

MEDI-CAL NOTICE OF ACTION

You recently submitted an application for Medi-Cal. Your child(ren) are not eligible for no-cost Medi-Cal under the Percent Program. However, you and your family may be eligible for Medi-Cal with a share of cost.

Enclosed are forms you need to complete for us to evaluate share-of-cost Medi-Cal. Please return this information within ten days. When we have received it, we will notify you of the time and date for your face-to-face interview. If we do not hear from you by _____, we will assume you are not interested in applying for share-of-cost Medi-Cal at this time.

As you requested on the application form, we have forwarded your application to the Healthy Families program for an eligibility determination.

If you have any questions, please contact _____.

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

On the application form, you checked that other family members would also like to apply for Medi-Cal. Enclosed are forms you need to complete for us to evaluate Medi-Cal eligibility for the other members of your family. Please return this information within ten days. When we have received it, we will notify you of the time and date for your face-to-face interview. If we do not hear from you by _____, we will assume you are no longer interested in completing a Medi-Cal application for other family members at this time.

If you have any questions, please contact _____.