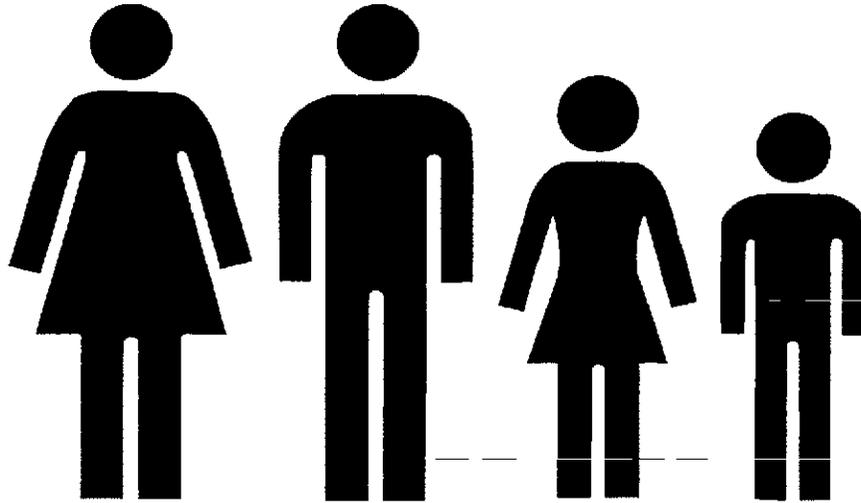


TRANSITIONAL MEDI-CAL (TMC)



***TMC May Provide You and Your Family with
FREE Continued Medical Coverage For Up To 12 Months.
Adults May Get TMC For Up To 24 Months.***

If you:

- Get a job, or**
- Get more money from your job, or**
- Get child or spousal support,**

tell your worker right away or complete the back of this form and mail it to your worker. You may still be eligible for no-cost Medi-Cal. Your worker will determine whether your Medi-Cal health coverage can continue.

Health care is important for you and your family. Receiving Medi-Cal does not affect your CalWORKs time limits.

REQUEST FOR TRANSITIONAL MEDI-CAL (TMC) OR FOUR MONTH CONTINUING MEDI-CAL

Did your Medi-Cal or CalWORKS cash aid stop and:

- You or your family has earnings from a job, a business you started, or a pay raise? Yes No
- You or your family started receiving or had an increase in child/spousal support payments? Yes No

If you answered "YES" to any of these questions, you and other family members may still be eligible for Medi-Cal. Complete the form and attach your and your spouse's or other parent's most recent pay stubs or other proof of earnings. If you are self-employed, list business costs on a separate sheet of paper and attach proof of income and costs.

RETURN THIS REQUEST FORM TO YOUR COUNTY WORKER OR YOUR WELFARE OFFICE. DO NOT RETURN THIS FORM TO THE CALIFORNIA DEPARTMENT OF HEALTH SERVICES.

Please type or print clearly.

Name	TOTAL HOURS WORKED IN REPORT MONTH:	DATE PAID: MM DD YY	MM DD YY	MM DD YY	MM DD YY	MM DD YY
Employer/source		GROSS AMOUNT: \$	\$	\$	\$	\$
Name	TOTAL HOURS WORKED IN REPORT MONTH:	DATE PAID: MM DD YY	MM DD YY	MM DD YY	MM DD YY	MM DD YY
Employer/source		GROSS AMOUNT: \$	\$	\$	\$	\$
Name	TOTAL HOURS WORKED IN REPORT MONTH:	DATE PAID: MM DD YY	MM DD YY	MM DD YY	MM DD YY	MM DD YY
Employer/source		GROSS AMOUNT: \$	\$	\$	\$	\$

Did your family have any other changes, such as someone moved in or out of the house or was married, divorced, or became pregnant? Yes No If yes, please explain: _____

If you can't read this notice, ask your worker for a translation.

- Spanish:** Si no puede leer esta notificación, pídale a su trabajador que se la traduzca.
- Cambodian:** បើសិនជាលោកអ្នកមិនយល់សេចក្តីប្រកាសនេះទេ សូមសាកសួរអ្នកសេចក្តីបកប្រែពីអ្នកកាន់សំណុំរឿងរបស់លោកអ្នក ។
- Chinese:** 假如你看不懂這份通知，可以要求你的工作人員幫助你翻譯。
- Russian:** Если Вы не можете прочитать и (или) понять это извещение, попросите Вашего работника перевести.
- Vietnamese:** Nếu quý vị không biết tiếng Anh để hiểu nội dung thông báo này, hãy xin nhân viên phụ trách tìm người dịch giúp cho quý vị.

I declare under penalty of perjury that all information provided is true and correct.

Name	Social security number
Signature	Telephone number ()
Address (number, street)	City ZIP code
Signature of witness, interpreter, or person assisting	Date Telephone number ()