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February 11, 2002

MEDI-CAL ELIGIBILITY PROCEDURES MANUAL LETTER NO.: 260

TO: All Holders of the Medi-Cal Eligibility Procedures Manual

ARTICLE 5B - FOUR-MONTH CONTINUING ELIGIBILITY, TRANSITIONAL MEDI-CAL, AND WEDFARE

Enclosed are updated pages and forms for the Transitional Medi-Cal (TMC) program. The changes and additions are marked with a black line in the right hand margin.

All County Welfare Directors Letter No. 01-25 stated that TMC status reporting is still required for months 10, 11, and 12. This has been eliminated because they would not be due until month 13 and the status reporting is no longer required for the second year of TMC. See Page 8.

Filing Instructions:

Remove Pages:	Insert Pages:
Article 5B	Article 5B
Entire Article 5B	Pages 5B-1 through 5B-33

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

Sincerely,

Original signed by

Richard Brantingham
Acting Chief
Medi-Cal Eligibility Branch

Enclosures

5B--FOUR-MONTH CONTINUING ELIGIBILITY, TRANSITIONAL MEDI-CAL AND WEDFARE

1. FOUR-MONTH CONTINUING COVERAGE

The original Medi-Cal regulations [Title 22, California Code of Regulations (CCR), Section 50243] allowed persons who were discontinued from Aid to Families with Dependent Children (AFDC) due (wholly or in part) to the collection or increased collection of child/spousal support four months of no-cost Medi-Cal provided they were receiving AFDC in at least three of the six months prior to the month they became ineligible for AFDC. This program was effective August 1, 1984. Benefits shall begin the month in which the family became ineligible for AFDC or should have been considered ineligible for an AFDC payment. Therefore, if the family received no share-of-cost Medi-Cal under Edwards v. Kizer or an AFDC overpayment after the date the family became technically ineligible for AFDC, these months count towards the four month limit. The family would only receive the remainder of the four months depending on how many months were remaining.

A. Background

Section 1931(b) of Title XIX of the Social Security Act was added by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) to establish a new mandatory coverage group at Section 1931(b) of the Social Security Act. Section 1931(b) requires that Medi-Cal be provided to low-income families, who met the provision of the July 16, 1996 AFDC program (or more liberal provisions at State option). Section 161 of AB 1542 (Chapter 270, Statutes of 1997) established the California Work Opportunity and Responsibility to Kids (CalWORKs) program which was implemented January 1, 1998. Persons receiving CalWORKs continue to receive automatic Medi-Cal under Section 1931(b), but it is not necessary to be receiving CalWORKs to be eligible for Section 1931(b). If they are terminated, are not eligible for, or chose not to apply for CalWORKs, they must be evaluated for Section 1931(b)-Only.

Those that met the requirements for Section 1931(b) would remain on that program until some change caused them to be ineligible. Those persons who received CalWORKs for three of the last six months, were terminated from CalWORKs due to increased collection of child/spousal support and are not eligible for Section 1931(b) would then receive Four-Month Continuing coverage as described in Section 1931(c). Persons who received Section 1931(b)-Only for three of the last six months and are terminated for increased child/support are also eligible for Four-Month Continuing even if they were never a recipient of CalWORKs.

B. Conditions of Eligibility

Once determined eligible, the only other requirements for this program are that the family must contain a deprived child as defined in the Section 1931(b) program and reside in California. Should the person(s) leave California but then return to California prior to the expiration of the four months, he/she may receive the remainder. Persons who were terminated from a cash program similar to CalWORKs in another state are not entitled to Four-Month Continuing benefits in California.

C. Determining the Causal Relationship ("Wholly or in Part")

There must be a causal relationship between the support increase and the ineligibility for CalWORKs or Section 1931(b). For example, the family may be terminated from CalWORKs due to a change in family circumstance at the same time that support increased. If this increase would not in itself be the cause of the CalWORKs termination, the family would not be eligible for Four-Month Continuing benefits. Four-Month Continuing is allowed if the increase or collection of support is not enough to terminate the family from AFDC, but the increase would if combined with another circumstance, e.g., an increase in unearned income.

Example 1: A Section 1931(b) family of four receives $300 in countable child support for two of three children. The third child turns 19 and moves out of the household. Assume that because the income exceeds the standard for assistance for a family of three, the family is ineligible for Section 1931(b). Four-Month Continuing benefits are not granted because there was no increase in support collection; ineligibility was caused by the adjustment in the standard of assistance.

Example 2: A CalWORKs family receives $325 in countable child support. The applicable standard of assistance is $775 for a family of that size. In the next month the countable support increases to $650 and at the same time one of the older children leaves home. The standard of assistance is reduced to $624 due to the reduction of family size and the family became ineligible for CalWORKs. Four-Month Continuing benefits were granted because although the increase in support collection was not sufficient in itself (wholly) to cause ineligibility, when combined (in part) with the reduction in the standard of assistance, the family lost eligibility.

Example 3: A Section 1931(b) family receives $300 in countable child support and $200 in Title II benefits. The applicable standard of assistance is $624 for a family of that size. In the next month both the child support and Title II increase by $150. The family's income (now at $650) makes them ineligible due to excess income. Because the increase in Title II benefits and child support were both necessary to cause ineligibility, that is, the child support actively contributes to ineligibility, the family is eligible for Four-Month Continuing benefits.

D. Medi-Cal Family Budget Unit (MFBU) Composition

Persons receiving Four-Month Continuing Medi-Cal shall be ineligible members of the MFBU when determining Medi-Cal eligibility for other family members and may use their noncovered Medi-Cal health care costs to reduce the other family members' share of cost (SOC) in accordance with Section 50379.

E. Intercounty Transfer Process (ICT)

When a family receiving Medi-Cal benefits under the Four-Month Continuing Medi-Cal coverage moves from the first county to the second county, an ICT must be initiated by the first county to the second county. The first county is responsible for case activities and benefit issuance until the last day of the final month in which eligibility exists for the family under the Four-Month Continuing Medi-Cal coverage. If a beneficiary becomes ineligible during the transfer period, the first county is responsible for the issuance of any notices to the beneficiary. The second county is responsible for determining new Medi-Cal eligibility under other programs when the four-month eligibility period ends. Through mutual agreement, the first county may transfer the responsibility of all case activities to the second county before the four-month eligibility period expires. (See MEPM Article 3D-3.)

F. Aid Codes

Persons who are eligible for Four-Month Continuing should be reported to MEDS under aid code 54. Because PRWORA also allows aliens who do not have satisfactory immigration status (SIS) to receive Section 1931(b) if they meet the income, property and deprivation requirements of the old AFDC program, they are also eligible for restricted benefits under the Four-Month Continuing program. This aid code is 5W. Persons who are no longer eligible for 5W are not eligible for aid code 38 because they are not entitled to a full scope card.

2. TRANSITIONAL MEDI-CAL (TMC)

Effective in California on April 1, 1990, (pursuant to the Family Support Act of 1988, which added Section 1925 to Title XIX of the Social Security Act), the TMC program increased no-cost continuing Medi-Cal from four to a maximum of twelve months for families who were discontinued from AFDC due to an increase in the earnings or hours from employment of the caretaker relative, or principal wage earner. Section 1925 also replaced the Nine-Month Continuing Eligibility program which offered nine months of continuing eligibility for persons who were discontinued from AFDC due solely to the expiration of the $30 plus 1/3 or the $30 earned income disregard. Under TMC, persons received a maximum of 12 months of no-cost Medi-Cal providing that they were members of a family who received AFDC in at least three of the six months immediately preceding the month in which they became ineligible for AFDC. Since this program was an incentive for families to obtain full time employment, increases in non-job related earned income such as state disability income which cause AFDC ineligibility did not qualify the family for TMC.

On January 1, 1998, pursuant to PRWORA and state law, Section 1931(b) of the Social Security Act as described above in Four-Month Continuing Coverage, was implemented. Now, any reference to AFDC has been changed to mean the CalWORKs or the Section 1931(b) program. Neither CalWORKs or Section 1931(b) has time limits on their earned income disregard although there are time limits on receipt of aid for adults. For recipients, these programs do not base unemployment on the 100-hour rule, i.e., on hours of employment; however, increased earnings from employment can make them ineligible for both programs. As with Four-Month Continuing Medi-Cal, all persons terminated from CalWORKs for increased earnings from employment must first be evaluated for Section 1931(b). If they are eligible, they may remain on the Section 1931(b) program indefinitely. If they are not eligible, they are evaluated for TMC.

