MCIEP TRANSMITTAL

Medi-Cal Inmate Eligibility Program (MCIEP)
DHCS-County Transmittal Form

Instructions: Complete each space or box. If information does not pertain to this case, indicate with N/A.

To:	From:
County: _____	DHCS, Medi-Cal Inmate Eligibility Program
Medi-Cal Liaison Name: _____	Eligibility Specialist (ES): _____
Liaison Telephone: _____	ES Telephone: _____
Fax Number: _____	ES Fax Number: _____
E-mail: _____	ES E-mail: _____

MCIEP Beneficiary Information

Name		CIN	Alternate/Message phone number
Address (number, street)			ZIP code
Authorized Representative ☐ Yes ☐ No	AR name	AR phone number	Beneficiary's primary language

Reason for Transmittal:

Parole Date _____	☐ Infants born to MCIEP Mom (MC 330 attached)
Linkage:	☐ Inmate active on county case Case # _____
☐ Aged	☐ Other _____
☐ Blind	
☐ Disabled	
☐ Pregnant	
☐ Under 21 years old	

Case Documents in Referral Packet:

- ☐ MC 210, Medi-Cal Application
- ☐ Disability Decision
- ☐ Statement of Citizenship, Alienage, and Immigration Status (MC13)
- ☐ Copy of Income verification
- ☐ Copy of property verification (Bank accounts, real property, vehicles registration, etc.)
- ☐ Identifications
- ☐ Social Security Card
- ☐ Citizenship/Immigration documents
- ☐ Last Notice of Action
- ☐ Case details
- ☐ AR Form
- ☐ Other _____