



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



GAVIN NEWSOM
GOVERNOR

DATE: November 17, 2021

Medi-Cal Eligibility Division Information Letter No.: I 21-35

TO: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY WELFARE ADMINISTRATIVE OFFICERS
ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIAISONS

SUBJECT: RESIDENCY VERIFICATION PROGRAM LETTER AND FORM UPDATE
FOR PERIODIC DATA MATCHING TO CONFIRM RESIDENCY

The purpose of this Medi-Cal Eligibility Division Information Letter (MEDIL) is to provide County Welfare Departments (CWDs) with the updated letters and forms used in the quarterly mailing for Periodic Data Matching to Confirm Residency. See [All County Welfare Director Letter \(ACWDL\) 17-18](#) for additional information.

Residency Verification Letter Packet Includes:

1. **Updated: Residency Verification Letter** has been modified to use language specific to the program and provide beneficiaries with clear instructions on how to return the MC 1006 (Revised 07/2021) or MC 1007 (07/2021).
2. **Updated: “Medi-Cal Address Update Form” MC 1006 (Revised 07/2021)** has been updated to specify whose information is needed and to include the beneficiary’s Date of Birth and Phone Number, as requested by counties.
3. **New: “Medi-Cal Withdrawal Request for Residency Verification Program” MC 1007 (07/2021)** was created to be specific to the Residency Verification Program. **Old:** Previous form, “Request for Withdrawal and/or Waiver of The-Day Advance Notice” MC 215, was used as a template.

Residency Verification Military Letter Packet Includes:

1. **Updated: Residency Verification Military Letter** has been modified to use language specific to the program and provide beneficiaries with clear instructions on how to return the MC 1006 (Revised 07/2021) or MC 1007 (07/2021).
2. **Updated: “Medi-Cal Address Update Form” MC 1006 (Revised 07/2021)** has been updated to specify whose information is needed and to include the beneficiary’s Date of Birth and Phone Number, as requested by counties.

- 3. New: “Medi-Cal Withdrawal Request for Residency Verification Program” MC 1007 (07/2021)** was created to be specific to the Residency Verification Program. **Old:** Previous form, “Request for Withdrawal and/or Waiver of The-Day Advance Notice” MC 215, was used as a template.

The letters and forms have been updated to obtain necessary information from the beneficiary to prevent negative action and any further delays in processing their forms.

Residency Verification Letter Packet Effective Date

The new letters and forms [MC 1006 (Revised 07/2021) and MC 1007 (07/2021)], will be used effective immediately. However, beneficiaries that were mailed the previous versions of the Residency Verification Letter Packet still have the ability to contact and communicate with CWDs and DHCS using the outdated letters and forms.

CWD Coordination

The CWDs responsibility has not changed. Please refer to [ACWDL 17-18](#) for more information.

Questions

If you have any questions regarding this letter please contact Yesenia Lopez-Ambriz at Yesenia.Lopez-Ambriz@dhcs.ca.gov or 916-345-8056.

Original Signed By

Yingjia Huang
Assistant Deputy Director
Health Care Benefits and Eligibility
Department of Health Care Services

Enclosures



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



GAVIN NEWSOM
GOVERNOR

DATE

«FirstName» «LastName»
«Address»
«City», «State» «ZipCode»

Dear «FirstName» «LastName»:

You are receiving this letter because you are currently enrolled in Medi-Cal and possibly living outside of California. Under California law, California residency is a requirement for a person to be eligible for Medi-Cal. (California Code Regulations, Title 22, Section 50320.) You are a resident if you live and intend to reside in California. This includes if you came to the state with a job or are looking for a job. You do not need to have a job or a fixed address to be a California resident. (Welfare & Institutions Code Section 14007.15.)

In addition, it appears you or a family member is serving on active duty status with the U.S. Armed Forces. Active duty members of the military and their dependents are entitled to medical and dental care through the federal government. (10 U.S.C. Section 1074, 1076.)

Please contact us within 30 days from the date of this letter or your Medi-Cal will be terminated.

How to Confirm Residency in California:

If our records are incorrect and you live in California, please provide the address where you currently live by sending the “**Medi-Cal Address Update Form**” by:

- an email to rvp@dhcs.ca.gov,
- a fax request to (916) 440-5243, or
- mailing the form and using the enclosed envelope.

How to Request for Withdrawal from Medi-Cal:

If you no longer intend to live in California or no longer need Medi-Cal, you can end your Medi-Cal benefits by sending the “**Medi-Cal Withdrawal Request for Residency Verification Program**” Form by:

- an email to rvp@dhcs.ca.gov,
- a fax request to (916) 440-5243, or
- mailing the form and using the enclosed envelope.

If other household members no longer intend to live in California or no longer need Medi-Cal, then each household member needs to notify us by sending an email to rvp@dhcs.ca.gov, sending a Medi-Cal Withdrawal Request for Residency Verification Program Form via fax (916) 440-5243, or by mailing with the enclosed envelope. Adults must sign their own form. For any minor children, a parent or legal guardian must sign on each minor's behalf.

