SAMPLE APPROVAL LETTER -GROUP 1

This is to advise you that your application for Specified Low-Income Medicare Beneficiary (SLMB) has been approved.

Effective 2/1/98, you are eligible for State payment of your Medicare Part B Premium.

You may expect payment of your Medicare premiums to begin 60 to 90 days from the date of this letter. The Division of Medical Services will make the premium payments directly to the Social Security Administration.

The only benefit of the SLMB program is the payment of your Medicare Part B (SMI) premium.

Additionally, this is to advise you that your application for Qualified Medicare Beneficiary coverage has been rejected because your countable monthly income of $750.00, exceeds the QMB maximum of $671.00 for a single person or $905.00 for a couple.
(13 CSR40-2.270)

IF YOUR SITUATION CHANGES, IT IS YOUR RESPONSIBILITY UNDER THE LAW TO REPORT THESE CHANGES AT ONCE TO THE LOCAL DIVISION OF FAMILY SERVICES OFFICE. THE LAW PROVIDES PENALTIES FOR ANY PERSONS WHO RECEIVE BENEFITS TO WHICH THEY ARE NOT ENTITLED THROUGH MISREPRESENTING THE FACTS OR NOT REPORTING FULL INFORMATION ABOUT THEIR SITUATION.

If you agree with the above decision, you do not have to request a hearing.

If you feel this decision is not correct, you have the right to request a hearing within 90 days of the date of this letter.

If you wish to have a hearing, you may advise us by mail, by telephone, or in person. We will then schedule a hearing for you and tell you the time and place of the hearing. If you request a hearing, you may present your information yourself or you may have your own attorney or other persons who have knowledge of your situation present your information. If you do not have an attorney, or cannot afford one, and you live in an area served by legal aid or a legal services office you may be eligible for this service. You have the right to present witnesses in your own behalf and to question witnesses who appear at the request of the Division of Family Services.

To request a hearing by telephone, call the office at the number listed above.

SAMPLE APPROVAL LETTER - GROUP 2

This is to advise you that your application for Specified Low-Income Medicare Beneficiary (SLMB) coverage as a qualifying individual, has been approved.

Effective 3/3/98, you are eligible for State payment of your Medicare Part B premium through December 1998. You will receive notification in December of your continued eligibility for payment of your Medicare Part B premium.

You may expect payment of your Medicare premiums to begin 60 to 90 days from the date of this letter. The Division of Medical Services will make the premium payments directly to the Social Security Administration.

The only benefit of the SLMB program is the payment of your Medicare Part B (SMI) premium.

Additionally, this is to advise you that your application for Qualified Medicare Beneficiary coverage has been rejected because your countable monthly income of $1000.00 exceed the QMB maximum of $671.00 for a single person or $905.00 for a couple.
(13 CSR40-2.270)

IF YOUR SITUATION CHANGES, IT IS YOUR RESPONSIBILITY UNDER THE LAW TO REPORT THESE CHANGES AT ONCE TO THE LOCAL DIVISION OF FAMILY SERVICES OFFICE. THE LAW PROVIDES PENALTIES FOR ANY PERSONS WHO RECEIVE BENEFITS TO WHICH THEY ARE NOT ENTITLED THROUGH MISREPRESENTING THE FACTS OR NOT REPORTING FULL INFORMATION ABOUT THEIR SITUATION.

If you agree with the above decision, you do not have to request a hearing.

If you feel this decision is not correct, you have the right to request a hearing within 90 days of the date of this letter.

If you wish to have a hearing, you may advise us by mail, by telephone, or in person. We will then schedule a hearing for you and tell you the time and place of the hearing. If you request a hearing, you may present your information yourself or you may have your own attorney or other persons who have knowledge of your situation present you information. If you do not have an attorney, or cannot afford one, and you live in an area served by legal aid or a legal services office you may be eligible for this service. You have the right to present witnesses in your own behalf and to question witnesses who appear at the request of the Division of Family Services.

To request a hearing by telephone, call the office at the number listed above.

SAMPLE APPROVAL LETTER - GROUP 3

This is to advise you that your application for Specified Low-Income Medicare Beneficiary (SLMB) coverage as a qualifying individual, has been approved.

Effective 3/3/98, you are eligible for State payment of a portion of your Medicare Part B premium through December 1998. You will receive notification in December, of your continued eligibility for payment of your Medicare Part B premium.

The only benefit of the SLMB program is the payment of a portion of your Part B (SMI) premium. For calendar year 1998, the State will pay $1.07 for each month you are eligible. The Division of Medical Services will make the payment directly to you in December.

You are ineligible for payment of your full Medicare Part B premium because your monthly income of $1,000.00 exceed the SLMB maximum income of $906.00 for a single person or $1221.00 for a couple. Additionally, this is to advise you that your application for Qualified Medicare Beneficiary coverage has been rejected because you countable monthly income exceeds the QMB maximum of $671.00 for a single person or $905.00 for a couple. (13 CSR40-2.270)

IF YOUR SITUATION CHANGES IT IS YOUR RESPONSIBILITY UNDER THE LAW TO REPORT THESE CHANGES AT ONCE TO THE LOCAL DIVISION OF FAMILY SERVICES OFFICE. THE LAW PROVIDES PENALTIES FOR ANY PERSONS WHO RECEIVE BENEFITS TO WHICH THEY ARE NOT ENTITLED THROUGH MISREPRESENTING THE FACTS OR NOT REPORTING FULL INFORMATION ABOUT THEIR SITUATION.

If you agree with the above decision, you do not have to request a hearing.

If you feel this decision is not correct, you have the right to request a hearing within 90 days of the date of this letter.

If you wish to have a hearing, you may advise us by mail, by telephone, or in person. We will then schedule a hearing for you and tell you the time and place of the hearing. If you request a hearing, you may present your information yourself or you may have your own attorney or other persons who have knowledge of your situation present your information. If you do not have an attorney, or cannot afford one, and you live in an area served by legal aid or a legal services office you may be eligible for this service. You have the right to present witnesses in your own behalf and to question witnesses who appear at the request of the Division of Family Services.

To request a hearing by telephone, call the office at the number listed above.