COUNTY MEDICAL SERVICES PROGRAM
NOTICE OF ACTION
APPLICATION FOR RETROACTIVE ELIGIBILITY

(COUNTY STAMP)

Case name: _____

Case number: _____

District: _____

This affects: _____

_____
(Names)

We have reviewed all information available to us about your circumstances and find that:

❒ Effective _____, you are eligible for full CMSP benefits. A plastic Benefits Identification Card (BIC) will be mailed to you soon. TAKE THIS PLASTIC CARD TO EACH MEDICAL PROVIDER WHERE YOU RECEIVED SERVICE. DO NOT THROW AWAY YOUR PLASTIC ID CARD.

❒ Because your income was more than the amount allowed for living expenses, you must pay or obligate to pay the following share-of-cost toward the cost of medical care received:

$_____ for _____

$_____ for _____

$_____ for _____

Take your Plastic Card to each medical provider where you received service in the above months. Your Plastic Card will show your provider if you have a share-of-cost to pay. The amount that you pay or are obligated to pay the medical providers will be automatically computed.

❒ You are not eligible for full CMSP benefits for the month of _____ because:

The regulations which require this action are California Administrative Code, Title 17, Section(s): 1498, et seq.

This action does not affect your application for current and continuing CMSP. If you have any questions about this action or if there are more facts about your conditions which you have not reported to us, please write or telephone. We will answer your questions or make an appointment to see you.

Eligibility Worker	Phone	Date

PLEASE READ THE REVERSE SIDE OF THIS NOTICE