DEPARTMENT OF HEALTH SERVICES
714/744 P Street
P.O. Box 942732
Sacramento, CA 94234-7320
(916) 657-2941

January 28, 1999

TO: All County Welfare Directors
All County Administrative Officers
All County Medi-Cal Program Specialists/Liaisons
All County Public Health Directors
All County Mental Health Directors

Letter No. 99-05

CAMERA-READY COPIES OF NOTICES OF ACTION FOR TRANSITIONAL MEDI-CAL (TMC), FOUR MONTH CONTINUING MEDI-CAL, AND THE TMC FLYER

Ref.: All County Welfare Directors Letter (ACWDL) No. 98-24 and 98-56

The purpose of this letter is to provide counties with camera ready copies of the new Notice of Action (NOA) approving benefits for the Four Month Continuing Medi-Cal program, a new NOA for the second year of TMC, and other revised NOAs and forms for the TMC program. Spanish versions of the NOAs and form are not yet available.

Four Month Continuing NOA (MC 323)

This is a new form. Although this program has been in existence for many years, we were unable to identify any Department NOA for this program. If counties wish to replace their existing form with this one, it can be ordered through the warehouse now. This program is no longer for Aid to Families With Dependent Children (AFDC) families who were discontinued for collection or increased collection of child or spousal support, but now applies to those persons who meet the AFDC program eligibility requirements as they existed on July 16, 1996 (referred to as Section 1931(b) cash or 1931(b) Only persons).

TMC NOAS

1. MC 239 TMC-1 Approval

This existing notice has been revised. This notice no longer makes reference to the AFDC program but rather uses a more generic description which includes both California Work Opportunity and Responsibility to Kids (CalWORKs) and Section 1931(b) Only families. Since 1931(b) Only persons may or may not receive full benefits depending on their status, TMC will no longer be limited to those who are eligible for full benefits. This NOA has been revised to include those eligible for restricted TMC benefits. Please note that TMC for families that are discontinued as a result of marriage or the reuniting of a spouse (Wedfare) will be ending next year because the federal waiver will expire in June 1999. Counties will be notified of the exact date in the future. At that time, this NOA will be revised.

2. MC 239 TMC-2 Denial or Discontinuance

This NOA has been revised so it may also be used to deny or discontinue those persons who were eligible for the first year of TMC but are not eligible for the second year or were receiving the second year of TMC and no longer meet the criteria.

3. MC 239 TMC-3 Approval for Second Year

This is a new form which may be used for a second year of TMC for persons age 19 and over who have already received the first year of TMC. Persons who received the first year of TMC under "Wedfare" are not eligible for this second year, nor are persons under age 19. The Spanish version is not yet available.

MC 176 TMC Quarterly Status Report

This form has been revised to delete any reference to the Transitional Child Care program which was administered by the Department of Social Services (DSS).

TMC Flyer

We are enclosing a revised color version of the original TMC flyer sent to you in ACWDL 98-24. This Department sent this colored flyer to all CalWORKs recipients in November. The new flyer makes reference to the second year of TMC and includes the toll free telephone number. Counties should continue to give a black and white version of this updated flyer to all CalWORKs applicants and begin giving it to 1931(b) Only applicants until it can be incorporated into the Statewide Automated Welfare System Rights and Responsibilities (SAW 2) application. In addition, counties should provide copies of the updated TMC flyer to all 1931(b) Only families and CalWORKs families who are discontinued for failure to report.

DSS is required to send TMC information to all CalWORKs persons who are terminated for any reason (except fraud). We are working with DSS to develop a joint form so that counties can use one form rather than two separate TMC informational notices. As soon as the DSS flyer is available, more information on this will be provided.

If you have any questions, please contact Ms. Margie Buzdas of my staff at (916) 657-0726.

Sincerely,

ORIGINAL SIGNED BY

ANGELINE MRVA, Chief
Medi-Cal Eligibility Branch

MEDI-CAL
NOTICE OF ACTION
TRANSITIONAL MEDI-CAL (TMC)
APPROVAL FOR FULL OR RESTRICTED 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 are entitled to full benefits.

