_____
_____
_____
_____

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

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_____

→ 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.

→ 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, call your eligibility worker whose name and telephone number are listed at the top of this form.