***FOR COUNTY USE ONLY***

Case name: _____
Case number: _____
Worker number: _____
Telephone number: _____

# REQUEST FOR WITHDRAWAL AND/OR WAIVER OF TEN-DAY ADVANCE NOTICE

## ❒ MEDI-CAL APPLICATION WITHDRAWAL

I, _____, ask that my application for Medi-Cal, dated _____/_____/_____, be withdrawn because _____

_____.

I understand that my Medi-Cal eligibility will not be determined at this time. I can reapply at any time.

## ❒ MEDI-CAL ELIGIBILITY DISCONTINUANCE

I, _____, ask that my Medi-Cal eligibility be discontinued effective _____/_____/_____ because _____

_____.

I understand that I can reapply at any time.

## ❒ BENEFICIARY WAIVER OF TEN-DAY NOTICE

I, _____, understand that based upon the information I have reported, effective _____/_____/_____,

❒ my Medi-Cal eligibility must be discontinued.

❒ my Medi-Cal share-of-cost must be increased.

I understand that I am supposed to be given a ten-day notice before this action becomes effective. However, since I know that the above action must be taken based on the information I reported, it is not necessary for the county to send me this notice within the ten-day limit.

I understand that the above request will not interfere with my right to a state hearing, and that I can reapply for Medi-Cal at any time. I understand that if I ask for a state hearing before the effective date of the action, the county's action will be delayed.

_____ _____
Signature of Applicant/Beneficiary Date