DISCOUNTED HEALTH CARE ENROLLMENT APPLICATION

APPLICANT INFORMATION

Name:		MRN:
Date of birth:	SSN:	Phone:
Current address:		Other Phone:
City:	State:	ZIP Code:

VISIT INFORMATION

Date(s) of medical bill that need to be covered?

SIGNATURES

I declare that:
My gross (amount before deductions) monthly family income is $ _____with family size of _____.

I have read and acknowledge each of the following:

1. I understand that DHC is not an insurance program and is only valid at pre-approved San Mateo Medical Center facilities and associated 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 DHC 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 that my eligibility for DHC will be reviewed prior to hospital stays or same-day surgeries.
5. I understand that I will be required to provide a deposit of $150 at every clinic and Emergency room visit. This amount will be applied to the visit and the difference will be bill.
6. I understand that I will pay no more than the highest amount that the San Mateo Medical Center would receive for providing the medical services in question from Medicare, Medi-Cal, Healthy Families or any other government-sponsored health benefit program in which San Mateo Medical Center participates.
7. I understand that an interest-free extended repayment plan is available to me, the terms of which will be based on my ability to pay.
8. I understand that if I am asked to apply for Medi-Cal or any other program, I must do so.
9. I acknowledge that I have received a copy of the Financial Assistance Programs brochure and I agree to abide by program terms and conditions.
10. I understand that if the information I provide as part of my application is found to be inaccurate, I will be immediately disqualified from DHC and may be billed retroactively for all services previously covered under DHC. I understand that providing false information in order to wrongfully obtain benefits may also be a criminal offense.
11. I understand that if I am denied eligibility, disenrolled from DHC 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 that allows me to present evidence of eligibility or argue special circumstances based on my inability to pay. I may complete and submit an appeal form within sixty (60) days after notice of denial or disenrollment. I will receive a written response within thirty (30) working days from the date my appeal form was received.
    a. 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.
    b. If I am not satisfied with the decision from the IER process, I can appeal to the Eligibility and Financial Review Committee (EFRC).

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.

Signature of applicant:	Date: