COUNTY MEDICAL SERVICES PROGRAM
NOTICE OF ACTION
DENIAL
OF RETROACTIVE BENEFITS

(County Stamp)

Case number: _____

District: _____

Denial for: _____

_____
(Names)

We have reviewed all information available to us about your circumstances. We find that your application for retroactive CMSP benefits has been denied for (month/year) _____.

The reason for this denial is:

Do not throw your plastic ID card away. You can use it again if you become eligible for CMSP or Medi-Cal. The authority that requires this action is in CMSP All County Letter No. 16-02 and/or CMSP Eligibility Manual sections 3-018, 3-028, 3-029, 3-030, 3-032.

If you have any questions about this action, or if there are additional facts relating to your circumstances which you have not reported to us, please write or telephone. We will answer your questions or make an appointment to see you in person. Please remember that this action pertains only to the circumstances you reported to us and that you may reapply at any time.

Eligibility Worker	Telephone number	Date