**READ AND DELETE PRIOR TO USE**: Use this form to show loss of Full Scope Medi-Cal when the Notice of Action **does not clearly indicate loss of Minimum Essential Coverage (MEC)**. The areas highlighted are for you to enter responses to the client’s case. Feel free to include your organization letterhead.

**REPLACE** the screenshots with those for your client and make sure the CHCP application is submitted within 60 calendar days of the Qualifying Life Event. A big thank you to the San Mateo County Health Coverage Unit for helping create this!

**Date:** \_\_\_\_\_\_\_\_\_\_\_

**Client Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The ORGANIZATION NAME has confirmed that the client went through the Medi-Cal renewal process and lost Full Scope Medi-Cal coverage because their household income exceeds 138% of the Federal Poverty Level (FPL).

The client is eligible for a Special Enrollment Period with the Qualifying Life Event: Loss of minimum essential coverage (Medi-Cal), effective MM/DD/YYYY.

We have provided two screenshots from the DHCS state website showing the client's loss of minimum essential health coverage:

1. On the first day of the month (Service Date: DD/MM/YYYY), the client has minimum essential coverage through Medi-Cal with code XX. Confirmed by the “Eligibility Message,” the client is covered under Full Scope Medi-Cal.
2. In the following month (Service Date:MM/DD/YYYY), the client's coverage has changed to Medi-Cal with a Share of Cost with no aid code. The “Eligibility Message” indicates that the client must meet a Share of Cost (SOC) before Medi-Cal will cover any medical expenses. Medi-Cal with a Share of Cost does not meet the definition of minimum essential health coverage.

The ORGANIZATION NAME is using this information to validate the client's loss of minimum essential coverage, effective the last date of the month (Service Date: DD/MM/YYYY).

