

**APPLICATION FOR BASIC HEALTH CARE, HEALTH COVERAGE INITIATIVE,  
MEDI-CAL EXPANSION AND CHARITY/DISCOUNT**

**RIGHTS AND RESPONSIBILITIES**

- I understand that I am applying for County Medical Coverage, BHC/HCI/MCE. If I am not eligible, I may receive a discount on my medical bills if I meet the eligibility criteria.
- I understand that I must provide certain facts to apply for the BHC/HCI/MCE program. This information will be used to determine my eligibility to the BHC/HCI/MCE program, for a discount, to process and pay medical claims, to verify eligibility by medical service providers, and to identify health insurance *coverage* and take *recovery* action.
- I agree that if asked, I will file a Medi-Cal and/or Social Security Disability/SSI application. My BHC/HCI/ MCE will be discontinued if I fail to apply and follow through with the application process. I agree to appeal a denial to my Medi-Cal, SSDI, or SSI.
- I understand that if I become eligible to receive Medicare, Medi-Cal, or any other program *coverage* or medical insurance, including third party liability settlements, my BHC/HCI/MCE will be discontinued effective with the date that I become eligible to receive the program *coverage* or insurance.
- I understand that if Medi-Cal *coverage* requires me to share in the cost of services, I will be responsible for the share of cost amount.
- I consent to allow the Financial Counseling office to verify any of the information in my application, including obtaining a certified copy of my birth certificate, if I am U.S. born.
- I understand that I have a right to file an appeal if my application is denied, disenrolled, or otherwise terminated before the end of my enrollment period. I understand that I must submit my appeal in writing to the Health Services Department within 30 calendar days from the date of the letter notifying me of the denial or termination.
- I agree to inform the Financial Counseling office (in writing) within 10 days if there are any changes to my income, possessions, number of persons in the household, or change of address.
- I understand that this program covers emergency medical care only at Contra Costa Regional Medical Center (CCRMC). I understand that if I receive emergency care at any other hospital, BHC/HCI/MCE will not pay for the care. I also understand that hospitals are required by law to provide emergency services to *everyone*, regardless of their ability to pay.
- I understand that medical services covered by the BHC/HCI/MCE program are provided at CCRMC and Health Centers or designated community providers, if authorized.
- I grant Limited Power of Attorney to Contra Costa Health Services or its representative, including a third party *vendor*, to prepare, complete, sign, and file any paperwork or documents on my behalf so that Contra Costa Health Services may attempt to obtain reimbursement for my prescriptions from their manufacturers. I understand that I may revoke this authorization by written request at any time to 2500 Alhambra Avenue, Martinez, CA 94553. This Power of Attorney shall be in full force from the date signed.
- I declare under penalty of perjury that the answers I have given are true and correct.

**IFI MAKE FALSE STATEMENTS OR WITHHOLD INFORMATION, I MAY LOSE MY BHC/HCI/MCE COVERAGE, BE BILLED FOR ALL SERVICES RECEIVED, AND BE PROSECUTED FOR FRAUD.**

Please keep the copy for your records and return the original to the Financial Counselor.

\_\_\_\_\_  
Print name of Patient

\_\_\_\_\_  
Health Center

\_\_\_\_\_  
Signature of Patient or Parent/Guardian if patient is under 18 years of age

\_\_\_\_\_  
Date