Program Review Form

To ask Healthy Families to review and change a decision

Instructions

Use this form if you do not agree with a decision Healthy Families made about you or your family. You may ask Healthy Families to change the decision. Fill out the form and mail it to Healthy Families so that we receive it within 60 days of the decision. Cross out and correct any information that is wrong.

Questions?

If you have any questions about the form, call Healthy Families: ***1-866-848-9166,*** *Monday to Friday, 8 a.m. to 8 p.m., or on Saturday from 8 a.m. to 5 p.m. The call is free.*

❑ **Check this box if you are sending new income or other new papers with the form.**

❑ **Check this box if you are including a request for payment of medical bills with the form (please include the bills).**

A. Information about you.

,

B. Information about the person or persons whose coverage was denied or has ended.

C. Reason for review.

You *must* answer questions 1 through 3 below. You can answer 4 if you want to. Use extra paper if you need more space to write.

1. What is the decision you would like us to review?

Tell us about the decision you would like us to review. Or, include a copy of the letter you got from Healthy Families that talks about the decision.

2. Why do you think our decision is wrong?

Write your reason below. Or, check the boxes below. Check as many as you wish.

- ❑ Income was figured wrong
- ❑ Member is not on no-cost Medi-Cal
- ❑ Sent papers that were asked for (tell us below when you mailed or faxed the papers)
- ❑ Payment was made
- ❑ I think decision violates Healthy Families policy or law (explain below)
- ❑ Other (explain below)

_____

_____

_____

3. What would you like us to do?

- ❑ Keep family members in Healthy Families
- ❑ Other (explain below)

_____

_____

_____

4. What else would you like us to know?

Is there any other information you think would help us review our decision? Write the information or send other papers that will help us understand.

_____

_____

_____

D. Sign the form and send it to us within 60 days of the decision.

Signature: _____ **Date:**_____

Mail the form and other papers to:

Healthy Families
Review Unit
P.O. Box 138005
Sacramento, CA 95813-8005

Or, you can fax the form and papers to:

Fax: 1-866-848-4974 The call is free.

Write your Family Member Number on each paper you send. **Your Family Member Number is:**

E. Permission to share information with the following person:

I give permission for the Healthy Families Program to give information over the telephone about the status of this application to a Certified Application Assistant of the Enrollment Entity organization identified. This permission will end on the date the program mails the results of the eligibility determination on this application.

Name: _____

➨ Signature: _____ Date:_____

CAA#: _____ EE#: _____