150 South Lena Rd

San Bernardino, CA 92415

COVERED CALIFORNIA

Your destination for affordable healthcare, including Medi-Cal

XXXX
XXXX
XXXXX

Notice Date: November 03, 2014
CalHEERS Case Number: XXXXXXX

SAWS Case Number: XXXXXX

Dear XXXXXXXX,

We have reviewed your eligibility for health coverage. We used the information you gave us and state and federal data to make this decision.

XXXXXXXX

We must check if you still qualify for Medi-Cal once a year. We checked your case and you still qualify for Medi-Cal because your household income is below the Medi-Cal limit for your family size. Your Medi-Cal coverage will continue unless you are found no longer eligible. This could happen at the time your eligibility is renewed or when your circumstances change.

We counted your household size and your household income to make our decision. If the information we list for your household size or income is not correct, please contact us to report your updated information.

For Medi-Cal, your household size is 1 and your monthly household income is $500.00. The monthly Medi-Cal income limit for your household size is $1061.00. Your income is below this limit, so you qualify for Medi-Cal.

42 CFR 435.603, Cal. Welf. & Inst. Code §14005.30 authorized this decision. If you think we made a mistake, you can appeal. See "**Your Hearing Rights**" on the last page of this notice to learn how to appeal. You have only 90 days to ask for a hearing. The 90 days started the day after the date on this notice.

XXXXXXXX

We must check if you still qualify for Medi-Cal once a year. We checked your case and you still qualify for Medi-Cal because your household income is below the Medi-Cal limit for your family size. Your Medi-Cal coverage will continue unless you are found no longer eligible. This could happen at the time your eligibility is renewed or when your circumstances change.

We counted your household size and your household income to make our decision. If the information we list for your household size or income is not correct, please contact us to report your updated information.

For Medi-Cal, your household size is 3 and your monthly household income is $2500.00. The monthly Medi-Cal income limit for your household size is $4389.00. Your income is below this limit, so you qualify for Medi-Cal.

42 CFR 435.603, Cal. Welf. & Inst. Code § 14005.26 authorized this decision. If you think we made a mistake, you can appeal. See "**Your Hearing Rights**" on the last page of this notice to learn how to appeal. You have only 90 days to ask for a hearing. The 90 days started the day after the date on this notice.

Do you have any changes?

Over the next year, you are obligated to report any changes that would affect your health insurance within 10 days of such a change. You are obligated to contact us if:

- You move
- Your income changes; or
- Your household changes, for example, you marry/divorce, become pregnant, or have a child(ren)
- You become qualified for other health insurance

To report changes, please contact your county office using one of the following ways:

- Telephone: (877) 410-8829
- In person: 150 South Lena Rd San Bernardino,CA 92415
- Fax: (209) 667-0002
- Office Hours: 8:00 AM - 4:30 PM

To report changes, please contact your county office using one of the following ways:

- County Worker: Super Duper Worker
- County Worker ID: 36LS010125

If you already have a Benefits Identification Card (BIC), do not throw it away.

You should keep using that card. If you have never received a BIC, one will be mailed to you soon. If you previously received a BIC but no longer have that BIC, contact your worker for a replacement. The BIC has the information your provider needs to check your Medi-Cal eligibility. You should bring the BIC to your medical provider whenever you need care.

Questions?

If you have questions or need assistance please contact (877) 410-8829

This notice is required by the Affordable Care Act per regulation 42 C.F.R. § 431.206 and Cal. Code Regs., tit. 22, § 50179

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 before 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:

Welfare to Work:

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.

Cal-Learn

- 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 the 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.
- **1-855-795-0634 toll free, 1-800-952-8349 TDD,**

  1-916-651-2789 Fax

  Mail to:

  California Department of Social Services
  State Hearings Division, ACAB
  744 P Street, MS 9-17-97
  Sacramento, CA 95814

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**.**

Inland Counties Legal Services:
High Desert (760) 241-7073
San Bernardino Area (909) 884-8615
,
CCWRO: (916) 736-0616

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

BIRTHDATE | PHONE NUMBER

STREET ADDRESS

CITY | STATE | ZIP CODE

SIGNATURE | DATE

NAME OF PERSON COMPLETING THIS FORM | PHONE NUM

☐ **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 can be a friend or relative but cannot interpret for you.)**

NAME | PHONE NUMBER

STREET ADDRESS

CITY | STATE | ZIP CODE