TRANSMITTAL TO CDCR PUBLIC BENEFIT SPECIALIST ON DETERMINATION OF A WARD'S/INMATE'S MEDI-CAL ELIGIBILITY

Date:	**CDCR Number:**
Benefits Information for:	

ELIGIBILITY PENDING *(Note: The eligibility status information provided below is subject to change if all eligibility requirements are not met at the time the ward/inmate is released.*

☐ This ward/inmate will be eligible to receive no-cost Medi-Cal benefits beginning on the following date: _____.

☐ This ward/inmate will be eligible to receive Medi-Cal benefits with a share-of-cost beginning on the following date: _____.

☐ This ward/inmate will be eligible to receive limited Medi-Cal benefits beginning on the following date: _____.

☐ Due to a change of his or her release date, this ward/inmate will not be eligible to receive Medi-Cal on _____; instead he or she will be eligible to receive Medi-Cal benefits on the following date: _____.

ELIGIBILITY DENIED

☐ This ward's/inmate's application for Medi-Cal, dated _____, has been denied. The reason for this denial is:

INFORMATION REQUEST *(Please contact the County immediately if you have questions or concerns regarding the denial of eligibility)*

☐ In order to determine the ward's/inmate's eligibility we need the following information: