MEDI-CAL
NOTICE OF ACTION
CONTINUATION OF SECTION 1931(b) BENEFITS

(COUNTY STAMP)

Notice date: _____
Case number: _____
Worker name: _____
Worker number: _____
Worker telephone number: _____
Office hours: _____
Notice for: _____

Although your cash benefits for the California Work Opportunity and Responsibility to Kids (CalWORKs) program have stopped, your Medi-Cal will continue under the Section 1931(b) program. This program provides no-cost Medi-Cal benefits to certain low-income persons with eligible children.

You do not have to fill out monthly or quarterly status reports to keep Medi-Cal; however, if your cash benefits stopped because you did not return your CalWORKs monthly report ***and*** you had changes that you haven't reported to your cash worker, you must report those to your Medi-Cal worker now.

Receiving these Medi-Cal benefits does not count against any CalWORKs program time limits.

In order to remain eligible for this Medi-Cal program, you must:

- Have an eligible child living in the home who qualifies for Medi-Cal with no share-of-cost because one parent is deceased, absent, incapacitated, unemployed (or working with limited earnings), or you must be an eligible child living with a relative.
- Have income and property under a certain limit.
- Continue to meet all other Medi-Cal requirements.
- Report within ten days any significant changes that could affect your eligibility such as changes in your income, property, medical condition, or household situation.
- Complete the form for your Medi-Cal annual review when it is sent to you.

Always show 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 PLASTIC BIC.

The regulation that requires this action is California Code of Regulations, Title 22, Section 50226.

MEDI-CAL
NOTICE OF ACTION
SECTION 1931(b)
APPROVAL FOR BENEFITS

(COUNTY STAMP)

Notice date: _____
Case number: _____
Worker name: _____
Worker number: _____
Worker telephone number: _____
Office hours: _____
Notice for: _____

The Section 1931(b) program provides no-cost Medi-Cal benefits to certain low-income persons with eligible children.

☐ You are entitled to full benefits beginning _____.

☐ Your benefits cover only emergency and pregnancy-related services beginning _____.

In order to remain eligible for this program, you must:

- Have an eligible child living in the home who qualifies for Medi-Cal with no share-of-cost because one parent is deceased, absent, incapacitated, unemployed (or working with limited earnings), or you must be an eligible child living with a relative.
- Have income and property under a certain limit.
- Continue to meet all other Medi-Cal requirements.
- Report within ten days any significant changes that could affect your eligibility, such as changes in your income, property, medical condition, or household situation.
- Complete the form for your Medi-Cal annual review when it is sent to you.

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 PLASTIC BIC.

The regulation that requires this action is California Code of Regulations, Title 22, Section 50226.

MEDI-CAL
NOTICE OF ACTION
SECTION 1931(b)
DENIAL OR DISCONTINUANCE OF BENEFITS

(COUNTY STAMP)

Notice date: _____
Case number: _____
Worker name: _____
Worker number: _____
Worker telephone number: _____
Office hours: _____
Notice for: _____

☐ Your benefits under the Section 1931(b) program will be discontinued effective the last day of _____.

☐ You are not eligible for the Section 1931(b) program.

Here is/are the reason(s) why:

☐ Your income is over the limit.

☐ Your property is over the limit. The limit is _____.

☐ You do not have an eligible child living in the home who qualifies for Medi-Cal without a share-of-cost.

☐ You are working 100 hours or more and your family's earned income is over the limit.

☐ Your child is over the age limit.

☐ Other: _____

_____

You will receive another notice if you are eligible for another Medi-Cal program.

DO NOT THROW AWAY YOUR PLASTIC BENEFITS IDENTIFICATION CARD (BIC). You can use it again if you become eligible or are eligible for another Medi-Cal program.

The regulation that requires this action is California Code of Regulations, Title 22, Section 50226.

MEDI-CAL
NOTICE OF ACTION
APPROVAL FOR THE MEDICALLY NEEDY OR MEDICALLY INDIGENT PROGRAM BENEFITS

(COUNTY STAMP)

Notice date: _____
Case number: _____
Worker name: _____
Worker number: _____
Worker telephone number: _____
Office hours: _____
Notice for: _____

You have been approved for the following program(s):

- ☐ Medically Needy Program for a family with a child whose parent(s) is/are absent from the home, deceased, incapacitated, unemployed, or working with limited earnings.
- ☐ Medically Needy Program for the aged, blind, or disabled.
- ☐ Medically Indigent Program for pregnant women.
- ☐ Medically Indigent Program for persons under age 21.
- ☐ Medically Indigent Program for a child who is the responsibility of a public agency.
- ☐ Other: _____
- ☐ You are entitled to receive Medi-Cal benefits beginning the first day of _____.
  - You do not have to fill out monthly or quarterly status reports to get Medi-Cal.
  - You must report within ten days any significant changes that could affect your eligibility such as changes in your income, property, medical condition, or household situation.
  - You will have to complete the form for your Medi-Cal annual review when it is sent to you.
  - Receiving these Medi-Cal benefits does not count against any CalWORKs program time limits.
- ☐ You are entitled to full benefits beginning _____.
- ☐ Your benefits cover only emergency and pregnancy-related services beginning _____.
- ☐ You are eligible with no share-of-cost.
- ☐ Your income exceeds the maintenance need amount. You have a share-of-cost to pay or obligate towards your monthly medical care. Your share-of-cost is $ _____ beginning _____.

