SCAN Medi-Cal Services
Application & Statement of Understanding

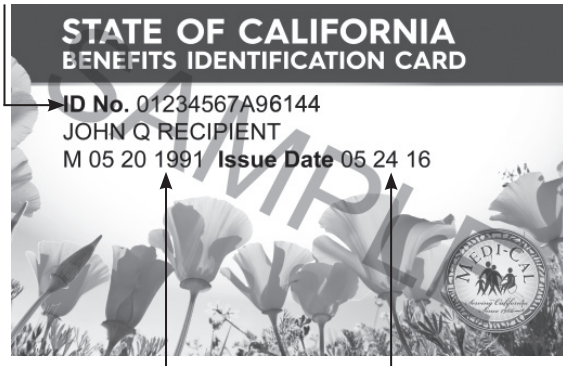
Social Security Number *(Required)*				—			—					Birthdate / /	☐ Male ☐ Female
Beneficiary Name: Last											First		M.I.
Home Address													Apt.#
City											State		Zip Code
County											Telephone ( )		**Effective Date**

Medi-Cal Information

Please write your Medi-Cal ID Number														
Issue Date			/			/								
	M	M		D	D		Y	Y	Y	Y				

I authorize the county of my residence to release information regarding my Medi-Cal status to SCAN Health Plan, County, State or Federal staff, whose job requires access to this information for the purpose of determining or maintaining my eligibility for SCAN coverage. I understand I am not legally required to authorize this release but that my failure to do so will make me ineligible for the SCAN Medicare/Medi-Cal Plan. I understand this authorization will expire one year from the date of my signature. I hereby enroll in SCAN Health Plan, so that SCAN may administer my Medi-Cal benefits, and in doing so I may receive health care services through SCAN. I understand that my Medi-Cal will be assigned to SCAN unless I lose Medi-Cal eligibility or disenroll voluntarily, and that it can take the Department of Health Care Services 15–45 days to officially disenroll my Medi-Cal from the SCAN Health Plan.

ID Number



Birthdate — Issue Date —

FOR OFFICE USE ONLY				
			County Code	Aid Code

Are you currently enrolled in any of the following programs?

1. Nursing Facility Acute Hospital (NF/AH) Waiver?	☐ Yes ☐ No
2. Multipurpose Senior Services Program (MSSP)?	☐ Yes ☐ No
3. In-Home Operations (IHO)?	☐ Yes ☐ No
4. Assisted Living Waiver Pilot Project (ALWPP)?	☐ Yes ☐ No
5. In-Home Supportive Services (IHSS)?	☐ Yes ☐ No

Per State requirements, if you are enrolled in any one of the programs listed above, you must first disenroll from any of these programs before you can enroll your Medi-Cal with SCAN Health Plan.

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Important Information — Please read the following:

1. I know that I must disenroll my Medi-Cal from the SCAN Health Plan if I choose to receive services from any of the programs listed above.
2. The person who enrolled me, gave me his/her name, showed me his/her SCAN ID badge and said he/she was an employee of SCAN.
3. **I have received complete and written information on SCAN benefits and understand I am to see only SCAN contracted providers.** I cannot use my current doctor once I am enrolled in SCAN unless he/she is on the Plan.
4. Enrollment is not effective until processing is completed.
5. If I am currently a beneficiary of another HMO, I am to **continue receiving medical care from my current HMO until my confirmed enrollment date with SCAN.**
6. I will be given a special identification card by SCAN upon enrollment. I will receive the Evidence of Coverage and Disclosure Information no later than 7 days after the effective date of enrollment.
7. The service area of SCAN is the approved zip codes listed in the Evidence of Coverage. If I move out of the service area I will need to notify SCAN so I can be disenrolled.
8. I may contact the Personal Assistance Line (PAL) any time I have a problem or complaint about the services I receive from SCAN Health Plan at 1-866-722-6725 (1-866-SCAN-PAL) or TTY users: 711, 8 A.M. to 8 P.M., 7 days per week from October 1 - March 31: 8 A.M. to 8 P.M., from April 1 - September 30: Monday - Friday.
9. SCAN will be sending a questionnaire to my home to accurately assess my needs. All information will be treated confidentially and no names will be used in reports.
10. I may disenroll at any time by contacting SCAN. I may call and request a disenrollment form be mailed to me. I do not have to appear in person to disenroll.
11. I was given a copy of this form by the SCAN Representative and I agree to the conditions of this agreement.

Signature

I acknowledge that my signature on this application and statement of understanding means that I have read and understand the contents of this application in its entirety.

Please sign here* _____ Date _____

*If anyone helped the beneficiary fill out this form he/she must sign here.

Signature_____ Date _____

Relationship to Individual _____

* If the individual cannot sign, a court appointed Legal Guardian or Designee assigned in a written advance directive, if authorized by state law, must sign below. Attach a copy of proof of Legal Guardianship, written advance directive, or proof of authorization by state law.

Signature_____ Date _____

OFFICE USE ONLY	NAME OF STAFF MEMBER (if assisted in enrollment)		REP. CODE
EFFECTIVE DATE OF COVERAGE / /		ICEP/IEP:____ SEP (type): ____	AEP: ____ Not Eligible: ____

SCAN Health Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SCAN Health Plan cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. SCAN Health Plan 遵守適用的聯邦民權法律規定, 不因種族、膚色、民族血統、年齡、殘障或性別而歧視 任何人。ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-866-722-6725 (TTY: 711). ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-722-6725 (TTY: 711). 注意: 如果您使用中文, 您可以免費獲得語言援助服務。請致電 1-866-722-6725 (聽障專線: 711) 。

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