DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: April 22, 2025

Medi-Cal Eligibility Division Information Letter No.: I 25-11

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

SUBJECT: RESIDENCY VERIFICATION PROGRAM LETTER AND NOTICE OF ACTION LETTERS UPDATE FOR PERIODIC DATA MATCHING TO CONFIRM RESIDENCY

The Department of Health Care Services (DHCS) performs periodic data matching to confirm California residency and detect whether Medi-Cal members have an unreported change in circumstance specific to state residency. The purpose of this Medi-Cal Eligibility Division Information Letter (MEDIL) is to provide county welfare departments (CWDs) with the updated Residency Verification and Notice of Action letters used in the quarterly mailing for Periodic Data Matching to Confirm Residency. See All County Welfare Director Letter (ACWDL) 17-18 for additional information.

**The Residency Verification Letter Packet Includes:**

1. **Residency Verification letter** has been modified to instruct household members how to discontinue their Medi-Cal because they no longer reside in California or no longer need Medi-Cal.
2. **"Medi-Cal Address Update Form" MC 1006 (Revised 07/2021).**
3. **"Medi-Cal Withdrawal Request for Residency Verification Program" MC 1007 (Revised 2021).**

**Three Residency Verification Notice of Action Letters:** The letters have been updated to inform members how to provide necessary information needed to prevent their Medi-Cal from being discontinued and instruct members how to discontinue their Medi-Cal if they no longer need it.

- The **No Response Letter** has been modified with a realigned title and return address. The return address has been updated to the new address used by the Residency Verification Program (RVP). The letter now instructs members to contact their CWD if they have received the letter in error.
- The **Request for Discontinuance Letter** has been modified with a realigned title and return address. The return address has been updated to the new address used by RVP.

- The **Residency Letter** has been modified with a realigned title and return address. The return address has been updated to the new address used by RVP.

## Residency Verification Letter Packet and Notice of Action Letters Effective Date

The new letters will be effective immediately. However, members who received previous versions of the Residency Verification Letter Packet and Notice of Action Letters may still contact CWDs and DHCS using the outdated letters.

## CWD Coordination

The CWD's responsibility has not changed. Please refer to ACWDL 17-18 for more information.

## Questions

If you have any questions, or if we can provide further information, please contact the Residency Verification Program team by email at RVP@dhcs.ca.gov.

Sincerely,

Sarah Crow, Chief
Medi-Cal Eligibility Division

Enclosures
Insert New Letter and Packet

Insert Three Notice of Action Letters

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

«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.

For the Medi-Cal Withdrawal Request Form, adults must sign their own form. For any minor children, a parent or legal guardian must sign on each minor's behalf. If you are submitting information on behalf of a minor, please also attach legal documentation to help us verify that you have decision-making authority for that individual (e.g. affidavit, authorized representative form, and other official documents.) or contact your local county office at:
www.dhcs.ca.gov/SERVICES/MEDI-CAL/Pages/CountyOffices.aspx

For more information regarding how we use and disclose any protected health information you submit to us, please visit: https://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/NoticeofPrivacyPractices.aspx

If other household members no longer intend to live in California or no longer need Medi-Cal, then each household member needs to notify their Medi-Cal eligibility worker at their local county office.

**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.

# NOTICE OF ACTION
# DISCONTINUANCE OF BENEFITS
# FAILURE TO COOPERATE

Department of Health Care Services
Residency Verification Program
P.O. Box 138017
Sacramento, CA 95813-9901

Notice Date: _____

DISCONTINUANCE OF BENEFITS NOTICE FOR:

Your Medi-Cal will end on [MM/DD/YYYY] because:

You did not confirm your California residency. You must live in California to receive Medi-Cal benefits. In order to complete our review of your Medi-Cal eligibility, we needed the following information from you:

1. Your current residence address.

We asked you for that information, but we have not received it and it is needed to process your eligibility.

You can still get Medi-Cal, but you need to give your county welfare department more information. They need it within 90 days, by (Month Day, Year). We can give you Medi-Cal from [Month Day, Year], if you are still eligible. If they do not get the information by (Month Day, Year), you must reapply for Medi-Cal. (Welfare and Institutions Code, Section 14005.37(i)).

Please note: Other family members with different eligibility status may receive a separate notice. Please call your county welfare department if you need additional information about this notice.

**DO NOT THROW AWAY YOUR BENEFITS IDENTIFICATION CARD (BIC)**
If you already have a plastic Benefits Identification Card (BIC), do not throw it away. You can use it again if you become eligible for Medi-Cal.

We did not have enough information to determine your California residency. You should call or write your county welfare department right away if you have any questions about this action or if the information in the notice is not correct. You can reapply for Medi-Cal at any time.

**RULES:** California Code of Regulations, Title 22, §50167, §50185, §50320, and §50320.1 are the regulations or laws we used to make this decision. If you think we made a mistake, you can request a hearing. The back of this page explains how to request a hearing.

## YOUR HEARING RIGHTS

**You have the right to ask for a hearing if you disagree with any county action. You have only 90 days to ask for a hearing. The 90 days started the day after the county gave or mailed you this notice. If you have good cause as to why you were not able to file for a hearing within the 90 days, you may still file for a hearing. If you provide good cause, a hearing may still be scheduled.**

**If you ask for a hearing <u>before</u> an action on Cash Aid, Medi-Cal, CalFresh, or Child Care takes place:**

- Your Cash Aid or Medi-Cal will stay the same while you wait for a hearing.
- Your Child Care Services may stay the same while you wait for a hearing.
- Your CalFresh benefits will stay the same until the hearing or the end of your certification period, whichever is earlier.

**If the hearing decision says we are right, you will owe us for any extra Cash Aid, CalFresh or Child Care Services you got.** To let us lower or stop your benefits before the hearing, check below:

Yes, lower or stop: ☐ Cash Aid ☐ CalFresh ☐ Child Care

**While You Wait for a Hearing Decision for:**

**<u>Welfare to Work</u>:**

You do not have to take part in the activities.

You may receive child care payments for employment and for activities approved by the county before this notice.

If we told you your other supportive services payments will stop, you will not get any more payments, even if you go to your activity.

If we told you we will pay your other supportive services, they will be paid in the amount and in the way we told you in this notice.

- To get those supportive services, you must go to the activity the county told you to attend.
- If the amount of supportive services the county pays while you wait for a hearing decision is not enough to allow you to participate, you can stop going to the activity.

**<u>Cal-Learn</u>:**

- You cannot participate in the Cal-Learn Program if we told you we cannot serve you.
- We will only pay for Cal-Learn supportive services for an approved activity.

### OTHER INFORMATION

**Medi-Cal Managed Care Plan Members:** The action on this notice may stop you from getting services from your managed care health plan. You may wish to contact your health plan membership services if you have questions.

**Child and/or Medical Support:** The local child support agency will help collect support at no cost even if you are not on cash aid. If they now collect support for you, they will keep doing so unless you tell them in writing to stop. They will send you current support money collected but will keep past due money collected that is owed to the county.

**Family Planning:** Your welfare office will give you information when you ask for it.

**Hearing File:** If you ask for a hearing, the State Hearing Division will set up a file. You have the right to see this file before your hearing and to get a copy of the county's written position on your case at least two days before the hearing. The state may give your hearing file to the Welfare Department and the U.S. Departments of Health and Human Services and Agriculture. **(W&I Code Sections 10850 and 10950.)**

## TO ASK FOR A HEARING:

- **Fill out this page.**
- Make a copy of the front and back of this page for your records. If you ask, your worker will get you a copy of this page.
- **Send or take this page to:**

  California Department of Social Services
  State Hearings Division, ACAB
  744 P Street, MS 9-17-97
  Sacramento, CA 95814
  **OR Fax to: 1-916-651-2789**
- **Call toll free: 1-855-795-0634 or** for hearing or speech impaired who use TDD, **1-800-952-8349.**

**To Get Help: You can ask about your hearing rights or for a legal aid referral at the toll-free state phone numbers listed above.** You may get free legal help at your local legal aid or welfare rights office.

**If you do not want to go to the hearing alone, you can bring a friend or someone with you.**

### HEARING REQUEST

I want a hearing due to an action by the Welfare Department of _____ County about my:

☐ Cash Aid ☐ CalFresh ☐ Medi-Cal

☐ Other (list)_____

**Here's Why:** _____

_____

_____

_____

_____

_____

☐ **If you need more space, check here and add a page.**

☐ I need the state to provide me with an interpreter at no cost to me. (A relative or friend cannot interpret for you at the hearing.)

My language or dialect is: _____

| NAME OF PERSON WHOSE BENEFITS WERE DENIED, CHANGED OR STOPPED | | |
|---|---|---|
| BIRTH DATE | PHONE NUMBER | |
| STREET ADDRESS | | |
| CITY | STATE | ZIP CODE |
| SIGNATURE | DATE | |
| NAME OF PERSON COMPLETING THIS FORM | PHONE NUMBER | |

☐ **I want the person named below to represent me at this hearing. I give my permission for this person to see my records or go to the hearing for me. (This person <u>can be</u> a friend or relative but cannot interpret for you.)**

| NAME | PHONE NUMBER | |
|---|---|---|
| STREET ADDRESS | | |
| CITY | STATE | ZIP CODE |

# NOTICE OF ACTION
# DISCONTINUANCE OF BENEFITS
# BENEFICIARY REQUEST FOR DISCONTINUANCE

Department of Health Care Services
Residency Verification Program
P.O. Box 138017
Sacramento, CA 95813-9901

Notice Date: _____

DISCONTINUANCE OF BENEFITS NOTICE FOR:

We asked you to confirm your California residency to continue your Medi-Cal coverage. Based on your response, your Medi-Cal will be discontinued on Month Day, Year.

