MAXIMUS

PROGRAM ALERT # 0695

Medi-Cal Notice of Action Notice of Discontinue (HF LT 986MC)

Family Member Number: FMN

DATE

REC_NUM HF 955MC 11 14 2013
HOH_NAME
ADDR_LINE_1
ADDR_LINE_2
CITY, STATE ZIP

Medi-Cal Notice of Action
Notice of Discontinuance

Dear Applicant:

Medi-Cal coverage will be discontinued for the following people for the reasons listed below.

> NAME_1
> The annual redetermination process was not completed because we did not get your Annual Eligibility Review (AER) information.
>
> NAME_2
> The annual redetermination process was not completed because we did not get your Annual Eligibility Review (AER) information.

Medi-Cal eligibility will be discontinued effective November 30, 2013.

If you have any questions about this action or if you would like another AER form, please contact Medi-Cal for Families at 1-800-880-5305.

If you think we made a mistake

If you think we made the wrong decision, you can ask us for a review. To ask for a review,

Fill out the Hearing Request (NA Back 9 form) that came with this letter. Tell us why you think we made a mistake. You can also send any other papers or information that you would like us to see. We cannot do a review over the phone. Write your Family Member Number on each paper. Your Family Member Number is: FMN.

There are several ways you can send your Hearing Request Form back to us:

- **Mail to:**

  Medi-Cal for Families Program
  Appeals Section
  P.O. Box 138005
  Sacramento, CA 95813-8005

- **Fax to: 1-866-848-4977**. The fax number is toll free.

Questions?

If you have questions, please call **1-800-880-5305**, Monday to Friday, 8 a.m. to 8 p.m., or on Saturday, 8 a.m. to 5 p.m. The call is free. Please remember that you may reapply for Medi-Cal any time at www.CoveredCA.com or contact your local county office.

DO NOT THROW YOUR PLASTIC CARD AWAY. You can use it again if you become eligible for Medi-Cal in the future.

Rules: These rules apply: California Code of Regulations, Title 22, Section 50189.

Department of Health Care Services Medi-Cal Program HF LT 986MC EN 11/13/2013

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Hearing Request Form (NA Back 9)

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 ask for a hearing before an action on Cash Aid, Medi-Cal, Food Stamps, 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 Food Stamps 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, Food Stamps 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 ☐ Food Stamps ☐ 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 this 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.)**

NA BACK 9 (REPLACES NA BACK 8 AND EP3) REQUIRED FORM – NO SUBSTITUTION PERMITTED

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.
- **Send or take this page to:**

Medi-Cal for Families
Appeals Section
PO Box 138005
Sacramento, CA 95813-8005

OR

- **Call toll free: 1-800-952-5253** or for hearing or speech impaired who use TDD, **1-800-952-8349**.

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.

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 ☐ Food Stamps ☐ 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 NUMBER

☐ **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

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Language Service Notice (MC4034)

Language Services Notice

If you do not understand this information or notification, call your county Medi-Cal worker. You have the right to interpreter services provided by the county at no cost to you.

Si no entiende esta información o notificación, llame al trabajador de Medi-Cal de su condado. Tiene derecho a obtener servicios de intérpretes proporcionados por el condado sin costo para Ud. (Spanish)

إذا لم تفهم هذه المعلومات أو هذا الإبلاغ . إتصل بموظف Medi-Cal الخاص بمقاطعتك. لديك حق الحصول على خدمات ترجمة مجانية متوفرة لك من قبل المقاطعة. (Arabic)

Եթե դուք չեք հասկանում այս տեղեկությունը կամ հայտարարությունը, զանգահարեք ձեր քաունթիի Medi-Cal-ի աշխատակցին: Դուք իրավունք ունեք քաունթիի կողմից տրամադրված թարգմանչական անվճար ծառայություն ստանալու: (Armenian)

បើសិនអ្នកមិនយល់ព័ត៌មាន ឬសេចក្តីជូនដំណឹងនេះទេ សូមទូរស័ព្ទទៅអ្នកធ្វើការងារ Medi-Cal នៅខោនធីរបស់អ្នក ។ អ្នកមានសិទ្ធិទទួលសេវាអ្នកបកប្រែ ដែលផ្តល់ដោយខោនធី ដោយឥតគិតថ្លៃពីអ្នកឡើយ ។ (Cambodian)

如果您不理解此處的資訊或通知,請電洽您所在縣的Medi-Cal工作人員。您有權免費獲得縣政府提供的免費口譯服務。 (Chinese)

اگر این اطلاعات و یا اطلاعیه را درک نمي کنید، با مددکار Medi-Cal کانتي خود تماس بگیرید. شما این حق را دارید که به طور رایگان از خدمات مترجم از طریق کانتي استفاده کنید. (Farsi)

Yog koj tsis totaub txog cov kev qhia lossis tsab ntawv no, hu rau koj tus neeg tuav ntaub ntawv Medi-Cal hauv lub county. Koj muaj cai tau txais kev pab txhais lus dawb los ntawm lub county. (Hmong)

이 정보나 통지서를 이해할 수 없는 경우에는 카운티 Medi-Cal 담당 직원에게 전화하십시오. 가입자는 카운티가 무료로 제공하는 통역 서비스를 받을 권리가 있습니다. (Korean)

Если вы не понимаете данную информацию или уведомление, позвоните сотруднику компании Medi-Cal вашего округа. У вас есть право на получение услуг переводчика, которые предоставляются округом бесплатно. (Russian)

Kung hindi ninyo naiintindihan ang impormasyon o paunawang ito, tawagan ang inyong manggagawa sa Medi-Cal ng county. Kayo ay may karapatang magkaroon ng mga serbisyo ng tagasalin na ibibigay ng county na walang bayad sa inyo. (Tagalog)

Nếu quý vị không hiểu chi tiết hoặc thông báo này, hãy điện thoại cho nhân viên Medi-Cal tại quận quý vị. Quý vị có quyền được quận cung cấp dịch vụ thông dịch miễn phí cho quý vị. (Vietnamese)

MC 4034 (01/08)