Request for a State Fair Hearing to Appeal a Covered California Eligibility Determination

- If you need help in another language, or would like this form in another language, please refer to the last page of this document.
- If you are blind or vision impaired and need this form in another format such as Braille, large font print or an electronic format, or you need assistance filling out this form, please call 1-800-743-8525 .
- If you would like free legal help, call Covered California at 1-800-300-1506 and we will refer you to your local legal aid or welfare rights office.

Does your appeal need to be expedited?* ⟶ **Yes** ☐ **No** ☐

***** *If you have an immediate need for health services and a delay could seriously jeopardize your health, you can ask for an expedited appeal by calling 1-800-743-8525.*

Have you been disenrolled and would like to keep your Covered California coverage?* ⟶ **Yes** ☐ **No** ☐

** If you, or your family members, were disenrolled from Covered California, you have a right to keep your coverage while you appeal. This is called Continued Enrollment. You can ask for Continued Enrollment at any time during the appeals process. See the Continued Enrollment form on page 6 for more information.*

Instructions:

You have a right to a hearing if you do not agree with the eligibility decision made by Covered California. You can appeal if you think we made a mistake about you or your family members' eligibility. For example, you can appeal if you think we determined your eligibility incorrectly because we made a mistake about your income, household size, citizenship, immigration status, or residency. If more than one family member wants to appeal, list each name so we know whose eligibility determination(s) are being appealed.

To ask for a hearing with an Administrative Law Judge who will review the decision, you can fill out this form and return within **90 days** of the date Covered California mailed you the eligibility decision. You can file an appeal using this form or by writing out that you request an appeal and sending your appeal by one of the methods below or by calling 1-800-743-8525 (TTY 1-888-889-4500) or one of the other numbers for other languages on the back of this form.

You can return the form in one of the ways listed below:

1. **Fax** to the State Hearings Division at: 833-281-0905

2. **Mail** your appeal to:
   CA Department of Social Services
   Attn: ACA Bureau
   P.O. Box 944243
   Mail Station 21-97
   Sacramento, CA 94244-2430

3. **Call** the State Hearings Division and submit your appeal over the phone: 800-743- 8525

4. **Email** your appeal to: SHDACAOperations@DSS.ca.gov
   (please do not email private information such as your Social Security Number)

5. Submit your appeal **in person** at your local County Welfare Department (call Covered California and we can refer you to your local CWD).

6. If you need more help, call Covered California at 1-800-300-1506, (TTY: 1-888-889-4500), Monday to Friday, 8 a.m. to 8 p.m. and Saturday, 8 a.m. to 6 p.m. The call is free.

If you use this form to appeal, the date of the postmark on the envelope or the date a fax or email is received will be considered the date you filed your appeal. You may be able to file your appeal after the 90 day deadline if you have a good reason for filing late. A judge will decide if there is good reason for a late appeal.

If you appeal and we agree with you, we may change our decision prior to the actual hearing. If we change our decision, your family members' eligibility may also change, even if they do not file their own appeal.

Please keep a copy of all forms for your records

CLAIMANT #1

(The *claimant* is the person whose eligibility is being appealed. This section should be filled out by the claimant or by a parent/guardian/Authorized Representative of the claimant.)

Case ID:			
First Name	Middle Initial	Last Name	Suffix
Date of Birth (mm/dd/yyyy)	Phone Number (with area code)		
Email Address			
Street Address			Apt./Ste. #
City	State	Zip Code	

List the names of other household members who are filing an appeal using this form. Use extra paper if there are more people in your household who want to file an appeal using this form.

Household Member #2: _____

Household Member #3: _____

Household Member #4: _____

Reasons for filing an appeal

Your eligibility notice explains what you are eligible for and the programs for which you do not qualify. Depending on your eligibility results, you may appeal any of the following (check as many boxes as you would like):

- ❑ I was denied enrollment into a Covered California health plan.
- ❑ The amount of premium assistance (tax credits that help pay my monthly premium) is not correct or I am ineligible for premium assistance.
- ❑ The level of cost-sharing reduction (help paying my out of pocket expenses) is not correct or I am ineligible for cost-sharing reduction.
- ❑ Covered California did not process my application/information in a timely manner.
- ❑ Covered California did not provide me with a notice of eligibility determination in a timely manner.
- ❑ Covered California stated that I am not a US citizen or US national or a lawfully present individual living in the United States.
- ❑ Covered California stated that I failed to complete my application.
- ❑ Covered California stated that I do not qualify for financial assistance because I am eligible for or enrolled in other health coverage (such as free Medi-Cal, Medicare, or employer-sponsored insurance).
- ❑ Covered California stated that I am not a California resident.
- ❑ My health plan carrier terminated my coverage through Covered California because I did not pay my premiums by the due date.
- ❑ Covered California stated that I am incarcerated or in jail.

Optional: Tell us more about why you disagree with Covered California's decision. You may attach additional sheets of paper if you need more space to write.

Privacy and use of your information. We will keep your information private as required by law. For more information, read the Privacy Act Statement below.

Privacy Act Statement

We are authorized to collect the information on this form and any supporting documentation, including Social Security numbers, under the Patient Protection and Affordable Care Act (Public Law No. 111–148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law No. 111–152) and the Social Security Act.

We need the information provided by you and the other individuals listed on this form to process your eligibility appeal request for: (1) enrollment in a qualified health plan through Covered California, (2) for insurance affordability programs, and (3) for certifications of exemption from the individual responsibility requirement. As part of that process, we will review all information provided on the form, may verify any new information gathered through the appeals process, and communicate with you or your Authorized Representative. We will also use the information provided as part of the ongoing operation of Covered California, including activities such as verifying continued eligibility for all programs, reporting on and managing the insurance affordability programs for eligible individuals, performing oversight and quality control activities, combatting fraud, and responding to any concerns about the security or confidentiality of the information. We will not share your immigration status for immigration enforcement purposes.

While providing the requested information (including Social Security numbers) is voluntary, failing to provide it may delay or prevent your ability to obtain health coverage through Covered California, advanced payment of the premium tax credits, cost sharing reductions, or an exemption from the requirement to have health insurance. If you do not qualify for an exemption from the requirement to have health insurance and you do not maintain qualifying health coverage for three months or longer during the year, you may be subject to a tax penalty. If you do not provide correct information on this form or knowingly and willfully provide false or fraudulent information, you may be subject to a penalty and other law enforcement action.
In order to verify and process an appeal request, determine eligibility, and operate Covered California, we will need to share selected information that we receive with:

1. Other federal agencies, (such as the Internal Revenue Service, Social Security Administration, Department of Homeland Security and the Health and Human Services appeals entity or the Center for Medicare and Medicaid Services(CMS)), state agencies (such as Medicaid or CHIP), or local government agencies. We may use the information you provide in computer matching programs with any of these groups only to make eligibility determinations or to verify continued eligibility for federal benefit programs;
2. Judicial review entities at the state or federal level as available by law;
3. Applicants/enrollees and Authorized Representatives of applicants/enrollees;
4. CMS contractors engaged to perform a function for Covered California; and
5. Anyone else as required by law or allowed under the Privacy Act System of Records Notice associated with this collection (CMS Health Insurance Exchanges System (HIX), CMS System No. 09-70-0560, as amended, 78 Federal Register, 8538, March 6, 2013, and 78 Federal Register, 32256, May 29, 2013).

This statement provides the notice required by the Privacy Act of 1974 (5 U.S.C. § 552a(e)(3)). You can learn more about how we handle your information at: www.coveredca.com/privacy/

Authorized Representative Form (optional)

Help completing this appeal

Instructions: An "Authorized Representative" is a person/organization you trust to help you with your application or appeal with us, who is able to see your personal information and to act for you on matters related to this application (including getting information about your application or signing your application on your behalf). If you would like to assign an Authorized Representative to act on your behalf, complete this page and return it to us. If you ever need to change your Authorized Representative, contact Covered California. If you would like to assign your Authorized Representative over the phone, call us at 1-800-300-1506.

Applicant/Enrollee Case ID:		
Name of Authorized Representative or Name of the Organization		
Address		Apt./Ste. #
City	State	ZIP Code
Phone Number (with area code)		ID number (if applicable)
Email Address		

For Certified Enrollment Counselors, agents, and brokers acting as Authorized Representatives

First name, Middle name, Last name, & Suffix	
Organization Name (if applicable)	
ID number (if applicable)	Agents/Brokers only: NPN number

Permission to share information

I **as the applicant/enrollee**, authorize the person/organization above to act on my behalf regarding my application or appeal with Covered California. I authorize Covered California to speak with this person/organization on my behalf. I understand that this permission to act for me ends on the date that Covered California sends me its decision regarding my application or appeal.

Do you want your Authorized Representative to receive notices on your behalf? → Yes ☐ No ☐

What is your representative's preferred method of communication? → E-mail ☐ *or* US postal mail ☐

- ✓ I have signed and dated this form below.
- ✓ I understand that the Covered California cannot speak with the person/organization I have appointed above (my Authorized Representative) until it receives this signed form from me.

By signing, you allow this person to sign your application, get official information about this application, and act for you on future matters related to this application until the end of the appeals process.

Applicant's/Enrollee's signature	Date (mm/dd/yyyy)

Authorized Representative declaration and signature. *This is required.*

By signing below, I hereby agree to the following conditions in order to serve as an Authorized Representative:

- I agree that I am legally bound to maintain the confidentiality of any information regarding the applicant or enrollee provided by Covered California;
- I agree to be responsible for fulfilling all my responsibilities within the scope of the authorized representation to the same extent as the applicant or enrollee who I represent; and
- I agree to comply with all applicable state and federal laws concerning conflicts of interest and confidentiality of information.

Authorized Representative's signature	Date (mm/dd/yyyy)

What happens next?

1. Acknowledgment letter of your appeal request and further instructions. Your appeal will be reviewed by a judge. If there is a problem with your appeal request, for example if it is missing information, we will inform you and ask you to provide or correct the information by a specific deadline.

2. Review of your information. You have the right to review the information being used to resolve your appeal, including the information in your Covered California online account.

3.Submitting additional information. You can submit additional information to support your appeal. Any information you submit will be reviewed along with the information on your application that was used to make your eligibility determination. You may submit additional information with this appeal form. You also have the right to provide additional information about your case to the judge before or at the time of the hearing.

4. Informal resolution. Before the appeal hearing is held, we may be able to resolve your appeal informally, by reviewing all of your information and discussing it with you. After reviewing your information and discussing your appeal with you, we will send you Covered California's informal resolution decision that tells you if we have changed our eligibility decision. If you agree with this informal resolution decision, we will send you a form to withdraw your appeal that you must sign and return to the California Department of Social Services. If you disagree with the informal resolution decision, you can continue your appeal at a hearing.

5. Hearing. Your hearing will take place over the phone, unless you would like to have it in person or by video-conference (through a computer). Call the California Department of Social Service's Affordable Care Act Bureau at 1-800-743-8525 if you would like to have the hearing in person.

You have the right to represent yourself at the hearing or to be represented by a friend, relative, lawyer, an Authorized Representative (if you have one), or another individual.

You have the right to review all the information that the judge will be considering for your appeal, including any information in your Covered California account. Covered California will send you a Statement of Position and evidence packet two business days before your hearing date. This information can also be found on your online account, or you can go to your local County Welfare Department to request it in person.

After the hearing, all your information will be reviewed and a final decision on your appeal will be mailed to you.

