

# MEDI-CAL NOTICE OF ACTION SECOND YEAR OF TRANSITIONAL MEDI-CAL (TMC) APPROVAL FOR BENEFITS

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(COUNTY STAMP)

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Notice date: \_\_\_\_\_

Case number: \_\_\_\_\_

Worker name/number: \_\_\_\_\_

Worker telephone number: \_\_\_\_\_

This affects: \_\_\_\_\_

\_\_\_\_\_

A SECOND YEAR OF TMC IS AVAILABLE TO WORKING PERSONS AGE 19 AND OVER WHO RECEIVED ONE YEAR OF TMC BECAUSE THEY WERE NO LONGER ELIGIBLE FOR THEIR CURRENT MEDI-CAL PROGRAM DUE TO EMPLOYMENT.

You are eligible for up to 12 additional months of TMC at no cost for the period \_\_\_\_\_ through \_\_\_\_\_

You are entitled to full benefits.

Your benefits only cover emergency and pregnancy-related services

You must:

- Continue to be employed.
- Have an eligible child in the home.
- Have average earnings minus child care costs at or below 185 percent of the Federal Poverty Level.
- Report any changes in your income or household composition with ten days.

Always present your Benefits Identification Card (BIC) to your medical provider whenever you need care. This card is good as long as you are eligible for Medi-Cal. DO NOT THROW AWAY YOUR BIC.

The regulation which requires this action is California Code of Regulations, Title 22, Section 50244.

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## TRANSITIONAL MEDI-CAL (TMC) QUARTERLY STATUS REPORT

This status report is for the months of			Return this form no later than the 21st day Of
Month 1	Month 2	Month 3	

**IMPORTANT: COMPLETE, SIGN, AND RETURN THIS REPORT TO THE WELFARE DEPARTMENT IN THE ENCLOSED ENVELOPE.** Attach proof of your income, actual child care expenses paid, and total hours of employment for the three months noted above. If you have any questions regarding this form or the items to be reported, contact your eligibility worker.

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**. For Transitional Medi-Cal (TMC)-You** will receive status reports during this period. If you do not complete and return these reports, your eligibility for TMC will be discontinued.

### PART A. DISCONTINUANCE REQUEST

I request that my **Transitional Medi-Cal** be stopped on the last day of \_\_\_\_\_  
Month/Year

I know that I can reapply for **Medi-Cal** at any time.

Applicant signature \_\_\_\_\_

Date \_\_\_\_\_

**IF YOU WANT YOUR TMC ELIGIBILITY TO CONTINUE, PLEASE COMPLETE AND SIGN PART B OF THIS REPORT.**

### PART B. ELIGIBILITY STATUS INFORMATION

1. Did anyone receive any income, money, or benefits during the report period such as salary, wages, tips, commissions, bonuses, vacation pay? **If yes, attach proof (all pay stubs) for each report month.**  Yes  No

	Month 1	Month 2	Month 3
Name _____			
Employer/source _____	Income received? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Total hours worked: _____		
Name _____			
Employer/source _____	Income received? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Total hours worked: _____		
Name _____			
Employer/source _____	Income received? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Total hours worked: _____		
Name _____			
Employer/source _____	Income received? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Total hours worked: _____		

2. Did you or any family member receive money or benefits from other sources such as disability, unemployment, child support, or social security? **If yes, attach proof (all pay stubs) for each report month.**  Yes  No

	Month 1	Month 2	Month 3
Name _____			
Employer/source _____	Income received? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name _____			
Employer/source _____	Income received? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name _____			
Employer/source _____	Income received? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

3. a. Did you or any family member **receive free** housing, utilities, food, or clothing in the report month?  Yes  No  
 b. Did you or any family member **work for** housing, utilities, food, or clothing in the report month?  Yes  No

**If yes to 4a and 4b, you must answer the three questions on the next line.**

(1) What was received?	(2) Who received it?	(3) Who provided it?
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4. Did you or anyone pay for child care expenses which have not or will not be reimbursed?  Yes  No  
 If yes, complete the following:

Name of Child(ren)	Age	Amount Paid for Child Care Expenses			Name of Child Care Provider
		Month 1	Month 2	Month 3	

5. Did you have changes in your family or household during the time specified? (Include change of address, change of child care provider, change of employment, **change** in property, anyone that moved into or out of your home, is pregnant, or anyone who was born or who died.)  Yes  No  
 If yes, complete the following:

Name	Relationship	What Happened	Date

6. a. Do you or anyone have or expect to receive private health, vision, or dental insurance? (This includes insurance paid by an absent parent.)  Yes  No  
 b. Do you have or expect to receive health insurance through your employer?  Yes  No  
 c. Does your employer offer health insurance for a monthly premium?  Yes  No  
 If yes, complete the following:

Name of Insurance	Person(s) Insured

**CERTIFICATION**

I understand that reported facts may result in benefits being changed or stopped.  
 I understand that the statements I have made on this form are subject to investigation and verification.  
 I understand that I must notify my worker within ten days of any change.  
 I understand that failing to report facts or giving wrong or incomplete facts can result in legal prosecution with penalties of a fine, imprisonment, or both.

**I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE UNITED STATES AND THE STATE OF CALIFORNIA THAT THE INFORMATION CONTAINED IN THIS REPORT IS TRUE AND CORRECT AND IS COMPLETE FOR THE ENTIRE REPORT PERIOD.**

Signature or mark of applicant	Date	Phone number (     )
Signature of witness to mark, interpreter, or other person	Date	Phone number

## TRANSITIONAL MEDI-CAL (TMC) QUARTERLY STATUS REPORT

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Applicant signature

Date

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### PART B. ELIGIBILITY STATUS INFORMATION

1. Did anyone receive any income, money, or benefits during the report period such as salary, wages, tips, commissions, bonuses, vacation pay? If yes, attach proof (all pay stubs) for each report month.  Yes  No

Name	Month 1	Month 2	Month 3
Employer/source	Income received? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name	Total hours worked: _____		
Employer/source	Income received? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name	Total hours worked: - - - - -		
Employer/source	Income received? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Employer/source	Income received? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name	Total hours worked: - - - - -		

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Name	Month 1	Month 2	Month 3
Employer/source	Income received? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name	Total hours worked: _____		
Employer/source	Income received? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
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 b. Do you have or expect to receive health insurance through your employer?  Yes  No  
 c. Does your employer offer health insurance for a monthly premium?  Yes  No  
 If yes, complete the following:

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Signature or mark of applicant	Date	Phone number (      )
Signature of witness to mark, interpreter, or other person	Date	Phone number (      )