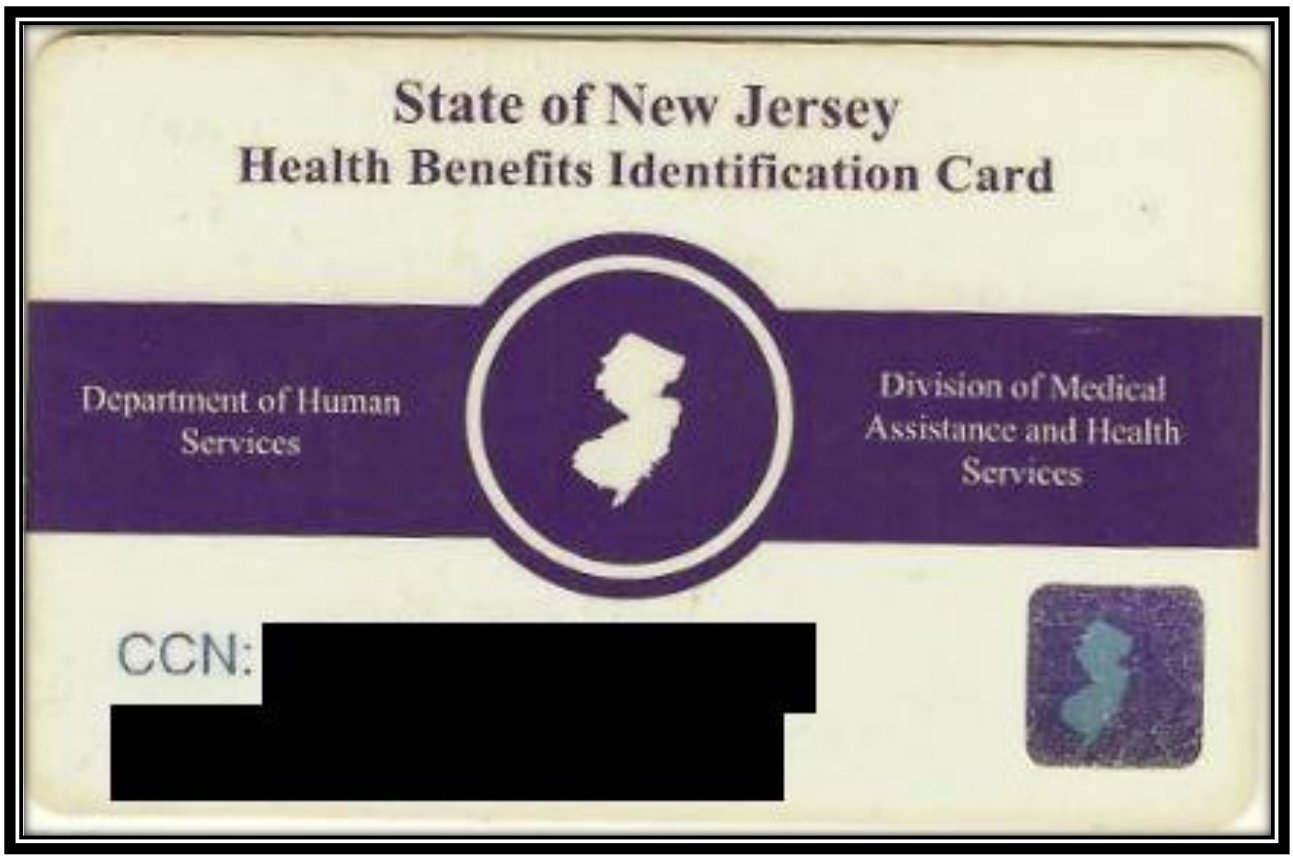
# Government Assistance Samples

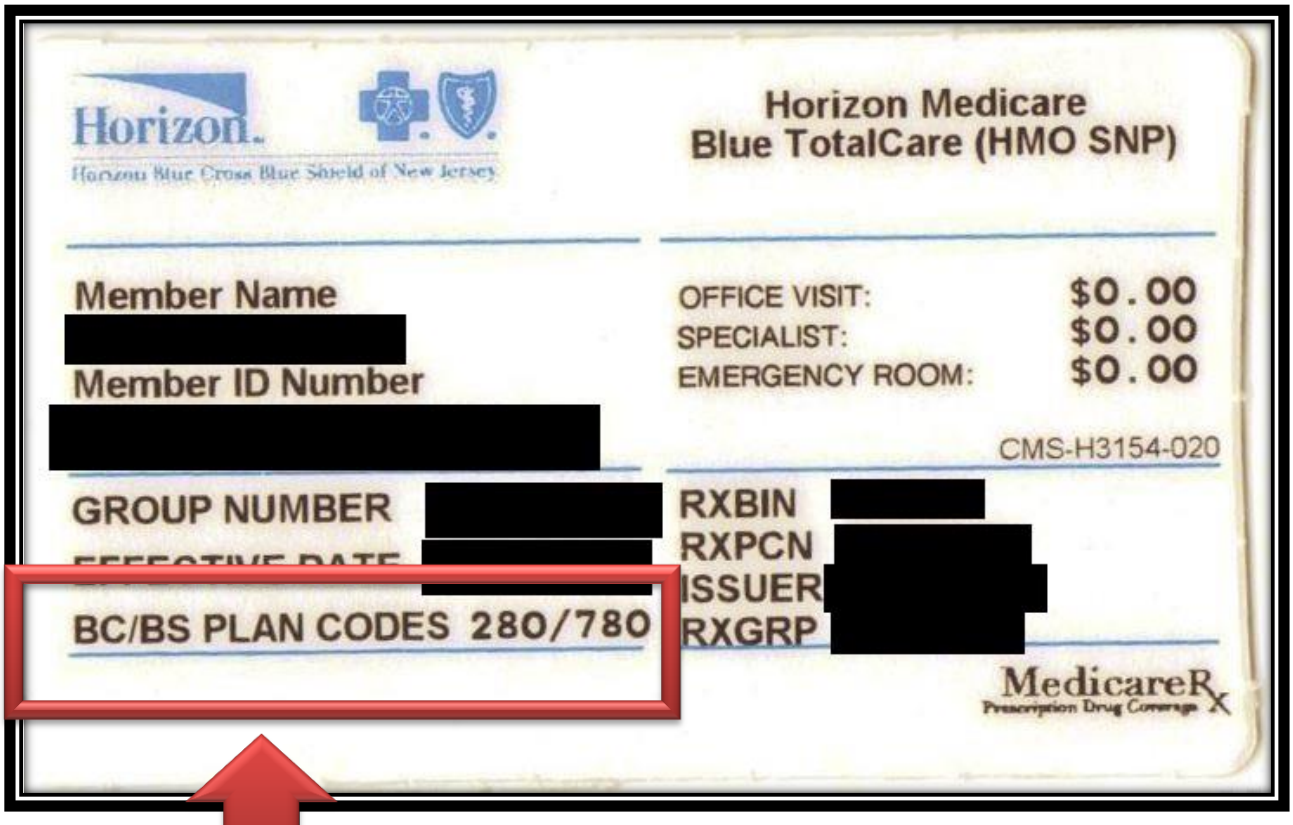
Patients and caregivers if qualified and approved for the below listed state and federal assistant programs are eligible to pay a discounted fee of $20 for their MMP ID card. Each registration period is valid for 2 years.

- NJ Medicaid Program
- Food Stamp Benefits
- NJ Temporary Disability Insurance Benefits
- Supplemental Security Income Benefits (SSI)
- Social Security Disability Benefits (SSD)

The following samples are documents that the Medicinal Marijuana Program (MMP) will accept for the Government Assistance discount.

# MEDICAID CARD EXAMPLES



# OCEAN COUNTY BOARD OF SOCIAL SERVICES

1027 HOOPER AVENUE
POST OFFICE BOX 547
TOMS RIVER, NEW JERSEY 08754-0547
(732) 349-1500
FAX#: (732) 244-8075
TDD#: (732) 244-3812

**MEDICAID SAMPLE**

In Reference [redacted]
Case Number: [redacted]
Reply To:
Date: 3/1/10
Program:

**Medicaid Only**
**Medically Needy**
**CCPED**
**Assisted Living**
**NJ Care**
**XX NJ Workability**

[redacted]

**Approval/Denial Notification**

**XX Eligible:** Financial eligibility has been established effective **2/1/10** for medical assistance in a community living arrangement. You will receive an Emergency Services Letter for the initial month of eligibility which you should present to your medical provider for payment of covered services. You will then receive a permanent plastic Health Benefits ID card for use during your Medicaid eligibility. This action is based on the following regulations. **NJCARE Manual 10:72-4.1 ( a )**

**Eligible:** Financial eligibility has been established effective _____ for medical assistance because of extended confinement in a hospital or special rehabilitation hospital. This approval is only for the period of time you are a patient. You must notify us immediately when you are discharged in order that continued eligibility can be determined. This action is based on the following regulations: _____.

