Alcohol and Other Drug Services (AOD) /Health Care for the Homeless (HCH)
Uninsured Client Screening, Referral and Certification Form

Today's Date: _____

STEP 1: AOD/HCH REFERRING AGENCY CONTACT INFORMATION

Agency Contact Person:	**Referring Agency:**
Email of Contact Person:	**Phone # of Contact Person**

STEP 2: APPLICANT DEMOGRAPHIC INFORMATION

A. Name:	B. Date of Birth
C. Social Security Number/Pseudo Number	D. Phone Number (if any)
E. Are you a U.S. Citizen? Yes No i. If Yes, What is applicant's County or State or Country of Birth? _____ ii. If No, Are you a Legal Permanent Resident LPR? Yes No iii. If applicant is born outside of the US, what is applicant's date of entry into the US? _____ iv. If not a LPR, have you recently filed for a restraining order and/or police report because of a domestic disturbance or any other crime that you might have been a victim of? Yes No If Yes, Please Specify: _____	
F. What is the client's ethnicity? ☐ Hispanic/Latino ☐ Black/ African-American ☐ White ☐ Asian ☐ Other	G. What is applicant's mother's maiden name? _____

STEP 3: MEDI-CAL SCREENING

If applicant answers yes to one of the following questions, then applicant is potentially eligible for Medi-Cal. The Medi-Cal SAWS 1 application form (ATTACHMENT 1 ENGLISH or ATTACHMENT #2 SPANISH) should be filled out for applicant. If applicant is Medi-Cal eligible, proceed to Step 5. If applicant is NOT Medi-Cal eligible, proceed to Step 4.

IS APPLICANT

A. Under 21 years old? Yes No

i. If yes, is the applicant living with the parent(s) for more than half of this current calendar year?

Yes No

B. A parent of a child age 21 or under who lives with him or her in the household? Yes No

i. If yes to B, is the applicant or the applicant's spouse unemployed, deceased, disabled, absent or working less than 100 hours per month?
Yes No Indicate Parent's Name: _____

C. Disabled? Does applicant have a physical or emotional disability that will last more than one year? Yes No

D. Age 65 or over Yes No

E. Pregnant Yes No

F. Blind Yes No

G. A Refugee Yes No

H. Does applicant receive any income? Yes No

i. If yes, indicate income: _____

I. Does applicant own a bank account within the past 2 years? Yes No

J. Does applicant have a retirement account such as an IRA or 401(K)? Yes No

K. Did applicant apply for Social Security Benefits (SSI/SSDI) in the past twelve months? Yes No

If Yes, what county do they apply in? _____-

STEP 4: ACE SCREENING

A. AOD/HCH STATUS

i. The above named applicant is a client/resident of the following agency (check one):

☐ Behavioral Health Recovery Services ☐ OTHER please indicate address below

_____ _____

_____ _____

ii. ☐ Check the box if the above agency address is where all client ACE correspondence should be mailed.

iii. If client has a separate mailing address such as post office box, please indicate address below:

_____

_____

B. INCOME ELIGIBILITY

i. ☐ Please check box if the above applicant's income has been verified upon intake and applicant's income is below 200% of the Federal Poverty Level. If client has no proof of income such as paystub, please have applicant sign income verification statement (ATTACHMENT 9).

Family Size	Maximum Gross Monthly Income
1	$1,815
2	$2,453
3	$3,089
4	$3,725
5	$4,362
6	$4,999
7	$5,635
8	$6,272
9	$6,910
10	$7,548
Additional Family Member	$638
*Please note that the income guideline is updated annually on the first of April.	

C. SAN MATEO COUNTY RESIDENCY

☐ The above applicant is a San Mateo County resident and intends to stay in San Mateo County at time of discharge from the AOD or HCH facility below.

D. APPLICANT MCE & ACE RIGHTS AND DECLARATIONS

Please review and have client sign the MCE or ACE Rights and Declarations if you have confirmed the client met the income and county residency requirement for a program. For applicants with income please provide both the MCE & ACE Rights and Declarations

STEP 5: SUBMISSION OF DOCUMENTS

1. If applicant is Medi-Cal eligible, please submit
a. This referral form and SAWS 1. For SAWS 1, please only fill out sections 1 to 13 and have applicant sign and date the form. (ATTACHMENT #1)
b. The other verifications listed below if available:

1. Proof of household income (pay stub or unemployment stub dated within the last 45 days, tax return, etc.) If applicant has no income, please bring a letter from the person providing financial support. The applicant can also bring the signed income verification statement (see Attachment #9).
2. Proof of San Mateo County residency (utility bill dated within the last 45 days, CA driver's license/ID, etc.) if applicant has a resident other than the AOD/HCH facility.
3. Proof of identity for the applicant such as driver's license, CA ID, etc. If no picture ID is available, please provide an affidavit from the facility (See Sample Attachment #10)
4. Applicants with children must bring proof of any assets (bank statements, car registrations, property tax statement for non-primary residence, life insurance policy face sheet)
5. U.S. citizens/Legal Permanent Residents should bring proof of citizenship/legal status (U.S. birth certificate or passport, Residency card).
6. If applicant is applying for their children, bring proof of their age (birth certificate, passport or green card)

c. The CHA will follow-up with agency staff person to complete the Medi-Cal application.

2. If applicant is MCE or ACE eligible, please submit the following:
a. This referral form.
b. The other verifications listed below if available:

1. Proof of household income (pay stub or unemployment stub **dated within the last 45 days**, tax return, etc.) If applicant has no income, please bring a letter from the person providing financial support. The applicant can also bring the signed income verification statement (see Attachment #9).
2. Proof of San Mateo County residency (utility bill dated within the last 45 days, CA driver's license/ID, etc.) if applicant has a resident other than the AOD/HCH facility.
3. Proof of identity for the applicant such as driver's license, CA ID, etc. If no ID is available, please provide the letter of identity from the AOD-HCH Facility (Sample on Attachment #10)

4. Applicants with children must bring proof of any assets (bank statements, car registrations, property tax statement for non-primary residence, life insurance policy face sheet)
5. U.S. citizens/Legal Permanent Residents should bring proof of citizenship/legal status (U.S. birth certificate or passport, Residency card).
6. If applicant is applying for their children, bring proof of their age (birth certificate, passport or green card)

3. Please FAX, PONY or EMAIL documents to:

Health Coverage Unit
Health Plan of San Mateo
ATTN: AOD/HCH Community Health Advocate- Graciela Lopez
FAX- 650-616-8049
PONY- HLT 412
EMAIL- grlopez@co.sanmateo.ca.us

For more information, please see the Instruction Sheet for AOD/HCH Uninsured Referral and Certification Form or call Graciela Lopez at 650-616-2048.

HCU STAFF USE ONLY

Referral Outcome:

☐ Applicant enrolled in Medi-Cal (Effective Date of Coverage:_____)
☐ Applicant enrolled in ACE (Effective Date of Coverage:_____)
☐ Applicant enrolled in SSI/SSDI (Effective Date of Coverage:_____)
☐ Other (Please Detail) _____

FAX COVER SHEET for AOD/HCH Uninsured Screening, Certification and Referral Process

Please Fax to Graciela Lopez, Health Coverage Unit- 650-616-8049

From: _____ (Name)

_____ (Agency)

_____ (Phone Number)

_____(Number of Pages Including Fax Cover Sheet)

CHECKLIST:

□ AOD/HCH referral form

□ SAWS 1. For SAWS 1, please only fill out sections 1 to 13 and have applicant sign and date the form. (FOR MEDI-CAL APPLICANTS ONLY)

□ MCE or ACE Rights and Declarations Form (For applicants with income please provide both the MCE & ACE Rights and Declarations)

□ Proof of Household Income

□ Proof of San Mateo County Residency

□ Proof of Identity or Facility Affidavit

□ Proof of Assets

□ Proof of US Citizenship or Legal Permanent Residency Card

ATTACHMENT #1

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
CALIFORNIA DEPARTMENT OF HEALTH SERVICES

APPLICATION FOR CASH AID, FOOD STAMPS, AND/OR MEDI-CAL/34-COUNTY CMSP

Before completing this application, read the coversheet. If you need more space to answer, write on the back of this sheet.

1. NAME OF APPLICANT (FIRST, MIDDLE INITIAL, LAST)
2. SOCIAL SECURITY NUMBER (SSN)
3. MAIDEN OR OTHER NAME (IF ANY)
2A. DATE OF BIRTH (MM-DD-YYYY)
4. HOME ADDRESS: NUMBER STREET — CITY STATE ZIP CODE
5. MAILING ADDRESS (IF DIFFERENT) — CITY STATE ZIP CODE
6. TELEPHONE NUMBER(S): HOME ( ) WORK ( ) MESSAGE ( )
7. Is your home address permanent? ☐ YES ☐ NO ☐ NO HOME
   If not permanent, please explain:
8. Is anyone applying for: Cash Aid ☐ YES ☐ NO; Food Stamps ☐ YES ☐ NO; Medi-Cal ☐ YES ☐ NO; 34-County CMSP ☐ YES ☐ NO
   Any Other Program(s) ☐ YES ☐ NO If "YES", explain:
9. Has anyone ever asked for or gotten aid or benefits, including Medi-Cal/34-County CMSP/Medicaid or Diversion cash or non-cash services? If "YES", list: ☐ YES ☐ NO
   TYPE OF AID/BENEFIT — DATE(S) RECEIVED
   NAME(S) USED — RECEIVED WHERE? (COUNTY/STATE/COUNTRY)
10. The law says we must record your ethnic group, race and language. This won't affect your eligibility.
   A. ETHNICITY *(Everyone must also answer B)*
   Are you Hispanic or Latino? ☐ YES ☐ NO
   B. RACE/ETHNIC ORIGIN - Check all boxes that apply to you. If you do not complete this question the county will do it for you.
   ☐ American Indian or Alaskan Native ☐ Black or African American ☐ White
   ☐ Asian *(If checked, please select one or more of the following)*
   ☐ Filipino ☐ Chinese ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Asian Indian
   ☐ Cambodian ☐ Laotian ☐ Other Asian *(specify)* _____
   ☐ Native Hawaiian or Other Pacific Islander *(If checked, please select one or more of the following)*
   ☐ Native Hawaiian ☐ Guamanian ☐ Samoan ☐ Other *(specify)* _____
   C. PRIMARY LANGUAGE:
   ☐ English ☐ Spanish ☐ Lao ☐ Tagalog ☐ American Sign ☐ Cantonese ☐ Cambodian
   ☐ Vietnamese ☐ Russian ☐ Other *(specify)* _____
11. Is anyone a migrant or seasonal farmworker? ☐ YES ☐ NO
12. Is anyone pregnant? ☐ YES ☐ NO If "YES", did she get a Presumptive Eligibility card? ☐ YES ☐ NO
13. Does anyone have a personal emergency? If "YES", check (✓) type: ☐ YES ☐ NO
   ☐ Immediate Medical Need ☐ Pregnancy ☐ Child Abuse ☐ Domestic Abuse
   ☐ Elder Abuse ☐ Other emergency which threatens health or safety. Explain:

IF YOU NEED: CASH AID IMMEDIATE NEED PAYMENT ..... **FILL IN ITEMS 14 - 18.**
FOOD STAMP EXPEDITED SERVICE ..... **FILL IN ITEMS 14 - 17.**

14. How much liquid resources does everyone, including children, have?
   ☐ Cash, uncashed checks or money orders $_____
   ☐ Checking/savings or credit union account(s) $_____
   ☐ Trust deeds, notes receivable, stocks or bonds $_____
   ☐ Other (explain) $_____
15. How much income did everyone, including children, get or will they get this month?
   Date Amount Date Amount
   _____ $_____ _____ $_____
   _____ $_____ _____ $_____
16. How much is your rent or mortgage this month?
   $_____
17. How much are your utilities that are not included in your rent this month? $

	YES	NO
18. Do you have an eviction notice or notice to pay or quit?		
Have your utilities been shut off or do you have a shut-off notice?		
Will your food run out in 3 days or less?		
Do you need essential clothing, such as diapers or clothing needed for cold weather?		
Do you need help with transportation to get food, clothing, medical care or other emergency item(s)?		

- I certify that I have been given a copy of the coversheet. I understand and agree that I have to comply with eligibility rules, some of which I may be asked to do before any aid can be given. I understand the statements I have made on this form may be checked and verified.
- I certify that if I have applied for Food Stamps the county has told me of my right to Expedited Service.
- **I declare under penalty of perjury under the laws of the United States of America and the State of California that the information I have given on this form is true, correct, and complete.**

19. SIGNATURE (OR MARK) OF APPLICANT OR AUTHORIZED REPRESENTATIVE — DATE SIGNED

SIGNATURE OF WITNESS TO MARK OR INTERPRETER — DATE SIGNED

COUNTY USE ONLY

CASE NAME

CASE NUMBER

DATE RECEIVED

TYPE OF APPLICATION:
CA: ☐ CA ☐ RCA
FS: ☐ Initial ☐ Recert ☐ Rest
MC: ☐ CMSP: ☐

Homeless:
FS: ☐ YES ☐ NO
CA: ☐ YES ☐ NO ☐ CW 42

☐ Pickle Screening

Ethnic Group:

Race:

Primary Language:

CA I.N.
☐ Denied/NOA prep
☐ Approved
☐ Expedited Grant
☐ Applicant requested CWD to complete SAWS 1
(_____) (Initials)

FS E.S.
☐ E.S. questions not completed
☐ Screened for E.S.
Date_____
(_____) (Initials)

FS Referral for:
☐ E.S. Processing
☐ Regular Processing

☐ CWD records cleared
☐ MEDS CDB cleared
☐ IEVS initiated

☐ Copy of SAWS 1 and coversheet given to applicant

TRANSITIONING CASE NUMBER

COUNTY OF APPLICATION

COUNTY OF RESIDENCE (IF DIFFERENT)

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

ATTACHEMENT #2

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
CALIFORNIA DEPARTMENT OF HEALTH SERVICES

SOLICITUD PARA ASISTENCIA MONETARIA, ESTAMPILLAS PARA COMIDA, Y/O BENEFICIOS DEL PROGRAMA DE ASISTENCIA MEDICA DE CALIFORNIA (MEDI-CAL)/PROGRAMA DE SERVICIOS MEDICOS DEL CONDADO (CMSP) ADMINISTRADO POR EL ESTADO

Antes de completar esta solicitud, lea la hoja de información. Si necesita más espacio para contestar, escriba en el reverso de esta hoja.

1. NOMBRE DEL SOLICITANTE (NOMBRE, INICIAL DEL NOMBRE QUE USA EN MEDIO, APELLIDO)

2. NUMERO DE SEGURO SOCIAL (SSN)

3. NOMBRE DE SOLTERA U OTRO NOMBRE (SI LO HAY)

4. DIRECCION DEL HOGAR: NUMERO CALLE
CIUDAD ESTADO CODIGO POSTAL

5. DIRECCION POSTAL (SI ES DIFERENTE)
CIUDAD ESTADO CODIGO POSTAL

6. NUMEROS DE TELEFONO: DEL HOGAR ( ) DEL TRABAJO ( ) PARA MENSAJES ( )

7. ¿Es permanente la dirección de su hogar? ☐ SI ☐ NO ☐ NO TENGO HOGAR
Si no es permanente, por favor explique:

8. ¿Está alguien solicitando: Asistencia monetaria ☐ SI ☐ NO Estampillas para comida ☐ SI ☐ NO
Medi-Cal ☐ SI ☐ NO CMSP administrado por el estado? ☐ SI ☐ NO
¿Cualquier otro programa? ☐ SI ☐ NO Si su respuesta es "SI", explique:

9. ¿Alguna vez alguien ha solicitado o recibido asistencia o beneficios, incluyendo Medi-Cal/CMSP administrado por el estado/ asistencia médica en otro estado (Medicaid), o servicios monetarios o no monetarios para evitar la necesidad de asistencia a largo plazo? Si su respuesta es "SI", anote: ☐ SI ☐ NO
CLASE DE ASISTENCIA/BENEFICIO FECHAS EN QUE SE RECIBIO
NOMBRES QUE HA USADO ¿DONDE SE RECIBIO? (CONDADO/ESTADO/PAIS)

10. La ley establece que tenemos que anotar su grupo étnico e idioma. Esto no afectará su elegibilidad para recibir beneficios.
a. Grupo étnico ☐ Blanco ☐ Hispano ☐ Negro ☐ Filipino ☐ Guameño ☐ Hindú ☐ Indio (indígena) de Alaska ☐ Indio (indígena) de los EE. UU. de América ☐ Laosiano ☐ Camboyano ☐ Japonés ☐ Coreano ☐ Chino ☐ Samoano ☐ Vietnamita ☐ Hawaiano ☐ Otro grupo asiático o isleño del Pacífico (especifique):
b. Idioma ☐ Inglés ☐ Cantonés ☐ Laotiano ☐ Tagalo ☐ Idioma americano de señas ☐ Español ☐ Camboyano ☐ Vietnamita ☐ Ruso ☐ Otro (especifique):

11. ¿Es alguien un trabajador del campo migratorio o de temporada? ☐ SI ☐ NO

12. ¿Está alguien embarazada? ☐ SI ☐ NO Si su respuesta es "SI", ¿recibió ella una tarjeta de presunta elegibilidad? ☐ SI ☐ NO

13. ¿Tiene alguien alguna emergencia personal? Si su respuesta es "SI", marque (✔) la clase: ☐ SI ☐ NO
☐ Necesidad médica inmediata ☐ Embarazo ☐ Abuso de niños ☐ Abuso de esposa(o)
☐ Abuso de ancianos ☐ Otra emergencia que amenaza la salud o la seguridad (explique):

SI NECESITA: UN PAGO DE ASISTENCIA MONETARIA POR NECESIDAD INMEDIATA ..... CONTESTE DEL 14 AL 18.
SERVICIO URGENTE DE ESTAMPILLAS PARA COMIDA..... CONTESTE DEL 14 AL 17.

