COUNTY MEDICAL SERVICES PROGRAM
NOTICE OF ACTION
APPROVAL OF RETROACTIVE BENEFITS

(County Stamp)

Case name: ____________________
Case number: ____________________
District: ____________________
This affects: ____________________
(Names)

Your application for retroactive CMSP benefits has been approved for (month/year) ______________. You will be eligible as follows:

Month: ______________
Gross income: $ _____________
Net nonexempt income: $ _____________
300% FPL: $ _____________

Eligible for the month: ☐ Yes ☐ No

Maintenance need: $ _____________
Excess income/monthly share-of-cost: $ _____________

CMSP eligibility is limited to individuals aged 21 through 64 years.

Eligibility Worker	Telephone number	Date

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 3-015, 3-027, 3-032, 8-011, 8-012, 8-053, 10-012, 11-011.

PLEASE READ THE REVERSE SIDE OF THIS NOTICE.