Please fill the following form.

COUNTY OF

Date:
Case Name:
Case Number:
Worker Name:
Worker ID:
Worker Phone Number:

→ REMINDER NOTICE ←

YOUR MEDI-CAL REDETERMINATION FORM FOR _____ HAS NOT BEEN RECEIVED

On _____, we sent you a packet containing your annual Medi-Cal Redetermination Form.
You were asked to complete and return this form no later than _____. The information requested on this form is needed to establish your continued eligibility to Medi-Cal benefits and your benefit level.

We have not received your form. If we do not receive your completed Medi-Cal Redetermination Form by _____, your benefits may be discontinued.
You can give us information by phone, mail, online, or in person.

→ REMEMBER ←

- Even if you are employed you may be eligible to receive Medi-Cal benefits.
- Receipt of Medi-Cal does not count against any CalWORKs time limits.
- You do not have to receive CalWORKs to receive Medi-Cal benefits.

If you have any questions or need more information about this form, contact the county at the number listed above.

CSF 164 (11/2020)

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