

Record of Denied Program Eligibility

If your application for ADAP, Family PACT, GHPP, or other state program 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 <u>must</u> <u>be filled out completely</u> 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):	
Breast and Cervical Cancer Treatment Program (BCCTP)	
California AIDS Drugs Assistance Program (ADAP)	
California Family Planning, Access, Care and Treatment Program (Family PACT)	
Genetically Handicapped Persons Program (GHPP)	
Patient Assistance Program for Hep-C Medication	
Covered California	
Date of Application Denial	
Authorized ADAP, Family PACT, GHPP, or other state or other program Representative who can be contacted to verify denial: (This section must be completed or the form will not be accepted.)	
Representative Name	
Representative Title	
Representative Phone	

If you have questions regarding completion of this form, call 1-916-649-2631, option 3.

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.