pending application for asylum, with Employment Authorization, or is under the age of 14 and has had a pending application for asylum for at least 180 days
- Pending application for withholding of removal, with Employment Authorization, or is under the age of 14 and has had a pending application for withholding of removal for at least 180 days
- Pending application for legalization under the LIFE Act, with Employment Authorization
- Pending application for suspension of deportation, cancellation of removal, or special rule cancellation of removal, with Employment Authorization
- Pending application for Special Immigrant Juvenile Status

Continue to "Frequently asked questions (FAQ)" ▶▶▶

Frequently asked questions (FAQ)

1. What type of health insurance plans can you buy through Covered California?

Covered California offers 4 coverage levels (metal tiers) of private health insurance plans:

Platinum plans have the highest monthly premium cost but they pay about 90% of your health care expenses.

Gold plans pay about 80% of your health care expenses.

Silver plans pay about 70% of your health care expenses.

Bronze plans have the lowest monthly premium cost but they pay about 60% of covered health expenses.

Visit CoveredCA.com to learn more and compare plans and rates. Or call **1-800-300-1506** (TTY: 1-888-889-4500).

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

2. How much does a Covered California plan cost?

The cost depends on what health insurance programs and financial help you qualify for, as well as which plan you choose. The amount of financial help is based on household size, income, and ZIP Code. You can use the **Shop and Compare** tool at CoveredCA.com to estimate the cost and see if you may qualify for help paying for insurance. After you submit your application, you will get a letter that tells you if you qualify for financial help and for how much. Or, you will get a letter that tells you if you qualify for free or low-cost insurance through Medi-Cal.

3. What is an offer of "affordable" health insurance?

A job-based health plan is considered "affordable" if the part the employee pays to cover themselves is less than 9.02%* of the whole family's income. If employees pay more than 9.02%*, they may qualify for financial help through Covered California. If the cost to cover only the employee is 9.02%* or less, but the cost to cover other family members is more than 9.02%*, those family members may qualify for financial help. You cannot get financial help with a Covered California health plan if you have, or are expected to have, employer-based coverage that is considered "affordable."

*The exact percentage that is considered "affordable" changes a little every year. For the most recent percentage, go to CoveredCA.com/employer-coverage-financial-help.
Or, call Covered California with your questions at **1-800-300-1506** (TTY: 1-888-889-4500).

4. What will happen after I apply?

Depending on your household size and income, your application may be processed for Covered California or for Medi-Cal. Either way, we will contact you to tell you which program you and your family members qualify for and when your insurance starts. For Covered California, you should hear from us within 10 days. For Medi-Cal, we are required to make a decision within 45 days, but you may hear from us sooner. If you want to check on the status of an application, please call us at **1-800-300-1506** (TTY: 1-888-889-4500).

5. How do I contact my local county office?

To get the phone number for your local county office, go to dhcs.ca.gov/mymedi-cal.

Continue on the next page ▶▶▶

6. What if I already have health insurance?

If you already have health insurance, you can still apply to find out if you or your family members qualify for free or low-cost health insurance.

7. Do I need to report my monthly or yearly income?

Start by reporting your current monthly income. If your current monthly income stays about the same every month, you don't need to provide your expected annual income. Your current monthly income is used to determine your expected annual household income and to decide what health programs you may qualify for. It is important that you report your current monthly income accurately. If your current monthly income goes up and down, it is also important that you give your best estimate for your annual income. You should base your annual estimate on past experience, recent trends, what you know about possible changes at your workplace, and similar information.

If the income you report does not match our records, you can explain the difference. This is called a **reasonable explanation.** After you give us the explanation, you may qualify for programs without having to send income proof.

8. If I qualify for a Covered California health plan, how can I make sure I get the right amount of financial help?

If you qualify for a Covered California health plan, financial help will be based on your expected annual household income for the year you want coverage. Income is counted for you, your spouse, and everyone you'll claim as a tax dependent on your federal tax return (if the dependents are expected to be required to file taxes). Include their income even if they don't need health coverage. It is very important to report any income changes as soon as possible because you could miss out on savings or may have to pay back money when you file your federal tax return for the year.

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

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

10. What does it mean to be a naturalized or derived citizen?

Naturalization is the process by which U.S. citizenship is granted to a foreign citizen or national after they fulfill the requirements established by Congress in the Immigration and Nationality Act (INA).

A **derived citizen** is a person born abroad to U.S. citizen parents, or who obtains their citizenship upon their parents' naturalization, or who is recognized automatically through other means, which may be documented by a Certificate of Citizenship.

11. Do I need to provide my Social Security number?

If you have a Social Security number (SSN) you must provide it when you are applying for health coverage for yourself. We use SSNs to check income and other information to see if you are eligible to get help paying for your family's health coverage. Giving us your SSN will help us process your application faster.

If you are **not** applying for coverage for yourself, you do not have to give us your SSN. Your family members can still apply even if you do not give us your SSN. You may be eligible for some coverage even if you do not have an SSN. If you are the primary tax filer applying for financial help for your tax household members, we will not be able to determine their eligibility for financial help through Covered California without your SSN. If you or someone in your household wants help getting an SSN, you can ask your local county office, or visit the Social Security Administration website at ssa.gov.

