DIVISION OF REHABILITATIVE PROGRAMS
P.O. Box 942883
Sacramento, CA 94283-0001

CUSTODY TO COMMUNITY TRANSITIONAL REENTRY PROGRAM
CCTRP Facility Address

DATE

Click or tap here to enter county of CCTRP facility, and Medi-Cal local county contact name.

In accordance with the Memorandum of Understanding between the California Department of Corrections and Rehabilitation (CDCR) and the California Department of Health Care Services (DHCS) attached is an Application for Health Insurance for processing.

Please mail application determinations and BIC Cards to the following Appointed Representative (AR):

Click or tap here to enter CCTRP contract staff name.
Custody to Community Transitional Reentry Program
Click or tap here to enter CCTRP contractor.
Click or tap here to enter CCTRP facility address.

PARTICIPANT NAME: Click or tap here to enter text.
PARTICIPANT CDCR NUMBER: Click or tap here to enter text.
DATE OF BIRTH: Click or tap here to enter text.
CURRENT PHASE: Click or tap here to enter text.
ANTICIPATED PHASE 3 DATE: Click or tap here to enter text.

Questions regarding the Application for Health Insurance for the above-mentioned participant may be directed to the contracted authorized representative at PHONE and/or EMAIL. The authorized representative's fax number is Click or tap here to enter text.

Thank you for your assistance.

DIVISION OF REHABILITATIVE PROGRAMS
P.O. Box 942883
Sacramento, CA 94283-0001

MALE COMMUNITY REENTRY PROGRAM
MCRP Facility Address

DATE

Click or tap here to enter county of MCRP facility, and Medi-Cal local county contact name.

In accordance with the Memorandum of Understanding between the California Department of Corrections and Rehabilitation (CDCR) and the California Department of Health Care Services (DHCS) attached is an Application for Health Insurance for processing.

Please mail application determinations and BIC Cards to the following Appointed Representative (AR):

Click or tap here to enter MCRP contract staff name.
Male Community Reentry Program
Click or tap here to enter MCRP contractor.
Click or tap here to enter MCRP facility address.

PARTICIPANT NAME: Click or tap here to enter text.
PARTICIPANT CDCR NUMBER: Click or tap here to enter text.
DATE OF BIRTH: Click or tap here to enter text.
CURRENT PHASE: Click or tap here to enter text.
ANTICIPATED PHASE 3 DATE: Click or tap here to enter text.

Questions regarding the Application for Health Insurance for the above-mentioned participant may be directed to the contracted authorized representative at PHONE and/or EMAIL. The authorized representative's fax number is Click or tap here to enter text.

Thank you for your assistance.