**Denied:** Your application has been denied because failure to provide verifications . This action is based on the following regulations: _____.

**Terminated:** Your benefits have been terminated effective _____ due to _____. This action is based on the following regulations: _____.

**Dismissed/Withdrawn:** Your application has been _____ due to : :your request. This action is based on the following regulations: _____.

Please remember it is **your** responsibility to report any changes in your financial circumstances or living arrangement in order that continued eligibility can be determined. **If you have any questions, please contact Sherry Janda of this agency, at 609-242-6157.**

Sincerely,

[redacted]

Human Services Specialist 4

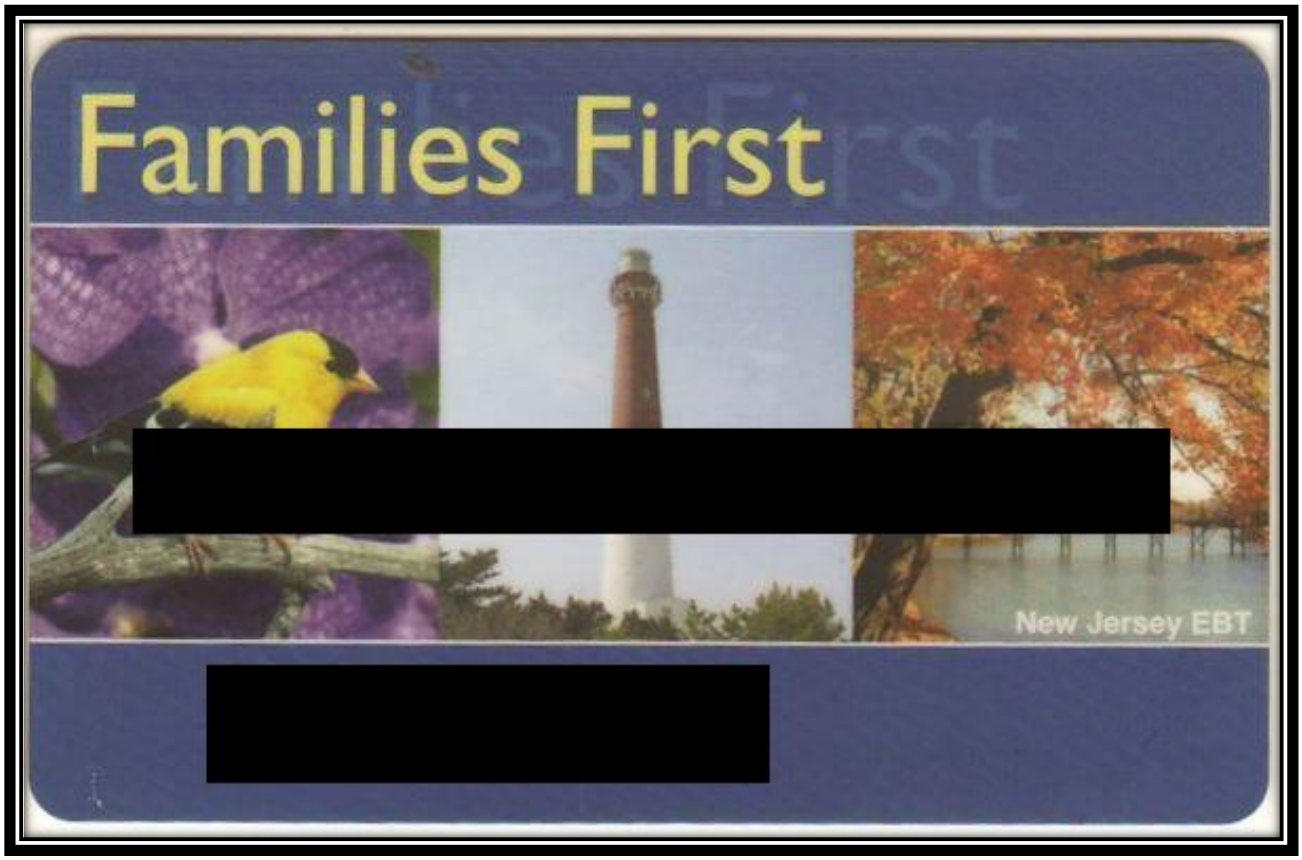
cc :



ESTA AGENCIA NO DISCRIMINA POR RAZA, CREDO, NACIONALIDAD DE ORIGEN, SEXO, IDENTIDAD DE GENERO O EXPRESIÓN, EDAD, ESTADO CIVIL O SOCIOS DOMÉSTICOS O UNIONES CIVILES, ANCESTROS, INCAPACIDAD, NACIONALIDAD, ORIENTACIÓN SEXUAL O AFECTIVA, RASGOS CELULARES O SANGRE HEREDITARIA ANORMAL, INFORMACIÓN GENETICA (INCLYUENDO LA DENGACIÓN A SOMETER A LA PRUEBA GENÉTICA), POR SERVICIOS EN LAS FUERZAS ARMADAS.