If you need an interpreter or need accommodations to attend your hearing, please contact CDSS's State Hearings Division. You can contact the State Hearings Division at 1-855-795-0634 (TTY 1-800-952-8349 for hearing or speech impaired). The call is free.

If you do not attend your scheduled hearing or withdraw your hearing before the date of your hearing, your appeal will be dismissed. You will not be able to have another hearing unless you can show a good reason (called "good cause") for missing your hearing.

If you would like to ***postpone*** your hearing, call the California Department of Social Service's Affordable Care Act Bureau at 1-855-795-0634.

6. Hearing by the United States Department of Health and Human Services. If you do not agree with the decision that the Administrative Law Judge made on your appeal case in the State Fair Hearing, you have the right to appeal to the federal agency called the United States Department of Health and Human Services (HHS) within 30 days of the date of the decision you receive from CDSS. You can send your request for a re-hearing directly to HHS at the following address:

Health Insurance Marketplace
465 Industrial Parkway
London, KY 40750-0061

Or you can call HHS at 1-800-318-2596 (TTY 1-855-889-4325). If you decide to appeal to HHS and you win your appeal, Covered California and CDSS will have to follow the decision HHS makes.

7. Continued Enrollment during your appeal. You may be able to keep your Covered California health plan while your appeal is pending if you are appealing an eligibility redetermination decision made by Covered California. This is called "Continued Enrollment." Please complete page 6 of this appeal form if you would like to request Continued Enrollment. Your appeal must be accepted before we can approve Continued Enrollment. We will notify you if your request for Continued Enrollment is approved.

8. Appeals regulations. If you would like to read Covered California's Appeals Regulations, please visit: hbex.coveredca.com/regulations/request-for-appeal

Continued Enrollment Form (optional)

Instructions:
If you submitted an appeal of an eligibility redetermination with Covered California, you may ask to keep your coverage while your appeal is being reviewed. This is called Continued Enrollment. If you choose to keep your coverage, you must continue to pay your premiums.

If your coverage has ended and you would like to be re-enrolled, Covered California may retroactively enroll you into the plan from the date on which your coverage has ended and you may be required to pay your premiums for those months.

Case ID:			
First Name	Middle Initial	Last Name	Suffix
Date of Birth (mm/dd/yyyy)	Phone Number (with area code)		
Email Address			
Street Address			Apt./Ste. #
City	State	Zip Code	

Check one:

☐ I would like to be retroactively enrolled into my previous Covered California health plan from the first day of the month during which CDSS received my valid appeal request. If I am retroactively enrolled, I understand that I will have to pay any past-due premiums.

☐ My coverage will soon be terminated. I would like to continue my coverage while my appeal is being reviewed. I understand that I will need to continue making my premium payments while my appeal is being reviewed.

☐ I am not losing my coverage, but I am appealing my Advanced Premium Tax Credit (APTC) amount or Cost-Sharing Reduction (CSR) level.

Sign the form and send it to us before your hearing date.

I am asking to keep coverage while my appeal is being reviewed. I understand that I must pay my monthly premium payments during the review process. I understand that if I do not make the payments, I will lose coverage or members of my family will lose coverage. I understand that if I receive too much premium assistance during the benefit year, including during the Continued Enrollment period, I will have to repay the extra premium assistance back to the IRS when I file my federal income tax return for the benefit year.

Signature: _____ **Date:** _____

Mail this form to:
CA Department of Social Services
Attn: ACA Bureau
P.O. Box 944243
Mail Station 21-97
Sacramento, CA 94244-2430

Fax this form to:
State Hearings Division
833-281-0905

Call State Hearings Customer Service at:
1-800-743-8525

Email this form to:
SHDACAOperations@dss.ca.gov
*(Please do not include private information such as your **Social Security Number**)*

Getting Help in a Language Other than English

IMPORTANT: Can you read this letter? You can call **1-800-300-1506** and ask for this letter translated to your language or in another format such as large print. For TTY call **1-888-889-4500** where you can also request this letter in alternate format.

