

**MEDI-CAL  
NOTICE OF ACTION  
DISCONTINUANCE FOR FAILURE TO PAY  
FULL PREMIUMS IN THE 250 PERCENT  
WORKING DISABLED PROGRAM**



(COUNTY STAMP)



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

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

Worker name: \_\_\_\_\_

District: \_\_\_\_\_

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

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

Worker hours: \_\_\_\_\_

Discontinuance from the 250 Percent Working Disabled program for: \_\_\_\_\_

(names)

We have reviewed all information about your payment of premiums in the 250 Percent Working Disabled program and have determined that you have not paid the required premiums for **two months**.

Your enrollment in the 250 Percent Working Disabled program will be discontinued, effective the last day of \_\_\_\_\_.

If you have any questions about your premium payments, you may call the Department of Health Services, Third Party Liability Branch, at (916) 324-4162.

If you are eligible for Medicare, this means that \_\_\_\_\_ is the last month the

(month)

State will pay your premium for Part B Medicare supplementary insurance coverage. You will receive a written notice from the Social Security Administration, or you may call your Social Security district office if you have questions about your Medicare status.

This discontinuance action does not affect your eligibility for any other Medi-Cal program. You will receive another notice from your county Department of Social Services concerning any other Medi-Cal coverage for which you may be eligible. If you have any questions about such eligibility, please write or telephone your county eligibility worker.

**DO NOT THROW YOUR PLASTIC ID CARD AWAY.** You can use it again if you become eligible for Medi-Cal in the future.

This action is required by All County Welfare Directors' Letter 00-16.

County Welfare Department Address

**PLEASE PRINT**

Retain Copy 4  
(Send copies 1, 2, and 3 to DAPD)  
**DO NOT MAIL TO APPLICANT**

County number	Aid code	Case number
<input type="text"/>	<input type="text"/>	<input type="text"/>

DAPD Address

Oakland State Programs Branch  
P.O. Box 23645  
Oakland, CA 94623-9945

1. Applicant name (first) (middle name) (last)

2. Social Security number	3. Date of birth
<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>
<input type="checkbox"/> Pending <input type="checkbox"/> None	Month Day Year

5. Date applied

-  -

Month Day Year

7. Mailing address

Telephone number:  -

(area code)

6. List retro month(s)

/  /

Months/Year Month/Year Month/Year

8. Type of referral (check appropriate box(es))

Initial referral  IHSS  Retro-onset

Redetermination  SGA IHSS  Limited referral

Reevaluation  SGA-disabled  Other—explain (item 10)

Pickle-blind  CAPI

Reexamination  Resubmitted packet

4. Sex  Male  Female

9. Is applicant in a hospital?  Yes  No

Name of hospital:

0. County worker comment(s) (If more space is needed, attach a separate sheet.)  See attached sheet (e.g., DHS 7045)

(MC 179) 90-Day Status Letter attached  Presumptive Disability approved

11. File reviewed and approved for transmittal

Worker number	Print worker name
<input type="text"/>	<input type="text"/>
Telephone number	FAX number
<input type="text"/> - <input type="text"/>	<input type="text"/> - <input type="text"/>
(area code)	(area code)

12. Date sent

-  -

Month Day Year

13.  See attached DAPD Documents (This is NOT a certification for in-home supportive services.)

Comment(s) or SP-DAPD Presumptive Disability decision

14. Analyst	15. Date
<input type="text"/>	<input type="text"/>
6. Team manager	17. Date
<input type="text"/>	<input type="text"/>

DISABILITY DETERMINATION AND TRANSMITTAL

SEE BACK OF COPY 4

Oakland

Los Angeles