STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY

GRAY DAVIS, Governor

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

November 10, 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.: 99-55

CORRECTED CAMERA-READY COPIES OF NOTICES OF ACTION (NOA) FOR TRANSITIONAL MEDI-CAL (TMC).

Ref.: All County Welfare Directors Letter (ACWDL) Nos. 99-05 and 99-44

The purpose of this letter is to provide counties with corrected camera-ready copies of the second year of TMC NOA, and the NOA for the approval for the first year of TMC benefits. Corrected Spanish versions of these NOAs are not yet available.

1. MC 239 TMC-1 Approval

   This existing notice has been revised. This notice no longer makes reference to families that are discontinued as a result of marriage or the reuniting of a spouse (Wedfare). This program ended on June 30, 1999.

2. MC 239 TMC-3 Approval for Second Year

   This form which is used for a second year of TMC for persons age 19 and over who have already received the first year of TMC has been corrected as the previous version had a typographical error.

Please do not use the previous versions of these forms.

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 EARNINGS FROM EMPLOYMENT.

☐ 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
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 AGE 19 AND OVER 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.

ıu 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.