**EXHIBIT 58**

*(Rev.)*

**EXAMPLE OF REGULAR DISALLOWANCE LETTER**

Certified Mail - Return Receipt Requested

FILE ID: RE: File No.__________________

ADDRESSEE: Dear (**Medicaid State Agency Director**):

INTRODUCTION: The Quarterly Statement of Expenditures, Form CMS-*435*, for the State provider certification program submitted by your Department for the quarter ending _______________has been reviewed by this office. The statement contains a claim totaling $_______________ in Federal financial participation (FFP) of which $_______________ is being disallowed.

BACKGROUND FACTS: (**Description of the issues involved and the findings of fact**.)

DISALLOWANCE DETERMINATION: (**Citation of statute and/or regulations, an explanation of how the statute or regulation has been violated, and the decision**.)

CMS regulation ________ CFR §_________ provides that:

(**Provide explanation here.**)

Therefore, in accordance with the regulation(s) cited above, this letter constitutes your notice of disallowance in the amount of $ ______ FFP. Please resubmit the Quarterly Statement of Expenditures for which this disallowance action was taken, making the applicable decreasing adjustment and referencing disallowance number.

NOTICE OF ADJUSTMENT: As this disallowance includes FFP previously paid the State for expenditures for services furnished on or after October 1, 1980, it is subject to the provisions of section 961(a) of the Omnibus Reconciliation Act of 1980 (Public Law 96-499) as amended by section 2163 of the Omnibus Reconciliation Act of 1981 (Public Law 97-35). If you appeal this disallowance as provided below, Public Law 96-499 provides you the option of retaining the funds disallowed by this notice pending a final administrative decision. If the final decision upholds the disallowance and you elected to retain the funds during the appeal process, the proper amount of the disallowance, plus interest computed pursuant to Public Laws 96-499 and 97-35, will be offset in a subsequent grant award. You may exercise your option to retain the disputed funds by notifying the Regional Administrator in writing no later than 30 days after the postmarked date of this letter. In the absence of your notification that you elect to retain the funds, the Secretary will recover the disputed funds pending the final decision of the Grant Appeals Board.

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| APPEAL RIGHTS: | Under Section 1116(d) of the Social Security Act, you have the right to request reconsideration of this disallowance. Your reconsideration request must be submitted to the Executive Secretary, Departmental Grant Appeals Board, U.S. Department of Health and Human Services, Washington, DC 20201, no later than 30 days after your receipt of this letter. Your request must include a copy of this decision, a brief statement of the amount in dispute in your appeal, and a brief statement as to why you believe this decision is incorrect. Please send one copy of your request to me and one copy to the Associate Regional Administrator, *Survey and Certification Group.* Your request will be processed pursuant to the rules and regulations of the Departmental Grant Appeals Board which are currently found at 45 CFR Part 16. (See "Federal Register", Vol. 46, No. 168, published August 31, 1981.) |
| RO/DHSQ PROGRAM CONTACT: | Should you require further details regarding this matter, please contact the Associate Regional Administrator, *Survey and Certification Group* at (**area code and telephone number**). |

Sincerely,

(Regional Administrator)

Enclosures: (if any)

cc: Central Office