14. ¿Cuánto tienen todos, incluyendo a los niños, en recursos que son o se pueden convertir en dinero en efectivo?
☐ Dinero en efectivo, cheques sin cambiar o giros $_____
☐ Cuentas de cheques/ahorros o en la unión de crédito $_____
☐ Escrituras de fideicomiso, pagarés por cobrar, acciones, o bonos $_____
☐ Otro (explique) $_____

15. ¿Cuánto recibieron o recibirán todos, incluyendo a los niños, en ingresos este mes?

Fecha	Cantidad	Fecha	Cantidad
_____	$_____	_____	$_____
_____	$_____	_____	$_____

16. ¿Cuánto es su alquiler o hipoteca este mes?
$ _____

17. ¿Cuál es la cantidad de sus gastos de servicios públicos y municipales que no están incluidos en su alquiler este mes? $ _____

	SI	NO
18. ¿Ha recibido una notificación de desalojamiento, u otra informándole que pague o se salga?		
¿Le cortaron o recibió aviso de que le van a cortar los servicios públicos y municipales?		
¿Se le acabará la comida en 3 días o menos?		
¿Necesita ropa esencial, tal como pañales o ropa necesaria para el frío?		
¿Necesita ayuda en relación a transporte para obtener alimentos, ropa, cuidado médico u otros artículos de emergencia?		

- Certifico que recibí una copia de la hoja de información. Entiendo y estoy de acuerdo con que tengo que cumplir las reglas de elegibilidad, algunas de las cuales quizás tenga que cumplir antes de que se me pueda dar cualquier clase de asistencia. Entiendo que es posible que se comprueben y verifiquen las declaraciones que he hecho en este formulario.
- Certifico que si es que solicité estampillas para comida, el condado me informó acerca de mi derecho al servicio urgente de estampillas para comida.
- **Declaro bajo pena de perjurio, en conformidad con las leyes de los Estados Unidos de América y del Estado de California, que la información que he dado en este formulario es verdadera, correcta, y completa.**

19. FIRMA (O MARCA) DEL SOLICITANTE O REPRESENTANTE AUTORIZADO — FECHA EN QUE FIRMO

FIRMA DEL TESTIGO QUE PRESENCIO LA MARCA, O DEL INTERPRETE — FECHA EN QUE FIRMO

SOLO PARA USO DEL CONDADO

CASE NAME

CASE NUMBER

DATE RECEIVED

TYPE OF APPLICATION:

CA: ☐ CA ☐ RCA
FS: ☐ Initial ☐ Recert ☐ Rest
MC: ☐ **CMSP:** ☐

Homeless:
FS: ☐ YES ☐ NO
CA: ☐ YES ☐ NO ☐ CA 42

☐ State called
☐ Pickle Screening
☐ Diversion

Ethnic Group:

Primary Language:

☐ Presumptive Eligibility input
☐ **Referral Date:**

CA IN
☐ Denied/NOA prep
☐ Approved
☐ Expedited Grant
☐ Applicant requested CWD to complete SAWS 1
(_____) (Initials)

FS E.S.
☐ E.S. questions not completed
☐ Screened for E.S.: Date _____
(_____) (Initials)

FS Referral for:
☐ E.S. Processing
☐ Regular Processing

☐ CWD records cleared
☐ MEDS CDB cleared
☐ IEVS initiated

☐ Copy of SAWS 1 and coversheet given to applicant

COUNTY OF APPLICATION

COUNTY OF RESIDENCE (IF DIFFERENT)

ATTACHMENT #3

San Mateo County Medicaid Coverage Expansion (MCE) Enrollment Form

Original One-e-App Application ID: _____

Certified Application Assistor: _____

Applicant: _____

I declare that:

1. I am a resident of San Mateo County.
2. My gross monthly family income is at or below 133% of the Federal Poverty Level as indicated on the San Mateo Medical Center website (see below for link). http://www.sanmateomedicalcenter.org/content/FinancialAssistance.htm.
3. The information I provided in this application is accurate.
4. I am not eligible for and I am unable to obtain Full-Scope Medi-Cal or Share of Cost Medi-Cal.
5. I am not eligible for and I am unable to obtain Medicare Part A and/or Part B.

I have read and acknowledge each of the following:

1. I understand that the San Mateo County MCE Program is not an insurance program and is only valid at pre-approved San Mateo Medical Center facilities, Ravenswood Family Health Center, or pre-authorized referral locations and pharmacies, except for emergencies.
2. I understand that when I select a Primary Care Provider Clinic I am also selecting a pharmacy where I will get my prescriptions.
3. I understand that my eligibility for the San Mateo County MCE Program will expire one year from the program's effective date, and that I must thereafter reapply. The eligibility period may include retroactive coverage.
5. I understand that since my income is at or below 133% of the federal poverty level, I will not be responsible for any program fees, co-payments, or charges at time of service. However, I may be responsible for Estate Recovery as indicated in paragraph 7.
7. I understand that my eligibility for the San Mateo County MCE Program will be reviewed prior to hospital stays or same-day surgeries. I may be responsible for an Estate Recovery.
8. I understand that if I have private or employer health insurance, then the San Mateo County MCE program will be the secondary coverage and my private or employer health insurance will be the primary coverage.
9. I understand that if I become eligible for health insurance during this year, I must notify registration staff immediately. I understand that failure to do so will result in being billed for all charges after the effective date of health coverage since the health insurance will now be my primary health coverage.
10. I understand that if I am asked to apply for Medi-Cal or any other program, I must do so and that I maybe disenrolled from the San Mateo County MCE program and that this disenrollment may be retroactive if I fail to follow-through with the application process.
11. I understand that if I become eligible for a federal or state program due to age or other circumstances then I may be disenrolled from the San Mateo County MCE Program and that this disenrollment may be retroactive.
12. I acknowledge that I have received copies of the Financial Assistance Programs brochure and the San Mateo County MCE Program brochure and I agree to abide by program terms and conditions.
13. I understand that if the information I provide as part of my application is found to be inaccurate, I will be immediately disqualified from the San Mateo County MCE Program and may be billed retroactively for all services previously covered under the San Mateo County MCE Program. I understand that providing false information in order to wrongfully obtain benefits may also be a criminal offense.
14. I understand that if I am denied eligibility or disenrolled from the San Mateo County MCE Program for any reason, then I have the right to a two-step appeals process. I may complete and submit an appeal form within sixty (60) days after notice of denial or disenrollment.

    - The first appeal step is an Individual Eligibility Review (IER) to appeal any financial and non-financial issues relating to my eligibility and ability to pay.

    - If I am not satisfied with the decision from the IER process, I can appeal to the Eligibility and Financial Review Committee (EFRC).

- If I am not satisfied with the EFRC appeal process as stated above, I may file a request for a State hearing.

15. I understand that the foregoing rights and declarations apply as long as I am a San Mateo County MCE participant. I understand that this rights and declarations form is only required at my initial San Mateo County MCE enrollment and not during my San Mateo County MCE program renewal.

I declare under penalty of perjury that the above information is true and correct. Further, by signing below, I hereby authorize County personnel, agents or contractors, to verify and/or investigate my eligibility. Such investigation/verification may include the obtaining and use of information and documents possessed by other public and private agencies, including, but not limited to, records of the Department of Child Support Services.

Participant Signature _____ **Date** _____

ATTACHMENT #4

Formulario de Inscripción al Programa de Expansión de Cobertura del Condado de San Mateo (MCE)

Numero de Solicitud Original de One-e-App: _____

Asistente Certificado(a): _____

Solicitante: _____

Yo declaro:

6. Soy residente del Condado de San Mateo.
7. Mi ingreso familiar en bruto es igual o menos de 133% del nivel federal de pobreza, como se indica en la página de Internet del Centro Medico de San Mateo. http://www.sanmateomedicalcenter.org/content/FinancialAssistance.htm.
8. La información que he proporcionado en esta solicitud es correcta
9. Yo no soy elegible o capaz de obtener Medi-Cal completo o Medi-Cal con costo compartido.
10. Yo no soy elegible o capaz de obtener Medicare Parte A o Parte

He leído y reconozco cada uno de los puntos a continuación:

1. Entiendo que el Programa MCE no es un seguro médico y sólo es válido en pre-aprobadas facilidades del Centro Médico de San Mateo, Centro de Salud Familiar de Ravenswood y en las farmacias asociadas y previamente autorizadas, a excepción de las emergencias.
2. Yo entiendo que cuando selecciono una clínica de proveedor de atención primaria también estoy seleccionando una farmacia donde voy a recoger mis medicamentos.
3. Yo entiendo que mi elegibilidad en el programa de MCE del condado de San Mateo es de un año, y después de un año el programa se vencerá y tender que volver a solicitar el programa. El período de elegibilidad puede incluir cobertura retroactiva.
5. Yo entiendo que como mi ingreso es igual o menos del 133% del nivel federal de pobreza, yo no seré responsable por costos del programa, co-pagos, o cargos al momento del servicio Sin embargo, puedo ser responsable de la recuperación de bienes, como se indica en el párrafo 7
7. Yo entiendo que mi elegibilidad al programa de MCE de San Mateo será revisado antes de hospitalización o cirugía del mismo día. Puedo ser responsable de recuperación de bienes
8. Yo entiendo que si tengo seguro de salud privado o del empleador, el Programa de MCE del Condado de San Mateo será la cobertura secundaria y mi seguro de salud privado o del empleador será la cobertura primaria.
9. Yo entiendo que si llego a tener un seguro de salud durante este año, tengo que notificar al personal del programa inmediatamente. Entiendo que de no hacerlo, dará lugar a la facturación de todos los cargos después de la fecha de vigencia de la cobertura de salud ya que el seguro de salud ahora será mi cobertura de salud primaria.
10. Yo entiendo que si me piden que solicite Medi-Cal o cualquier otro programa, tengo que hacerlo, y que tal vez seré dado de baja del programa MCE del Condado de San Mateo y que esta cancelación de inscripción puede ser retroactiva si no sigo el proceso de la solicitud.
11. Yo entiendo que si soy elegible para un programa federal o estatal por razones de edad u otras circunstancias que puedo ser dado de baja del programa de MCE del Condado de San Mateo y que esta cancelación de la inscripción puede ser retroactiva.
12. Reconozco que he recibido un folleto de los programas de asistencia financiera y del Programa de MCE del Condado de San Mateo y me comprometo a respetar los términos y condiciones del programa.
13. Yo entiendo que si la información que proporcione como parte de mi solicitud resulta ser incorrecta, seré inmediatamente descalificado del programa de MCE del Condado de San Mateo y puedo ser facturado retroactivo por todos los servicios cubiertos anteriormente bajo el programa de MCE del Condado de San Mateo. Entiendo que el proporcionar información falsa a fin de obtener ilícitamente beneficios también puede ser un delito
14. Yo entiendo que si se me niega la elegibilidad o soy dado de baja del programa MCE del Condado de San Mateo por cualquier razón, tengo derecho a un proceso de apelación de dos pasos. Puedo completar y presentar un formulario de apelación dentro de los sesenta (60) días después de la notificación de negación o cancelación de la inscripción.

- El paso primero de apelación es una revisión de elegibilidad individual (Individual Eligibility Review IER) para apelar cualquier cuestión financiera y no financiera relacionada con mi elegibilidad y la capacidad de pagar.

- Si no estoy satisfecho con la decisión del proceso de IER, puedo apelar a la elegibilidad y la comisión de evaluación financiera (Financial Review Committee EFRC).

- Si no estoy satisfecho con el proceso de apelación EFRC como se anota arriba, puedo pedir una audiencia estatal.

15. Yo entiendo que los derechos y las declaraciones anteriores se aplican siempre y cuando sea participante en el programa de MCE del Condado de San Mateo. Yo entiendo que esta forma de derechos y declaraciones sólo se requiere en mi primera solicitud al programa de MCE del Condado de San Mateo y no durante mi renovación del programa de MCE del condado de San Mateo.

Declaro bajo pena de perjurio que la información proporcionada es verdadera y correcta. Además, al firmar a continuación, por la presente autorizo al personal del Condado de San Mateo, agentes o contratistas, a verificar y/o investigar mi elegibilidad. Dicha investigación/verificación puede incluir la obtención y uso de la información y los documentos que poseen otros organismos públicos y privados, incluyendo pero no limitado a, los registros del departamento de servicios de manutención infantil. (Department of Child Support Services).

Firma Del Participante _____ **Fecha** _____

ATTACHMENT #5

San Mateo Access and Care for Everyone (ACE) Enrollment Form

Original One-e-App Application ID: _____

Certified Application Assistor: _____

Applicant: _____

I declare that:

11. I am a resident of San Mateo County.
12. My gross monthly family income is at or below 200% of the Federal Poverty Level as indicated on the San Mateo Medical Center website (see below for link). http://www.sanmateomedicalcenter.org/content/FinancialAssistance.htm.
13. The information I provided in this application is accurate.
14. I am not eligible for and I am unable to obtain Full-Scope Medi-Cal or Share of Cost Medi-Cal.
15. I am not eligible for and I am unable to obtain Medicare Part A or Part B.
16. I am currently unable to obtain any private insurance.
17. I have not had private or employer-sponsored health insurance for the past three (3) months.

I have read and acknowledge each of the following:

1. I understand that the ACE Program is not an insurance program and is only valid at pre-approved San Mateo Medical Center facilities, Ravenswood Family Health Center, or pre-authorized referral locations and pharmacies.
2. I understand that when I select a Primary Care Provider Clinic I am also selecting a pharmacy where I will get my prescriptions.
3. I understand that my eligibility for the ACE Program will expire one year from the program's effective date, and that I must thereafter reapply. The eligibility period may include retroactive coverage.
4. I understand if my income is between 133.01 to 200% of the federal poverty level, I will be charged a $240 enrollment fee and I agree to pay this. I understand that I am responsible for paying all program fees, co-payments, and charges. I understand that an enrollment fee assistance may be available based on my personal financial circumstances. I understand that I can ask a Community Health Advocate (CHA) or Certified Application Assistor (CAA) how to apply for assistance. I understand that I will be referred to a collection agency if I have an unpaid enrollment fee balance that is more than a year old.
5. I understand that if my income is at or below 133% of the federal poverty level, I will not be responsible for any program fees, co-payments, or charges at time of service. However, I may be responsible for Estate Recovery as indicated in paragraph 7.
6. I understand that there are co-payments associated with the health services that I receive including but not limited to inpatient stays, same day surgeries, doctor visits, prescriptions, and that I may be responsible for these co-payments if I am not placed in a fee waiver category. I understand that I can pay these co-payments at the time of service or will be billed for any unpaid balance. I understand that I can speak to a Financial Counselor if I need to establish a payment plan or need assistance in making payments.
7. I understand that my eligibility for the ACE Program will be reviewed prior to hospital stays or same-day surgeries. I may be responsible for an Estate Recovery.
8. I understand that if I had private or employer health insurance and dropped it then I must wait three (3) months before I can be eligible for the ACE Program.
9. I understand that if I become eligible for health insurance during this year, I must notify registration staff immediately. I understand that failure to do so will result in being billed for all charges after the effective date of health coverage.
10. I understand that if I am asked to apply for Medi-Cal or any other program, I must do so and that I maybe disenrolled from the ACE program and that this disenrollment may be retroactive if I fail to follow-through with the application process.
11. I understand that if I become eligible for a federal or state program due to age or other circumstances then I may be disenrolled from the ACE Program and that this disenrollment may be retroactive.
12. I acknowledge that I have received copies of the Financial Assistance Programs brochure and the ACE Program brochure and I agree to abide by program terms and conditions.

13. I understand that if the information I provide as part of my application is found to be inaccurate, I will be immediately disqualified from the ACE Program and may be billed retroactively for all services previously covered under the ACE Program. I understand that providing false information in order to wrongfully obtain benefits may also be a criminal offense.
14. I understand that if I am denied eligibility, disenrolled from the ACE Program for any reason or wish to request a waiver or reduction of co-pays, fees or charges; I have the right to a two-step appeals process. I I may complete and submit an appeal form within sixty (60) days after notice of denial or disenrollment.

    - The first appeal step is an Individual Eligibility Review (IER) to appeal any financial and non-financial issues relating to my eligibility and ability to pay.

    - If I am not satisfied with the decision from the IER process, I can appeal to the Eligibility and Financial Review Committee (EFRC).

    - I understand that if my ACE program is funded under the State's Low Income Health Program (LIHP), then I may request to file for a State hearing If I am not satisfied with the EFRC appeal process as stated above.

15. I understand that the foregoing rights and declarations apply as long as I am an ACE participant. I understand that this rights and declarations form is only required at my initial ACE enrollment and not during my ACE program renewal.

I declare under penalty of perjury that the above information is true and correct. Further, by signing below, I hereby authorize County personnel, agents or contractors, to verify and/or investigate my eligibility. Such investigation/verification may include the obtaining and use of information and documents possessed by other public and private agencies, including, but not limited to, records of the Department of Child Support Services.

Participant Signature _____ **Date** _____

ATTACHMENT # 6

Formulario de Inscripción al Programa de Acceso y Cuidado Para Todos (ACE) de San Mateo
Solicitud No.: _____ Asistente Certificado: _____
Solicitante: _____

I declare that:

1. Soy residente del Condado de San Mateo.
2. Mi ingreso familiar en bruto es igual o menos de 200% del nivel federal de pobreza, como se indica en la página de Internet del Centro Medico de San Mateo http://www.sanmateomedicalcenter.org/content/FinancialAssistance.htm
3. La información que he proporcionado en esta solicitud es correcta
4. No soy elegible y no puedo obtener Medi-Cal de cobertura completa o de costo compartido.
5. No soy elegible y no puedo obtener Medicare Parte A o Parte B.
6. No tengo la habilidad de obtener un seguro medico privado.
7. Por los últimos tres meses no he participado en ningún seguro médico privado u ofrecido por mi empleador.

He leído y reconozco cada uno de los puntos a continuación:

1. Entiendo que el Programa ACE no es un programa de seguro médico y solamente es válido en las facilidades del Centro Médico de San Mateo, Centro de Salud Familiar de Ravenswood y en las farmacias asociadas y previamente autorizadas.
2. Yo entiendo que cuando selecciono una clínica de proveedor de atención primaria también estoy seleccionando la farmacia donde voy a recoger mis medicamentos.
3. Entiendo que mi elegibilidad para el Programa ACE vence un año a partir del primer día del mes en el que hice la solicitud, y tendré que solicitar renovación de mi programa a partir de entonces.
4. Entiendo que se me cobrará una cuota de inscripción $250 la cual estoy de acuerdo a pagar, si mis ingresos son más de 133% del nivel de pobreza federal. Entiendo que puedo escoger hacer pagos de pequeñas cantidades durante todo el año hasta pagar el total. Si tengo problemas cumpliendo con los pagos, podré preguntar acerca de mi elegibilidad para asistencia de pagos llamando al Asesor de Salud Comunitaria o una asistente de solicitud. Entiendo que después de un año mi balance será mandado a una agencia de colección.
5. Yo entiendo que como mi ingreso es igual o menos del 133% del nivel federal de pobreza, yo no seré responsable por costos del programa, co-pagos, o cargos al momento del servicio Sin embargo, puedo ser responsable de la recuperación de bienes, como se indica en el párrafo 7
6. Yo entiendo que hay co-pagos asociados con servicios de salud, incluyendo pero no limitado a, hospitalizaciones, cirugías el mismo día, las visitas al médico, recetas médicas, y que pueden ser responsables de estos co-pagos si no estoy en una categoría de sin costo. Yo entiendo que pueden pagar estos copagos en el momento del servicio o se me cobrará por cualquier servicio que no pagado. Yo entiendo que yo puedo hablar con un consejero financiero si tengo que establecer un plan de pago o necesita ayuda para hacer los pagos.
7. Entiendo que mi elegibilidad para el Programa ACE será revisada antes de cualquier hospitalización o cirugía ambulatoria y puede ser responsable por Recuperación de bienes.
8. Yo entiendo que si yo tenía seguro de salud privado o del empleador y la cancelo, entonces debo esperar tres meses antes de que pueda ser elegible para el programa de ACE.
9. Entiendo que si yo resulto elegible para algún seguro médico durante este año, deberé notificar inmediatamente al personal de registro. De no hacer esto, se me cobrarán los cargos desde la fecha efectiva de mi cobertura médica.
10. Entiendo que si se me pide solicitar cobertura de Medi-Cal u otro programa deberé hacerlo.
11. Yo entiendo que si soy elegible para un programa federal o estatal por razones de edad u otras circunstancias que entonces puede ser dado de baja del programa de la ACE y que esta cancelación de inscripción puede ser retroactiva
12. Reconozco que he recibido copia del folleto del ACE y estoy de acuerdo a atenerme a todos sus términos y condiciones.
13. Entiendo que si la información que proporciono como parte de la solicitud de inscripción está incorrecta, seré descalificado(a) inmediatamente del programa y recibiré cobros en forma retroactiva de servicios prestados anteriormente cubiertos bajo el Programa ACE. También

entiendo que proporcionar información incorrecta para obtener algún beneficio es ilegal y constituye una ofensa criminal.

14. Entiendo que si se me niega elegibilidad, o se me descalifica del ACE por alguna razón, o deseo pedir exoneración o reducción de pagos complementarios, cuotas o cargos, tengo el derecho a un proceso de apelación de dos pasos y se me permitirá presentar evidencia de elegibilidad o argumentar circunstancias especiales basadas en mi incapacidad de pago. Podré completar y someter a aprobación el formulario de apelación dentro de los 60 días subsiguientes a la notificación de rechazo o descalificación. Recibiré una respuesta por escrito dentro de los próximos 30 días laborales a partir de la fecha en que mi apelación fue recibida.
    - El primer paso de apelación es una Revisión de Elegibilidad Individual (IER) para apelar cualquier problema financiero o no financiero relacionado con mi elegibilidad y capacidad de pago.
    - Si no estoy satisfecho con la decisión del proceso de IER, podré apelar al Comité de Revisión Financiera y Elegibilidad (EFRC).