☐ You are entitled to emergency and pregnancy-related benefits.

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 six 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 six months for the period _____ through _____ .

To remain eligible for the additional six 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 six-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.

MEDI-CAL
NOTICE OF ACTION
Transitional Medi–Cal (TMC)
Denial or Discontinuance of Benefits

(COUNTY STAMP)

Notice date: _____

Case number: _____

Worker name/number: _____

Worker telephone number: _____

This affects: _____

_____

- ☐ Your benefits under TMC will be discontinued effective the last day of _____.
- ☐ Eligibility for benefits under the initial TMC program ends _____ because:
  - ☐ There is no longer a child in the home.
  - ☐ Other:
- ☐ Eligibility for benefits for the additional or second-year TMC program ends because:
  - ☐ There is no longer a child in the home.
  - ☐ You failed to return a completed status report.
  - ☐ Your family's gross average earnings (less child care costs) exceed the limit.
  - ☐ The caretaker relative or principal wage earner is no longer employed.
  - ☐ Other:
- ☐ You are not eligible for:
  - ☐ Additional TMC
  - ☐ Second Year TMC
  - ☐ Any other Medi-Cal program

Here is the reason:

- ☐ You will receive a separate notice about your eligibility for the regular Medi-Cal program.

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

The regulation which requires this action is California Code of Regulations, Title 22, Section 50244.

_____ (Eligibility Worker) _____ (Phone) _____ (Date)

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

(COUNTY STAMP)

Notice date: _____

Case number: _____

Worker name/number: _____

Worker telephone number: _____

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
FOUR-MONTH CONTINUING MEDI-CAL APPROVAL FOR FULL OR RESTRICTED 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 are entitled to full benefits.

☐ Your benefits only cover emergency and pregnancy-related services.

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.

TRANSITIONAL MEDI-CAL (TMC) QUARTERLY STATUS REPORT

This status report is for the months of			Return this form no later than the 21st day of
Month 1	Month 2	Month 3	

IMPORTANT: COMPLETE, SIGN, AND RETURN THIS REPORT TO THE WELFARE DEPARTMENT IN THE ENCLOSED ENVELOPE. Attach proof of your income, actual child care expenses paid, and total hours of employment for the three months noted above. If you have any questions regarding this form or the items to be reported, contact your eligibility worker.

- **For Transitional Medi-Cal (TMC)**—You will receive status reports during this period. If you do not complete and return these reports, your eligibility for TMC will be discontinued.

PART A.—DISCONTINUANCE REQUEST

I request that my ***Transitional Medi-Cal*** be stopped on the last day of _____
Month/Year

I know that I can reapply for ***Medi-Cal*** at any time. _____ _____
Applicant signature Date

IF YOU WANT YOUR TMC ELIGIBILITY TO CONTINUE, PLEASE COMPLETE AND SIGN PART B OF THIS REPORT.

PART B.—ELIGIBILITY STATUS INFORMATION

1. Did anyone receive any earned income, money, or benefits during the report period? (Salary, wages, tips, commissions, bonuses, vacation pay.) ..... ☐ Yes ☐ No
If yes, attach proof.

Who Received Income, Money, or Benefits	Type of Income, Money, or Benefits (See Above)	Amount Before Deductions		
		Month 1	Month 2	Month 3
		Gross amount $	Gross amount $	Gross amount $
		Hours worked	Hours worked	Hours worked
		Dates received	Dates received	Dates received
		Gross amount $	Gross amount $	Gross amount $
		Hours worked	Hours worked	Hours worked
		Dates received	Dates received	Dates received
		Gross amount $	Gross amount $	Gross amount $
		Hours worked	Hours worked	Hours worked
		Dates received	Dates received	Dates received
		Gross amount $	Gross amount $	Gross amount $
		Hours worked	Hours worked	Hours worked
		Dates received	Dates received	Dates received

2. Did you or anyone pay for child care expenses which have not or will not be reimbursed? ..... ☐ Yes ☐ No
If yes, complete the following:

Name of Child(ren)	Age	Amount Paid for Child Care Expenses			Name of Child Care Provider
		Month 1	Month 2	Month 3	

3. Did you have changes in your family or household during the time specified? (Include change of address, change of child care provider, change of employment, anyone that moved into or out of your home, or anyone who was born or who died.) ..... ☐ Yes ☐ No
If yes, complete the following:

Name	Relationship	What Happened	Date

4. a. Do you or anyone have or expect to receive private health insurance? (This includes health, hospitalization such as Kaiser, Blue Cross, vision, long-term care insurance, or dental insurance paid by an employer, absent parent, or other person who is in or out of the home.) ..... ☐ Yes ☐ No
b. Do you have or expect to receive health insurance through your employer? ..... ☐ Yes ☐ No
c. Is health insurance available from your employer for a fee? ..... ☐ Yes ☐
If yes, complete the following:

Name of Insurance	Person(s) Insured

CERTIFICATION

I understand that reported facts may result in benefits being changed or stopped.

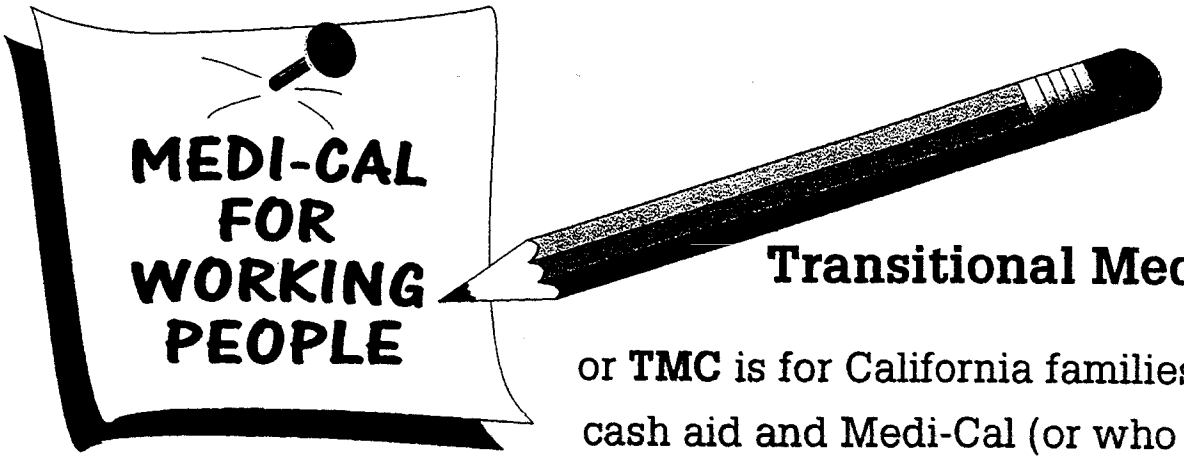
I understand that the statements I have made on this form are subject to investigation and verification.

I understand that I must notify my worker within 10 days of any change.

I understand that failing to report facts or giving wrong or incomplete facts can result in legal prosecution with penalties of a fine, imprisonment, or both.

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE UNITED STATES AND THE STATE OF CALIFORNIA THAT THE INFORMATION CONTAINED IN THIS REPORT IS TRUE AND CORRECT AND IS COMPLETE FOR THE ENTIRE REPORT PERIOD.

Signature or mark of applicant	Social Security number	Date	Phone number ( )
Signature of witness to mark, interpreter, or other person		Date	Phone number ( )



Transitional Medi-Cal

or **TMC** is for California families who lose cash aid and Medi-Cal (or who would have been eligible for cash under old rules) but are no longer eligible because of higher earnings from work. If you are the principal earner or caretaker and get a job or your job pays you more money, you may get no-cost Medi-Cal for 12 months or more.