The reason your benefits are stopping is:

You asked the Department of Health Care Services (DHCS) to end your Medi-Cal.

Please note: Other family members with different eligibility status may receive a separate notice. Please call your county welfare department if you need additional information about this notice.

**DO NOT THROW AWAY YOUR BENEFITS IDENTIFICATION CARD (BIC)**
If you already have a plastic Benefits Identification Card (BIC), do not throw it away. You can use it again if you become eligible for Medi-Cal.

We used the information you gave us on your recent contact with DHCS to make our decision. You should call or write your county welfare department right away if you have any questions about this action or if the information in the notice is not correct. You can reapply for Medi-Cal at any time.

**RULES:** California Code of Regulations, Title 22, §50155 is the regulation or law we used to make this decision. If you think we made a mistake, you can request a hearing. The back of this page explains how to request a hearing.

## YOUR HEARING RIGHTS

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**If you ask for a hearing <u>before</u> an action on Cash Aid, Medi-Cal, CalFresh, or Child Care takes place:**

- Your Cash Aid or Medi-Cal will stay the same while you wait for a hearing.
- Your Child Care Services may stay the same while you wait for a hearing.
- Your CalFresh benefits will stay the same until the hearing or the end of your certification period, whichever is earlier.

**If the hearing decision says we are right, you will owe us for any extra Cash Aid, CalFresh or Child Care Services you got.** To let us lower or stop your benefits before the hearing, check below:

Yes, lower or stop: ☐ Cash Aid ☐ CalFresh ☐ Child Care

**While You Wait for a Hearing Decision for:**

**<u>Welfare to Work</u>:**

You do not have to take part in the activities.

You may receive child care payments for employment and for activities approved by the county before this notice.

If we told you your other supportive services payments will stop, you will not get any more payments, even if you go to your activity.

If we told you we will pay your other supportive services, they will be paid in the amount and in the way we told you in this notice.

- To get those supportive services, you must go to the activity the county told you to attend.
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- You cannot participate in the Cal-Learn Program if we told you we cannot serve you.
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☐ Cash Aid ☐ CalFresh ☐ Medi-Cal

☐ Other (list)_____

**Here's Why:** _____

_____

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|---|---|---|
| BIRTH DATE | PHONE NUMBER | |
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| CITY | STATE | ZIP CODE |
| SIGNATURE | DATE | |
| NAME OF PERSON COMPLETING THIS FORM | PHONE NUMBER | |

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| NAME | PHONE NUMBER | |
|---|---|---|
| STREET ADDRESS | | |
| CITY | STATE | ZIP CODE |

# NOTICE OF ACTION
# DISCONTINUANCE OF BENEFITS
# NOT A CALIFORNIA RESIDENT

Department of Health Care Services
Residency Verification Program
P.O. Box 138017
Sacramento, CA 95813-9901

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Notice Date: _____

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DISCONTINUANCE OF BENEFITS NOTICE FOR:

We asked you to confirm your California residency to continue your Medi-Cal coverage. Based on your response, your Medi-Cal will be discontinued on Month Day, Year.

The reason your benefits are stopping is:

You no longer live in California. You must live in California to receive Medi-Cal benefits.

Please note: Other family members with different eligibility status may receive a separate notice. Please call your county welfare department if you need additional information about this notice.

**DO NOT THROW AWAY YOUR BENEFITS IDENTIFICATION CARD (BIC)**
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We used the information you gave us on your recent contact with DHCS to make our decision. You should call or write your county welfare department right away if you have any questions about this action or if the information in the notice is not correct. You can reapply for Medi-Cal at any time.

**RULES:** This action is required by California Code of Regulations, Title 22, §50320. If you think this action is incorrect, you can request a hearing. The back of this page explains how to request a hearing.

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- Your CalFresh benefits will stay the same until the hearing or the end of your certification period, whichever is earlier.

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  **OR Fax to: 1-916-651-2789**
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☐ Cash Aid ☐ CalFresh ☐ Medi-Cal

☐ Other (list) _____

**Here's Why:** _____

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☐ **If you need more space, check here and add a page.**

☐ I need the state to provide me with an interpreter at no cost to me. (A relative or friend cannot interpret for you at the hearing.)

My language or dialect is: _____

NAME OF PERSON WHOSE BENEFITS WERE DENIED, CHANGED OR STOPPED

BIRTH DATE | PHONE NUMBER

STREET ADDRESS

CITY | STATE | ZIP CODE

SIGNATURE | DATE

NAME OF PERSON COMPLETING THIS FORM | PHONE NUMBER

☐ **I want the person named below to represent me at this hearing. I give my permission for this person to see my records or go to the hearing for me. (This person <u>can be</u> a friend or relative but cannot interpret for you.)**

NAME | PHONE NUMBER

STREET ADDRESS

CITY | STATE | ZIP CODE