THIS AGENCY DOES NOT DISCRIMINATE ON THE BASIS OF RACE, CREED, COLOR, NATIONAL ORIGIN, AGE, ANCESTRY, NATIONALITY, MARITAL, OR DOMESTIC PARTNERSHIP OR CIVIL UNION STATUS, SEX, GENDER IDENTITY OR EXPRESSION, DISABILITY, LIABILITY FOR MILITARY SERVICE, AFFECTIONAL OR SEXUAL ORIENTATION, ATYPICAL CELLULAR OR BLOOD TRAIT, GENETIC INFORMATION (INCLUDING THE REFUSAL TO SUBMIT TO GENETIC TESTING).

# FOOD STAMP CARD EXAMPLE

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# NOTICE OF ELIGIBLE DETERMINATIONS - STATE PLAN (D10)

| 1. Issued By: | 6. Claimant's S.S. No. | 7. Seq. No. | 8. Date of Claim | 9. Claim Rec'd |
|---|---|---|---|---|
| New Jersey Department of Labor<br>and Workforce Development<br>Division of Temporary Disability Insurance<br>PO Box 387<br>Trenton, New Jersey 08625-0387 | XXX-XX-[redacted] | 001 | 03/20/12 | 04/17/12 |

2. CLAIMANT'S NAME AND ADDRESS:

[redacted]

| 10. Mailing Date | 11. Det. No. | 12. Exam No. |
|---|---|---|
| 04/20/12 | 001 | 320 |

13. Claimant's Base Year
From: 03/20/11 To: 03/17/12

14. Minimum Requirements For Valid Claim
Wages = $ [redacted] or 20 Base Weeks
Base Week Amount = $ [redacted]

3. EIN [redacted] 4. CHG% [redacted]

5. EMPLOYER'S NAME AND ADDRESS:
[redacted]

15. Claimant's Covered NJ Earnings in Base Year
A. Wages = $ [redacted] B. Base Weeks = 52

16. Claimant Entitlement: (Payable as eligible periods are established)
A. Weekly Benefit Rate: $ 293.00 B. Max. Benefit Amt: $ [redacted]

17.

WE HAVE REVIEWED YOUR CLAIM AND DETERMINED THAT YOU ARE ELIGIBLE FOR BENEFITS.

YOUR MOST RECENT EMPLOYER WILL RECEIVE A COPY OF THIS DETERMINATION. YOU AND YOUR EMPLOYER HAVE THE RIGHT TO APPEAL OR DISAGREE WITH ANY DETERMINATION ISSUED ON YOUR CLAIM

IF YOU ARE INELIGIBLE FOR ANY PERIOD OR YOUR BENEFITS ARE REDUCED, YOU WILL RECEIVE A SEPARATE NOTICE EXPLAINING WHY.

GENERAL INFORMATION

PREGNANCY RELATED CLAIMS: For information pertaining to bonding with your newborn child, visit our web site at www.state.nj.gov/labor. If you are covered under the State Plan for Family Leave Insurance you will receive instructions for filing a claim after we receive your child's date of birth.

DISABILITY BENEFITS WILL NOT BE PAID FOR ANY PERIOD:
- You worked.
- You were not under medical care of a licensed doctor.
- You received:
  - Unemployment Compensation.

(CONTINUED ON REVERSE ->)

[redacted]
Assistant Commissioner

**RIGHT OF APPEAL**

**IF YOU DISAGREE WITH ANY PART OF THIS DETERMINATION, YOU MAY FILE AN APPEAL BY WRITING TO THE ADDRESS GIVEN ABOVE IN ITEM 1. THIS DETERMINATION WILL BECOME FINAL UNLESS AN APPEAL IS RECEIVED OR POSTMARKED WITHIN SEVEN DAYS AFTER DELIVERY OR TEN DAYS AFTER THE DATE OF MAILING OF THIS NOTICE GIVEN ABOVE IN ITEM 10.**

**ESTA DETERMINACION AFECTA SU ELIGIBILIDAD PARA BENEFICIOS Y DESCRIBE SU DERECHO DE APELACION. SI USTED NO HABLA INGLES, BUSQUE, DE INMEDIATO, A UNA PERSONA QUE PUEDA INTERPRETAR ESTA DETERMINACION...**

