Medi-Cal Inmate Eligibility Program (MCIEP)
DHCS-County Transmittal Form

To:	**From:**
County: ______	**DHCS, Medi-Cal Inmate Eligibility Program**
Liaison Name: ______	Eligibility Specialist (ES): ______
Liaison Telephone: ______	ES Telephone: ______
Fax Number: ______	ES Fax: ______
E-mail: ______	ES E-mail: ______

Reason For Transmittal:

- Ex-Parte Review for Change in Circumstance
- Newborn Referral
- Other:

MCIEP Beneficiary Information:

Name:	CIN

Linkage:

ABD MAGI Pregnant Juvenile Medical Parole

Ex-Parte Review Information	**Deemed Infant Information**
Parole Date: ______	Newborn Name: ______
County Paroled To: ______	Newborn CIN: ______
Current MCIEP Aid Code: ______	**Caregiver Information** *(if available)* **:**
	Name: ______
	Address: ______
	______
	Phone Number: ______

Ex-Parte Review Documents Attached	**Newborn Referral Documents Attached**
MCIEP Information Update (Update to original application)	MC330
Single Streamlined Application	Other:
Redetermination Packet	
Last Notice of Action (NOA)	
Disability Decision Documents	
Other:	

Notes/Request:

Sample