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.