San Mateo County Access and Care for Everyone (ACE) Rights and Declarations

Original One-e-App Application ID: _____

Certified Enrollment Counselor (CEC): _____

Applicant: _____

I declare that:

1. I am a resident of San Mateo County.
2. My gross monthly family income is under 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.
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 to the best of my knowledge.
5. I am not eligible for and I am unable to obtain Medicare Part A or Part B to the best of my knowledge.
6. I am currently unable to obtain any private insurance to the best of my knowledge.

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 preapproved San Mateo Medical Center facilities, Ravenswood Family Health Center, North East Medical Services, 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 if I become eligible for Medi-Cal, or enroll into Covered California or other State and Federal programs, I will be disenrolled from the ACE program.
4. 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 from the first day of the month that I start the application process.
5. I understand that if my income is between 138 and 200% of the federal poverty level, I will be charged a $360 non-refundable application processing fee and I agree to pay this. This fee is applicable regardless of the number of months of program coverage. I understand that I am responsible for paying all program fees, co-payments, and charges. I understand that financial assistance may be available for the processing fee based on my personal financial and health circumstances. I understand that I can ask a Certified Enrollment Counselor (CEC) how to apply for assistance. I understand that I will be referred to a collection agency if I have an unpaid balance on the application processing fee, once the coverage period has ended.
6. If my eligibility for the ACE Program is extended beyond the initial twelve-month coverage period due to another household member enrolling into ACE or Healthy

Kids, my application processing fee will be adjusted to match the number of months I actually have coverage. There will not be any proration or refund of fees if I choose to disenroll from ACE or become ineligible for any reason, including because of enrollment into other available public and/or private health insurance coverage.

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 am enrolled in health insurance during this year, I must immediately notify the Health Plan of San Mateo Member Services at 650-616-2194. I understand that failure to do so will result in being billed for all charges after the effective date of health coverage.
9. I understand that if I am asked to apply for Medi-Cal or any other federal or state program, I must do so. I may be disenrolled from the ACE program if I fail to follow-through with the application process for Medi-Cal or any other federal or state program.
10. I understand that eligibility for other public programs, such as Medi-Cal, may result in my having additional financial responsibilities that are a part of these programs' requirements.
11. 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.
12. I understand that if the information I provided as part of my application is found to be inaccurate, I will be immediately disqualified from the ACE Program. I understand that I may also be billed retroactively for all services previously covered under the ACE Program. I further understand that providing false information in order to wrongfully obtain benefits may also be a criminal offense.
13. I understand that I must notify the Health Coverage Unit at 650-616-2002 within 10 days if there are any changes to my income, address or immigration status.
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 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).
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 such as Manufacturer's Pharmaceutical Patient Assistance Programs, 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.

Participant Signature _____ **Date** _____