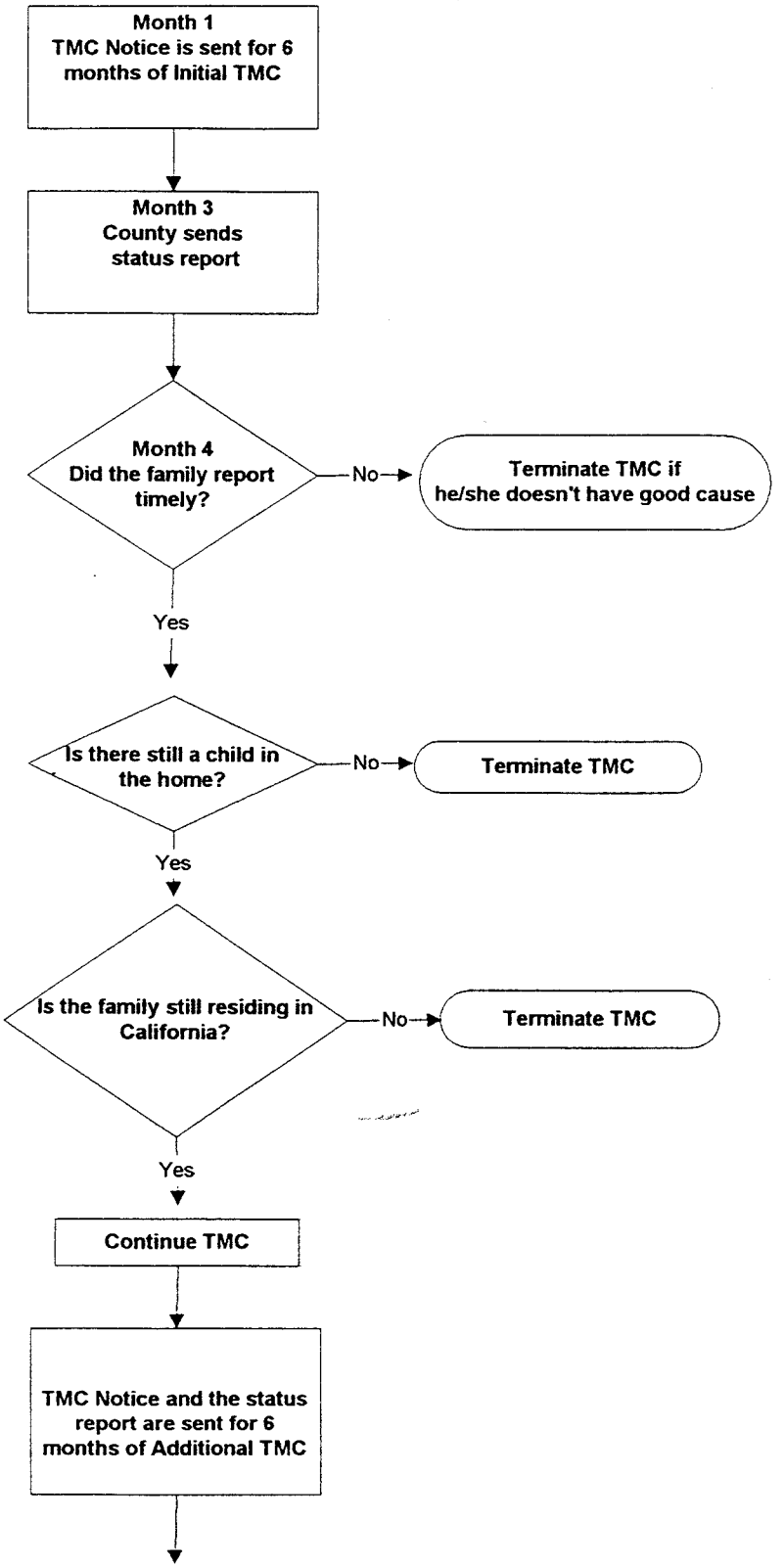
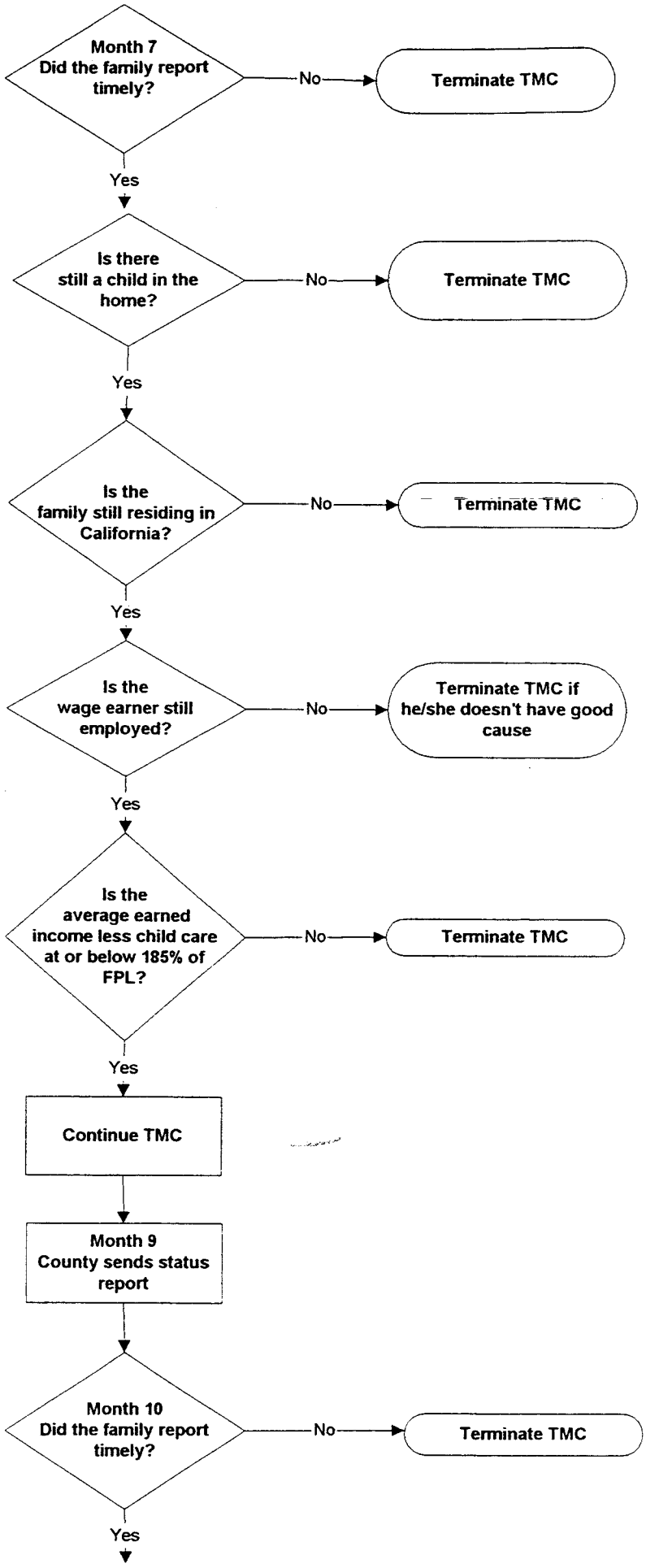
