DATE[[1]](#footnote-1)\*

Beneficiary Name[\*](#FN)
Address[\*](#FN)
City, State Zip[\*](#FN)

# **Re: Your Medi-Cal Targeted Case Management Services**

Dear [BENEFICIARY NAME][\*](#FN):

This letter is notification that in accordance with Welfare and Institutions Code § 14132.44, [LGA NAME][\*](#FN) (the Agency) has notified the Department of Health Care services (DHCS) that it is no longer participating in the [TARGET POPULATION][\*](#FN) of Medi-Cal’s Targeted Case Management (TCM) program effective [DATE][\*](#FN), due to [LGA’s REASON FOR LEAVING THE PROGRAM][\*](#FN).

As a member of the [TARGET POPULATION][\*](#FN), you currently receive TCM services. The Agency’s election to forego federal funding through the TCM program, and its termination, suspension, or the reduction of its participation therein will **not** affect your ability to receive other similar services supported by the Agency or your receipt of other Medi-Cal benefits.

The information provided in this notice is not subjected to an administrative hearing or appeal. The Medi-Cal TCM program is a voluntary program and the Agency’s participation is not mandated.

[If the beneficiary is shifted into a similar program, the LGA must notify the beneficiary of the fair hearing and appeals process applicable to the new program][\*](#FN).

If you have any questions regarding this notice, please contact [LGA CONTACT INFORMATION][\*](#FN).

[LGA SIGNATURE BLOCK][\*](#FN)

1. \* This field is required to be filled out [↑](#footnote-ref-1)