  Your share-of-cost was computed as follows:

Gross income	$ _____
Net nonexempt income	$ _____
Maintenance need	$ _____
Excess income/share-of-cost	$ _____

Always show 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 PLASTIC BIC.

The regulations that require this action are California Code of Regulations, Title 22, Sections 50203, 50251, and 50653.

MEDI-CAL
NOTICE OF ACTION
DENIAL OR DISCONTINUANCE FOR THE MEDICALLY NEEDY OR MEDICALLY INDIGENT PROGRAM BENEFITS

(COUNTY STAMP)

Notice date: _____
Case number: _____
Worker name: _____
Worker number: _____
Worker telephone number: _____
Office hours: _____
Notice for: _____

☐ Your application for Medi-Cal dated _____ has been denied because you are not eligible for any of the following programs:

☐ You are being discontinued from the following program(s) effective _____:

- ☐ Medically Needy Program for a family with a child whose parent(s) is/are absent from the home, deceased, incapacitated, unemployed, or working with limited earnings.
- ☐ Medically Needy Program for the aged, blind, or disabled.
- ☐ Medically Indigent Program for pregnant women.
- ☐ Medically Indigent Program for persons under age 21.
- ☐ Medically Indigent Program for a child who is the responsibility of a public agency.
- ☐ Other: _____.

Here's why:

- ☐ You are no longer blind or disabled and you are not aged.
- ☐ You are no longer pregnant.
- ☐ You are age 21 or older but under age 65.
- ☐ You are not a family with a child whose parent(s) is/are absent from the home, deceased, incapacitated, unemployed, or working with limited earnings.
- ☐ You are no longer the responsibility of a public agency.
- ☐ Your property is above the allowable limit. The limit is_____.
- ☐ Other: _____.

You will receive another notice if you are eligible for another program. DO NOT THROW AWAY YOUR BENEFITS IDENTIFICATION CARD (BIC) IF YOU RECEIVED ONE. You can use it again if you become eligible for Medi-Cal.

The regulations that require this action are California Code of Regulations, Title 22, Sections 50203 and 50251.

MEDI-CAL
NOTICE OF ACTION
PERSONS AGE 21 TO 65 IN A NURSING FACILITY
APPROVAL FOR BENEFITS

(COUNTY STAMP)

Notice date: _____

Case number: _____

Worker name _____

Worker number: _____

Worker telephone: _____

Office hours: _____

Notice for: _____
(Name)

This program provides Medi-Cal benefits to persons age 21 to 65 residing in a nursing facility who are not eligible for any other Medi-Cal program. Your benefits cover only services received while residing in a skilled or intermediate care nursing facility. They do not cover acute care benefits received while in a hospital.

☐ You are entitled to benefits beginning _____.

☐ Since your income exceeds the amount allowed, you have a share-of-cost to pay or obligate toward your medical care. Your share-of-cost is $ _____ beginning _____. Your share-of-cost was computed as follows:

Gross income	$ _____
Net nonexempt income	$ _____
Maintenance need	$ _____
Excess income/share-of-cost	$ _____

In order to remain eligible for this program, you must:

- Have property under a certain limit.
- Continue to meet all other Medi-Cal requirements.
- You do not have to fill out monthly or quarterly status reports to get Medi-Cal.
- You must report within ten days any changes in your income, property, or household situation. Also report if your medical condition becomes worse.
- You will have to complete a form for your Medi-Cal annual review.

Your plastic Benefits Identification Card (BIC) will be mailed to you at the long-term care facility. DO NOT THROW THIS CARD AWAY. It is good as long as you are eligible for Medi-Cal benefits.

The regulation that requires this action is California Code of Regulations, Title 22, Section 50251(b).

MEDI-CAL
NOTICE OF ACTION
PERSONS AGE 21 TO 65 IN A NURSING FACILITY
DENIAL OR DISCONTINUANCE OF BENEFITS

(COUNTY STAMP)

Notice date: _____
Case number: _____
Worker name _____
Worker number: _____
Worker telephone number: _____
Office hours: _____
Notice for: _____

☐ Your benefits under this program will be discontinued effective the last day of _____.

☐ You are not eligible for this program.

Here is/are the reason(s) why:

☐ Your property is over the limit. The property limit is _____.

☐ You are not or are no longer residing in a nursing facility.

☐ Other: _____

_____

You will receive another notice if you are eligible for another Medi-Cal program.

DO NOT THROW AWAY YOUR PLASTIC BENEFITS IDENTIFICATION CARD (BIC). You can use it again if you become eligible or are eligible for another Medi-Cal program.

The regulation that requires this action is California Code of Regulations, Title 22, Section 50251(b).

MEDI-CAL
NOTICE OF ACTION
TRANSITIONAL MEDI-CAL (TMC)
APPROVAL FOR FULL OR RESTRICTED BENEFITS

(COUNTY STAMP)

Notice date: _____
Case number: _____
Worker name: _____
Worker number: _____
Worker telephone number: _____
Office hours: _____
Notice for: _____

TMC IS A PROGRAM THAT PROVIDES CONTINUING MEDI-CAL BENEFITS FOR UP TO TWO YEARS FOR CERTAIN PERSONS NO LONGER ELIGIBLE FOR THEIR CURRENT MEDI-CAL PROGRAM AS A RESULT OF EARNINGS FROM EMPLOYMENT.

☐ You are eligible for initial TMC for the period _____ through _____.

☐ You are entitled to full benefits.

☐ You are entitled to emergency and pregnancy-related benefits.

You will continue to receive TMC during this period if you have an eligible child in the home and remain employed. Receiving these Medi-Cal benefits does not count against any CalWORKs program time limits.

You may be eligible for an additional six months of TMC at no cost if you:

- Return the status report which the county will send you by the 21st day of _____ and be within income limits.
- Attach to the status report proof of your family's monthly gross earnings and actual child care costs paid by you. Save all your earnings statements and child care receipts.

☐ You are eligible for an additional six months for the period _____ through _____.

To remain eligible for the additional six months of TMC, you will be required to complete and return two status reports sent to you by the county during this period. The first report will be due by the 21st day of the first month and the second report will be due by the 21st day of the fourth month of this additional six-month period. You must also:

- Continue to be employed.
- Have earnings below a certain limit.
- Have an eligible child in the home.

When your additional six months of TMC benefits have ended, you will be evaluated for the second year of TMC or other Medi-Cal programs.

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.

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

(COUNTY STAMP)

Notice date: _____
Case number: _____
Worker name: _____
Worker number: _____
Worker telephone number: _____
Office hours: _____
Notice for: _____

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.

When your benefits have ended, you will be evaluated for other Medi-Cal programs.

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.

MEDI-CAL
NOTICE OF ACTION
APPROVAL FOR SPECIAL ZERO SHARE-OF-COST PROGRAM FOR PREGNANT WOMEN AND BABIES UP TO ONE YEAR OLD

(COUNTY STAMP)

Notice date: _____
Case number: _____
Worker name: _____
Worker number: _____
Worker telephone number: _____
Office hours: _____
Notice for: _____

☐ Beginning _____, you are eligible to receive limited Medi-Cal services without a share-of-cost under a special program for pregnant women. Under this program, you can receive only pregnancy-related services which include prenatal care, services for complications of pregnancy, labor, delivery, postpartum care, and family planning.

☐ You continue to be eligible for benefits with a share-of-cost under the regular Medi-Cal program. Under this program you may also receive medical services not related to your pregnancy.

☐ Beginning _____, your baby is eligible to receive Medi-Cal benefits without a share-of-cost under a special program for babies up to one year old. Under this program, the baby's Medi-Cal coverage will provide:

- ☐ full Medi-Cal benefits.
- ☐ restricted Medi-Cal benefits (emergency and pregnancy only).

In addition to other program requirements, eligibility under this program is based on your pregnancy and/or on your family's income.

You must report within ten days any significant changes that could affect your or your child's eligibility, such as changes in your income, property, medical condition, or household situation.

The regulation which requires this action is California Code of Regulations, Title 22, Section 50262.

MEDI-CAL
NOTICE OF ACTION
DENIAL OR DISCONTINUANCE OF BENEFITS UNDER THE INCOME DISREGARD PROGRAM FOR PREGNANT WOMEN AND INFANTS

(COUNTY STAMP)

Notice date: _____
Case number: _____
Worker name: _____
Worker number: _____
Worker telephone number: _____
Office hours: _____
Notice for: _____

The Income Disregard Program is a special program for pregnant women and infants up to one year old with family income at or below 200 percent of the federal poverty level. It provides zero share-of-cost pregnancy-related services and postpartum care to women and medical care to infants under one year of age. A review of your case shows that:

You are not eligible for this program because:

- ☐ Your family's income is over the allowable limit.
  - ☐ This does not affect your regular Medi-Cal eligibility.
- ☐ Your eligibility for benefits under this program ends _____ because:
  - ☐ You are no longer pregnant and your 60-day postpartum period has ended.
  - ☐ Other: _____
  - ☐ This does not affect your regular Medi-Cal eligibility.
- ☐ You will receive another notice if you are eligible for another program.