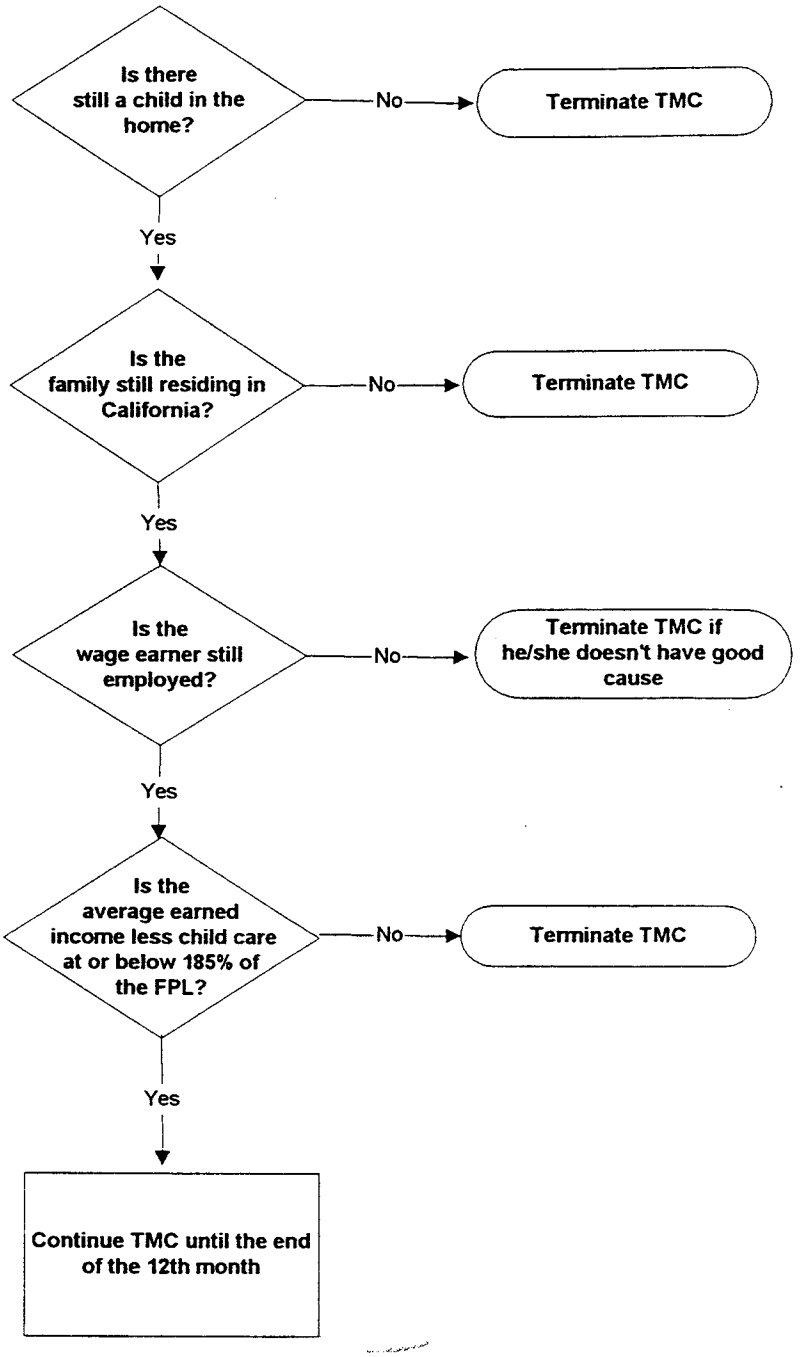
TRANSITIONAL MEDI-CAL (TMC)

