

# APPLICATION WITHDRAWAL REQUEST

I wish to withdraw my application dated \_\_\_\_\_ for:

- Cash Aid
- Food Stamps
- Medi-Cal/State-Run CMSP

Reason: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

Please answer the following questions:

Did you decide to drop this application? .....  YES  NO

Did anyone from the County tell you to drop this application? .....  YES  NO

I understand that I may reapply at any time. I also understand that by withdrawing my application, I will have no appeal rights.

YOU WILL NOT GET A HEARING IF YOU SIGN THIS FORM. THE COUNTY WILL SEND YOU A LETTER TO CONFIRM YOUR APPLICATION WITHDRAWAL.

SIGNATURE OF APPLICANT	DATE
SIGNATURE OF APPLICANT	DATE
COUNTY REPRESENTATIVE	DATE