

# CMSP

COUNTY MEDICAL  
SERVICES PROGRAM

## Record of Denied Program Eligibility

If your application for ADAP or Family PACT has been denied because you did not meet the program eligibility requirements and you were not given a document verifying this denial, please complete this form. ***All sections of this form must be filled out completely including the name and phone number of the person who can verify the program denial.***

FAX the completed form to: **1-916-848-3349**. Your eligibility worker, medical provider or pharmacy may be able to help you fax this form.

CMSP Member Name:	CMSP Client ID Number (CIN):
Address:	Date of Birth:
	Phone Number: (     )     -

Program Applied For (check appropriate program):  <input type="checkbox"/> California AIDS Drugs Assistance Program (ADAP)  <input type="checkbox"/> California Family Planning, Access, Care and Treatment Program (Family PACT)
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Date of Application Denial	
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Authorized ADAP or Family PACT Representative who can be contacted to verify denial: <i>(This section must be completed or the form will not be accepted.)</i>  Representative Name _____  Representative Title _____  Representative Phone _____
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If you have questions regarding completion of this form, call 1-916-649-2631, ext.17

NOTE: The information contained on this form may be confidential and is intended only to be received by the party with the e-FAX number listed above. If you are not the intended recipient (or the employee or agent responsible to deliver this to the intended recipient), you are hereby notified that any distribution or copying of the information contained on this form is strictly prohibited. If you have received this form in error, please destroy this document.