

YOUR APPLICATION FOR MEDICAID IS PENDING

Date _____

Name

Address

Your application for Medicaid cannot be completed because we do not have all the needed information.

Case Number _____

District Number _____

Dear _____:

Your application for Medicaid cannot be completed because we do not have the following information:

Disability Determination Services (DDS) has not determined if your medical condition meets the definition of disability for Medicaid. Your application will be held until DDS makes a decision. As soon as DDS makes the decision, we will notify you.

We have asked for medical records needed to determine if you had a medical emergency. We asked for those records from the following medical providers: _____

_____ The records have not been provided. Your application will be denied on _____ if we do not get the records.

We need a completed FL-2/MR-2 or CAP Plan of Care to prove you need long term care services. The form has not been provided. Your application will be denied on _____ if we do not get the form.

If you have any questions, please contact your caseworker immediately.

Caseworker

Address

Phone Number