

Please fill the following form.

COUNTY OF

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**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.

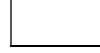
**We have not received your form. If we do not receive your completed Medi-Cal Redetermination Form by \_\_\_\_\_, your benefits may be discontinued. You can give us information by phone, mail, online, or in person.**

**→ 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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