Effective October 1, 1998, Section 73 of AB 2780 (Chapter 310, Statutes of 1998) added Section 14005.81 to the Welfare and Institutions (W&I) Code which established a second year of state-only funded TMC for persons who received the first year of TMC and who are age 19 years old or older. Counties are requested to report any pregnant women to MEDS if they are eligible for the Income Disregard (200 Percent) program with the second year TMC aid code and the appropriate secondary Percent program aid code in order to claim federal financial participation. There is no Edwards process for those being terminated from the second year of TMC. Counties should evaluate those persons for any other Medi-Cal program as usual. Effective September 30, 2000, Senate Bill 87 (Chapter #1088) amended Section 14005.81 of the W&I Code that eliminated quarterly status reporting for the second year of Transitional Medi-Cal. A request to waive federal law and eliminate status reporting for the first year of TMC was denied by the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration).

The following examples illustrate situations in which the family may or may not be eligible for TMC coverage:

Example 1: A family received CalWORKs for 18 months. The parents were terminated because the time limit to receive aid expired, but the children continued on CalWORKs. The parents were determined eligible for Section 1931(b) (Aid Code 3N). In the next month, because the PWE's earnings increased, the family was terminated from cash and Section 1931(b). Because the children were eligible for CalWORKs and the parents for Section 1931(b) in three of the last six months, the family is entitled to TMC.

Example 2: A family is receiving CalWORKs. The PWE just started working over 100 hours. The PWE would not be subject to the 100-hour rule. However, assume the increase in earnings makes the family ineligible for CalWORKs. The county evaluates the family for Section 1931(b). Assume the family's income does not exceed the Section 1931 (b) limits. This family is on Section 1931(b) and does not need TMC.

A. Period of Eligibility

Benefits shall begin the month in which the family became ineligible for CalWORKs or Section 1931(b). If the family received no share-of-cost Medi-Cal under aid code 38 or a CalWORKs overpayment after the date the family became technically ineligible for CalWORKs, those months count towards the 12 month TMC limit and the family would only receive the remainder the 12 months depending on how many months were remaining. The same rule applies if the family should have been terminated from Section 1931(b) Only or the family moves out of state then returns within the Initial or Additional TMC period.

Example 1. (Prior to the Implementation of the Section 1931(b) program)

If the family inadvertently received Medi-Cal-Only under aid code 38 rather than TMC for three months, the family would only receive the remaining three months of initial TMC (aid code 39). Since the same zero share-of-cost Medi-Cal is available under TMC and aid code 38, counties do not have to make any retroactive adjustments for the first three months. However, if theoretically, the family received Medi-Cal with a SOC during the first three months, the county would have to ensure the family received zero SOC TMC for the first three months.

Example 2. (After the Implementation of the Section 1931(b) program)

Persons terminated from CalWORKs must be evaluated for Section 1931(b) prior to the county determining eligibility for TMC. If they are eligible for Section 1931(b), they would remain on that program until some change caused them to be ineligible. Those persons who received CalWORKs for three of the last six month, were terminated from CalWORKs due to increased earnings and are not eligible for Section 1931(b) would then receive TMC. Persons who received Section 1931(b)-Only for three of the last six months and are terminated for increased earnings or hours of employment are also eligible for TMC even if they were never a recipient of CalWORKs.

B. Conditions of Eligibility

1. Initial Six-Month Period

The first six-month period has no eligibility requirements other than the family must continue to have a child living in the home and the family must reside in California. Persons age 18 or older are not eligible as children for CalWORKs, Section 1931(b), or the first year of TMC unless they are 18, enrolled in school and expected to graduate before their 19th birthday.

2. Additional Six-Month Period

The additional six-month period requires that in addition to the above requirements, that the family must remain employed unless good cause exists, received Initial TMC for the entire six-month period, and meet certain reporting requirements unless good cause for failure to report exists. The family's average gross monthly earnings less child care costs necessary for the employment of the caretaker relative or principal wage earner may not exceed 185 percent of the FPL for a family of the same size.

Example A: The only child left the home in the third month of the Initial TMC period. The family was terminated from TMC. In the fifth month, the child returned. The family is eligible to receive the remaining two months of the Initial TMC period; however, they are not eligible for additional TMC because they did not receive the entire initial six months of TMC.

Example B: The family moved to another state in the first month of the Initial TMC period. Although the family continues to meet all the TMC requirements, benefits must be discontinued because they are no longer in California. The family returned to California in the third month of the Initial TMC period. They may receive the remainder of the Initial six-month period and the six months of Additional TMC if they are otherwise eligible since the family continued to be eligible for TMC even though they did not actually receive TMC when they were living out of state. This is an exception to the rule that the family must have actually received the entire Initial period of TMC. This rule also applies to the second six months and the second year.

3. Second Year of TMC

Persons age 19 years and older are eligible for a second year of TMC if they were eligible, received the first year of federal TMC , and continue to meet the same TMC eligibility criteria as in Additional TMC. This includes a child who became an adult during the first year of TMC and who is 19 years old at the beginning of the second year of TMC. Counties should report pregnant women in this program to MEDS under the Income Disregard (200 Percent) program aid code in the secondary field if eligible. Persons under age 19 should be evaluated for other Medi-Cal programs and the Bridging program.

C. Determining the TMC Family Members

1. Eligible Persons

In addition to the individuals who were included in the CalWORKs or Section 1931(b) family unit at the time the family lost eligibility, those who were members of a family who received CalWORKs or Section 1931(b), and family members who enter the home during the Initial or Additional six-month period, or the second year (if 19 or older), may be added to the TMC case.

These persons include:

- Newborn or adopted children.
- Persons under CalWORKs sanction for failure to cooperate with GAIN or other sanctions whose income was included in that unit.
- Persons who would have been considered family members for CalWORKs or Section 1931(b) if they had been in the home in the month the family was determined to be ineligible or whose income and resources would have or were counted in the budget regardless of whether deprivation exists now.
- Persons in the family who were terminated from Supplemental Security Income (SSI) due to increased earnings from other family members on CalWORKs or Section 1931(b).
- Other CalWORKs sanctioned or ineligible persons such undocumented aliens, fleeing felons, etc. whose income but not needs were included in that unit or who were receiving Section 1931(b).
- Children, parents, or spouses who are members of a family who are eligible for TMC.

The earned income of an individual who has entered or returned must be included in the gross family TMC income assessment if he/she wishes to receive TMC. Persons added to the TMC case only receive TMC for the remainder of the family's TMC period. NOTE: An absent parent or spouse who returns home with earnings from employment which causes the family to lose CalWORKs or Section 1931(b) no longer qualifies the family for TMC. (See Wedfare).

2. Ineligible Persons

The following persons are not eligible for TMC:

- Persons who were not eligible for CalWORKs or Section 1931(b) and whose income and resources were not counted when determining family members who were receiving CalWORKs or Section 1931(b) such as the non-needy caretaker relative.
- Persons terminated from CalWORKs or Section 1931(b) due to the change in the treatment of state disability insurance (SDI) payments from unearned to earned income are not eligible for TMC since this is not considered actual earnings from employment.
- Persons who were convicted of fraud during the last six months in which the family was receiving Section 1931(b)-Only are also not eligible for TMC.
- Persons who remain eligible for Section 1931(b) because they are a Sneede class member and they are in a separate MBU.
- Persons who do not meet the CalWORKs definition of a child (over 18 and not enrolled in school and expected to graduate by age 19) are not eligible for TMC unless they met the definition of a child when Initial TMC was approved. A child who becomes an adult during the TMC period may remain in TMC unless he/she is the youngest child in the home. In that case, the entire family must be terminated from TMC.
- Family members who were terminated from CalWORKs or the 1931(b) program due to the loss of deprivation when a parent or spouse with earnings from employment returns home or is added to the family. This was a Wedfare case and that program has ended.

3. Persons Leaving the Home

TMC will continue for families if the parent/spouse or children leave the home in either the Initial or Additional TMC period; however, the remaining TMC family must continue to reside in the State and include a child. The family size will be reduced when comparing average earned income during the Additional six-month period since the person(s) who left will no longer be included in the MFBU. The family's earned income may also be reduced to the extent the person who left had earned income. If the family size has changed during the preceding three-month period, use the current family size.

D. Determining the Causal Relationship ("Entirely or Partially")

Loss of CalWORKs or Section 1931(b) eligibility would be considered to be "because of" an increase in hours or earned income if the increase in hours or earned income from employment was, by itself or in combination, sufficient to make the family ineligible.

Step 1.

Determine if the increase in hours or earnings from employment would have resulted in the loss of CalWORKs or Section 1931(b) eligibility if all other factors in the case remained the same (i.e., as if there were no other change in income, no change in family composition, no change in income standards, etc.) If yes, the family is eligible for TMC. If no, go to Step 2

Step 2.

Determine if events other than the increase in hours or earnings from employment would have resulted in loss of CalWORKs or Section 1931(b) eligibility if the income (hours or disregards) had stayed the same. If yes, the family is not eligible for TMC. Do not go to Step 3. If no, go to Step 3.

Step 3.

Determine if the family is ineligible for CalWORKs or Section 1931(b) when all changes are

considered. If yes, the family is eligible for extended Medicaid benefits. The increase in earnings from employment was essential to the loss of CalWORKs or Section 1931(b) eligibility. Without that increase, the family would not have lost CalWORKs or Section 1931(b) eligibility.

Example A: The caretaker relative, in a family with no other income, becomes employed on June 1 and reports countable earned income of $400 in June. At the same time the caretaker relative reports that beginning with June, the family is receiving monthly unearned income of $800. Assume the CalWORKs standard is $775 and the family is no longer eligible for CalWORKs or Section 1931(b) in June due to excess income which is both earned and unearned.

Step 1. Did the increase in income result in termination if all other factors remained the same? The answer is "no". The earned income of $400 alone did not result in the loss of CalWORKs or Section 1931(b). That is, if all other factors in the case remained the same, the $400 would not have caused ineligibility. Continue to Step 2.

Step 2. Did other events cause the termination? The answer is "yes". The unearned income alone would have resulted in the loss of CalWORKs or Section 1931(b). Therefore, the family is not eligible for TMC. Do not continue to Step 3.

That is, the $800 increase in unearned income was sufficient alone to make the family ineligible for AFDC even if all other factors stayed the same.

Example B: The principal wage earner (PWE), in a family with no other income, becomes employed on June 1 and reports countable earned income of $700 in June. In July, one child leaves the household. As a result, the income standard for the family in July is reduced to $624. The family is no longer eligible for Section 1931(b) in July due to excess income, all of which is earned. However, the family is not eligible for TMC because the earnings of the PWE did not increase in July, the month in which Section 1931(b) eligibility was lost.

Example C: A caretaker relative is employed and has monthly countable earned income of $375. The caretaker relative reports that she no longer has to pay for day care in June because free care is available. Without child care expenses, her countable earned income increased to $750 in June.

The family is no longer eligible for Section 1931(b) in June because of excess income. However, the family is not eligible for TMC because the earnings of the caretaker relative did not increase in June, the month in which Section 1931(b) eligibility is lost.

Example D: A mother and her child are recipients of Section 1931(b) on the basis of absence of the father. The father returns home and is determined to be the PWE. He is working over 100 hours and the parent's earned income is over the Unemployed Parent deprivation limit which is required because there has been a change in deprivation. The family's income is also over the Section 1931(b) limit. This family is not eligible for TMC because the family was discontinued from Section 1931(b) due to loss of deprivation rather than increased hours or earnings from the mother's employment. She was the caretaker/principal wage earner in the home. NOTE: The Wedfare program (described in Section 3) is no longer applicable.

E. Reporting Requirements

1. The family should receive a Notice of Action (NOA) upon approval of TMC which also informs them to keep their earning and child care receipts.

1. In the third month, the MC176 TMC status report should be sent to the family informing them to report by the 21st day of the next month (fourth), the family's gross monthly earnings and the cost for child care necessary for the employment of the caretaker relative or principal wage earner for the preceding three months (months 1, 2, and 3). In the sixth month, the MC 176 TMC status report should be sent to the family informing them to report the same information by the 21st day of the next month (seventh), for each of months 4, 5, and 6 and in the tenth month for months 7, 8, and 9.

2. There are no reporting requirements for the second year of TMC.

This status form (MC 176 TMC) has been revised so that more information is requested so that the county can evaluate the family for other Medi-Cal programs if the family is no longer eligible for TMC. The earnings from employment and child care costs are used to determine if the family is eligible for the additional six months and the second year of TMC. If the income goes down, the family should be reevaluated for Section 1931(b) or other Medi-Cal programs.

Families who fail to report by the 21st day of the required months must be provided a ten-day notice prior to termination unless the county determines that they have good cause for filing late as specified in Title 22, Section 50175 of the California Code of Regulations.

F. Determining Earned Income

Family earnings must remain at or below 185 percent of the FPL to be eligible for additional TMC. The average monthly gross earnings for the preceding three-month period after deduction of any monthly child care expenses necessary for the employment of the caretaker are compared to 185 percent of the FPL for the current family size even if some family members are not eligible for TMC. Child care expenses that are reimbursed by the State are not allowable nor are any other deductions. Family earnings include those of a child as well as the parent. Persons who are not eligible for TMC and are receiving Medi-Cal under another program such as the Section 1931(b), Medically Needy, or Medically Indigent program are included in the TMC case to determine family size. Their earnings from employment are counted to determine if the family is eligible for the second six months or second year of TMC. A person who is not receiving any Medi-Cal benefits and does not wish to be added to the TMC case, such as a absent parent returning home during the TMC period of his family, is not required to be included and his/her income is not counted, nor is he/she considered in the family size.

Example: The Smith family budget (four members of the household).

Month	Gross Earned Income	Child Care Expenses
May	$200	$ 95
June	$300	$105
July	$400	$100
Total	$900	$300

Average Monthly Gross Income = $900 divided by 3 = $300
Average Monthly Child Care = $300 divided by 3 = $100
Adjusted Monthly Income $200

A family is eligible for TMC when its "adjusted" monthly income is less than or equal to 185 percent of the FPL for a family of that size. For purposes of the TMC program, adjusted monthly income is the family's average monthly gross income less the family's average monthly expenses for child care. Thus, in the above example the family is eligible for TMC because its adjusted monthly income of $200 is less than 185 percent of the FPL for four persons. After calculating the adjusted monthly income, round it to the nearest dollar before comparing to the 185 percent of the FPL income standard. Use the usual Medi-Cal rounding rules: if the decimal number is .49 or less, round down; and if the decimal number is .50 or larger, round up. Unearned income is not counted when computing this income test. Individuals receiving TMC are not affected by excess resources.
NOTE: Self employed persons are allowed to deduct actual business expenses from their gross earnings, but they are not allowed the 40 percent "deduction" from their total business revenue as may be allowed in the Section 1931(b) program.

If the family had no earnings in one or more of the months in the preceding three-month period unless the lack of earnings were due to involuntary loss of employment or illness, the family is no longer eligible for TMC.

G. Intercounty Transfer

Persons receiving TMC who move to another county are treated no differently from any other family receiving regular Medi-Cal in accordance with Section 50137.

H. Aid Codes

39 Initial TMC Full Scope

Persons who are eligible for initial TMC should be reported to MEDS under aid code 39.

59 Additional TMC Full Scope

Persons who are eligible for additional TMC should be reported to MEDS under aid code 59.

3T Initial TMC (Emergency and Pregnancy-Related Benefits Only)

This initial six-month aid code should be used for aliens who do not have satisfactory immigration status (SIS).

5T Additional TMC (Emergency and Pregnancy-Related Benefits Only)

This additional six-month aid code should be used for aliens who do not have SIS.

5X Second Year State Only TMC (Zero SOC) Full Scope

This aid code should be used for citizens and aliens with SIS who are age 19 and older and who received the first year of federal TMC benefits. Pregnant women in this aid code should also be reported to MEDS in the secondary aid code if they are eligible under the Income Disregard program (aid code 44) to secure some federal financial participation. Aliens with SIS receiving Medi-Cal benefits in Aid Code 5X must have their alien status tracked per instructions in ACWDL 97-42.

5Y Second Year State Only TMC (Zero SOC) Emergency and Pregnancy-Related Benefits Only

This aid code should be used for aliens who do not have SIS, are age 19 and older, who received the first year of restricted federal TMC benefits under Aid Code 5T. Pregnant women in this aid code should also be reported to MEDS in the secondary aid code if they are eligible under the Income Disregard program (aid code 48) to secure some federal financial participation.

The MEDS edits have been removed which prevented counties from adding persons to TMC who were not in a CalWORKs, Edwards, or Section 1931(b) aid codes in the previous month.

I. MFBU Composition, Linkage, and Sneede v. Kizer

Persons receiving TMC shall be ineligible members of the MFBU of those persons who are not eligible for TMC when determining Medi-Cal eligibility for other family members and may use their noncovered Medi-Cal health care costs to reduce other family members' or responsible relatives' share of cost in accordance with Section 50379 and the Sneede v. Kizer lawsuit settlement.