DHCS recommends using e-mail or fax to avoid potential delays in receiving your response.

If you have any questions regarding this letter, send them by email to rvp@dhcs.ca.gov. You can also fax questions to (916) 440-5243 or contact your Medi-Cal eligibility worker at your local county office.



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



GAVIN NEWSOM
GOVERNOR

DATE

«FirstName» «LastName»
«Address»
«City», «State» «ZipCode»

Dear «FirstName» «LastName»:

You are receiving this letter because you are currently enrolled in Medi-Cal and possibly living outside of California. Under California law, California residency is a requirement for a person to be eligible for Medi-Cal. (California Code Regulations, Title 22, Section 50320.) You are a resident if you live and intend to reside in California. This includes if you came to the state with a job or are looking for a job. You do not need to have a job or a fixed address to be a California resident. (Welfare & Institutions Code Section 14007.15.)

Please contact us within 30 days from the date of this letter or your Medi-Cal will be terminated.

How to Confirm Residency in California:

If our records are incorrect and you live in California, please provide the address where you currently live by sending the “**Medi-Cal Address Update Form**” by:

- an email to rvp@dhcs.ca.gov,
- a fax request to (916) 440-5243, or
- mailing the form and using the enclosed envelope.

How to Request for Withdrawal from Medi-Cal:

If you no longer intend to live in California or no longer need Medi-Cal, you can end your Medi-Cal benefits by sending the “**Medi-Cal Withdrawal Request for Residency Verification Program**” Form by:

- an email to rvp@dhcs.ca.gov,
- a fax request to (916) 440-5243, or
- mailing the form and using the enclosed envelope.

If other household members no longer intend to live in California or no longer need Medi-Cal, then each household member needs to notify us by sending an email to

rvp@dhcs.ca.gov, sending a Medi-Cal Withdrawal Request for Residency Verification Program Form via fax (916) 440-5243, or by mailing with the enclosed envelope. Adults must sign their own form. For any minor children, a parent or legal guardian must sign on each minor's behalf.

DHCS recommends using e-mail or fax to avoid potential delays in receiving your response.

If you have any questions regarding this letter, send them by email to rvp@dhcs.ca.gov. You can also fax questions to (916) 440-5243 or contact your Medi-Cal eligibility worker at your local county office.

Medi-Cal Withdrawal Request for Residency Verification Program

Request to end Medi-Cal eligibility:

I, _____, ask that my Medi-Cal eligibility end on _____(month) / _____(day) / _____(year) because:

- I am serving as Active Duty Military.
- I am no longer a California Resident as of _____(month) / _____(day) / _____(year).
- I no longer need Medi-Cal.

I understand that I can reapply for Medi-Cal at any time. I understand that the above request will not interfere with my right to a state hearing. I understand that if I ask for a state hearing before the effective date of the action, the action will be delayed.

X

Signature of Beneficiary/Authorized Representative

Date (month/day/year)

«RVP_Code»

Medi-Cal Address Update Form

Complete this form for the member listed on the letter.

Home Address

Write your name, date of birth, and home address (where you live most of the time).

Name (first, middle, last)

Date of Birth (month/day/year):

Home address (include apartment or unit #):

City, State, ZIP Code:

Homeless (do not have a home address)

Phone:

Email (optional):

Mailing Address

Check the box below **or** write your mailing address.

My mailing address is the same as my home address.

Mailing address (include apartment or unit #):

City, State, ZIP Code:

«RVP_Code»

DHCS PRIVACY STATEMENT

This form is for receiving benefits through the Department of Health Care Services (DHCS). The personal and medical information you provide on it is private and confidential as required by law. DHCS needs it to identify you and the other people on this form and to administer our programs. Therefore, DHCS will share your information with other state, federal, and local agencies, contractors, health plans, and programs only to enroll you in a plan or program or to administer programs, and with others as permitted or required by law. For more information, see the Notice of Privacy Practices at <https://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/NoticeofPrivacyPractices.aspx>

You must answer all of the questions on this form unless they are marked “optional.” If your form is missing anything that we require, we will contact you to get it. If you do not provide it, we will not be able to make a decision on your benefits. You may have to submit a new application, or services may be discontinued.

In most cases, you have the right to see personal information about you that is in federal and state records. You can also request to see your information in an alternative format (such as large print) if needed. For more information, contact the DHCS Information Protection Unit at:

P.O. Box 997413, MS 4721
Sacramento, CA
95899-7413
Phone: 1-866-866-0602
TTY: 1-877-735-2929

These state laws give us the right to collect and keep the information: CA Welfare and Institutions Code Section 14011 and Article 3, Chapters 5 and 7, Parts 2 and 3, Division 9. We must give you this Privacy Statement under CA Civil Code Section 1798.17.