HealthPAC
Health Program of Alameda County

HealthPAC Application Rights and Declarations

I, _____, am eligible for the HealthPAC program.
(Print your Full Name - First Name, Last Name)

I have read and agree to the following for myself and household members eligible for the HealthPAC program:

1. I am a resident of Alameda County.
2. I am not enrolled in the full scope Medi-Cal program, and I was screened for Medi-Cal eligibility and was found not to be eligible at this time. If I am found to be enrolled in Medi-Cal, I will be disenrolled from HealthPAC.
3. I know that HealthPAC *is not* an insurance program and is only valid at *contracted HealthPAC* providers for non-emergency services. If I get care outside of the HealthPAC Provider network for non-emergency services, I know that I must pay for the care.
4. I know that I may be disenrolled for the reasons stated in the HealthPAC Participant Handbook.
5. I know that my eligibility will be checked each year and that I must complete a yearly redetermination to stay in HealthPAC.
6. I agree to call HealthPAC Customer Service to disenroll from HealthPAC if I move out of Alameda County.
7. If I am asked to apply for any other public coverage program, I must do so. If I refuse to apply for a public coverage program when asked to, I may be disenrolled from HealthPAC and may have to pay for my care.
8. I know that if the information I give as part of my application is found to be fraudulent or misleading, I will be disenrolled and may be billed for all services that were covered under the HealthPAC program.
9. I approve release of my information for billing and the assignment of health services benefits.
10. I know that I can file a complaint within 60 days of the event giving rise to the complaint by calling HealthPAC Customer Service.
11. I know that I can file an appeal in response to a Notice of Action from HealthPAC about an eligibility or service authorization within 60 days by calling HealthPAC Customer Service. If I do not agree with how this appeal is resolved, I may have a right to a State Fair Hearing.
12. I know that by signing my name to this form, I agree to contact by HealthPAC or Alameda Alliance for Health for enrollee surveys or focus groups at the mailing address and/or phone number in this application. Taking part in these is my choice.

I have read this form and have been given the chance to discuss the items above with an Application Assistor. I declare that the above is true and correct. Further, by signing below, I authorize County staff, agents or contractors to check my eligibility.

Applicant Signature: Date:

Application Assistor Signature: Date:

Agency Name:

Client InSyst Number: Medical Home: