CONNECT TO CARE BY CMSP

PATH TO HEALTH™

RIGHTS AND RESPONSIBILITIES

Read the following carefully before signing.

I UNDERSTAND THAT:

1. I am applying for CMSP's healthcare programs and I am currently not enrolled in full-scope Medi-Cal, Medicare, Covered California or another health insurance program.
2. At the time of application, I must provide verification that I am a resident of one of the 35 counties served by CMSP.
3. If the information I provide as a part of my application is found to be inaccurate, I may be immediately disqualified from the program. In addition, I may be billed for all services provided to me under a CMSP healthcare program, and I may be investigated for suspected fraud.
4. I am not eligible for any of CMSP's healthcare programs if I am fleeing to avoid prosecution, custody or confinement after conviction for a crime that is a felony under the laws of the place that I am fleeing or violating a condition of probation or parole imposed under Federal or State Law.
5. CMSP's healthcare programs are not insurance programs and most health care benefits under these programs are available only through designated health care providers and pharmacies that contract with CMSP.
6. If my application is approved, I will need to reapply within 30 days of my coverage end date to extend my benefits for another 6-month term.
7. Following enrollment in a CMSP healthcare program, I am responsible for telling my medical provider that I am a member.
8. I must show my Member Identification Card to my medical provider when I get medical care and to the pharmacy when I get my prescriptions.
9. I must notify CMSP or the health center completing this application if:
    - I move or plan to move to another address in my county, to another county, or to another state or country.
    - Any person moves into or out of my home.
    - I become pregnant.
    - There's a significant change in my household's income and/or assets.
    - There's a change in my marital status, my immigration status, or I get other healthcare coverage.
10. I may be disenrolled from CMSP's healthcare programs if I abuse the program, such as making threats or disrupting other patients or health care provider staff at the medical offices and pharmacies that participate in CMSP's healthcare programs.

I HAVE THE RIGHT TO:

1. Be treated fairly and equally regardless of race, color, religion, national origin, sex, age, sexual orientation, marital status or political beliefs.
2. Receive a Member Identification Card and member guide within fourteen (14) days of enrollment.

3. Have all information I give to the health care provider where I enroll in CMSP's healthcare programs kept in the strictest confidence, in compliance with all federal and state confidentiality laws.
4. Disenroll from a CMSP healthcare program upon request.

I hereby state that I have read the information on this form and that I fully understand my rights and responsibilities associated with my enrollment and participation in a CMSP healthcare program. Further, I understand that these rights and responsibilities apply as long as I am a member.

I certify and declare under penalty of perjury under the laws of the State of California that the information I have provided for enrollment in a CMSP healthcare program, including my documentation of my identity, income and my declaration regarding assets, is true, correct and complete to the best of my knowledge. Further, by signing this form I authorize the community health center, as well as any other agents and contractors of CMSP's healthcare programs, to utilize my enrollment and health care services information for health care administration purposes that comply with all federal and state confidentiality laws.

DIGITAL SIGNATURE **DATE**