Declaro bajo pena de perjurio que la información anterior es verdadera y correcta. Al firmar abajo, por este medio autorizo al personal, agentes y contratistas del Condado a verificar y/o investigar mi elegibilidad. Dicha investigación o verificación puede incluir la adquisición y uso de información y documentos en posesión de otras agencias públicas y privadas, incluyendo, pero sin limitarse a, los registros del Departamento de Servicios de Manutención de Hijos.

Firma del Participante _____ **Fecha** _____

ATTACHMENT #7

Income and County Residency Certification Of Alcohol & Other Drug Program (AOD) or Healthcare for the Homeless (HCH) ACE County Applicants

This certification is only valid for applicants who cannot provide US citizenship or legal permanent residency verifications. These applicants will only be enrolled in the ACE County program and will not be eligible for any Coverage Initiative benefits

Applicant Name_____

Date of Birth _____ SMMC Medical Record Number _____

This document certifies that the applicant is

A AOD/HCH CLIENT:

i. The above named applicant is a client/resident of the following agency (check one) or is a homeless applicant living at the address below:

☐ Behavioral Health Recovery Services ☐ OTHER please indicate address below

_____ _____

_____ _____

ii. ☐ Check the box if the above agency address is where all client ACE correspondence should be mailed.

ii. If client has a separate mailing address such as post office box, please indicate address below:

_____

_____

INCOME ELIGIBLE (See Income Guideline Attachment):

The above applicant's income has been verified upon agency/shelter intake and:

☐ Applicant's income is at or below 133% of the Federal Poverty Level.

OR

☐ Applicant's income is between 134% and 200% of the Federal Poverty Level.

SAN MATEO COUNTY RESIDENT:

☐ The above applicant is a San Mateo County resident at intake at the above AOD/HCH agency and intends to reside in San Mateo County upon discharge from the above AOD/HCH agency.

_____ _____

Name of agency contact person or CAA Date

_____ _____

Signature of agency contact person or CAA Date

ATTACHMENT #8

Remember your ACE application is still not complete. You still need to provide the original copies of your US citizenship and identity documents OR a copy of your Legal Permanent Residency status (green card, passport with I-94 stamp, etc.) Once you have the appropriate documents please bring them to the San Mateo Medical Center or any of its Satellite Clinic. For more information, please call the Health Coverage Unit Hotline at 650-616-2002.

Applicant Name:_____

Date of Birth: _____

One-e-App Application ID: _____

HOW TO PROVIDE YOUR CITIZENSHIP AND IDENTITY DOCUMENTS:

The easiest way for U.S. citizens or nationals to provide **both** proof of citizenship and Identity is with **one** of these documents:

- ☐ U.S. Passport issued without limitation (expired ones are acceptable)
- ☐ Certificate of Naturalization (n-55 or N570)
- ☐ Certificate of US Citizenship (N-560 or N-561)

-OR-

If you do not have one of the documents above, please provide….

One Citizenship document

- ☐ U.S. Birth Certificate
- ☐ Certification of Report of Birth (DS-1350)
- ☐ Report of Birth Abroad of a U.S. Citizen (FS-240)
- ☐ State Department certification of Birth (FS-545 or DS-1350)
- ☐ U.S. Citizen Identification Card (I-197 or I-179)

AND

One Identity document

- ☐ Driver's License issued by a U.S. State or Territory with photograph or other identifying information
- ☐ School Identification Card with Photograph
- ☐ U.S. Military I.D. Card or draft record
- ☐ A U.S. Passport (issued with limitation)

Good Faith Effort Affidavit

I, _____, hereby confirm that I will work with the San Mateo County Health Coverage Unit and Certified Application Assistors to collect my U.S. citizenship, U.S. legal permanent residency, and/or identity information to meet the program requirements under the San Mateo County Medicaid Expansion Program (MCE) and/or the Access and Care for Everyone (ACE) program.

_____ _____

Signature Date

ATTACHMENT #9

SELF AFFIDAVIT OF INCOME LETTER

Applicant's Name: _____

Address:_____

City, State, Zip Code: _____

Phone Number:_____

Today's Date: _____

To Whom It May Concern:

I am providing this affidavit to verify my income as I have no other income documentation available to me.

□ I receive $_____ (gross amount), and the frequency of pay is (weekly, every two weeks, twice a month or monthly). I last received this amount on _____.
My employer's name is _____, and their phone number is (____)_____-_____.

□ I have no income and am being financially supported by _____. My relationship to this person is _____ and the contact information for this person is _____(address) and _____ (phone number).

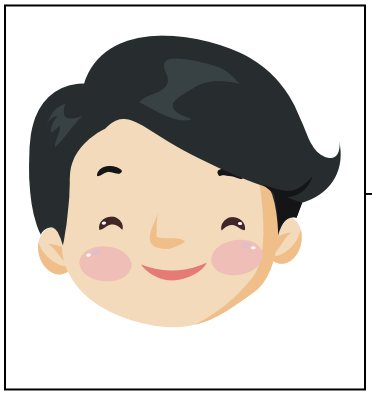
I understand that this information is subject to verification by the County of San Mateo. I certify that this information presented in this letter is true and correct to the best of my knowledge and belief.

Sincerely,

_____
Applicant Signature

ATTACHEMNT #10

Sample Agency Letter Head



Applicants picture taken by agency. Please make sure it is clear and visible.

Today's Date: _____

I, (Agency Contact person) certify that Applicant Full Name & Lastname, was born on (Date of birth) in (County & State). He/She is a US citizen or Legal Permanent Resident, and his/her Social Security number is (SSN#). (Applicant Name) is receiving services at our agency (agency name) since (date). If you have any question, please call (Phone Number of agency contact).

I understand the Statements I have made on this form may be checked and verified by San Mateo County Staff. I declare under penalty of perjury under the laws of California and the County of San Mateo that the information I have given on this form is true, correct, and complete.

Sincerely,

_____
Applicant Signature

_____
Agency Contact Name (PRINT)

_____
Agency Contact Signature