Continue on the next page ▶▶▶

12. 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 financial help. We will use your income to find the health insurance that is most affordable for you and your family.

If you qualify for a Medi-Cal plan: You do not need to file taxes to qualify for Medi-Cal.

To qualify for financial help to lower the cost of your Covered California plan:

- You must file taxes for the year you get health insurance with financial help (advanced premium tax credit); and
- For the year you get health insurance, married applicants and their spouse need to file taxes as married filing jointly. For exceptions, talk to your tax preparer.

If you have questions, talk to your tax preparer. Or go to the IRS website on the Affordable Care Act at irs.gov/aca.

13. How can I add a child to my Covered California health insurance?

You should report a change by logging in to your CoveredCA.com account or calling Covered California if you had a baby, adopted a child, or added a child to your household.

14. I have Medi-Cal and I just had a baby. What should I do?

If you have Medi-Cal during your pregnancy and you are only applying for your baby, you do not need to fill out this entire application.
Instead, you can:

- Contact your local county office to make sure your baby is covered from birth, or
- Print and fill out a newborn referral form by visiting dhcs.ca.gov and typing "MC 330" into the search bar.

If you did not have Medi-Cal at the time of delivery, fill out this application for your baby.

15. I was in foster care on or after my 18th birthday. Do I qualify for Medi-Cal?

If you were in foster care on your 18th birthday or later, you may qualify for free Medi-Cal up to age 26. Your income does not matter. You do not need to fill out this application if you are only applying for yourself. You can continue with this application or apply at CoveredCA.com. Or you can apply through the county by phone or using a simple one-page form for former foster youth, called the MC 250A. If you were in foster care, contact your local county office to get insurance right away.

16. What do you mean by disability?

You may qualify for Medi-Cal if any of the following apply:

- You are deaf or have serious difficulty hearing.
- You have serious difficulty seeing even when wearing glasses.
- Because of a physical, mental, or emotional condition, you have serious difficulty concentrating, remembering, or making decisions.
- You have serious difficulty walking or climbing stairs.
- You have difficulty dressing, bathing, or doing similar daily activities.
- Because of a physical, mental, or emotional condition, you have difficulty doing errands alone, such as visiting a doctor's office or shopping.

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. In order to qualify for disability-based Medi-Cal, you may need to provide additional information about your income.

Continue on the next page ▶▶▶

17. Can I get health insurance if I have a pre-existing condition or disability, or if I am pregnant?

Yes, you can get health insurance regardless of any current or past health conditions, including disability or pregnancy. Most health insurance plans can't refuse to cover you or charge you more just because you have a pre-existing health condition.

18. What is Medicare?

Medicare is the federal health insurance program for people 65 or older. Younger people with disabilities may also be eligible. People of any age with End-Stage Renal Disease (kidney failure requiring dialysis or a transplant) or ALS can also qualify.

19. I am eligible for free Medicare Part A, but I don't want to enroll in Medicare Part B or C. Can I enroll in a plan through Covered California instead and still qualify for financial help?

If you are eligible for free Medicare Part A, you cannot get financial help to pay for a private health plan through Covered California, even if you do not enroll in Medicare Part B or C. If you are not sure if you are eligible for free Medicare Part A, please call the Social Security Administration at **1-800-772-1213** (TTY: 1-800-325-0778). Remember to ask if Part A will be free.

Note: If you have to pay a premium for Medicare Part A coverage and have not enrolled in Part A, you may be able to keep Covered California coverage and financial help. This is not common. An individual may be eligible for both Medicare and Medi-Cal.

Did you remember to:

☐ **Tell us** about everyone in your family and household even if they don't need insurance? See page 4 for the list of whom to include. Include copies of pages 5-14 if you need more room.

☐ **Ask** your employer about any job-related insurance you may qualify for?

☐ **Sign** this application on **page 25?** If you chose an authorized representative, also sign page 18.

☐ **Enclose** any required Attachments? Please review Attachments A-E, pages 29-36, to see if there is additional information you want to share with us.

☐ **Mail your signed application to:**
Covered California
P.O. Box 989725
West Sacramento, CA 95798-9725

Or fax your signed application to:
1-888-329-3700

Continue to "Getting help in other languages" ▶▶▶

Getting help in other languages

Call 1-800-300-1506 (TTY: 1-888-889-4500) or the numbers below to get help with this application in other languages or other formats, such as large print, or to get information about free auxiliary aids and services.