It is possible that some persons will be eligible for Section 1931(b) and some will be eligible for TMC because deprivation still exists for certain family members. For example, assume unmarried parents with mutual and separate children are eligible for Section 1931(b) based on the father's incapacity. The father recovers and is determined to be the Principal Wage Earner. Since he is working 100 hours or more and there has been a change in circumstances, the earned income U-Parent test is required. The family fails this test. Dad and the mutual children are eligible for TMC due to increased hours of employment, but the mother and her separate children are still income eligible for Section 1931(b) as recipients based on absence of the separate children's father. It is also possible that a family is eligible for TMC, but their 20 year old "child" is not because he/she does not meet the definition of a child for Section 1931(b) or the first year of TMC. He is aided as a MI.

Due to Sneede rules, some persons may continue to be eligible for Section 1931(b) even if some of the other family members are over the income or resource limits and eligible for TMC. Section 1931(b) persons may continue to receive Medi-Cal until they are no longer eligible. If they have received Medi-Cal under the Section 1931(b) program for three of the last six months, and have been terminated for increased hours or earnings from employment, they are then entitled to TMC for the entire TMC period if they remain eligible even though other members of the family have already been receiving TMC in prior months. They will have status reporting due dates different from the other members of the family who began TMC in earlier months.

J. Returning to CalWORKs or Section 1931(b)

If a family returns to CalWORKs or Section 1931(b) during any of the TMC periods and is then terminated due to another reason which does not meet the requirements of TMC, e.g., is not related to employment or does not meet the three out of the preceding six-month requirement, the family is eligible for the remainder of the original TMC period if they are otherwise eligible. The months of zero share-of-cost Medi-Cal which the family received when they returned to CalWORKs, aid code 38, or Section 1931(b) are counted as if TMC were received in those months, i.e., they are counted as part of Initial or Additional TMC or the second year of TMC for purposes of determining the remaining months in the original TMC period. If they met the requirements of TMC when terminated, they are evaluated for a new initial TMC period.

Example: The family was terminated from CalWORKs due to increased hours or earnings from employment of the caretaker relative. They received TMC for four months. The

caretaker became unemployed and the family was again eligible for CalWORKs. After two months, the caretaker found another job and was terminated from CalWORKs. The family is not eligible for a new Initial TMC period because they did not receive CalWORKs or Section 1931(b) for three out of the preceding six-month requirement. They are eligible to receive an additional six months of the original TMC period (if all other eligibility criteria are met) because the two months of CalWORKs cash-based Medi-Cal counted as if TMC were received and this completes the initial TMC period.

K. The TMC Flyer

Senate Bill 391, Chapter 294, Statutes of 1997, amended Section 14005.76 of the Welfare and Institutions (W&I) Code to require the Department of Health Services (DHS) to implement certain informing provisions in the TMC program. The first informing provision was to be implemented May 18, 1998. This section now requires that:

- A written TMC notice (flyer) be given to CalWORKs and Section 1931-Only recipients at the time that Medi-Cal eligibility is conferred and every six months thereafter. The Department developed a TMC flyer and form to meet this requirement. Counties are responsible for providing the flyer and form to new beneficiaries. Counties may provide the flyer and notice to applicants rather than newly approved beneficiaries if it is more convenient. DHS will mail the flyer and notice to these persons every six months.

- The above flyer and form are to be provided to recipients when they are terminated from CalWORKs or Section 1931-Only for failure to meet reporting requirements. NOTE: Since status reporting for regular Medi-Cal programs has been eliminated, the flyer and form should be sent out with the discontinuance notice if the family fails to respond to the annual redetermination request.

Assembly Bill 2780, Chapter 310, Statutes of 1998, also requires the Department of Social Services (DSS) to send a brief summary of the requirements of TMC and a form which can be returned when any individual or family is discontinued from CalWORKs for reasons other than fraud. Counties may wish to coordinate their efforts rather than to separately send the TMC flyer and form out to those CalWORKs persons who are terminated for failure to report.

L. Questions and Answers

1. Even though TMC is no longer available to an 18-year-old person not enrolled in school and expected to graduate before age 19 because he or she is not eligible for CalWORKs or Section 1931(b), should the county terminate those beneficiaries who are currently receiving TMC under the old rules?

   No. Until the TMC regulations are final, counties should continue to allow those persons between 18 and 21 to receive TMC; however, counties should not put any new persons into TMC who are considered adults under Section 1931(b). If they should become adults during the TMC period, they may remain unless there is no other eligible child in the home. In that case, the family must be discontinued from TMC.

2. When the first year of TMC ends, is the beneficiary evaluated for Section 1931(b) again before granting the second year of TMC?

   The parents are not routinely evaluated unless their earnings decreased which might lead to Section 1931(b) eligibility or an annual redetermination is due. Since the children are not eligible for the second year of TMC, they should be evaluated for

Continuous Eligibility, other Medi-Cal programs, or the Healthy Families program if they have a SOC.

3. Is the family eligible for TMC if they lose CalWORKs or Section 1931(b) due to increased earnings from State disability, or temporary Workers Compensation?

   No. As in the current TMC program, only an increase in earnings from actual employment can make the family eligible for the TMC program.

4. If a family's income drops while receiving TMC, should counties redetermine eligibility for Section 1931(b) or CalWORKs?

   Yes. Section 1931(b) is more beneficial to the family since there are no time limits. However, the family must pass the U-Parent test if the PWE is working 100 hours or more and must meet applicant rules if they do not return to Section 1931(b) within four months.

5. If a family received CalWORKs for two months before being terminated and Section 1931(b) for two months before being ineligible due to increased earnings from employment, can they have TMC based on receiving CalWORKs or TMC for three of the last six months?

   Yes.

6. In the second six months and the second year of TMC, do we use the limit for the entire family even if there is a 20-year-old who is not receiving TMC when comparing the TMC family's average last three month's earnings minus child care deductions to 185 percent of the Federal Poverty Level? If yes, do we also include the income of other family members receiving Medi-Cal who are not eligible for TMC?

   Yes. The family size includes everyone who is a family member in the household if they are receiving TMC or other Medi-Cal except it does not include the person who is PA or Other PA. The earned income of the other family members is also included when comparing the total to the 185 percent limit.

7. If the TMC flyer is returned months after the CalWORKs or Section 1931(b) case has been terminated and it is determined that the family was terminated for increased earnings from employment, should the county process the case for TMC?

   Yes. If the family still meets the TMC eligibility criteria, they may be eligible for TMC if they are not eligible for Section 1931(b). The county must report the TMC aid code 39 retroactively to MEDS immediately following the CalWORKs, aid code 38, or Section 1931(b) aid code when they were terminated and the family may only receive the remainder of the initial TMC period. If eligible for the next six months, they may continue.

8. May an employed parent return home and be added to the TMC case with the other parent and children?

   Yes. He/she may be added if his/her income/resources would have been included in the CalWORKs or Section 1931(b) case. If he/she chooses to be added, his/her income will be counted. Once added, he/she may not be later excluded.

9. May an 18-year-old child who is not enrolled in school return home and be added to the TMC unit?

Not unless he/she would have met the definition of a child if he/she had been in the home at the time that TMC began.

10. May undocumented parents be added to the TMC unit with their children if their citizen children were terminated from CalWORKs due to increased earnings of the PWE and the family is not eligible for Section 1931(b) even if the parents never received benefits under Section 1931(b)?

    Yes. The parents could receive restricted TMC benefits because they were members of a family who received CalWORKs and their income was used in the CalWORKs determination.

11. May a "child" who is 19, or 20 be added to the second year of TMC with his/her parents and other siblings?

    Not unless he/she would have met the definition of a child if he/she had been in the home at the time that the Initial TMC began.

12. If a family loses TMC because there was no eligible child in the household and the child returns several months later, is the family again eligible to TMC?

    The family may receive the remainder of the first year of TMC if they meet the eligibility criteria; however, they are not eligible for the second year of TMC because no family member received the entire first year of TMC.

13. May a family be discontinued from TMC for failure to complete a request for information that is not required for the TMC program?

    No. Redeterminations are not required during the TMC nor should the county request information or verifications which are not applicable to the TMC program.

14. If the stepparent with no children of his/her own is not the PWE and his/her earnings from employment cause the family to lose Section 1931(b), is the family eligible for TMC?

    Yes, if the stepparent meets the definition of a caretaker relative because he/she shares in the care and control of his/her spouse's children. Counties are not required to verify this for TMC purposes.

15. Is there a limit to amount of child care expenses which are necessary for the employment of the parents or spouse of a parent?

    No.