Terminated from Aid to Families with Dependent Children (AFDC) due to increased hours or earnings from employment or loss of the earned income disregard

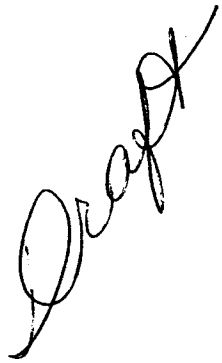



Month 7
Did the family report timely?
No
Terminate TMC
Yes
Is there still a child in the home?
No
Terminate TMC
Yes
Is the family still residing in California?
No
Terminate TMC
Yes
Is the wage earner still employed?
No
Terminate TMC if he/she doesn't have good cause
Yes
Is the average earned income less child care at or below 185% of FPL?
No
Terminate TMC
Yes
Continue TMC
Month 9
County sends status report
Month 10
Did the family report timely?
No
Terminate TMC
Yes


Is there still a child in the home?
No
Terminate TMC
Yes
Is the family still residing in California?
No
Terminate TMC
Yes
Is the wage earner still employed?
No
Terminate TMC if he/she doesn't have good cause
Yes
Is the average earned income less child care at or below 185% of the FPL?
No
Terminate TMC
Yes
Continue TMC until the end of the 12th month

_____ (COUNTY STAMP) _____

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



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_____ _____

Notice Date:_____
Case No.: _____
Worker Name/No.:_____
Worker Telephone No.:_____
This affects :_____

A SECOND YEAR OF TMC IS AVAILABLE TO WORKING PERSONS OVER AGE 19 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.
- Complete and return any status reports which the county will send you and attach your family's monthly gross earnings and actual child care costs paid by you.

☐ Enclosed is a status report. Please return it by the 21st day of next month. Please attach your family's monthly gross earnings and actual child care costs paid by you.

You will be required to complete and return ___ status reports sent to you by the county during this period. The first report will be due by the 21st day of the ____ month.

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
TRANSITIONAL MEDI-CAL (TMC)
APPROVAL FOR BENEFITS

(COUNTY STAMP)

Notice date: _____

Case number: _____

Worker name/number: _____

Worker telephone number: _____

This affects: _____

_____

TMC IS A PROGRAM THAT PROVIDES CONTINUING MEDI-CAL BENEFITS FOR A MAXIMUM OF 12 MONTHS FOR CERTAIN PERSONS NO LONGER ELIGIBLE FOR THEIR CURRENT MEDI-CAL PROGRAM AS A RESULT OF EMPLOYMENT, MARRIAGE, OR RETURNING TO LIVE WITH THEIR HUSBAND OR WIFE.

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

You will continue to receive TMC during this period if you have an eligible child in the home and remain employed.

You may be eligible for an additional 6 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 6 months for the period _____ through _____.

To remain eligible for the additional 6 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 6 month period. You must also:

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

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.

