

Notice Type/ Description/ Snippet ID	Current Dynamic Snippet in CalHEERS	Planned Dynamic Snippet Change in CalHEERS	CR Where Change Shown in Column C is Expected to Occur	Updated Dynamic Snippet Language Based on May 2015 Advocate Feedback
Full Scope Approval Snippet ID: 421	<p>You qualify for Medi-Cal because your household income is below the Medi-Cal limit. You are eligible for Medi-Cal coverage in <application month>. Your Medi-Cal coverage will continue until your eligibility is reevaluated at your annual renewal, or until you report a change.</p> <p>We counted your household size and income to make our decision.</p> <p>For Medi-Cal, your household size is <MAGI_SIZE> and your monthly household income is <MAGI_INCOME>. The monthly Medi-Cal income limit for your household size is <MAGI_INCOME_LIMIT>. Your income is below this limit, so you qualify for health coverage.</p> <p><Regulation> authorized this decision. If you think we made a mistake, you can appeal. See "Your Hearing Rights" on the last page to learn how to appeal. You have only 90 days to ask for a hearing. The 90 days started the day after the county sent you this notice.</p>	<p>Good news! Your application dated <month dd, yyyy> has been approved. You qualify for Medi-Cal because your household income is below the Medi-Cal limit. Your eligibility for Medi-Cal begins <effective date- Month Day, Year>. 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 situation changes.</p> <p>We counted your household size and income to make our decision. For Medi-Cal, your household size is <MAGI_SIZE> and your monthly household income is <MAGI_INCOME>. The monthly Medi-Cal income limit for your household size is <MAGI_INCOME_LIMIT>. Your income is below this limit, so you qualify for Medi-Cal.</p> <p><Regulation> 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.</p>	15.7 (CR 32297)	<p>Good news! Your application *for health coverage* dated <month dd, yyyy> has been approved. You qualify for Medi-Cal because your household income is below the Medi-Cal limit. Your eligibility for Medi-Cal begins <effective date- Month Day, Year>. 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 situation changes.</p> <p>We counted your household size and income to make our decision. For Medi-Cal, your household size is <MAGI_SIZE> and your monthly household income is <MAGI_INCOME>. The monthly Medi-Cal income limit for your household size is <MAGI_INCOME_LIMIT>. Your income is below this limit, so you qualify for Medi-Cal.</p> <p><Regulation> *is the regulation or law we relied on for 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.</p>

<p>Full Scope Approval for Retro Month</p> <p>Snippet ID: 190</p>	<p>N/A</p>	<p>Good news! We evaluated your request for Medi-Cal for the month of <eligibility month year>. You qualify for Medi-Cal in <eligibility month year> because your household income is below the Medi-Cal limit. This notice is only related to your request for eligibility for this month. This notice does not affect your application for current and continuing Medi-Cal.</p> <p>We counted your household size and income to make our decision.</p> <p>For Medi-Cal, your household size is <MAGI_SIZE> and your monthly household income is <MAGI_INCOME>. The monthly Medi-Cal income limit for your household size is <MAGI_INCOME_LIMIT>. Your income is below this limit, so you qualify for Medi-Cal.</p> <p><Regulation> authorized this decision. If you think we made a mistake, you can appeal. See "Your Hearing Rights" on the last page to learn how to appeal. You have only 90 days to ask for a hearing. The 90 days started the day after the county sent you this notice.</p>	<p>15.7 (CR 32297)</p>	<p>Good news! We evaluated your request for *retroactive* Medi-Cal *for a month prior to your application month of [application month year]—for the month of <eligibility month-year>.* You qualify for Medi-Cal in <eligibility month year> because your household income is below the Medi-Cal limit. *This notice is only related to your request for eligibility for this month.* This notice does not affect your application for current and continuing Medi-Cal. *It only covers the time before your application was submitted. You will receive a separate notice about your eligibility for other retroactive months that you requested and for current and continuing Medi-Cal.*</p> <p>We counted your household size and income to make our decision.</p> <p>For Medi-Cal, your household size is <MAGI_SIZE> and your monthly household income is <MAGI_INCOME>. The monthly Medi-Cal income limit for your household size is <MAGI_INCOME_LIMIT>. Your income is below this limit, so you qualify for Medi-Cal.</p> <p><Regulation> *is the regulation or law we relied on for-authorized* this decision. If you think we made a mistake, you can appeal. See "Your Hearing Rights" on the last page to learn how to appeal. You have only 90 days to ask for a hearing. The 90 days started the day after the county sent you this notice.</p>
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Full Scope Approval at Annual Renewal Snippet ID: 350	<p>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.</p> <p>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.</p> <p>For Medi-Cal, your household size is <household size> and your monthly household income is <modified adjusted gross income>. The monthly Medi-Cal income limit for your household size is <MAGI limit>. Your income is below this limit, so you qualify for Medi-Cal.</p> <p><Regulation> 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.</p>		No Planned Changes	
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<p>Full Scope Approval with a Premium (OTLICP)</p> <p>Snippet ID: N/A</p>	<p>N/A</p>	<p>Your application dated <month dd, yyyy> has been approved. You qualify for Medi-Cal because your household income is below the Medi-Cal limit. You are eligible for Medi-Cal coverage in <eligibility month, yyyy>. 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 situation changes.</p> <p>We counted your household size and income to make our decision.</p> <p>For Medi-Cal, your household size is <household size> and your monthly household income is <modified adjusted gross income>. The monthly Medi-Cal income limit for your household size is <MAGI limit>. Your income is below this limit, so you qualify for Medi-Cal.</p> <p>Your household size and income requires that you pay a monthly premium to remain eligible for Medi-Cal.</p> <p>You will receive a separate billing statement from the Medi-Cal Premium Payment Section. It will tell you the monthly premium amount you must pay and your payment options. Monthly premiums are from \$13 up to \$39 per family. Please allow up to 60 days to receive this information.</p> <p>Your first premium payment is not due until you receive the first billing statement. You must pay the monthly premium to maintain your eligibility for this program. Until you receive this information, if you have questions on your premium, you can</p>	<p>16.6 (CR 32299)</p>	<p>Your application *for health coverage* dated <month dd, yyyy> has been approved. You qualify for Medi-Cal because your household income is below the Medi-Cal limit. You are eligible for Medi-Cal coverage in <eligibility month, yyyy>. 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 situation changes.</p> <p>We counted your household size and income to make our decision.</p> <p>For Medi-Cal, your household size is <household size> and your monthly household income is <modified adjusted gross income>. The monthly Medi-Cal income limit for your household size is <MAGI limit>. Your income is below this limit, so you qualify for Medi-Cal.</p> <p>Your household size and income requires that you pay a monthly premium to remain eligible for Medi-Cal.</p> <p>You will receive a separate billing statement from the Medi-Cal Premium Payment Section. It will tell you the monthly premium amount you must pay and your payment options. Monthly premiums are from \$13 up to \$39 per family. Please allow up to 60 days to receive this information.</p> <p>Your first premium payment is not due until you receive the first billing statement. You must pay the monthly premium to maintain your eligibility for this program. Until you receive this information, if you have questions on your premium, you can visit: http://www.dhcs.ca.gov/services/Pages/Medi-CalPremiumPayments.aspx</p> <p><Regulation> *is the regulation or law we relied on for-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.</p>
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visit:

<http://www.dhcs.ca.gov/services/Pages/Medi-CalPremiumPayments.aspx>

<Regulation> 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.

<p>Limited Scope Approval</p> <p>Snippet ID: 422</p>	<p>You qualify for limited-scope Medi-Cal because you are pregnant and your household income is below the Medi-Cal limit. You are eligible for Medi-Cal coverage in <application month>. Your Medi-Cal coverage will continue until your eligibility is reevaluated at your annual renewal or until you report a change.</p> <p>Limited-scope Medi-Cal only covers pregnancy-related services. This includes prenatal care, services for pregnancy complications, labor, delivery, postpartum care, and family planning.</p> <p>We counted your household size and income to make our decision.</p> <p>For Medi-Cal, your household size is <household size> and your monthly household income is <modified adjusted gross income>. The monthly Medi-Cal income limit for your household size is <MAGI limit>. Your income is below this limit, so you qualify for health coverage.</p> <p><Regulation> authorized this decision. If you think we made a mistake, you can appeal. See "Your Hearing Rights" on the last page to learn how to appeal. You have only 90 days to ask for a hearing. The 90 days started the day after the county sent you this notice.</p>	<p>Your application dated <month dd, yyyy> has been approved. You qualify for pregnancy related Medi-Cal because you are pregnant and your household income is below the Medi-Cal limit. Your eligibility for pregnancy related Medi-Cal begins <effective date- Month Day, Year>. 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 situation changes.</p> <p>Pregnancy related Medi-Cal covers pregnancy-related services such as prenatal care, labor, delivery, postpartum care, family planning, emergency care, some dental services, and any medical condition that can affect your health during your pregnancy or the health of your unborn child.</p> <p>We counted your household size and income to make our decision.</p> <p>For Medi-Cal, your household size is <household size> and your monthly household income is <modified adjusted gross income>. The monthly Medi-Cal income limit for your household size is <MAGI limit>. Your income is below this limit, so you qualify for Medi-Cal.</p> <p><Regulation> 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.</p>	<p>15.7 (CR 32297)</p>	<p>Your application *for health coverage* dated <month dd, yyyy> has been approved. You qualify for pregnancy related Medi-Cal because you are pregnant and your household income is below the Medi-Cal limit. Your eligibility for pregnancy related Medi-Cal begins <effective date- Month Day, Year>. Your *pregnancy related* 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 situation changes.</p> <p>Pregnancy related Medi-Cal covers *only* pregnancy-related services such as prenatal care, labor, delivery, postpartum care, family planning, emergency care, some dental services, and any medical condition that can affect your health during your pregnancy or the health of your unborn child.</p> <p>We counted your household size and income to make our decision.</p> <p>For Medi-Cal, your household size is <household size> and your monthly household income is <modified adjusted gross income>. The monthly Medi-Cal income limit for your household size is <MAGI limit>. Your income is below this limit, so you qualify for Medi-Cal.</p> <p><Regulation> *is the regulation or law we relied on for-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.</p>
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<p>Limited Scope Approval for a Retro Month</p> <p>Snippet ID: 189</p>	<p>N/A</p>	<p>We evaluated your request for Medi-Cal for the month of <eligibility month year>. You qualify for pregnancy related Medi-Cal in <eligibility month year> because you are pregnant and your household income is below the Medi-Cal limit. This notice is only related to your request for eligibility for this month. This notice does not affect your application for current and continuing Medi-Cal.</p> <p>Pregnancy related Medi-Cal covers pregnancy-related services such as prenatal care, labor, delivery, postpartum care, family planning, emergency care, some dental services, and any medical condition that can affect your health during your pregnancy or the health of your unborn child.</p> <p>We counted your household size and income to make our decision.</p> <p>For Medi-Cal, your household size is <household size> and your monthly household income is <modified adjusted gross income>. The monthly Medi-Cal income limit for your household size is <MAGI limit>. Your income is below this limit, so you qualify for Medi-Cal.</p> <p><Regulation> authorized this decision. If you think we made a mistake, you can appeal. See "Your Hearing Rights" on the last page to learn how to appeal. You have only 90 days to ask for a hearing. The 90 days started the day after the county sent you this notice.</p>	<p>15.7 (CR 32297)</p>	<p>We evaluated your request for *retroactive* Medi-Cal *for a month prior to your application month of [application month year]*the month of <eligibility month year>. You qualify for pregnancy related Medi-Cal in <eligibility month year> because you pregnant and your household income is below the Medi-Cal limit. This notice is only related to your request for eligibility for this month. This notice does not affect your application for current and continuing Medi-Cal. *It only covers the time before application was submitted. You will receive a separate notice about your eligibility for other retroactive months that you requested and for current and continuing Medi-Cal.</p> <p>Pregnancy related Medi-Cal covers *only* pregnancy-related services such as prenatal care, labor, delivery, postpartum care, family planning, emergency care, some dental services, and any medical condition that can affect your health during your pregnancy or the health of your unborn child.</p> <p>We counted your household size and income to make our decision.</p> <p>For Medi-Cal, your household size is <household size> and your monthly household income is <modified adjusted gross income>. The monthly Medi-Cal income limit for your household size is <MAGI limit>. Your income is below this limit, so you qualify for Medi-Cal.</p> <p><Regulation> *is the regulation or law we relied on forauthorized* this decision. If you think we made a mistake, you can appeal. See "Your Hearing Rights" on the last page to learn how to appeal. You have only 90 days to ask for a hearing. The 90 days started the day after the county sent you this notice.</p>
<p>Restricted Scope Approval</p> <p>Snippet ID: 423</p>	<p>You qualify for restricted-scope Medi-Cal because your household income is below the Medi-Cal limit. You are eligible for Medi-Cal coverage in <application month>. Your Medi-Cal coverage will continue until your eligibility is reevaluated at your annual renewal, or until you report a change.</p>	<p>Your application dated <month dd, yyyy> has been approved. You qualify for restricted-scope Medi-Cal because you did not provide written proof of your U.S. Citizenship or satisfactory immigration status for Medi-Cal purposes.</p> <p>Your eligibility for restricted-scope Medi-Cal begins <effective date- Month Day, Year>. Your Medi-Cal coverage will continue unless you are found no longer eligible. This could happen at the</p>	<p>15.7 (CR 32297)</p>	<p>Your application dated <month dd, yyyy> has been approved. You qualify for *only restricted-scope Medi-Cal because you did not provide written proof of your U.S. Citizenship or satisfactory immigration status for Medi-Cal purposes. *Restricted-scope Medical only covers emergency services, pregnancy related services such as prenatal care, labor, delivery, postpartum care, and long-term care service. If you are not sure if a service is covered, ask your medical provider. *</p> <p>Your eligibility for restricted-scope Medi-Cal begins <effective date- Month Day, Year>.</p>

<p>Restricted Scope Approval (Age 6 - 19) Snippet ID: 424</p>	<p>You qualify for restricted-scope Medi-Cal because you are a child aged 6-19 and your household income is below the Medi-Cal limit. You are eligible for Medi-Cal coverage in <application month>. Your Medi-Cal coverage will continue until your eligibility is reevaluated at your annual renewal, or until you report a change.</p>	<p>unless you are found no longer eligible. This could happen at the time your eligibility is renewed or when your situation changes.</p> <p>If you have written proof of your immigration status that you can give us now, or want to let us know you are having problems getting your document, please call your county worker at the number listed on this notice. Your benefits may change from restricted-scope to full-scope when you provide us with your documents.</p>		<p>Your eligibility for restricted scope Medi Cal begins effective date Month Day, Year . 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 situation changes.</p> <p>If you have written proof of your immigration status that you can give us now, or want to let us know you are having problems getting your document, please call your county worker at the number listed on this notice. Your benefits may change from restricted-scope to full-scope when you provide us with your documents. *Full scope benefits allow you to see a doctor for all of your medical needs. *</p> <p>*Restricted scope Medi-Cal only covers emergency, pregnancy related, and long term care services. If you are not sure if a service is covered, ask your medical provider.*</p> <p>We counted your household size and income to make our decision.</p> <p>For Medi-Cal, your household size is <household size> and your monthly household income is <modified adjusted gross income>. The monthly Medi-Cal income limit for your household size is <MAGI limit>. Your income is below this limit, so you qualify for Medi-Cal.</p> <p>*If you have written proof of your immigration status that you have not sent us, it's not too late. If you can show us proof, you might be eligible for full scope Medi-Cal coverage.*</p> <p><Regulation> *is the regulation or law we relied on forauthorized* 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.</p>
<p>Restricted Scope Approval (Age 1 - 6) Snippet ID: 425</p>	<p>You qualify for restricted-scope Medi-Cal because you are a child aged 1-6 and your household income is below the Medi-Cal limit. You are eligible for Medi-Cal coverage in <application month>. Your Medi-Cal coverage will continue until your eligibility is reevaluated at your annual renewal, or until you report a change.</p>	<p>(Snippets 423, 424, 425 and 426 will all read the same as of 15.7 regardless of age) *</p>		
<p>Restricted Scope Approval (Up to 1 Year) Snippet ID: 426</p>	<p>You qualify for restricted-scope Medi-Cal because you are an infant up to 1 year old and your household income is below the Medi-Cal limit. You are eligible for Medi-Cal coverage in <application month>. Your Medi-Cal coverage will continue until your eligibility is reevaluated at your annual renewal, or until you report a change.</p>			

<p>Restricted Scope Approval for Retro Month</p> <p>Snippet ID: 209, 213, 207 and 206</p>	<p>N/A</p>	<p>We evaluated your request for Medi-Cal for the month of <eligibility month year>. You qualify for restricted-scope Medi-Cal in <eligibility month year> because you did not provide written proof of your U.S. Citizenship or satisfactory immigration status for Medi-Cal purposes. This notice is only related to your request for eligibility for this month. This notice does not affect your application for current and continuing Medi-Cal.</p> <p>If you have written proof of your immigration status that you can give us now, or want to let us know you are having problems getting your document, please call your county worker at the number listed on this notice. Your benefits may change from restricted-scope to full-scope when you provide us with your documents.</p>	<p>15.7 (CR 32297)</p>	<p>We evaluated your request for *retroactive Medi-Cal *for a month prior to your application month of [application month year].-for the month of <eligibility month year>. You qualify for restricted-scope Medi-Cal in <eligibility month year> because you did not provide written proof of your U.S. Citizenship or satisfactory immigration status for Medi-Cal purposes. *Restricted-scope Medical only covers emergency services, pregnancy related services such as prenatal care, labor, delivery, postpartum care, and long-term care service. If you are not sure if a service is covered, ask your medical provider.*</p> <p>*This notice is only related to your request for eligibility for this month.* This notice does not affect your application for current and continuing Medi-Cal. *It only covers the time before your application was submitted. You will receive a separate notice about your eligibility for other retroactive months that you requested and for current and continuing Medi-Cal. *</p> <p>If you have written proof of your immigration status that you can give us now, or want to let us know you are having problems getting your document, please call your county worker at the number listed on this notice. Your benefits may change from restricted-scope to full-scope when you provide us with your documents. *Full scope benefits allow you to see a doctor for all of your medical needs. *</p> <p>We counted your household size and income to make our decision.</p> <p>For Medi-Cal, your household size is <household size> and your monthly household income is <modified adjusted gross income>. The monthly Medi-Cal income limit for your household size is <MAGI limit>. Your income is below this limit, so you qualify for Medi-Cal.</p> <p>*If you have written proof of your immigration status that you have not sent us, it's not too late. If you can show us proof, you might be eligible for full scope Medi-Cal coverage*.</p> <p><Regulation> *is the regulation or law we relied on for-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.</p>
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<p>Restricted Scope Approval (Footer)</p> <p>Snippet ID: 278</p>	<p>Restricted-scope Medi-Cal only covers emergency, pregnancy related, and long-term care services. If you are not sure if a service is covered, ask your medical provider.</p> <p>We counted your household size and income to make our decision.</p> <p>For Medi-Cal, your household size is <household size> and your monthly household income is <modified adjusted gross income>. The monthly Medi-Cal income limit for your household size is <MAGI limit>. Your income is below this limit, so you qualify for health coverage.</p> <p><Regulation> authorized this decision. If you think we made a mistake, you can appeal. See "Your Hearing Rights" on the last page to learn how to appeal. You have only 90 days to ask for a hearing. The 90 days started the day after the county sent you this notice.</p>	<p>Restricted-scope Medi-Cal only covers emergency, pregnancy related, and long-term care services. If you are not sure if a service is covered, ask your medical provider.</p> <p>We counted your household size and income to make our decision.</p> <p>For Medi-Cal, your household size is <household size> and your monthly household income is <modified adjusted gross income>. The monthly Medi-Cal income limit for your household size is <MAGI limit>. Your income is below this limit, so you qualify for Medi-Cal.</p> <p>If you have written proof of your immigration status that you have not sent us, it's not too late. If you can show us proof, you might be eligible for full-scope Medi-Cal coverage.</p> <p><Regulation> 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.</p>	<p>16.6 (CR 32299)</p>	<p>*(Updated Languaged as requested by advocates has been moved into restricted scope approval snippets that are shown in this column above) *</p>
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<p>Restricted Scope Approval with a Premium (OTLICP)</p> <p>Snippet ID: N/A</p>	<p>N/A</p>	<p>Your application dated <month dd, yyyy> has been approved. You qualify for restricted-scope Medi-Cal because you did not provide written proof of your U.S. citizenship or satisfactory immigration status for Medi-Cal purposes.</p> <p>If you have written proof of your immigration status that you can give us now, or want to let us know you are having problems getting your document, please call your county worker at the number listed on this notice. Your benefits may change from restricted-scope to full-scope when you send us your documents.</p> <p>You are eligible for Medi-Cal coverage in <eligibility month, yyyy>. 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 situation changes.</p> <p>Restricted-scope Medi-Cal only covers emergency, pregnancy related, and long-term care services. If you are not sure if a service is covered, ask your medical provider.</p> <p>We counted your household size and income to make our decision.</p> <p>For Medi-Cal, your household size is <household size> and your monthly household income is <modified adjusted gross income>. The monthly Medi-Cal income limit for your household size is <MAGI limit>. Your income is below this limit, so you qualify for Medi-Cal.</p> <p>Your household size and income requires that you pay a monthly</p>	<p>16.6 (CR 32299)</p>	<p>Your application *for health coverage* dated <month dd, yyyy> has been approved. You qualify for *only* restricted-scope Medi-Cal because you did not provide written proof of your U.S. citizenship or satisfactory immigration status for Medi-Cal purposes. *Restricted-scope Medical only covers emergency services, pregnancy related services such as prenatal care, labor, delivery, postpartum care, and long-term care service. If you are not sure if a service is covered, ask your medical provider.*</p> <p>If you have written proof of your immigration status that you can give us now, or want to let us know you are having problems getting your document, please call your county worker at the number listed on this notice. Your benefits may change from restricted-scope to full-scope when you send us your documents. *Full scope benefits allow you to see a doctor for all of your medical needs.*</p> <p>You are eligible for Medi-Cal coverage in <eligibility month, yyyy>. 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 situation changes.</p> <p>*Restricted-scope Medi-Cal only covers emergency, pregnancy related, and long-term care services. If you are not sure if a service is covered, ask your medical provider.*</p> <p>We counted your household size and income to make our decision.</p> <p>For Medi-Cal, your household size is <household size> and your monthly household income is <modified adjusted gross income>. The monthly Medi-Cal income limit for your household size is <MAGI limit>. Your income is below this limit, so you qualify for Medi-Cal.</p> <p>Your household size and income requires that you pay a monthly premium to remain eligible for Medi-Cal.</p>
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premium to remain eligible for Medi-Cal.