16. If the county receives information that would cause the TMC family to lose eligibility, e.g., the earned income went above the 185 percent FPL limit in the Additional TMC period, may the county take action to terminate the family prior to the date the TMC status report is due?

    No. Federal law only requires the family to report on specific dates and the earned income must be the average of the previous three months minus child care expenses.

17. Since there are no status reports required in the second year of TMC, may the county terminate the TMC family at any time during that year if their earned income goes above the 185 percent FPL limit?

Yes. As long as the calculation is the same as used for the Additional TMC Period and the three month average was not already used in a previous calculation.

18. If the parent was terminated from Section 1931(b) and is eligible for TMC, but the child was only eligible for the MN program with a SOC or the Percent programs due to Sneede, is the child also eligible for TMC?

Yes. The child may be added to the TMC case with the parent.

3. WEDFARE

Wedfare was a federal demonstration project initiated by the Department of Social Services that was effective October 1, 1995, and provided TMC to families who were discontinued from AFDC due to marriage or the reuniting of spouses. These families were discontinued because of excess assets, excess income, or they no longer met the deprivation requirements. This program did not apply to unmarried parents who reunited. This program did not apply to certain control cases in some counties. The same basic rules, regulations, and aid codes applied to persons receiving TMC due to the Wedfare program as those receiving TMC due to the loss of the disregard or increased hours or earnings from employment. Wedfare persons were not eligible for the Second Year of TMC. This special waiver group ended June 30,1999. Families who were receiving TMC under the Wedfare provision continued receiving benefits until their maximum of one-year federal TMC benefits was completed.

4. FORMS (English and Spanish)

1. MC 176 TMC Quarterly Status Report	Revised 11/00
2. MC 176 TMC (SP) Quarterly Status Report	Revised 11/00
3. MC 176 TMC A Quarterly Status Report (Pin Fed)	Revised 11/00
4. MC 176 TMC A (SP) Quarterly Status Report (Pin Fed)	Revised 11/00
5. MC 239 TMC-1 Approval	Revised 3/01
6. MC 239 TMC-1 (SP) Approval	Revised 3/01
7. MC 239 TMC 2 Denial/Discontinuance	Revised 11/01
8. MC 239 TMC 2 (SP) Denial/Discontinuance	Revised 11/01
9. MC 239 TMC-3 Second Year Approval	Revised 7/01
10. MC 239 TMC-3 (SP) Second Year Approval	Revised 7/01
11. MC 323 Four-Month Continuing Approval	Revised 8/01
12. MC 323 (SP) Four-Month Continuing Approval	Revised 8/01
13. MC 357 Four-Month Continuing Denial/Discontinuance	New 11/01
14. TMC Flyer and the MC 325 Back	Revised 4/01

State of California—Health and Human Services Agency | Department of Health Services

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 income, money, or benefits during the report period such as salary, wages, tips, commissions, bonuses, vacation pay? **If yes, attach proof (all pay stubs) for each report month.** ☐ Yes ☐ No

Name / Employer/source		Month 1	Month 2	Month 3
	Income received?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Total hours worked:			
	Income received?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Total hours worked:			
	Income received?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Total hours worked:			
	Income received?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Total hours worked:			

2. Did you or any family member receive money or benefits from other sources such as disability, unemployment, child support, or social security? **If yes, attach proof (all pay stubs) for each report month.** ☐ Yes ☐ No

Name / Employer/source		Month 1	Month 2	Month 3
	Income received?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Income received?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Income received?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

MC 176 TMC (11/00)

3. a. Did you or any family member **receive free** housing, utilities, food, or clothing in the report month? ☐ Yes ☐ No
   b. Did you or any family member **work for** housing, utilities, food, or clothing in the report month? ☐ Yes ☐ No
   If yes to 4a and 4b, you must answer the three questions on the next line.

(1) What was received?	(2) Who received it?	(3) Who provided it?

4. 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	

5. 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, change in property, anyone that moved into or out of your home, is pregnant, or anyone who was born or who died.) ☐ Yes ☐ No
   If yes, complete the following:

Name	Relationship	What Happened	Date

6. a. Do you or anyone have or expect to receive private health, vision, or dental insurance? (This includes insurance paid by an absent parent.) ☐ Yes ☐ No
   b. Do you have or expect to receive health insurance through your employer? ☐ Yes ☐ No
   c. Does your employer offer health insurance for a monthly premium? ☐ Yes ☐ No
   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 ten 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	Date	Phone number
		( )
Signature of witness to mark, interpreter, or other person	Date	Phone number
		( )

MC 176 TMC (11/00)

State of California—Health and Human Services Agency | Department of Health Services

REPORTE TRIMESTRAL SOBRE LA SITUACIÓN MEDI-CAL DE TRANSICIÓN *(TMC)*

Este reporte es para los meses de			Devuelva este formulario a
Mes 1	Mes 2	Mes 3	más tardar el día 21 de

IMPORTANTE: COMPLETE, FIRME Y DEVUELVA ESTE REPORTE AL DEPARTAMENTO DE BIENESTAR SOCIAL EN EL SOBRE ADJUNTO. Adjunte comprobante de sus ingresos, los gastos reales pagados por el cuidado de niños y el total de horas de empleo de los tres meses indicados anteriormente. Si tiene alguna pregunta referente a este formulario o a los artículos que se deben reportar, comuníquese con su trabajador(a) de elegibilidad.

- **Para Medi-Cal de Transición *(TMC)***—Usted recibirá reportes sobre la situación durante este período. Si no completa y devuelve estos reportes, se descontinuará su elegibilidad para recibir beneficios de *TMC*.

PARTE A. PETICIÓN DE DESCONTINUACIÓN

Pido que mi ***Medi-Cal de Transición*** pare el último día de _____ (Mes/Año)

Sé que puedo volver a solicitar ***Medi-Cal*** en cualquier momento. _____ (Firma del/de la solicitante) _____ (Fecha)

SI DESEA QUE CONTINÚE SU ELEGIBILIDAD DE *TMC*, POR FAVOR COMPLETE Y FIRME LA PARTE B DE ESTE REPORTE.

PARTE B. INFORMACIÓN SOBRE LA SITUACIÓN DE ELEGIBILIDAD

1. ¿Recibió alguien algún ingreso, dinero o beneficios durante el período del reporte, como sueldo, salario, propinas, comisiones, bonificaciones, pago por vacaciones? **Si así fue, adjunte comprobante (todos los talones de cheque) para cada mes del reporte.** ..... ☐ Sí ☐ No

Nombre / Empleador/fuente		Mes 1	Mes 2	Mes 3
	¿Ingresos recibidos?	☐ Sí ☐ No	☐ Sí ☐ No	☐ Sí ☐ No
	Total de horas trabajadas:			
	¿Ingresos recibidos?	☐ Sí ☐ No	☐ Sí ☐ No	☐ Sí ☐ No
	Total de horas trabajadas:			
	¿Ingresos recibidos?	☐ Sí ☐ No	☐ Sí ☐ No	☐ Sí ☐ No
	Total de horas trabajadas:			
	¿Ingresos recibidos?	☐ Sí ☐ No	☐ Sí ☐ No	☐ Sí ☐ No
	Total de horas trabajadas:			

2. ¿Usted o alguien de su familia recibió dinero o beneficios de otras fuentes, como seguro de incapacidad, de desempleo, manutención de niños o del seguro social? **Si así fue, adjunte comprobante (todos los talones de cheque) para cada mes del reporte.** ..... ☐ Sí ☐ No

Nombre / Empleador/fuente		Mes 1	Mes 2	Mes 3
	¿Ingresos recibidos?	☐ Sí ☐ No	☐ Sí ☐ No	☐ Sí ☐ No
	¿Ingresos recibidos?	☐ Sí ☐ No	☐ Sí ☐ No	☐ Sí ☐ No
	¿Ingresos recibidos?	☐ Sí ☐ No	☐ Sí ☐ No	☐ Sí ☐ No

MC 176 TMC (SP) (11/00)

3. a. ¿Recibió usted o algún familiar vivienda, servicios públicos y comunitarios, alimentos o ropa gratis en el mes del reporte? ☐ Sí ☐ No
   b. ¿Usted o algún familiar trabajó por vivienda, servicios públicos y comunitarios, alimentos o ropa en el mes del reporte? ☐ Sí ☐ No

Si la respuesta a las preguntas 4a y 4b es sí, usted tiene que contestar las tres preguntas en el siguiente renglón.

(1) ¿Qué se recibió?	(2) ¿Quién lo recibió?	(3) ¿Quién lo proporcionó?

4. ¿Usted o alguien pagó gastos por el cuidado de niños que no se han reembolsado o que no se reembolsarán? ☐ Sí ☐ No
   Si así fue, complete lo siguiente:

Nombre del/de los niño(s)	Edad	Cantidad pagada por gastos del cuidado de niños			Nombre del proveedor del cuidado de niños
		Mes 1	Mes 2	Mes 3	

5. ¿Hubo cambios en su familia u hogar durante el período especificado? (Incluya cambio de dirección, cambio de proveedor de cuidado de niños, cambio de empleo, cambio de propiedad, alguien que se mudó a o de su hogar, alguien que esté embarazada o alguien que nació o murió.) Si así fue, complete lo siguiente: ☐ Sí ☐ No

Nombre	Parentesco	¿Qué ocurrió?	Fecha

6. a. ¿Usted o alguien tiene o espera recibir seguro médico, de la vista o dental privado? (Esto incluye seguro pagado por un padre ausente.) ☐ Sí ☐ No
   b. ¿Usted tiene o espera recibir seguro médico por medio de su empleador? ☐ Sí ☐ No
   c. ¿Ofrece su empleador seguro médico a cambio de una cuota mínima? ☐ Sí ☐ No
   Si así es, complete lo siguiente:

Nombre del Seguro	Persona(s) Asegurada(s)

CERTIFICACIÓN

Entiendo que los datos reportados podrían ocasionar que los beneficios se cambien o se suspendan.

Entiendo que las declaraciones que he hecho en este formulario están sujetas a investigación y verificación.

Entiendo que tengo que notificar a mi trabajador(a) cualquier cambio en un plazo de diez días.

Entiendo que el no reportar los datos o darlos erróneos o incompletos puede resultar en enjuiciamiento legal con sanciones de una multa, encarcelamiento o ambos.

DECLARO BAJO PENA DE PERJURIO CONFORME A LAS LEYES DE LOS ESTADOS UNIDOS Y DEL ESTADO DE CALIFORNIA QUE LA INFORMACIÓN CONTENIDA EN ESTE REPORTE ES VERDADERA Y CORRECTA Y ES COMPLETA PARA EL PERÍODO TOTAL DEL REPORTE.

Firma o marca del/de la solicitante	Fecha	Número de teléfono
		( )
Firma del/de la testigo para la marca, intérprete u otra persona	Fecha	Número de teléfono
		( )

MC 176 TMC (SP) (11/00)

State of California—Health and Human Services Agency | Department of Health Services

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 income, money, or benefits during the report period such as salary, wages, tips, commissions, bonuses, vacation pay? **If yes, attach proof (all pay stubs) for each report month.** ☐ Yes ☐ No

Name / Employer/source		Month 1	Month 2	Month 3
	Income received?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Total hours worked:			
	Income received?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Total hours worked:			
	Income received?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Total hours worked:			
	Income received?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Total hours worked:			

2. Did you or any family member receive money or benefits from other sources such as disability, unemployment, child support, or social security? **If yes, attach proof (all pay stubs) for each report month.** ☐ Yes ☐ No

Name / Employer/source		Month 1	Month 2	Month 3
	Income received?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Income received?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Income received?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

MC 176 TMC A (11/00)

3. a. Did you or any family member **receive free** housing, utilities, food, or clothing in the report month? ☐ Yes ☐ No
   b. Did you or any family member **work for** housing, utilities, food, or clothing in the report month? ☐ Yes ☐ No
   If yes to 4a and 4b, you must answer the three questions on the next line.

(1) What was received?	(2) Who received it?	(3) Who provided it?

4. 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	

5. 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, change in property, anyone that moved into or out of your home, is pregnant, or anyone who was born or who died.) ☐ Yes ☐ No
   If yes, complete the following:

Name	Relationship	What Happened	Date

6. a. Do you or anyone have or expect to receive private health, vision, or dental insurance? (This includes insurance paid by an absent parent.) ☐ Yes ☐ No
   b. Do you have or expect to receive health insurance through your employer? ☐ Yes ☐ No
   c. Does your employer offer health insurance for a monthly premium? ☐ Yes ☐ No
   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 ten 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	Date	Phone number
		( )
Signature of witness to mark, interpreter, or other person	Date	Phone number
		( )

MC 176 TMC A (11/00)

State of California—Health and Human Services Agency — Department of Health Services

REPORTE TRIMESTRAL SOBRE LA SITUACIÓN MEDI-CAL DE TRANSICIÓN *(TMC)*

Este reporte es para los meses de			Devuelva este formulario a más tardar el día 21 de
Mes 1	Mes 2	Mes 3	

IMPORTANTE: COMPLETE, FIRME Y DEVUELVA ESTE REPORTE AL DEPARTAMENTO DE BIENESTAR SOCIAL EN EL SOBRE ADJUNTO. Adjunte comprobante de sus ingresos, los gastos reales pagados por el cuidado de niños y el total de horas de empleo de los tres meses indicados anteriormente. Si tiene alguna pregunta referente a este formulario o a los artículos que se deben reportar, comuníquese con su trabajador(a) de elegibilidad.

- **Para Medi-Cal de Transición *(TMC)*—**Usted recibirá reportes sobre la situación durante este período. Si no completa y devuelve estos reportes, se descontinuará su elegibilidad para recibir beneficios de *TMC*.

PARTE A. PETICIÓN DE DESCONTINUACIÓN

Pido que mi ***Medi-Cal de Transición*** pare el último día de _____ (Mes/Año)

Sé que puedo volver a solicitar ***Medi-Cal*** en cualquier momento. _____ (Firma del/de la solicitante) _____ (Fecha)

SI DESEA QUE CONTINÚE SU ELEGIBILIDAD DE *TMC*, POR FAVOR COMPLETE Y FIRME LA PARTE B DE ESTE REPORTE.

PARTE B. INFORMACIÓN SOBRE LA SITUACIÓN DE ELEGIBILIDAD

1. ¿Recibió alguien algún ingreso, dinero o beneficios durante el período del reporte, como sueldo, salario, propinas, comisiones, bonificaciones; pago por vacaciones? **Si así fue, adjunte comprobante (todos los talones de cheque) para cada mes del reporte.** ..... ☐ Sí ☐ No

Nombre / Empleador/fuente		Mes 1	Mes 2	Mes 3
	¿Ingresos recibidos?	☐ Sí ☐ No	☐ Sí ☐ No	☐ Sí ☐ No
	Total de horas trabajadas:			
	¿Ingresos recibidos?	☐ Sí ☐ No	☐ Sí ☐ No	☐ Sí ☐ No
	Total de horas trabajadas:			
	¿Ingresos recibidos?	☐ Sí ☐ No	☐ Sí ☐ No	☐ Sí ☐ No
	Total de horas trabajadas:			
	¿Ingresos recibidos?	☐ Sí ☐ No	☐ Sí ☐ No	☐ Sí ☐ No
	Total de horas trabajadas:			

2. ¿Usted o alguien de su familia recibió dinero o beneficios de otras fuentes, como seguro de incapacidad, de desempleo, manutención de niños o del seguro social? **Si así fue, adjunte comprobante (todos los talones de cheque) para cada mes del reporte.** ..... ☐ Sí ☐ No

Nombre / Empleador/fuente		Mes 1	Mes 2	Mes 3
	¿Ingresos recibidos?	☐ Sí ☐ No	☐ Sí ☐ No	☐ Sí ☐ No
	¿Ingresos recibidos?	☐ Sí ☐ No	☐ Sí ☐ No	☐ Sí ☐ No
	¿Ingresos recibidos?	☐ Sí ☐ No	☐ Sí ☐ No	☐ Sí ☐ No

MC 176 TMC A (SP) (11/00)

3. a. ¿**Recibió** usted o algún familiar vivienda, servicios públicos y comunitarios, alimentos o ropa **gratis** en el mes del reporte? ☐ Sí ☐ No
   b. ¿Usted o algún familiar trabajó por vivienda, servicios públicos y comunitarios, alimentos o ropa en el mes del reporte? ☐ Sí ☐ No

   Si la respuesta a las preguntas 4a y 4b es sí, usted tiene que contestar las tres preguntas en el siguiente renglón.

(1) ¿Qué se recibió?	(2) ¿Quién lo recibió?	(3) ¿Quién lo proporcionó?