Español IMPORTANTE: ¿Puede leer esta carta? Usted puede llamar al **1-800-300-0213** y pedir esta carta traducida en su idioma o en otro formato como en letras grandes. Para TTY, llame al **1-888-889-4500**, donde también puede pedir esta carta en algún formato diferente. **(Spanish)**

中文/繁體字 重要事项：您能否阅读此信件？您可以致电 **1-800-300-1533，要求将此信件翻**译为您的母语或者索要其他格式（如，大字版本）的信件。如需 TTY **服**务或者索要其他格式的信件，请致电 **1-888-889-4500。(Chinese)**

Tiếng Việt QUAN TRỌNG: Quý vị có thể đọc được bức thư này không? Quý vị có thể gọi điện đến số **1-800-652-9528** và yêu cầu được dịch bức thư này sang ngôn ngữ của quý vị hoặc chuyển sang định dạng khác như bản in khổ lớn. Người dùng TTY, hãy gọi số **1-888-889-4500** quý vị cũng có thể yêu cầu định dạng thay thế khác cho bức thư này. **(Vietnamese)**

한국어 중요: 이 편지를 읽을 수 있나요? **1-800-738-9116** 에 연락하셔서 번역되어 있거나 인쇄물 등 다른 포맷으로 되어 있는 편지를 요청해보세요. TTY **1-888-889-4500** 에서도 이 편지의 다른 포맷을 요청할 수도 있습니다. **(Korean)**

Tagalog MAHALAGA: Makakabasa ka ba sa sulat na ito? Maaari kang tumawag sa **1-800-983-8816** at humiling na isalin ang sulat na ito sa iyong wika o sa iba pang format katulad ng malalaking titik. Para sa TTY, tumawag sa **1-888-889-4500** kung saan maaari kang humiling ng alternatibong format ng sulat na ito.

العربية هام: هل يمكنك قراءة هذا الخطاب؟ يمكنك الاتصال بـ **1-800-826-6317** وطلب هذا الخطاب مترجماً إلى لغتك أو بصيغة أخرى، بخط كبير مثلاً. للصم والبكم، اتصل بـ **1-888-889-4500** حيث يمكنك أيضاً أن تطلب هذا الخطاب بصيغة مختلفة. **(Arabic)**

հայերեն ԿԱՐԵՎՈՐ Է: Դուք կարո՞ղ եք կարդալ այս նամակը: Դուք կարող եք զանգահարել **1-800-996-1009** և խնդրել, որ այս նամակը թարգմանվի Ձեր լեզվով կամ Ձեզ տրվի մեկ այլ ձևաչափով, օրինակ՝ խոշորատառ: TTY-ի համար զանգահարեք **1-888-889-4500,** որտեղ կարող եք նաև այլընտրանքային ձևաչափով խնդրել այս նամակը: **(Armenian)**

ភាសាខ្មែរ សំខាន់៖ តើលោកអ្នកអាចអានលិខិតនេះបានដែរឬទេ? លោកអ្នកអាចទូរស័ព្ទមកលេខ **1-800-906-8528** និងស្នើសុំឲ្យគេបកប្រែលិខិតនេះជាភាសារបស់លោកអ្នក ឬជាទម្រង់មួយផ្សេងទៀតដូចជាអក្សរពុម្ពធំៗ។ សម្រាប់ TTY ទូរស័ព្ទមកលេខ **1-888-889-4500** ដែលលោកអ្នកក៏អាចស្នើសុំលិខិតនេះជាទម្រង់ផ្សេងទៀតបានផងដែរ។ **(Khmer)**