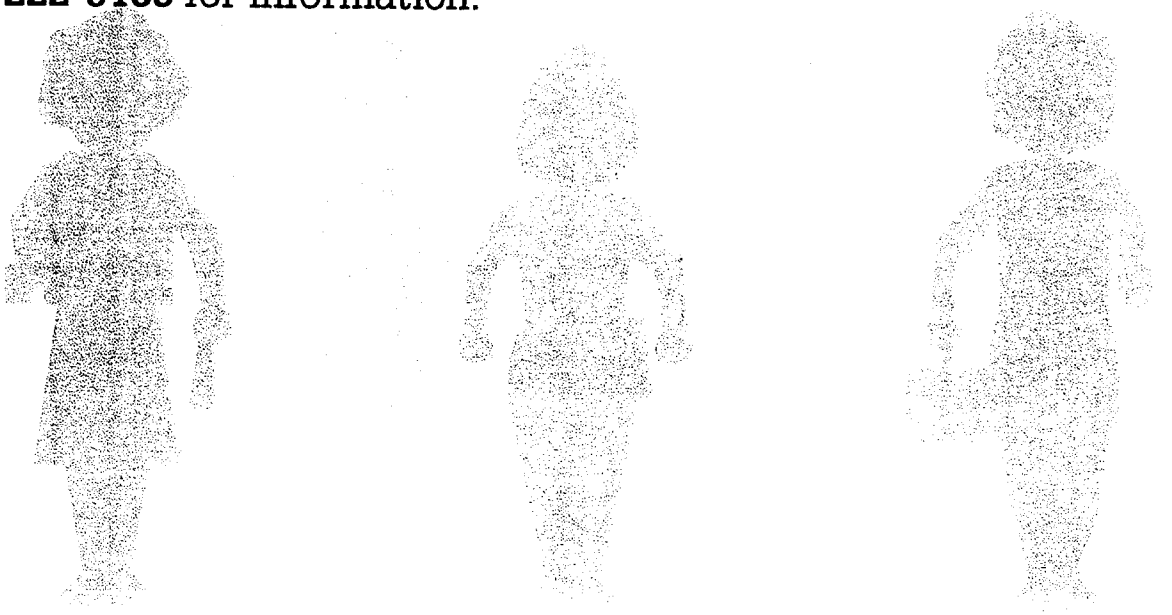
To get the first 6 months of **TMC**, you must:

- ☑ have a child in the home.

To get the second 6 months of **TMC**, you must also:

- ☑ continue to work, and
- ☑ earn under a certain amount.

Be sure to let your worker know if you get a job or have more earnings from your job. You can do this by filling out and returning the form on the back of this flyer to your county welfare department. Call toll free **1-877-222-9133** for information.



TRANSITIONAL MEDI-CAL

Did you go off Medi-Cal or cash aid because you got a job?

If you got money from a job, please answer the questions below and attach pay stubs or other proof of earnings. Please include tips or income in-kind, such as earned housing. If self employed, list business costs on a separate sheet of paper and attach proof of income and costs. Please return this form to:

Please type or print clearly.

Name / Employer/source	TOTAL HOURS WORKED IN REPORT MONTH:						
		DATE PAID:	MM DD YY ___/___/___	MM DD YY ___/___/___	MM DD YY ___/___/___	MM DD YY ___/___/___	MM DD YY ___/___/___
		GROSS AMOUNT:	$	$	$	$	$
Name / Employer/source	TOTAL HOURS WORKED IN REPORT MONTH:						
		DATE PAID:	MM DD YY ___/___/___	MM DD YY ___/___/___	MM DD YY ___/___/___	MM DD YY ___/___/___	MM DD YY ___/___/___
		GROSS AMOUNT:	$	$	$	$	$
Name / Employer/source	TOTAL HOURS WORKED IN REPORT MONTH:						
		DATE PAID:	MM DD YY ___/___/___	MM DD YY ___/___/___	MM DD YY ___/___/___	MM DD YY ___/___/___	MM DD YY ___/___/___
		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: ប្រសិនជាលោកអ្នកមិនយល់សេចក្តីប្រកាសនេះទេ សូមសាកសួររកសេចក្តីបកប្រែពីអ្នកកាន់សំណុំរឿងរបស់លោកអ្នក ។

Chinese: 假如你看不懂這份通知，可以要求你的工作員幫助你翻譯。

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.

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