YOLO COUNTY
Health & Human Services Agency
Resource · Partner · Support System

BENEFICIARY CHANGE IN CIRCUMSTANCES REPORT FORM

Date of Report:	Person Making Report:
Type Of Change	
☐ Change in residence that impacts Yolo County Medi-Cal Benefits	☐ Death
Beneficiary Information	
Beneficiary Name:	Beneficiary MR #:
Date Program Became Aware:	Estimated Date Change Occurred:
Additional Comments (if applicable):	
SIGNATURE OF PERSON MAKING REPORT	DATE
Please submit this form within 5 business days of becoming aware of a change in beneficiary circumstance to HHSAQualityManagement@yolocounty.gov. Email submissions must be encrypted.	

Finalized: October 2024