Русский ВАЖНАЯ ИНФОРМАЦИЯ: Вы можете прочитать это письмо? Вы можете позвонить по телефону **1-800-778-7695** и запросить получение этого письма, переведенного на Ваш родной язык, или распечатанного крупным шрифтом. Лица со сниженным слухом могут позвонить по телефону **1-888-889-4500,** чтобы запросить это письмо в ином формате. **(Russian)**

فارسی مهم: آیا می توانید این نامه را بخوانید؟ می توانید با شماره **1-800-921-8879** تماس بگیرید و تقاضا کنید که این نامه به زبان شما ترجمه شود یا به فرمت دیگری مانند حروف درشت به شما ارسال شود. برای TTY با شماره **1-888-889-4500** تماس بگیرید و از طریق همان شماره همچنین می توانید درخواست کنید که این نامه به فرمت دیگری به شما ارسال شود. **(Farsi)**

Hmoob TSEEM CEEB: Koj nyeem puas tau tsab ntawv no? Koj hu tau rau **1-800-771-2156** nug daim ntawv txais ua yog koj cov lus los yog lwm hom xws lis tus ntawv loj. Hu tau TTY ntawm **1-800-889-4500** ua koj thov hloov tau lwm hom. **(Hmong)**

महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? इस पत्र को अपनी भाषा में अनुवाद करने के लिए या बड़े प्रिंट की तरह किसी अन्य प्रारूप में प्राप्त करने के लिए 1-800-300-1506 पर कॉल करके अनुरोध कर सकते हैं। TTY **के लिए 1-888-889-4500 पर कॉल करें जहाँ आप इस पत्र को किसी अन्य प्रारूप में प्राप्त करने का अनुरोध कर सकते हैं। (Hindi)**

重要：この文書を読むことができますか？希望の言語に翻訳された文書、または大きな文字など別の形式の文書をご希望の場合、**1-800-300-1506**までお電話ください。TTY の場合、**1-888-889-4500** にお電話いただければ、その他の形式の文書をリクエストすることもできます。**(Japanese)**

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਸ ਪੱਤਰ ਨੂੰ ਪੜ ਸਕਦੇ ਹੋ ਤੁਸੀਂ **1-800-300-1506** 'ਤੇ ਕਾਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਇਸ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਜਾਂ ਕਿਸੇ ਹੋਰ ਸਰੂਪ ਵਿਚ, ਜਿਵੇਂ ਕਿ ਵੱਡੇ ਪਰਿੰਟ ਲਈ ਪੁੱਛ ਸਕਦੇ ਹੋ। ਟੀਟੀਵਾਇ ਲਈ **1-888-889-4500** 'ਤੇ ਕਲ ਕਰੋ ਜਿੱਥੇ ਕਿ ਤੁਸੀਂ ਇਸ ਪੱਤਰ ਦੇ ਵਿਕਲਪਕ ਰੂਪ ਵਿਚ ਸਰੂਪ ਲਈ ਬੇਨਤੀ ਵੀ ਕਰ ਸਕਦੇ ਹੋ। **(Punjabi)**

สำคัญ: คุณสามารถอ่านจดหมายฉบับนี้ได้หรือไม่? ถ้าคุณมีข้อสงสัย คุณสามารถติดต่อได้ที่เบอร์ **1-800-300-1506** เพื่อทำการพูดคุยกับเจ้าหน้าที่ที่ใช้ภาษาของคุณ นอกจากนี้คุณยังสามารถร้องขอให้แปลจดหมายฉบับนี้เป็นภาษาที่คุณต้อง การได้หรือเปลี่ยนแปลงรูปแบบตัวอักษรให้เป็นรูปแบบอื่น เช่น ตัวอักษรพิมพ์ใหญ่หรือทำให้มีขนาดใหญ่ขึ้น สำหรับระบบ TTY คุณสามารถติดต่อได้ที่เบอร์ **1-888-889-4500** ซึ่งคุณสามารถขอจดหมายฉบับนี้ในรูปแบบอื่น ๆ ได้ตามที่คุณต้องการ **(Thai)**