4. ¿Usted o alguien pagó gastos por el cuidado de niños que no se han reembolsado o que no se reembolsarán? ☐ Sí ☐ No
   Si así fue, complete lo siguiente:

Nombre del/de los niño(s)	Edad	Cantidad pagada por gastos del cuidado de niños			Nombre del proveedor del cuidado de niños
		Mes 1	Mes 2	Mes 3	

5. ¿Hubo cambios en su familia u hogar durante el periodo especificado? (Incluya cambio de dirección, cambio de proveedor de cuidado de niños, cambio de empleo, cambio de propiedad, alguien que se mudó a o de su hogar, alguien que esté embarazada o alguien que nació o murió.) Si así fue, complete lo siguiente: ☐ Sí ☐ No

Nombre	Parentesco	¿Qué ocurrió?	Fecha

6. a. ¿Usted o alguien tiene o espera recibir seguro médico, de la vista o dental privado? (Esto incluye seguro pagado por un padre ausente.) ☐ Sí ☐ No
   b. ¿Usted tiene o espera recibir seguro médico por medio de su empleador? ☐ Sí ☐ No
   c. ¿Ofrece su empleador seguro médico a cambio de una cuota mínima? ☐ Sí ☐ No
   Si así es, complete lo siguiente:

Nombre del Seguro	Persona(s) Asegurada(s)

CERTIFICACIÓN

Entiendo que los datos reportados podrían ocasionar que los beneficios se cambien o se suspendan.

Entiendo que las declaraciones que he hecho en este formulario están sujetas a investigación y verificación.

Entiendo que tengo que notificar a mi trabajador(a) cualquier cambio en un plazo de diez días.

Entiendo que el no reportar los datos o darlos erróneos o incompletos puede resultar en enjuiciamiento legal con sanciones de una multa, encarcelamiento o ambos.

DECLARO BAJO PENA DE PERJURIO CONFORME A LAS LEYES DE LOS ESTADOS UNIDOS Y DEL ESTADO DE CALIFORNIA QUE LA INFORMACIÓN CONTENIDA EN ESTE REPORTE ES VERDADERA Y CORRECTA Y ES COMPLETA PARA EL PERÍODO TOTAL DEL REPORTE.

Firma o marca del/de la solicitante	Fecha	Número de teléfono ( )
Firma del/de la testigo para la marca, intérprete u otra persona	Fecha	Número de teléfono ( )

MC 176 TMC A (SP) (11/00)

State of California—Health and Human Services Agency

Department of Health Services
Medi-Cal Program

MEDI-CAL
NOTICE OF ACTION
TRANSITIONAL MEDI-CAL (TMC)
APPROVAL FOR FULL OR RESTRICTED BENEFITS

(COUNTY STAMP)

Notice date: _____
Case number: _____
Worker name: _____
Worker number: _____
Worker telephone number: _____
Office hours: _____
Notice for: _____

TMC IS A PROGRAM THAT PROVIDES CONTINUING MEDI-CAL BENEFITS FOR UP TO TWO YEARS 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. Receiving these Medi-Cal benefits does not count against any CalWORKs program time limits.

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.

When your additional six months of TMC benefits have ended, you will be evaluated for the second year of TMC *or other Medi-Cal programs.*

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.

MC 239 TMC-1 (3/01)

State of California—Health and Human Services Agency

Department of Health Services
Medi-Cal Program

NOTIFICACIÓN DE ACCIÓN DE MEDI-CAL
APROBACIÓN DE BENEFICIOS COMPLETOS O LIMITADOS BAJO EL PROGRAMA DE MEDI-CAL DE TRANSICIÓN *(TMC)*

(COUNTY STAMP)

Fecha de la notificación: _____
Número del caso: _____
Nombre del/de la trabajador(a): _____
Número del/de la trabajador(a): _____
Número de teléfono del/de la trabajador(a): _____
Horas hábiles: _____
Notificación para: _____

EL *TMC* ES UN PROGRAMA QUE PROPORCIONA BENEFICIOS CONTINUOS DEL PROGRAMA DE MEDI-CAL, DURANTE UN MÁXIMO DE DOS AÑOS, A CIERTAS PERSONAS QUE YA NO REÚNEN LOS REQUISITOS BAJO SU PROGRAMA DE MEDI-CAL ACTUAL, DEBIDO A SUS INGRESOS DE EMPLEO.

☐ Usted reúne los requisitos para recibir beneficios iniciales bajo el *TMC* durante el período del_____ al_____.

☐ Usted tiene derecho a beneficios completos.

☐ Usted tiene derecho a beneficios en caso de emergencia y relacionados con el embarazo.

Usted continuará recibiendo beneficios bajo el *TMC* durante este período, si usted tiene un(a) niño(a) que reúna los requisitos viviendo en su hogar, y usted sigue trabajando. El recibir estos beneficios de Medi-Cal no se toma en cuenta para cualesquier límites de tiempo del programa de *CalWORKs*.

Es posible que reúna los requisitos para recibir seis meses adicionales de beneficios del *TMC*, sin costo alguno, si usted:

- Devuelve el reporte sobre su situación, que el condado le enviará, a más tardar el día 21 de _____ y cae dentro de los límites de ingresos.
- Adjunta, al reporte sobre su situación, una prueba de los ingresos mensuales en bruto de su familia, y los costos reales de cuidado de niños que usted pague. Guarde todos sus estados de cuenta de ingresos y sus recibos de cuidado de niños.

☐ Usted reúne los requisitos para recibir seis meses adicionales de beneficios durante el período del_____ al_____.

A fin de seguir reuniendo los requisitos para recibir los seis meses adicionales de beneficios del *TMC*, a usted se le requerirá completar y devolver dos reportes sobre su situación, que el condado le envíe durante este período. El primer reporte se vencerá el día 21 del primer mes, y el segundo reporte se vencerá el día 21 del cuarto mes de este período adicional de seis meses. Además, usted tiene que:

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

Cuando sus seis meses adicionales de beneficios del *TMC* se hayan terminado, se evaluará su situación para determinar si reúne los requisitos para recibir el segundo año de beneficios del *TMC* o de otros programas de Medi-Cal.

Siempre presente su Tarjeta de Identificación de Beneficios *(BIC)* a su proveedor médico, cada vez que necesite atención. Esta tarjeta es válida, mientras usted reúna los requisitos para recibir beneficios de 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.

MC 239 TMC-1 (SP) (3/01)

State of California—Health and Human Services Agency

Department of Health Services

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

(COUNTY STAMP)

Notice date: _____
Case number: _____
Worker name: _____
Worker number: _____
Worker telephone number: _____
Office hours: _____
Notice for: _____

☐ 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:

- ☐ Initial TMC
- ☐ 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.

MC 239 TMC-2 (11/01)

State of California—Health and Human Services Agency

Department of Health Services

NOTIFICACIÓN DE ACCIÓN DE MEDI-CAL

Medi-Cal de Transición *(TMC)*

Negación o Descontinuación de Beneficios

(COUNTY STAMP)

Fecha de la notificación: _____

Número del caso: _____

Nombre del trabajador: _____

Número del trabajador: _____

Número de teléfono del trabajador: _____

Horario de la oficina: _____

Notificación para: _____

☐ Sus beneficios bajo el *TMC* se descontinuarán a partir del último día de _____.

☐ La elegibilidad para recibir beneficios bajo el programa inicial del *TMC* termina _____ porque:

- ☐ Ya no vive un(a) niño(a) en el hogar.
- ☐ Otro: _____

☐ La elegibilidad para recibir beneficios adicionales o durante el segundo año del programa de *TMC* termina _____ porque:

- ☐ Ya no vive un(a) niño(a) en el hogar.
- ☐ Usted no regresó un reporte completado sobre la situación.
- ☐ Los ingresos brutos promedio de su familia (menos los costos del cuidado de niños) exceden el límite.
- ☐ El pariente encargado del cuidado o el proveedor principal ya no trabaja.
- ☐ Otro: _____

☐ Usted no reúne los requisitos para recibir beneficios:

- ☐ *TMC* inicial
- ☐ Adicionales del *TMC*
- ☐ Del Segundo Año del *TMC*
- ☐ De cualquier otro programa de Medi-Cal

La razón es la siguiente: _____

☐ Usted recibirá una notificación por separado sobre su elegibilidad para el programa regular de Medi-Cal.

NO TIRE SU TARJETA DE IDENTIFICACIÓN DE PLÁSTICO. Usted puede usarla nuevamente si vuelve a reunir los requisitos para recibir beneficios de Medi-Cal.

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

MC 239 TMC-2 (SP) (11/01)

State of California—Health and Human Services Agency

Department of Health Services
Medi-Cal Program

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

(COUNTY STAMP)

Notice date: _____
Case number: _____
Worker name: _____
Worker number: _____
Worker telephone number: _____
Office hours: _____
Notice for: _____

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.

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.
- Report any changes in your income or household composition within ten days.