SPANISH Puede obtener ayuda con esta solicitud en español. O puede obtener otros formatos, tales como letra grande, ayudas auxiliares gratuitas y servicios. Llame **1-800-300-0213.**

CHINESE 您可獲得本申請表的中文協助；亦可索取大字版等其他格式及免費的輔助溝通方式與服務。請致電 **1-800-300-1533.**

VIETNAMESE Quý vị có thể được trợ giúp về đơn đăng ký này bằng tiếng Việt. Hoặc quý vị có thể nhận được các định dạng khác, như bản in khổ lớn, sự hỗ trợ và dịch vụ phụ trợ miễn phí. Vui lòng gọi **1-800-652-9528.**

KOREAN 신청서와 관련한 도움을 한국어로 받아보실 수 있습니다. 또는 큰 글씨로 인쇄된 문서, 무료 보조 지원 및 서비스 등 기타 형식의 지원을 받아볼 수도 있습니다. **1-800-738-9116**번으로 전화하세요.

TAGALOG Makakakuha ka ng tulong sa aplikasyon na ito sa Tagalog. O maaari kang makakuha ng iba pang format, tulad na malalaking print, libreng mga pandagdag na tulong, at serbisyo. Tumawag sa **1-800-983-8816.**

HMONG Koj tuaj yeem thov kev pab txog daim ntawv thov no ua Lus Hmoob tau. Los sis koj tuaj yeem thov lwm hom qauv ntaub ntawv, xws li luam ua tus ntawv loj, kev pab ntaub ntxiv, thiab kev pab cuam pub dawb. Hu rau **1-800-771-2156.**

HINDI आप हिंदी में इस आवेदन-पत्र में मदद प्राप्त कर सकते हैं। अथवा आप अन्य फॉर्मैट प्राप्त कर सकते हैं, जैसे बड़ा प्रिंट, मुफ्त सहायक साधन, और सेवाएं। **1-800-300-1506** पर फोन करें।

JAPANESE 申請に関するサポートは日本語でも受けられます。また、大活字版などの代替形式やサービスも無料でご利用いただけます。**1-800-300-1506**までお電話ください。

LAO ທ່ານສາມາດຮັບການຊ່ວຍເຫຼືອກັບຄໍາຮ້ອງນີ້ເປັນພາສາລາວ ຫຼື ທ່ານສາມາດຮັບການຊ່ວຍເຫຼືອໃນຮູບແບບອື່ນເຊັ່ນ: ໜັງສືຕົວພິມໃຫຍ່, ເຄື່ອງຊ່ວຍເຫຼືອເສີມຟຣີ ແລະ ການບໍລິການຕ່າງ. ກະລຸນາໂທຫາ **1-800-357-7976.**

RUSSIAN При заполнении этой заявки вы можете получить помощь на русском языке. Также доступны другие форматы (например, бланки, напечатанные крупным шрифтом), бесплатные вспомогательные средства и услуги. Звоните по телефону **1-800-778-7695.**

ARMENIAN Դուք կարող եք այս դիմումի հետ կապված աջակցություն ստանալ հայերենով: Հասանելի են այլընտրանքային տարբերակներ, օրինակ՝ խոշոր տառատեսակով ձևաչափեր, անվճար աջակցության գործիքներ և ծառայություններ: Զանգահարեք **1-800-996-1009:**

FARSI شما می‌توانید برای این درخواست به زبان فارسی کمک دریافت کنید. همچنین می‌توانید به فرمت‌های دیگر مانند چاپ بزرگ، کمکهای رایگان و خدمات دیگر دسترسی داشته باشید. با شماره **1-800-921-8879** تماس بگیرید.

KHMER អ្នកអាចទទួលបានជំនួយសម្រាប់ការដាក់ពាក្យស្នើនេះជាភាសាខ្មែរបាន។ អ្នកក៏អាចទទួលបានជំនួយក្នុងទម្រង់ផ្សេងទៀតបានផងដែរ មានដូចជា ឯកសារដែលមានអក្សរធំៗ ជំនួយ និងសេវាកម្មពិសេសផ្សេងៗដោយឥតគិតថ្លៃ។ សូមហៅទូរសព្ទទៅលេខ **1-800-906-8528**។

ARABIC يمكنك الحصول على مساعدة بشأن هذا الطلب باللغة العربية. أو يمكنك الحصول على الطلب بأشكال أخرى، مثل حروف الطباعة الكبيرة، والخدمات والوسائل المساعدة المجانية. اتصل بالهاتف رقم **1-800-826-6317**.

IO MIEN Meih haih zipv mienh tengx liuc leiz zoux naaiv zeiv sou-gorn benx Mienh waac. A'fai meih corc haih zipv longc benx da'nyeic nyungc daan, beiv taux aamx benx domh zeiv, wangv henh maaih jaa-dorngx tengx, aengx caux gong-bou jauv-louc. Mborqv finx lorz taux **1-800-300-1506.**

PUNJABI ਤੁਸੀ ਪੰਜਾਬੀ ਵਿੱਚ ਇਸ ਅਰਜ਼ੀ ਵਿੱਚ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਜਾਂ ਤੁਸੀ ਦੂਜੇ ਫੌਰਮੈਟ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ, ਜਿਵੇਂ ਵੱਡਾ ਪ੍ਰਿੰਟ, ਮੁਫ਼ਤ ਸਹਾਇਕ ਸਾਧਨ, ਅਤੇ ਸੇਵਾਵਾਂ। **1-800-300-1506** ਤੇ ਫੋਨ ਕਰੋ।

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