STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY GRAY DAVIS, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320
(916) 657-2941

August 07, 2001

TO: All County Welfare Directors
All County Administrative Officers
All County Medi-Cal Program Specialists/Liaisons
All County Health Executives Directors
All County Mental Health Directors

Letter No.: 01-45

CAMERA-READY COPIES OF THE REVISED TRANSITIONAL MEDI-CAL (TMC) FLYER

Ref.: All County Welfare Directors Letter (ACWDL) Nos. 98-24 and 98-56.

The purpose of this letter is to provide counties with an updated camera-ready copy of the TMC flyer.

Background

Senate Bill 391 amended the Welfare and Institutions (W&I) Code and requires the Department of Health Services (DHS) to implement certain informing provisions in the TMC program. These requirements include:

- A written TMC notice must be given to California Work Opportunity and Responsibility to Kids (CalWORKs), and Section 1931(b) recipients at the time that Medi-Cal eligibility is conferred and every six months thereafter.

- The above notice and form is to be provided to recipients when they are terminated from CalWORKs or Section 1931(b) for failure to meet reporting requirements.

Since Assembly Bill 2780 amended the W&I Code and requires the Department of Social Services (DSS) to provide information on TMC and Four-Month Continuing in all Notices of Action (NOA) messages as well as a flyer when CalWORKs recipients are terminated for any reason except for fraud, the DHS TMC notice is not required for those recipients.

Since Medi-Cal has dropped the status reporting requirements, the DHS TMC flyer is only required for CalWORKs and Section 1931(b) applicants and for Section 1931(b) recipients if they fail to return the annual redetermination.

DHS will continue to send out the flyer every six months to all CalWORKs and Section 1931(b) recipients.

REVISED FLYER

We have revised the existing TMC flyer to include information about the Four Month Continuing program and to delete the toll free telephone number. We have also redesigned the form on the back of the flyer. A camera-ready copy of this is enclosed for your information. Counties should begin using the revised form immediately.

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

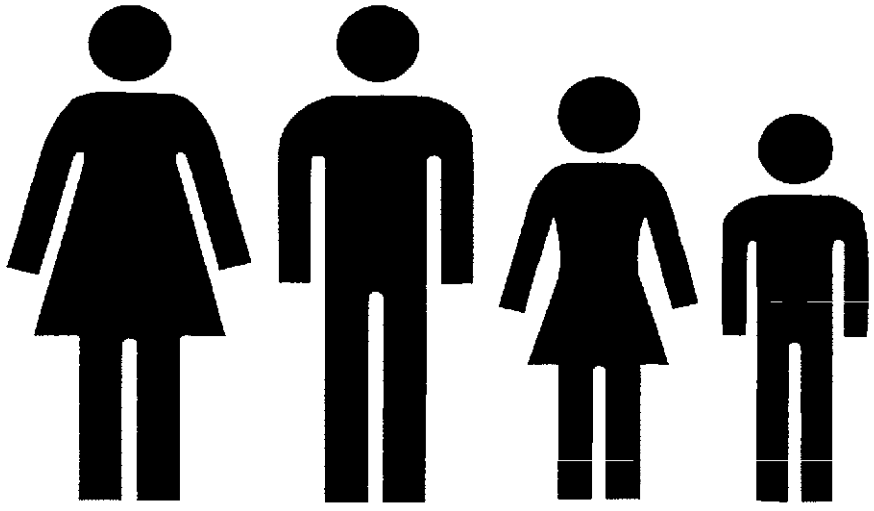
Sincerely,

ORIGINAL SIGNED BY

Shar Schroepfer, Chief
Medi-Cal Eligibility Branch

Enclosures

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.

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 សូមសាកសួរពាក្យសេចក្តីបកប្រែពីអ្នកកាន់សំណុំរឿងរបស់លោកអ្នក ។

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 ( )