

\_\_\_\_\_ County Department of Social Services

Date \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dear \_\_\_\_\_:

We have received your application for Medicaid. ***Your application is being returned to you because:***

\_\_\_\_\_ You did not sign your application

\_\_\_\_\_ We need your complete mailing address

\_\_\_\_\_ We need the full name/date of birth/sex of person(s) applying

\_\_\_\_\_ We cannot read your application. Please come to our office for assistance or ask a friend or relative to help you complete the application.

We can not accept your application until it is ***signed and we have all of the above information.*** It is very important that you return your application with the missing information as soon as possible. If you are found eligible for Medicaid, your benefits cannot begin until three calendar months before the month we receive a complete application.

If you have questions, please feel free to contact me at the telephone number shown below.  
Thank you.

Sincerely,

\_\_\_\_\_  
Name

\_\_\_\_\_  
Phone Number