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** _____