NOTIFICACIÓN DE ACCIÓN DE MEDI-CAL
APROBACIÓN DE BENEFICIOS DE MEDI-CAL DE TRANSICIÓN (*TMC*)

(COUNTY STAMP)

Fecha de la notificación: _____

Número del caso: _____

Nombre/número del trabajador(a): _____

Teléfono del trabajador(a): _____

Esto afecta a: _____

_____

EL *TMC* ES UN PROGRAMA QUE PROPORCIONA UNA EXTENSIÓN DE BENEFICIOS DE MEDI-CAL DE UN MÁXIMO DE 12 MESES A CIERTAS PERSONAS QUE YA NO REÚNEN LOS REQUISITOS PARA RECIBIR BENEFICIOS DE SU ACTUAL PROGRAMA DE MEDI-CAL DEBIDO A EMPLEO, MATRIMONIO O REGRESO A VIVIR CON SU ESPOSO(A).

☐ Usted reúne los requisitos para *TMC* inicial durante el período del _____ al _____.

Usted seguirá recibiendo *TMC* durante este período si un(a) niño(a) que reúne los requisitos vive en el hogar y usted sigue trabajando.

Usted podría reunir los requisitos para recibir *TMC* durante 6 meses adicionales, sin costo alguno, si usted:

Devuelve el informe de situación que le enviará el condado, a más tardar el 21 del _____ y permanece dentro de los límites de ingresos.

Adjunta, al informe de situación, pruebas de los ingresos brutos mensuales de su familia y los costos reales de cuidado infantil que pagó. Guarde todos sus comprobantes de ingresos y recibos de cuidado infantil.

☐ Usted reúne los requisitos para los 6 meses adicionales durante el período del _____ al_____.

A fin de seguir reuniendo los requisitos para los 6 meses adicionales de *TMC*, se le exigirá que llene y devuelva dos informes de situación que el condado le envió durante este período. El primer informe se deberá entregar el 21 del primer mes y el segundo informe se deberá entregar el 21 del cuarto mes de este período de 6 meses adicionales. Además, usted tiene que:

- Seguir trabajando.
- Tener ingresos por debajo de un cierto límite.
- Tener un(a) niño(a) que reúna los requisitos viviendo en el hogar.

Siempre presente su Tarjeta de Identificación de Beneficios (*BIC*) a su proveedor médico, cada vez que necesite atención médica. Esta tarjeta es válida mientras usted reúna los requisitos para recibir Medi-Cal. NO TIRE SU *BIC*.

La regulación que exige esta acción es la Sección 50244, del Título 22, del Código de Regulaciones de California.

MEDI-CAL
NOTICE OF ACTION
FOUR-MONTH CONTINUING MEDI-CAL APPROVAL FOR BENEFITS

(COUNTY STAMP)

Notice date: _____

Case number: _____

Worker name/number: _____

Worker telephone number: _____

This affects: _____

_____

THIS PROGRAM PROVIDES FOUR MONTHS OF CONTINUING MEDI-CAL BENEFITS FOR CERTAIN PERSONS NO LONGER ELIGIBLE FOR THEIR CURRENT MEDI-CAL PROGRAM AS A RESULT OF COLLECTION OR INCREASED COLLECTION OF CHILD OR SPOUSAL SUPPORT.

❒ You are eligible for the period _____ through _____.

You will receive Four-month Continuing Medi-Cal through the month indicated above as long as you remain a resident of California.

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 50243.

NOTIFICACIÓN DE ACCIÓN DE MEDI-CAL
APROBACIÓN DE EXTENSIÓN DE CUATRO MESES DE BENEFICIOS DE MEDI-CAL

(COUNTY STAMP)

Fecha de la notificación: _____

Número del caso: _____

Nombre/número del trabajador(a): _____

Teléfono del trabajador(a): _____

Esto afecta a: _____

_____

ESTE PROGRAMA PROPORCIONA UNA EXTENSIÓN DE CUATRO MESES DE BENEFICIOS DE MEDI-CAL A CIERTAS PERSONAS QUE YA NO REÚNEN LOS REQUISITOS DE SU PROGRAMA ACTUAL DE MEDI-CAL DEBIDO AL COBRO O AUMENTO EN EL COBRO DE MANUTENCIÓN DE HIJOS O DE CÓNYUGE.

☐ Usted reúne los requisitos para el período del _____ al _____.

Usted recibirá una extensión de cuatro meses de beneficios de Medi-Cal hasta el mes que se indica anteriormente mientras siga siendo residente de California.

Siempre presente su Tarjeta de Identificación de Beneficios (*BIC*) a su proveedor médico cada vez que necesite atención médica. Esta tarjeta es válida mientras usted reúna los requisitos para recibir Medi-Cal. NO TIRE SU *BIC*.

La regulación que exige esta acción es la Sección 50243, del Título 22, del Código de Regulaciones de California.