

STATEMENT REGARDING YOUR MEDICAID DISABILITY APPLICATION

AGENCY NAME AND ADDRESS	CASE NAME: (c/o name if present) (Last) (First) (Middle)
_____ _____ _____	_____ _____
Agency telephone number _____	Address: _____ _____
	Date: _____

We have been unable to determine your eligibility for Medical Assistance Disability within 90 days of the date of application because:

- Medical reports have not been received from your treating sources.
- Additional medical and/or social information is needed. (Specify)

- You have not provided this agency with medical and/or social information.
- Other. (Specify)

Your disability determination is still under review and you will be notified as soon as a determination is made.

Signature of Worker: _____ Telephone: _____
Name of Worker: _____ Title: _____

IF YOU ARE CURRENTLY IN RECEIPT OF MEDICAID, YOU WILL CONTINUE TO RECEIVE MEDICAID BENEFITS UNCHANGED.