DABS1 (Rev. 4/5/11) D10/D20

12042000618

0006199972

**Temporary Disability Benefits Sample**

SOCIAL SECURITY
2200 STATE RT 10
SUITE 200
PARSIPPANY NJ 07054
Date: August 16, 2012
Claim Number: [redacted] DI

[redacted]

***Must have DI after claim number**

# Supplemental Security Income (SSI) Benefits sample letter

We are writing to tell you about changes in your Supplemental Security Income (SSI) payments. The following chart shows the SSI money due you for the months we changed. As you can see from the chart, we are changing your payments for both past and future months. The rest of this letter will tell you more about this change.

We explain how we figured the monthly payment amounts on the worksheets at the end of this letter. The explanation shows how your income, other than any SSI payments, affects your SSI payment. We include explanations only for months where payment amounts change.

**Your Payments Will Be Changed As Follows:**

| From | Through | Amount Due Each Month |
|---|---|---|
| May 1, 2012 | July 31, 2012 | [redacted] This includes [redacted] from the State of New Jersey. |
| August 1, 2012 | Continuing | [redacted] This includes [redacted] from the State of New Jersey. |

**Our Decision About How We Will Pay You**

We have decided that your Supplemental Security Income payments will be paid directly to you.

See Next Page

SSA-L8151

[redacted]

Social Security Administration
**Retirement, Survivors and Disability Insurance**
Notice of Award

Office of Central Operations
1500 Woodlawn Drive
Baltimore, Maryland 21241-1500
Date: February 15, 2009
Claim Number: [redacted]HA

***Must have HA or DI after claim number**

[redacted]

[redacted]

You are entitled to monthly disability benefits beginning [redacted]

**What We Will Pay And When**

- You will receive $2,257.00 for March 2009 around April 22, 2009.
- After that you will receive $2,257.00 on or about the fourth Wednesday of each month.
- These and any future payments will go to the financial institution you selected. Please let us know if you change your mailing address, so we can send you letters directly.

The day we make payments on this record is based on your date of birth.

**Other Social Security Benefits**

The benefit described in this letter is the only one you can receive from Social Security. If you think that you might qualify for another kind of Social Security benefit in the future, you will have to file another application.

**Your Responsibilities**

You are due disability benefits because you are expected to be disabled under our rules for at least 5 full calendar months. Therefore, you should let us know if your health improves or you are able to return to work.

The decisions we made on your claim are based on information you gave us. If this information changes, it could affect your benefits. For this reason, it is important that you report changes to us right away.

Enclosure(s):
Pub 05-10153
Pub 05-10058

C

See Next Page

**Social Security Disability Benefits sample**

BENEFIT VERIFICATION SAMPLE LETTER

This letter can be obtained by creating an account at www.ssa.gov

Social Security Administration

Date:January 22, 2013

Claim Number **xxx-xx-xxxxHA**
**or DI**

NAME
STREET ADDRESS
CITY, STATE, ZIP

You asked us for information from your record. The information that you requested is shown below. If you want anyone else to have this information, you may send them this letter.

**Information About Current Social Security Benefits**

Beginning December 2012, the full monthly Social Security benefit before any deductions is $[redacted] We deduct $[redacted] for medical insurance premiums each month.

The regular monthly Social Security payment is $[redacted]. (We must round down to the whole dollar.)

Social Security benefits for a given month are paid the following month. (For example, Social Security benefits for March are paid in April.)

Your Social Security benefits are paid on or about the third Wednesday of each month.

**Information About Past Social Security Benefits**

From December 2011 to November 2012, the full monthly Social Security benefit before any deductions was $[redacted]

We deducted $[redacted] for medical insurance premiums each month. The regular monthly Social Security payment was $[redacted]. (We must round down to the whole dollar.) **Type of**

**Social Security Benefit Information**

You are entitled to monthly disability benefits.

**Date of Birth Information**

The date of birth shown on our records is November [redacted]

**Medicare Information**
You are entitled to hospital insurance under Medicare beginning May 2004. You are entitled to medical insurance under Medicare beginning May 2004.

**If You Have Any Questions**

If you have any questions, you may call us at 1-800-772-1213, or call your local Social Security office at 877-405-5870. We can answer most questions over the phone. You can also write or visit any Social Security office. The office that serves your area is located at:

SOCIAL
SECURITY
2620 YORKTOWNE
BLVD BRICK, NJ 08723

If you do call or visit an office, please have this letter with you. It will help us answer your questions.

*Social Security Administration*