COUNTY MEDICAL SERVICES PROGRAM
NOTICE OF ACTION
OVERPAYMENT AND REPAYMENT INSTRUCTIONS

(County Stamp)

State number: _____
Name of beneficiary affected: _____

Date: _____

We have determined that the CMSP has incorrectly paid $ _____ for your medical care for the month(s) of _____. This overpayment was the result of:

I. Share-of-Cost

☐ Your share-of-cost should have been $ _____ because _____ and you did not report this information to the county.

The overpayment was computed as follows:

1. Month	2. Correct Net Income	3. Correct Maintenance Need	4. Correct Share-of-Cost (2–3)	5. Share-of-Cost You Met	6. Possible Overpayment (4–5)	7. Amount Paid By CMSP	8. Overpayment (Lower of 6 or 7)
	$	$	$	$	$	$	$
	$	$	$	$	$	$	$
	$	$	$	$	$	$	$

II. Property

☐ You should have been ineligible for CMSP for the month(s) of _____ because you had countable, nonexempt property worth $ _____ which is $ _____ above the property limit. CMSP paid $ _____ of your health care costs during this time. You are responsible for repaying $ _____ (the lower of your excess property or the amount that CMSP paid).

III. Other

☐ _____

IV. Repayment Instructions

You are responsible for repaying $ _____. Send your check or money order for this amount to _____ within 30 days. The regulations which require this action are Sections 7-029, 8-011, 8-012, 10-012, 14-010 through 14-017 of the County Medical Services Eligibility Manual.

If you have any questions, please contact _____ at _____.
You may request a hearing on this matter if you do not agree, by contacting your county welfare department.