You will receive a separate billing statement from the Medi-Cal Premium Payment Section. It will tell you the monthly premium amount you must pay and your payment options. Monthly premiums are from \$13 up to \$39 per family. Please allow up to 60 days to receive this information.

Your first premium payment is not due until you receive the first billing statement. You must pay the monthly premium to maintain eligibility for this program. Until you receive this information, if you have questions on your premium, you can visit:

<http://www.dhcs.ca.gov/services/Pages/Medi-CalPremiumPayments.aspx>

If you have written proof of your immigration status that you have not sent us, it's not too late. If you can show us proof, you might be eligible for full-scope Medi-Cal coverage.

<Regulation> 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.

You will receive a separate billing statement from the Medi-Cal Premium Payment Section. It will tell you the monthly premium amount you must pay and your payment options. Monthly premiums are from \$13 up to \$39 per family. Please allow up to 60 days to receive this information.

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~~*If you have written proof of your immigration status that you have not sent us, it's not too late. If you can show us proof, you might be eligible for full-scope Medi-Cal coverage.*~~

<Regulation> ~~is the regulation or law we relied on for~~ ~~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.

<p>Accelerated Enrollment</p> <p>Snippet ID: 210</p>	<p>Good news! You qualify for Medi-Cal for now. If you don't have a California Benefits Identification Card (BIC), we will send one in the mail. You can use your BIC to get medical services as soon as you get it. You qualify for Medi-Cal until we make our final decision.</p> <p>We need more information to make our final decision. Fill out and sign the form that came with this letter.</p> <p><Regulation> authorized this decision. If you think we made a mistake, you can appeal. See "Your Hearing Rights" on the last page to learn how to appeal. You have only 90 days to ask for a hearing. The 90 days started the day after the county sent you this notice.</p>	<p>Good News! You qualify for Medi-Cal for now, while we are processing your application. If you don't have a California Benefits Identification Card (BIC), we will send one in the mail. You can use your BIC to get medical services from a Medi-Cal provider as soon as you get the card.</p> <p>When we make our final decision, you may still qualify for Medi-Cal, or your circumstances may have changed and you may no longer qualify for Medi-Cal. We will send you a letter to let you know whether you qualify for Medi-Cal or another health program. If you do not qualify for Medi-Cal after our review, you will not need to pay back the costs of any services you got from a Medi-Cal provider during this period.</p> <p>We may need more information to make our final decision. Your county social services office may contact you to get this information. It is important you provide any information that is requested otherwise you may risk losing your Medi-Cal coverage.</p>	<p>16.6 (CR 32307)</p>	<p>Good News! You qualify for Medi-Cal for now, while we are processing your application. If you don't have a California Benefits Identification Card (BIC), we will send one in the mail. You can use your BIC to get medical services from a Medi-Cal provider as soon as you get the card.</p> <p>When we make our final decision, you may still qualify for Medi-Cal, or your circumstances may have changed and you may no longer qualify for Medi-Cal. We will send you a letter to let you know whether you *still* qualify for Medi-Cal or another health program. If you do not qualify for Medi-Cal after our review, *we will send you another letter and your Medi-Cal benefits will stop. Yy*ou will not need to pay back the costs of any services you got from a Medi-Cal provider during this period.</p> <p>*We may If we* need more information to make our final decision*,. Yy*our county social services office *will may* contact you to get this information. It is important you provide any information that is requested otherwise you may risk losing your Medi-Cal coverage.</p>
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<p>Change in Benefits: Full to Restricted</p> <p>Snippet ID: 205</p>	<p>Your Medi-Cal changed to restricted-scope on <date>.</p> <p>Restricted-scope Medi-Cal only covers emergency, pregnancy-related and long-term care services. If you are not sure if a service is covered, call your medical provider.</p> <p>Your Medi-Cal is changing from full to restricted because you did not give us acceptable proof of citizenship/immigration status or identity. And you stopped making a good faith effort to give us your proof. If you give us acceptable proof within one year, your Medi-Cal will change from restricted back to full Medi-Cal starting the month your restricted benefits began.</p> <p>If your Medi-Cal changes to full-scope in the future, and you paid for medical care that was not covered while you were getting restricted Medi-Cal, you may be able to ask for a reimbursement. This means you may get back the money you paid for the service. If you have questions about reimbursement, call 1-916-403-2007.</p> <p><Regulation> authorized this decision. If you think we made a mistake, you can appeal. See "Your Hearing Rights" on the last page to learn how to appeal. You have only 90 days to ask for a hearing. The 90 days started the day after the county sent you this notice.</p>	<p>Your Medi-Cal changed to restricted-scope on <month 01, yyyy>.</p> <p>Restricted-scope Medi-Cal only covers emergency, pregnancy-related and long-term care services. If you are not sure if a service is covered, call your medical provider.</p> <p>Your Medi-Cal is changing from full to restricted because you did not provide written proof of your U.S citizenship or satisfactory immigration status for Medi-Cal purposes. You have not contacted us to let us know that you are trying to provide proof.</p> <p>If you have written proof of your immigration status that you can give us now, or want to let us know you are having problems getting your document, please call your county worker at the number listed on this notice. Your benefits may change from restricted-scope to full-scope when you send us your documents.</p> <p>If you give us acceptable proof within one year, your Medi-Cal may change back to full-scope Medi-Cal starting the month your restricted benefits began.</p> <p>In the meantime, 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 situation changes.</p> <p><Regulation> 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.</p>	<p>16.6 (CR 33932)</p>	<p>*Important change to your benefits.* Your Medi-Cal changed to restricted-scope on <month 01, yyyy>. Restricted-scope Medi-Cal only covers emergency *services, pregnancy-related *services such as prenatal care, labor, delivery, postpartum care, and long-term care services. If you are not sure if a service is covered, call your medical provider.</p> <p>Your Medi-Cal is changing from full to restricted because you did not provide written proof of your U.S citizenship or satisfactory immigration status for Medi-Cal purposes. You have not contacted us to let us know that you are trying to provide proof.</p> <p>If you have written proof of your immigration status that you can give us now, or want to let us know you are having problems getting your document, please call your county worker at the number listed on this notice. Your benefits may change from restricted-scope to full-scope when you send us your documents. *Full scope benefits allow you to see a doctor for all of your medical needs.*</p> <p>If you give us acceptable proof within one year, your Medi-Cal may change back to full-scope Medi-Cal starting the month your restricted benefits began.</p> <p>In the meantime, 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 situation changes.</p> <p><Regulation> *is the regulation or law we relied on for-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.</p>
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<p>Change in Benefits: Restricted to Full</p> <p>Snippet ID: N/A</p>	<p>N/A</p>	<p>Good news! Your Medi-Cal changed to full-scope on <month dd, yyyy>.</p> <p>Your Medi-Cal is changing from restricted-scope to full-scope because you were able to prove your U.S. citizenship or satisfactory immigration status. 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 situation changes.</p> <p>If Your eligibility for full-scope Medi-Cal benefits may be effective for past months. If you paid for medical care that was not an emergency, pregnancy-related, or long-term care service while you had restricted Medi-Cal benefits, you may be able to get your money back. Call Beneficiary Services at the Department of Health Care Services for answers to your reimbursement questions at 1-916-403-2007.</p> <p><Regulation> 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.</p>	<p>16.6 (CR 33932)</p>	<p>Good news! Your Medi-Cal changed to full-scope on <month dd, yyyy>.</p> <p>Your Medi-Cal is changing from restricted-scope to full-scope because you were able to prove your U.S. citizenship or satisfactory immigration status. 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 situation changes.</p> <p>Your eligibility for full-scope Medi-Cal benefits may be effective for past months. If you paid for medical care that was not an emergency, pregnancy-related, or long-term care service while you had restricted Medi-Cal benefits, you may be able to get your money back. Call Beneficiary Services at the Department of Health Care Services for answers to your reimbursement questions at 1-916-403-2007.</p> <p><Regulation> *is the regulation or law we relied on for-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.</p>
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<p>Change in Benefits: Full to Limited</p> <p>Snippet ID: N/A</p>	<p>N/A</p>	<p>Your Medi-Cal will change from full-scope coverage to pregnancy related Medi-Cal on <month 01, yyyy> because your income and/or household size changed. Your pregnancy related 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 situation changes.</p> <p>Pregnancy related Medi-Cal covers pregnancy-related services such as prenatal care, labor, delivery, postpartum care, family planning, emergency care, some dental services, and any medical condition that can affect your health during your pregnancy or the health of your unborn child.</p> <p>We counted your household size and income to make our decision.</p> <p>For Medi-Cal, your household size is <household size> and your household income is <modified adjusted gross income>. The Medi-Cal income limit for your household size is <MAGI limit>. Your income is below this limit, so you qualify for pregnancy related Medi-Cal.</p> <p>If you have questions or think we made a mistake, call or write to your county eligibility worker right away.</p> <p>Because you are eligible for pregnancy related Medi-Cal, you may also be able to enroll in a Covered California health plan. For more information contact your county eligibility worker at the number listed on this notice or call 1-800-300-1506.</p>	<p>16.6 (CR 33932)</p>	<p>*Important change to your benefits*. Your Medi-Cal will change from full-scope coverage to pregnancy related Medi-Cal on <month 01, yyyy> because your income and/or household size changed. Your pregnancy related 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 situation changes.</p> <p>Pregnancy related Medi-Cal covers *only* pregnancy-related services such as prenatal care, labor, delivery, postpartum care, family planning, emergency care, some dental services, and any medical condition that can affect your health during your pregnancy or the health of your unborn child.</p> <p>We counted your household size and income to make our decision.</p> <p>For Medi-Cal, your household size is <household size> and your household income is <modified adjusted gross income>. The Medi-Cal income limit for your household size is <MAGI limit>. Your income is below this limit, so you qualify for pregnancy related Medi-Cal.</p> <p>If you have questions or think we made a mistake, call or write to your county eligibility worker right away.</p> <p>Because you are eligible for pregnancy related Medi-Cal, you may also be able to enroll in a Covered California health plan. For more information contact your county eligibility worker at the number listed on this notice or call 1-800-300-1506.</p> <p><Regulation> *is the regulation or law we relied on for-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.</p>
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<p>Change in Benefits: Limited to Full</p> <p>Snippet ID: N/A</p>	<p>N/A</p>	<p>Good news! Your Medi-Cal is changing to full-scope on <month 01, yyyy> because your income and/or household size changed. 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 situation changes.</p> <p>We counted your household size and income to make our decision.</p> <p>For Medi-Cal, your household size is <household size> and your household income is <modified adjusted gross income>. The Medi-Cal income limit for your household size is <MAGI limit>. Your income is below this limit, so you qualify for full-scope Medi-Cal.</p> <p><Regulation> 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.</p>	<p>16.6 (CR 33932)</p>	<p>Good news! Your Medi-Cal is changing to full-scope on <month 01, yyyy> because your income and/or household size changed. 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 situation changes.</p> <p>We counted your household size and income to make our decision.</p> <p>For Medi-Cal, your household size is <household size> and your household income is <modified adjusted gross income>. The Medi-Cal income limit for your household size is <MAGI limit>. Your income is below this limit, so you qualify for full-scope Medi-Cal.</p> <p><Regulation> *is the regulation or law we relied on for-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.</p>

<p>Change in Benefits: Premium to No Premium</p> <p>Snippet ID: N/A</p>	<p>N/A</p>	<p>Good news! You will no longer have to pay a premium for Medi-Cal because your income and/or household size changed. 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 situation changes.</p> <p>We counted your household size and income to make our decision.</p> <p>For Medi-Cal, your household size is <household size> and your household income is <modified adjusted gross income>. The Medi-Cal income limit for your household size is <MAGI limit>. Your income is below this limit, so you qualify for Medi-Cal without a premium.</p> <p><Regulation> 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.</p>	<p>16.6 (CR 33932)</p>	<p>Good news! You will no longer have to pay a premium for Medi-Cal because your income and/or household size changed. 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 situation changes.</p> <p>We counted your household size and income to make our decision.</p> <p>For Medi-Cal, your household size is <household size> and your household income is <modified adjusted gross income>. The Medi-Cal income limit for your household size is <MAGI limit>. Your income is below this limit, so you qualify for Medi-Cal without a premium.</p> <p><Regulation> *is the regulation or law we relied on for 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.</p>
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<p>Change in Benefits: No Premium to Premium</p> <p>Snippet ID: N/A</p>	<p>N/A</p>	<p>Your Medi-Cal is changing to Medi-Cal with a premium on <month 01, yyyy> because your income and/or household size changed. 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 situation changes.</p> <p>We counted your household size and income to make our decision.</p> <p>For Medi-Cal, your household size is <household size> and your monthly household income is <modified adjusted gross income>. The monthly Medi-Cal income limit for your household size is <MAGI limit>. Your income is below this limit, so you qualify for Medi-Cal.</p> <p>Your household size and income requires that you pay a You must pay a monthly premium to remain eligible for Medi-Cal.</p> <p>You will receive a separate billing statement from the Medi-Cal Premium Payment Section. It will tell you the monthly premium amount you must pay and your payment options. Monthly premiums are from \$13 up to \$39 per family. Please allow up to 60 days to receive this information.</p> <p>Your first premium payment is not due until you receive the first billing statement. You must pay the monthly premium to be eligible for this program. Until you receive this information, if</p>	<p>16.6 (CR 33932)</p>	<p>*Important change to your benefits.* Your Medi-Cal is changing to Medi-Cal with a premium on <month 01, yyyy> because your income and/or household size changed. *That means you have to pay a small fee each month to keep your Medi-Cal.* Your Medi-Cal coverage will continue unless you are found no longer eligible *or stop paying your premium.* This could happen at the time your eligibility is renewed or when your situation changes.</p> <p>We counted your household size and income to make our decision.</p> <p>For Medi-Cal, your household size is <household size> and your monthly household income is <modified adjusted gross income>. The monthly Medi-Cal income limit for your household size is <MAGI limit>. Your income is below this limit, so you qualify for Medi-Cal.</p> <p>Your household size and income requires that you pay a You must pay a monthly premium to remain eligible for Medi-Cal.</p> <p>You will receive a separate billing statement from the Medi-Cal Premium Payment Section. It will tell you the monthly premium amount you must pay and your payment options. Monthly premiums are from \$13 up to \$39 per family. Please allow up to 60 days to receive this information.</p> <p>Your first premium payment is not due until you receive the first billing statement. You must pay the monthly premium to be eligible for this program. Until you receive this information, if you have questions on your premium, you can visit: http://www.dhcs.ca.gov/services/Pages/Medi-CalPremiumPayments.aspx</p>
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		<p>you have questions on your premium, you can visit: http://www.dhcs.ca.gov/services/Pages/Medi-CalPremiumPayments.aspx</p> <p><Regulation> 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.</p>		<p><Regulation> *is the regulation or law we relied on for-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.</p>
Former Foster Youth Generic Language <i>Snippet to be included on any NOD02 where the individual is age 18 to 26 (including 18 year olds and 26 year olds)</i>	N/A	<p>If you believe that you were in foster care under the responsibility of any state or tribe on or after your 18th birthday, you may qualify for Medi-Cal up to age 26 and your income does not matter. If you are a former foster youth, contact your county social services office and tell them you want to be moved into the Medi-Cal program for former foster youth.</p>	16.6 (CR 32299)	<p>If you believe that you were in foster care *under the responsibility of in* any state or tribe on or after your 18th birthday, you may qualify for Medi-Cal up to age 26 and your income does not matter. If you are a former foster youth, contact your county social services office and tell them you want to be *put-moved* into the Medi-Cal program for former foster youth.</p>
Denial (Header) Snippet ID: 297	You do not qualify for Medi-Cal because:	Your application dated <Month Day, Year> has been denied. You do not qualify for Medi-Cal because:	15.7 (CR 27802)	Your application dated <Month Day, Year> has been denied. You do not qualify for Medi-Cal because:

Denial for Retro Month (Header) Snippet ID: 427	N/A	Your application for the month of <month year> has been denied. This notice is only related to your request for eligibility for this month. This notice does not affect your application for current and continuing Medi-Cal. You do not qualify for Medi-Cal because:	15.7 (CR 32297)	*We evaluated your request for retroactive Medi-Cal for a month prior to your application month of [application month year]. *Your application for the month of <month year> has been denied. *This notice is only related to your request for eligibility for this month.* This notice does not affect your application for current and continuing Medi-Cal. *It only covers the time before your application was submitted. You will receive a separate notice about your eligibility for other retroactive months that you requested and for current and continuing Medi-Cal. * You do not qualify for Medi-Cal because:
Denial Reason (No CA Residency) Snippet ID: 212	You are not a resident of California.		No Planned Change	You are not a resident of California.
Denial Reason (Incarcerated) Snippet ID: 295	You are incarcerated.		No Planned Change	You are in *jail or prison. incarcerated. *

<p>Denial Reason (Failed to Complete Determination) <i>The current snippet was programmed with the original Negative Action CR 7900 but was never implemented or sent.</i></p> <p>Snippet ID: 308</p>	<p>You did not give us the information we asked for.</p>	<p>You did not give us the information needed to complete your eligibility determination.</p>	<p>15.7 (CR 27802)</p>	<p>*In order to complete our review of your application, we needed the following information from you:</p> <p>*[List what was requested].</p> <p>*We asked for that information, but you did not give us the information needed to complete your eligibility determination.</p>
<p>Denial Reason (On Aid Another Case) <i>The current snippet was programmed with the original Negative Action CR 7900 but was never implemented or sent.</i></p> <p>Snippet ID: 409</p>	<p>You are already receiving Medi-Cal benefits on another case.</p>	<p>You are already receiving Medi-Cal benefits on another case therefore you are not entitled to receive Medi-Cal benefits on this case.</p>	<p>15.7 (CR 27802)</p>	<p>You are already receiving Medi-Cal benefits on another case therefore you are not entitled to receive Medi-Cal benefits on this case. *You can use the BIC card you already have to get services. If you do not have one contact your worker right away.*</p>

Denial Reason (Withdrawn Application) <i>The current snippet was programmed with the original Negative Action CR 7900 but was never implemented or sent.</i> Snippet ID: 316	You withdrew your application for Medi-Cal.	You withdrew your application for Medi-Cal and requested that we do not evaluate you for eligibility.	15.7 (CR 27802)	You withdrew your application for Medi-Cal and requested that we do not evaluate you for eligibility.
Denial Reason (Duplicate Application) Snippet ID: 408	N/A	This was a duplicate application. If you have questions or think we made a mistake, or if you have more information to give us, call or write to your worker right away.	15.7 (CR 27802)	This was a duplicate application. *If you have questions or think we made a mistake, or if you have more information to give us, call or write to your worker right away* .
Denial Reason (Deceased) Snippet ID: 415	N/A	We received notification of the death of <PersonName>. Also, for your information, there are no special death or burial benefits provided under the Medi-Cal program.	15.7 (CR 27802)	We received notification of the death of <PersonName>. Also, for your information, there are no special death or burial benefits provided under the Medi-Cal program.
Denial Reason (Whereabouts Unknown) Snippet ID: 413	N/A	We do not know where you live and do not have a way to reach you. We sent this notice to your last known address.	15.7 (CR 27802)	We do not know where you live and do not have a way to reach you. We sent this notice to your last known address.

Denial Reason (Receives SSI) Snippet ID: 410	N/A	You are already receiving Medi-Cal benefits through the Supplemental Security Income/State Supplementary Payment (SSI/SSP) program, therefore you are not entitled to receive Medi-Cal benefits on another case.	15.7 (CR 27802)	You are already receiving Medi-Cal benefits through the Supplemental Security Income/State Supplementary Payment (SSI/SSP) program, therefore you are not entitled to receive Medi-Cal benefits on another case. *You can use the BIC card you already have to get services. If you do not have one contact your worker right away. *
Denial Reason (Child Applied for Self) Snippet ID: 406	N/A	You are a child and an adult must apply for you. If you have questions or think we made a mistake, or if you have more information to give us, call or write to your worker right away.	15.7 (CR 27802)	You are a child and an adult must apply for you. *If you have questions or think we made a mistake, or if you have more information to give us, call or write to your worker right away.*
Denial (Footer) Snippet ID; 211	<p>We used the information you gave us and our records to make our decision. If you have questions or think we made a mistake, call or write to your worker right away. You can ask for an appeal. Read the back of this page to learn how to appeal.</p> <p>You can re-apply at any time.</p> <p><Regulation> authorized this decision. If you think we made a mistake, you can appeal. See "Your Hearing Rights" on the last page to learn how to appeal. You have only 90 days to ask for a hearing. The 90 days started the day after the county sent you this notice.</p>	<p>We used the information you gave us and our records to make our decision. If you have questions or think we made a mistake, or if you have more information to give us, call or write to your worker right away.</p> <p>You can also ask for an appeal.</p> <p><Regulation> authorized this decision. If you think we made a mistake, you can appeal. See "Your Hearing Rights" on the last page to learn how to appeal. You have only 90 days to ask for a hearing. The 90 days started the day after the county sent you this notice.</p>	15.7 (CR 27802)	<p>We used the information you gave us and our records to make our decision. If you have questions or think we made a mistake, or if you have more information to give us, call or write to your worker right away.</p> <p>*You can also ask for an appeal.*</p> <p><Regulation> *is the regulation or law we relied on for authorized* this decision. If you think we made a mistake, you can appeal. See "Your Hearing Rights" on the last page to learn how to appeal. You have only 90 days to ask for a hearing. The 90 days started the day after the county sent you this notice.</p>

<p>Discontinuance (Header) <i>The current snippet was programmed with the original Negative Action CR 7900 but was never implemented or sent.</i></p> <p>Snippet ID: 293</p>	<p>Your Medi-Cal will end the last day of <month> because:</p>		<p>No Planned Changes</p>	<p>Your Medi-Cal will end the last day of <month> because:</p>
<p>Discontinuance Reason (No CA Residency)</p> <p>Snippet ID: 212</p>	<p>You are not a resident of California.</p>		<p>No Planned Changes</p>	<p>You are not a resident of California.</p>

Discontinuance Reason (Incarcerated) Snippet ID: 295	You are incarcerated.		No Planned Changes	<p>*Beginning on ____ (date) ____, Medi-Cal benefits will be suspended for the person named above.</p> <p>*Here's why:</p> <p>*We have received information that the person named above is an inmate of a public institution. State law requires that when someone on Medi-Cal becomes an inmate, Medi-Cal benefits must be suspended. Medi-Cal benefits remain suspended, as long as the person named above remains otherwise eligible for Medi-Cal, for up to one year from the date the person became an inmate or until the person is no longer an inmate, whichever is sooner.</p> <p>*While benefits are suspended, Medi-Cal cannot be used to pay for health care services. If an inmate is released from incarceration while Medi-Cal benefits are suspended, he or she can receive Medi-Cal benefits without a new application if still eligible. While benefits are suspended, you must still complete the annual redetermination.</p> <p>*If Medi-Cal eligibility ends for any reason while benefits are suspended, the county will send a separate notice of action.</p>
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<p>Discontinuance Reason (Failed to Complete Annual Redetermination or Comply with Change in Circumstances)</p> <p><i>The current snippet was programmed with the original Negative Action CR 7900 but was never implemented or sent.</i></p> <p>Snippet ID: 309</p>	<p>You no longer qualify for Medi-Cal because you did not complete the annual redetermination process.</p> <p>We did not get the information we asked for. You have 90 days to send the information. If we do not get the information by <date> you must re-apply for Medi-Cal.</p>	<p>You did not complete the annual redetermination process.</p> <p>We did not get the information we asked for. You have 90 days from the date you are discontinued to send the information to the county so we can review your case to determine if you are still eligible. If we do not get the information by <date> you must re-apply for Medi-Cal.</p>	<p>15.7 (CR 27802)</p>	<p>*You did not complete the annual redetermination process. In order to see if you are still eligible for Medi-Cal, we needed the following information from you: *</p> <p>*[List what was requested].</p> <p>*We asked for that information, but you did not give us the information needed to complete your eligibility determination. We did not get the information we asked for.* You have 90 days from the date you are discontinued to send the information to the county so we can review your case to determine if you are still eligible. If we do not get the information by <date> you must re-apply for Medi-Cal.</p>
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<p>Discontinuance Reason (Beneficiary Request for Discontinuance)</p> <p><i>The current snippet was programmed with the original Negative Action CR 7900 but was never implemented or sent.</i></p> <p>Snippet ID: 311</p>	<p>You no longer qualify for Medi-Cal because you told us you wanted your Medi-Cal benefits to end.</p>	<p>You told us you wanted your Medi-Cal benefits to end.</p>	<p>15.7 (CR 27802)</p>	<p>You told us you wanted your Medi-Cal benefits to end.</p>
<p>Discontinuance Reason (Stop Aid for Optional Member)</p> <p><i>The current snippet was programmed with the original Negative Action CR 7900 but was never implemented or sent.</i></p> <p>Snippet ID:</p>	<p>You no longer qualify for Medi-Cal because you told us you wanted your Medi-Cal benefits to end.</p>	<p>You told us you wanted your Medi-Cal benefits to end.</p>	<p>15.7 (CR 27802)</p>	<p>You told us you wanted your Medi-Cal benefits to end.</p>

<p>Discontinuance Reason (Whereabouts Unknown) <i>The current snippet was programmed with the original Negative Action CR 7900 but was never implemented or sent.</i></p> <p>Snippet ID: 413</p>	<p>You no longer qualify for Medi-Cal because we do not know where you live and do not have a way to reach you. We sent this notice to your last known address.</p>	<p>We do not know where you live and do not have a way to reach you. We sent this notice to your last known address.</p>	<p>15.7 (CR 27802)</p>	<p>We do not know where you live and do not have a way to reach you. We sent this notice to your last known address.</p>
<p>Discontinuance Reason (TMC Report Not Completed)</p> <p>Snippet ID: 411</p>	<p>N/A</p>	<p>You failed to return a completed TMC status report. The completion of this report is required to continue receiving Medi-Cal benefits.</p>	<p>15.7 (CR 27802)</p>	<p>You failed to return a completed *Transitional Medi-Cal (TMC)* status report. The completion of this report is required to continue receiving Medi-Cal benefits.</p>
<p>Discontinuance Reason (TMC Report Not Received)</p> <p>Snippet ID: 412</p>	<p>N/A</p>	<p>You failed to return a completed TMC status report. The completion of this report is required to continue receiving Medi-Cal benefits.</p>	<p>15.7 (CR 27802)</p>	<p>You failed to return a completed *Transitional Medi-Cal (TMC)* status report. The completion of this report is required to continue receiving Medi-Cal benefits.</p>

<p>Discontinuance Reason (On Aid Another Case)</p> <p>Snippet ID: 409</p>	<p>N/A</p>	<p>You are already receiving Medi-Cal benefits on another case therefore you are not entitled to receive Medi-Cal benefits on this case.</p>	<p>15.7 (CR 27802)</p>	<p>You are already receiving Medi-Cal benefits on another case therefore you are not entitled to receive Medi-Cal benefits on this case. Y*ou can use the BIC card you already have to get services. If you do not have one contact your worker right away. *</p>
<p>Discontinuance Reason (Non-Payment of Premium - OTLICP)</p> <p>Snippet ID: 414</p>	<p>N/A</p>	<p>Premiums have not been paid for two consecutive months. If you wish to pay the premiums and remain eligible for Medi-Cal, please contact the Medi-Cal Premium Payment Section at (800) 880-5305 to arrange for repayment and then let your worker know you have paid your premiums.</p> <p>Please note that you may be required to pay past due premiums if your child(ren) become eligible for Medi-Cal with a premium in the next twelve (12) months.</p>	<p>15.7 (CR 27802)</p>	<p>Premiums have not been paid for two consecutive months. If you wish to pay the premiums and remain eligible for Medi-Cal, please contact the Medi-Cal Premium Payment Section at (800) 880-5305 to arrange for repayment and then let your worker know you have paid your premiums.</p> <p>Please note that you may be required to pay past due premiums if your child(ren) become eligible for Medi-Cal with a premium in the next twelve (12) months.</p>
<p>Discontinuance (Footer)</p> <p>Snippet ID: 208</p>	<p>If you have questions or think we made a mistake, call or write to your worker right away. You can appeal this decision. Read the back of this page to learn how to appeal.</p> <p><Regulation> authorized this decision. If you think we made a mistake, you can appeal. See "Your Hearing Rights" on the last page to learn how to appeal. You have only 90 days to ask for a hearing. The 90 days started the day after the county sent you this notice.</p>	<p>We used the information you gave us and our records to make our decision. If you have questions or think we made a mistake, or if you have more information to give us, call or write to your worker right away.</p> <p>You can also ask for an appeal.</p> <p><Regulation> authorized this decision. If you think we made a mistake, you can appeal. See "Your Hearing Rights" on the last page to learn how to appeal. You have only 90 days to ask for a hearing. The 90 days started the day after the county sent you this notice.</p>	<p>15.7 (CR 27802)</p>	<p>We used the information you gave us and our records to make our decision. If you have questions or think we made a mistake, or if you have more information to give us, call or write to your worker right away.</p> <p>*You can also ask for an appeal*.</p> <p><Regulation>* is the regulation or law we relied on for authorized *this decision. If you think we made a mistake, you can appeal. See "Your Hearing Rights" on the last page to learn how to appeal. You have only 90 days to ask for a hearing. The 90 days started the day after the county sent you this notice.</p>

<p>MCAP MAGI Approval - (Currently Enrolled in MCAP, become MAGI eligible also. Will also get MAGI approval language)</p> <p>Snippet ID: TBD</p>	<p>N/A</p>	<p>You are enrolled in MCAP and can keep your coverage through the end of your pregnancy and post-partum period. If you want to voluntarily end your MCAP coverage and have Medi-Cal coverage only, you must call MCAP at 800-433-2611 and tell them that.</p>	<p>15.9 (CR 8517)</p>	<p>You are enrolled in MCAP and can keep your coverage through the end of your pregnancy and post-partum period. If you want to voluntarily end your MCAP coverage and have Medi-Cal coverage only, you must call MCAP at 800-433-2611 and tell them that.</p>
<p>MCAP MAGI Approval - (Currently Enrolled in MCAP, become MAGI eligible also.</p> <p>Snippet ID: TBD</p>	<p>N/A</p>	<p>If you think this is a mistake, you may appeal to the Medi-Cal Access Program. Your appeal must be in writing and submitted to the address provided below within 60 calendar days from the date of the decision letter.</p> <p>Mail your appeal to:</p> <p>Executive Director-Benefits Appeal P.O. Box 15559 Sacramento, CA 95852-0559</p>	<p>15.9 (CR 8517)</p>	<p>If you think this is a mistake, you may appeal to the Medi-Cal Access Program. Your appeal must be in writing and submitted to the address provided below within 60 calendar days from the date of the decision letter.</p> <p>Mail your appeal to:</p> <p>Executive Director-Benefits Appeal P.O. Box 15559 Sacramento, CA 95852-0559</p>