

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 1-855-795-0634.
- 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 CDSS at 1-855-795-0634.

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 8 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 your 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 member wants to appeal their determinations on your eligibility notice list each name who want to appeal so we know whose determination(s) are being appealed.

To ask for a hearing with an Administrative Law Judge (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 above or by calling 1-855-795-0634 (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:
(916) 651-2789
2. **Mail** your appeal to:
CA Department of Social Services
Attn: **ACA Bureau**
P.O. Box 944243
Mail Station 9-17-37
Sacramento, California 94244-2430
3. You can **call** the State Hearings Division and submit your appeal over the phone:
1-855-795-0634
4. **Email** your appeal to:
SHDACABureau@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 postmark date 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 days 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. 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 there are more people in your household who want to file an appeal using this form.

Name(s):

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):

- | | |
|---|--|
| <input type="checkbox"/> I was denied enrollment into a Covered California health plan | <input type="checkbox"/> Covered California stated that my application was incomplete |
| <input type="checkbox"/> The amount of Premium Assistance (tax credits that help pay my monthly premium) is not correct | <input type="checkbox"/> I do not have other health coverage (such as free Medi-Cal or employer sponsored insurance) that prevents me from qualifying for insurance through Covered California |
| <input type="checkbox"/> The level of Cost Sharing Reduction (help paying my out of pocket expenses) is not correct | <input type="checkbox"/> Covered California stated that I am not a California Resident |
| <input type="checkbox"/> I was denied eligibility for an exemption from the individual responsibility | <input type="checkbox"/> Covered California stated that I did not pay my premiums by my due date |
| <input type="checkbox"/> Covered California did not process my information in a timely manner | <input type="checkbox"/> Covered California stated that my income is too low to qualify for Covered California coverage |
| <input type="checkbox"/> Covered California stated that I am not a US Citizen or US National or a lawfully present individual living in the United States | <input type="checkbox"/> Other (please provide reason in the space located on the next page) |

Covered California Authorized Representative Form



Assistance with completing this appeal

Instructions: An “authorized representative” is a person you trust to help you with your application or appeal with us, to be 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, fill in the boxes below, sign this document 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

Case ID:

1. Name of authorized representative (First name, Middle initial, Last name)

2. Address

3. Apt./Ste. #

4. City

5. State

6. ZIP Code

7. Phone Number (with area code)

8. Organization Name (if applicable)

9. ID number (if applicable)

10. Email Address

For certified enrollment counselors, navigators, agents, and brokers only.

Complete this section if you are a certified counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)

2. First name, Middle name, Last name, & Suffix

3. Organization Name (if applicable)

4. ID number (if applicable)

5. Agents/Brokers only: NPN number

Permission to share information

I authorize the person/organization above to act on my behalf regarding my application to enroll in an insurance affordability program available through 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.

- ✓ I have completed the “Permission to Share Information” section of this form that authorizes Covered California to speak with the person/organization above.
- ✓ 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.

Do you want your authorized representative to receive notices on your behalf? → Yes No

What is your representatives preferred method of communication? → E-mail or US postal mail

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

10. Your signature

Date (mm/dd/yyyy)

Mail this form to:

Covered California
P.O. Box 989725

West Sacramento, CA 95798

Fax this form to:

1-888-329-3700
(1-888-FAX-3700)

Call the service center at:

1-800-300-1506
(TTY 1-888-889-4500)

What happens next?

1. You will receive an 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.

Submitting Additional Information. You can submit additional information to support your appeal. Any information you submit will be reviewed along with the information you submitted on your application and that was used to make your eligibility determination. You may submit additional information by sending it to Covered California through one of the following ways:

1. Upload through your account at:
www.CoveredCA.com
2. Fax to: 1-888-329-3700 (1-888-FAX-3700)
3. Mail your information to:
Covered California
ATTN: **Appeals Department**
P.O. Box 989725
West Sacramento, CA 95798-9725
4. Scan and send your information through email to:
Appeals@Covered.ca.gov

If you mail your information separately, include the complete contact information of the appellant (as it appears on this form), including name, date of birth, phone number, email address (optional), and address. If there are multiple appellants listed on this form, identify the specific appellant(s) whose appeal(s) the additional information supports.

3. 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 would like to **postpone** your hearing, call the California Department of Social Service's Affordable Care Act Bureau at 1-800-743-8525.

If you disagree with the informal resolution decision, you can continue your appeal at a hearing.

4. 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 can attend the hearing by yourself or have someone be at the hearing with you. This person can be a friend, relative, lawyer, your authorized representative (if you have one), or another individual. You have the right to provide additional

information about your case to the judge before or at the time of the hearing.

You also 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, the judge will review all your information and make a final decision about your appeal, which 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.

5. Hearing by the United States Department of Health and Human Services. If you do not agree with the decision the Administrative Law Judge made on your case in the State Fair Hearing, you have a 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 notice of appeal 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.

Continued Enrollment during your appeal. You may be able to keep your eligibility for coverage while your appeal is pending. This is called "Continued Enrollment." We will notify you if you can keep your eligibility while your appeal is pending.

Language assistance services. If you need assistance in a language other than English, you have the right to get help and information in your language at no cost. Call Covered California at 1-800-300-1506 for more information.

Accessibility. If you have a disability and need extra assistance to attend your hearing, call CDSS at 1-855-795-0634 to request "reasonable accommodations." This help is available and provided at no cost to you.

Where can I find more information?

Follow the link to view Covered California's Appeals Regulations:

<https://www.coveredca.com/hbex/regulations/>

Covered California Continued Enrollment Form



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. 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 will retroactively enroll you into the plan from the date on which your coverage has ended and you will need to pay your premiums for those months.

Questions?

If you have any questions about this form, call Covered California at 1-800-300-1506 (TTY: 1-888-889-4500). You can call Monday to Friday, 8 a.m. to 6 p.m. and Saturday, 8 a.m. to 5 p.m. The call is free.

Information about you


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 a Covered California Plan from the date in which my coverage has ended. 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) or Cost-Sharing Reduction (CSR) amount. I will continue to receive my current APTC amount until my appeal resolves. I understand that if I receive too much premium assistance during the benefit year, including during continued enrollment, I will have to repay the extra premium assistance back to the IRS when I file my federal income taxes for the benefit year.
- I do not wish to keep my coverage while my appeal is being reviewed.

[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.

Signature:  _____ **Date:** _____

Mail this form to:
Covered California
P.O. Box 989725
West Sacramento, CA 95798

Fax this form to:
1-888-329-3700
(1-888-FAX-3700)

Call the service center at:
1-800-300-1506
(TTY 1-888-889-4500)

Email this form to:
Appeals@Covered.ca.gov

Need help in another language?



**COVERED
CALIFORNIA**

*Your destination for affordable
healthcare, including Medi-Cal*

Getting Help in a Language Other than English

IMPORTANT: Can you read this letter? You can call **1-(800)-300-0213** 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.

Espanol

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. Si usa TTY, llame al **1-(888)-889-4500**, donde también puede pedir esta carta en algún formato alterno.

Mandarin or Cantonese

重要事項：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**。

Vietnamese

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.

Korean

중요: 이 편지를 읽을 수 있나요? **1-(800)-300-0213**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.

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.

Arabic

طخب، یرخأ ةغیصب وأ کتغل ىل! مترجماً باطخل اذه بلطو **1 (800) 826-6317** ب لاصتال اکن کمي؟ باطخل اذه ةءارق اکن کمي له: ماه "ففلتخم ةغیصب باطخل اذه بلطت نأ ایضاً اکن کمي ثيح **1 (888) 4500-889** ب لاصتا، مکبل او مصلل. مثلاً ريبك

Armenian

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:

Khmer

សំខាន់: តើលោកអ្នកអាចអានលិខិតនេះបានដែរឬទេ? លោកអ្នកអាចទូរស័ព្ទមកលេខ **1-(800)-906-8528** និងស្នើសុំឱ្យគេបកប្រែលិខិតនេះជាភាសារបស់លោកអ្នក ឬជានប្រដំមួយផ្សេងទៀតដូចជាអក្សរពុម្ពធំៗ។ សម្រាប់ TTY ទូរស័ព្ទមកលេខ **1-(888)-889-4500** ដែលលោកអ្នកក៏អាចស្នើសុំលិខិតនេះជានប្រដំផ្សេងទៀតបានផងដែរ។

Russian

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.

Farsi

مرامش اب دین اوت یم؟ دین اوخب ار ممان نی ا دین اوت یم ای آ: مام
تشرذ فورح دن نام یرگی د تمرف هب ای دوش مچرت امش ن ابز م ممان نی ا مک دینک اض ا قت و دیری گب س امت **1 (800) 921-8879**
تس اوخر د دین اوت یم نی ن چمه مرامش نامه قی رطزا و دیری گب س امت **1 (888) 4500-889** مرامش اب TTY یارب. دوش لاسرا امش هب
"دوش لاسرا امش هب یرگی د تمرف هب ممان نی ا هک دینک"

Hmong

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.