Your child is not eligible for this program because:

- ☐ Your family's income is over the allowable limit.
- ☐ Your child's eligibility for benefits under this program ends _____ because:
  - ☐ Your child has reached age one.
  - ☐ Other: _____
- ☐ You will receive another notice if your child is eligible for another program.
- ☐ Enclosed are forms that you need to complete and return to us to determine if you or your child is eligible for another program. Please return this information within ten days.

If you have any questions about this action, please write or telephone. We will answer your questions or make an appointment to see you. You may reapply for Medi-Cal at any time. DO NOT THROW AWAY YOUR BENEFITS IDENTIFICATION CARD (BIC). You can use it again if you become eligible for Medi-Cal.

The regulations which require this action are California Code of Regulations, Title 22, Sections 50260 and 50262.

MEDI-CAL
NOTICE OF ACTION
APPROVAL FOR THE 100 PERCENT PROGRAM

(COUNTY STAMP)

Notice date: _____
Case number: _____
Worker name: _____
Worker number: _____
Worker telephone number: _____
Office hours: _____
Notice for: _____

Beginning _____, your child(ren) is eligible to receive Medi-Cal benefits without a share-of-cost under the 100 Percent Program for children who are at least 6 years of age up to age 19.

Under this program, Medi-Cal will provide:

☐ Full Medi-Cal benefits.

☐ Restricted Medi-Cal benefits (pregnancy and emergency medical conditions only).

Eligibility under this program is based on your family's income, in addition to other program requirements.

You must report within ten days any significant changes that could affect your child's eligibility, such as changes in your income, property, medical condition, or household situation.

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 PLASTIC BIC.

The regulations which require this action are California Code of Regulations, Title 22, Section 50262.6.

MEDI-CAL
NOTICE OF ACTION
APPROVAL FOR
THE 133 PERCENT PROGRAM

(COUNTY STAMP)

Notice date: _____
Case number: _____
Worker name: _____
Worker number: _____
Worker telephone number: _____
Office hours: _____
Notice for: _____

Beginning _____, your child(ren) is eligible to receive Medi-Cal benefits without a share-of-cost under the 133 percent program for children from one to six years of age. Under this program, the child's Medi-Cal benefits will provide:

☐ Full Medi-Cal benefits.

☐ Restricted Medi-Cal benefits (services for treatment of emergency medical conditions only).

Eligibility under this program is based on your family's income, in addition to other program requirements.

You must report within ten days any significant changes that could affect your child's eligibility, such as changes in your income, property, medical condition, or household situation.

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 PLASTIC BIC.

The regulation which requires this action is California Code of Regulations, Title 22, Section 50262.5.

MEDI-CAL
NOTICE OF ACTION
DENIAL OR DISCONTINUANCE OF BENEFITS UNDER THE 133 PERCENT PROGRAM

(COUNTY STAMP)

Notice date: _____
Case number: _____
Worker name: _____
Worker number: _____
Worker telephone number: _____
Office hours: _____
Notice for: _____

The 133 Percent Program provides Medi-Cal benefits at no share-of-cost for children who are at one year of age up to age six whose family income is at or below 133 percent of the federal poverty level. A review of your case shows that:

- ☐ Your child(ren) does not qualify for this program because your family's income is over the allowable limit. You will receive a separate notice about regular Medi-Cal.
- ☐ Your child(ren) does not qualify for this program because your family's income is over the allowable limit. Enclosed are forms that you need to complete and return to us to determine if he/she is eligible for regular Medi-Cal with a share of cost. Please return this information within ten days. If we do not receive this, your child's benefits will end _____.
- ☐ Eligibility for benefits under the 133 Percent Program ends because your child has reached age six.
  - ☐ A separate notice will be sent to you about regular Medi-Cal. If your child is hospitalized, let your worker know right away.
  - ☐ Enclosed are forms that you need to complete for us to determine if he/she is eligible for regular Medi-Cal with a share-of-cost. Please return this information within ten days. If we do not receive this, your child's benefits will end _____.
- ☐ Eligibility for benefits under the 133 Percent Program ends _____ because:

The regulations which require this action are California Code of Regulations, Title 22, Section 50262.5.

If you have any questions about this action, please write or telephone. We will answer your questions or make an appointment to see you. You may reapply for Medi-Cal at any time. DO NOT THROW AWAY YOUR CHILD'S BENEFITS IDENTIFICATION CARD (BIC). Your child can use it again under another regular Medi-Cal program even if your child has a share-of-cost.

PLEASE READ THE REVERSE SIDE OF THIS NOTICE FOR APPEAL INFORMATION.