When your benefits have ended, you will be evaluated for other Medi-Cal programs.

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.

MC 239 TMC-3 (7/01)

State of California—Health and Welfare Agency

Department of Health Services
Medi-Cal Program

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

(COUNTY STAMP)

Fecha de la notificación: _____
Número del caso: _____
Nombre del trabajador: _____
Número del trabajador: _____
Número de teléfono del trabajador: _____
Horario del trabajador: _____
Notificación para: _____

UN SEGUNDO AÑO DE BENEFICIOS DEL *TMC* ESTÁ A LA DISPOSICIÓN DE PERSONAS QUE TRABAJAN DE 19 AÑOS DE EDAD Y MAYORES QUE RECIBIERON UN AÑO DE BENEFICIOS DEL *TMC* PORQUE YA NO REUNÍAN LOS REQUISITOS PARA RECIBIR BENEFICIOS DE SU PROGRAMA DE MEDI-CAL ACTUAL DEBIDO A SU EMPLEO.

☐ Usted reúne los requisitos para recibir 12 meses adicionales de beneficios del *TMC*, sin costo alguno, para el período del _____ al _____ .

☐ Usted tiene derecho a recibir beneficios completos.

☐ Sus beneficios sólo cubren los servicios en casos de emergencia o relacionados con el embarazo.

Usted tiene que:

- Seguir empleado(a).
- Tener un(a) niño(a) que reúna los requisitos viviendo en su hogar.
- Contar con ingresos promedio, menos los costos de cuidado de niños, al o por debajo del 185 por ciento del Nivel de Pobreza Federal.
- Informar a este Departamento dentro de diez días si sus ingresos o composición en los miembros de su familia cambian.

Cuando sus beneficios terminen, se le evaluará para ver si es elegible para otros programas de Medi-Cal.

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

El ordenamiento que exige esta acción es la Sección 50244, del Título 22, del Código de Ordenamientos de California.

MC 239 TMC-3 (SP) (7/01)

State of California—Health and Human Services Agency

Department of Health Services

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

(COUNTY STAMP)

Notice date: _____
Case number: _____
Worker name: _____
Worker number: _____
Worker telephone number: _____
Office hours: _____
Notice for: _____

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.

MC 323 (8/01)

State of California—Health and Human Services Agency | Department of Health Services

NOTIFICACIÓN DE ACCIÓN DE MEDI-CAL

APROBACIÓN DE BENEFICIOS COMPLETOS O LIMITADOS DEL PROGRAMA DE MEDI-CAL DE CUATRO MESES CONTINUOS

(COUNTY STAMP)

Fecha de la notificación: _____
Número del caso: _____
Nombre del trabajador: _____
Número del trabajador: _____
Número de teléfono del trabajador: _____
Horario de la oficina: _____
Notificación para: _____

ESTE PROGRAMA PROPORCIONA CUATRO MESES DE BENEFICIOS CONTINUOS DE MEDI-CAL A CIERTAS PERSONAS QUE YA NO REÚNEN LOS REQUISITOS PARA SU PROGRAMA ACTUAL DE MEDI-CAL, POR HABER COBRADO O RECIBIDO UN AUMENTO EN EL COBRO DE MANUTENCIÓN DE HIJOS O CÓNYUGES.

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

☐ Usted tiene derecho a beneficios completos.

☐ Sus beneficios solamente cubrirán servicios de emergencia y los relacionados al embarazo.

Usted recibirá beneficios del Programa de Medi-Cal de Cuatro Meses Continuos, hasta el mes indicado anteriormente, mientras siga siendo residente de California.

Presente siempre su Tarjeta de Identificación de Beneficios *(BIC)* a su proveedor médico, cada vez que necesite atención. Esta tarjeta es válida mientras usted reúna los requisitos para recibir beneficios de 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.

MC 323 (SP) (8/01)

State of California—Health and Human Services Agency

Department of Health Services
Medi-Cal Program

MEDI-CAL
NOTICE OF ACTION
FOUR-MONTH CONTINUING PROGRAM
DENIAL OR DISCONTINUANCE OF BENEFITS

(COUNTY STAMP)

Notice date: _____
Case number: _____
Worker name: _____
Worker number: _____
Worker telephone number: _____
Office hours: _____
Notice for: _____

The Four-Month Continuing Medi-Cal program is for families who were discontinued from CalWORKs or Section 1931(b) Medi-Cal due to an increase or receipt of child or spousal support payments.

☐ Your benefits under the Four-Month Continuing program will be discontinued effective the last day of _____.

☐ You are not eligible for the Four-Month Continuing program.

Here is/are the reasons(s) why:

☐ You do not have an eligible child living in the home.

☐ Your only eligible child is over the age limit.

☐ You did not receive CalWORKs or Section 1931(b) in three of the last six months.

☐ You moved out of California.

☐ Other: _____

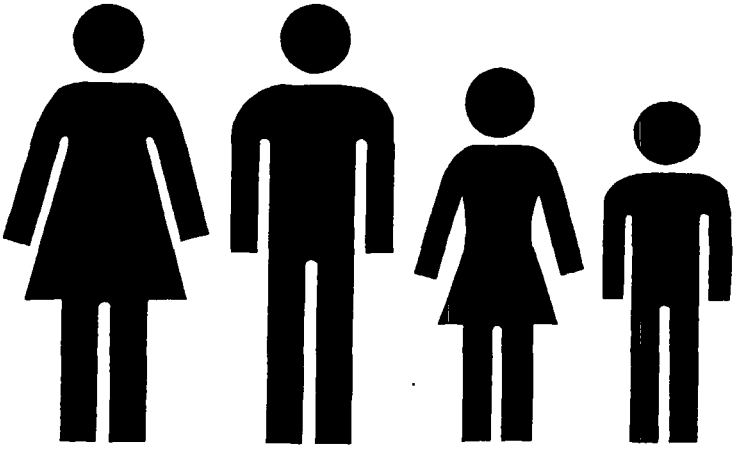
You will receive another notice if you are eligible for another Medi-Cal program.

DO NOT THROW AWAY YOUR PLASTIC BENEFITS IDENTIFICATION CARD (BIC). You can use it again if you become eligible or are eligible for another Medi-Cal program.

The regulation that requires this action is California Code of Regulations, Title 22, Section 50243.

MC 357 (11/01)

TRANSITIONAL MEDI-CAL (TMC)



TMC May Provide You and Your Family with FREE Continued Medical Coverage For Up To 12 Months. Adults May Get TMC For Up To 24 Months.

If you:

- **Get a job, or**
- **Get more money from your job, or**
- **Get child or spousal support,**

tell your worker right away or complete the back of this form and mail it to your worker. You may still be eligible for no-cost Medi-Cal. Your worker will determine whether your Medi-Cal health coverage can continue.

Health care is important for you and your family. Receiving Medi-Cal does not affect your CalWORKs time limits.

State of California—Health and Human Services Agency | Department of Health Services

REQUEST FOR TRANSITIONAL MEDI-CAL (TMC) OR FOUR MONTH CONTINUING MEDI-CAL

Did your Medi-Cal or CalWORKS cash aid stop and:

- You or your family has earnings from a job, a business you started, or a pay raise? ☐ Yes ☐ No
- You or your family started receiving or had an increase in child/spousal support payments? ☐ Yes ☐ No

If you answered "YES" to any of these questions, you and other family members may still be eligible for Medi-Cal. Complete the form and attach your and your spouse's or other parent's most recent pay stubs or other proof of earnings. If you are self-employed, list business costs on a separate sheet of paper and attach proof of income and costs.

RETURN THIS REQUEST FORM TO YOUR COUNTY WORKER OR YOUR WELFARE OFFICE. DO *NOT* RETURN THIS FORM TO THE CALIFORNIA DEPARTMENT OF HEALTH SERVICES.

Please type or print clearly.

Name / Employer/source	TOTAL HOURS WORKED IN REPORT MONTH:									
		DATE PAID: (MM DD YY)								
		GROSS AMOUNT:	$		$		$		$	
Name / Employer/source	TOTAL HOURS WORKED IN REPORT MONTH:									
		DATE PAID: (MM DD YY)								
		GROSS AMOUNT:	$		$		$		$	
Name / Employer/source	TOTAL HOURS WORKED IN REPORT MONTH:									
		DATE PAID: (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: បើសិនជាលោកអ្នកមិនយល់សេចក្តីប្រកាសនេះទេ សូមសាកសួរពេកសេចក្តីបកប្រែពីអ្នកការងំសំណុំរឿងរបស់លោកអ្នក ។

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.

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

MC 325 (4/01)