

**TRANSMITTAL TO CDCR PUBLIC BENEFIT SPECIALIST ON
DETERMINATION OF A WARD’S/INMATE’S MEDI-CAL ELIGIBILITY**

Date:	CDCR Number:
Benefits Information for:	
ELIGIBILITY PENDING <i>(Note: The eligibility status information provided below is subject to change if all eligibility requirements are not met at the time the ward/inmate is released.)</i>	
<input type="checkbox"/> This ward/inmate will be eligible to receive no-cost Medi-Cal benefits beginning on the following date: _____.	
<input type="checkbox"/> This ward/inmate will be eligible to receive Medi-Cal benefits with a share-of-cost beginning on the following date: _____.	
<input type="checkbox"/> This ward/inmate will be eligible to receive limited Medi-Cal benefits beginning on the following date: _____.	
<input type="checkbox"/> Due to a change of his or her release date, this ward/inmate will not be eligible to receive Medi-Cal on _____; instead he or she will be eligible to receive Medi-Cal benefits on the following date: _____.	
ELIGIBILITY DENIED	
<input type="checkbox"/> This ward’s/inmate’s application for Medi-Cal, dated _____, has been denied. The reason for this denial is:	
INFORMATION REQUEST <i>(Please contact the County immediately if you have questions or concerns regarding the denial of eligibility)</i>	
<input type="checkbox"/> In order to determine the ward’s/inmate’s eligibility we need the following information:	

DIVISION OF ADULT PAROLE OPERATIONS

1515 S Street, Room 212-N, Sacramento, CA 95814
P.O. Box 942883, Room 212-N
Sacramento, CA 94283-0001



<INSERT DATE>

County Welfare Department:

<INSERT COUNTY REPRESENTATIVE>

<INSERT COUNTY>

In accordance with the Memorandum of Understanding between the California Department of Corrections and Rehabilitation (CDCR) and the California Department of Health Care Services (DHCS), this is to notify you that the Parolee's release date has changed.

INMATE NAME:

INMATE CDCR NUMBER:

DATE OF BIRTH:

UPDATED PAROLE DATE:

COUNTY OF RECORD:

Questions regarding the parole release date for the above mentioned inmate may be directed to the contracted authorized representative at **<INSERT TELEPHONE NUMBER>**, **<INSERT E-MAIL ADDRESS>**. The authorized representative fax number is **<INSERT FAX NUMBER>**.

Thank you for your assistance.

<INSERT YOUR NAME>, **<INSERT YOUR TITLE>**

<INSERT YOUR INSTITUTION>

Transitional Case Management Program

DIVISION OF JUVENILE JUSTICE FACILITIES
4241 WILLIAMSBURG DRIVE
SACRAMENTO, CA 95823



<INSERT DATE>

County Welfare Department:

<INSERT COUNTY REPRESENTATIVE>

<INSERT COUNTY>

In accordance with the Memorandum of Understanding between the California Department of Corrections and Rehabilitation (CDCR) and the California Department of Health Care Services (DHCS), attached is a Medi-Cal application for processing.

WARD NAME:

WARD CDCR NUMBER:

DATE OF BIRTH:

PAROLE DATE:

COUNTY OF PAROLE:

HAS RESIDENCE PLANS UPON RELEASE: YES NO

If no, he/she intends to reside in this area of the county:

PLANS TO WORK UPON RELEASE: YES NO

APPLIED FOR SOCIAL SECURITY BENEFITS: YES NO

Questions regarding the parole release date for the above mentioned ward may be directed to the contracted authorized representative at **<INSERT TELEPHONE NUMBER>**, **<INSERT E-MAIL ADDRESS>**. The authorized representative fax number is **<INSERT FAX NUMBER>**.

Thank you for your assistance.

<INSERT YOUR NAME>, **<INSERT YOUR TITLE>**
<INSERT YOUR PROGRAM>

DIVISION OF JUVENILE JUSTICE FACILITIES
4241 WILLIAMSBOROUGH DRIVE
SACRAMENTO, CA 95823



<INSERT DATE>

County Welfare Department:

<INSERT COUNTY REPRESENTATIVE>
<INSERT COUNTY>

In accordance with the Memorandum of Understanding between the California Department of Corrections and Rehabilitation (CDCR) and the California Department of Health Care Services (DHCS), this is to notify you that the Ward's release date has changed. See information below:

WARD NAME:

WARD CDCR NUMBER:

DATE OF BIRTH:

UPDATED PAROLE DATE:

COUNTY OF RECORD:

Questions regarding the parole release date for the above mentioned ward may be directed to the contracted authorized representative at **<INSERT TELEPHONE NUMBER>**, **<INSERT E-MAIL ADDRESS>**. The authorized representative fax number is **<INSERT FAX NUMBER>**.

Thank you for your assistance.

<INSERT YOUR NAME>, **<INSERT YOUR TITLE>**
<INSERT YOUR PROGRAM>