STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY PETE WILSON, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
BOX 942732
SACRAMENTO, CA 94234-7320

April 8, 1993

TO: All County Welfare Directors Letter No.: 93-25
All County Administrative officers
All County Medi-Cal Program Specialists/Liaisons

SUBJECT: SLMB DENIAL/DISCONTINUANCE FORM, MC 239 SLMB-2

The purpose of this All County Welfare Directors Letter is to notify the counties that the Specified Low-Income Medicare Beneficiary (SLMB) forms, MC 239 SLMB-2 (Denial/Discontinuance Notice of Action), previously distributed to the counties are incorrect. It stated, "The Social Security Administration states you are eligible for Medicare Part B". A copy of the revised MC 239 SLMB-2 forms (English and Spanish) have been enclosed for your use. It states,"The Social Security Administration states you are not eligible for Medicare Part B".

Forms will be available from the Department of Health Services Warehouse located at 1037 North Market Boulevard, Suite 9, Sacramento, CA 95834 on April 15, 1993. When you need forms, please complete order form DHS 2031 and mail to the above address.

If you have any questions, please call Sylvia Finberg at (916) 657-0080.

Sincerely,

ORIGINAL SIGNED BY

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Enclosures

(County Stamp)

MEDI-CAL
NOTICE OF ACTION
Denial or Discontinuance of Benefits as a Specified Low-Income Medicare Beneficiary

Case No: _____

District: _____

IF YOU ARE ALREADY RECEIVING MEDI-CAL BENEFITS, THIS DOES NOT AFFECT THESE BENEFITS.

We reviewed your application to see if you are eligible for a new program called the Specified Low-Income Medicare Beneficiary (SLMB) program.

We determined that:

☐ You are not eligible for the SLMB program.

☐ Your eligibility for the SLMB program ends _____/_____/_____.

Here is why:

☐ Your _____ (income/property) is above the limit. If you have Part A Medicare and should your _____ (income/property) decrease, you may reapply. The limit is $ _____. The income limit may rise in future years.

☐ The Social Security Administration states you are not eligible for Medicare Part B. Contact your local SSA office for more information.

☐ Other reasons _____

☐ You are not eligible for the regular Medi-Cal program because: _____

_____

☐ If you also applied for regular Medi-Cal benefits, you will receive a separate notice about that program.

The regulations which require this action are California Code of Regulations, Title 22,

Sections _____.

_____ (Eligibility Worker) _____ (Phone) _____ (Dated)

MEDI-CAL
NOTIFICACION DE ACCION
Negación o Descontinuación de Beneficios como Beneficiario Especificado de Medicare de Bajos Ingresos

(Sello del Condado)

No. de Caso: _____

Distrito: _____

SI USTED YA ESTA RECIBIENDO BENEFICIOS DE MEDI-CAL ESTO NO AFECTA ESTOS BENEFICIOS.

Hemos revisado su solicitud para ver si usted reúne los requisitos para un programa nuevo que se llama Beneficiario Especificado de Medicare de Bajos Ingresos (SLMB).

Hemos establecido que:

☐ Usted no reúne los requisitos para el programa SLMB.

☐ Su elegibilidad para el programa SLMB termina el _____ / _____ / _____ .

La razón es la siguiente:

☐ Sus _____ (ingresos/bienes) exceden el límite. Si usted tiene la Parte A de de Medicare y si el valor de sus _____ (ingresos/bienes) disminuyen, usted puede volver a presentar una solicitud. El límite es de $ _____. Es posible que el límite de ingreso aumente en los próximos años.

☐ La Administración del Seguro Social (SSA) informa que usted no reúne los requisitos para la Parte B de Medicare. Para más información comuníquese con su oficina local de la SSA.

☐ Otras razones _____

☐ Usted no reúne los requisitos para recibir beneficios normales del programa de Medi-Cal porque:

_____

_____

☐ Si también solicitó beneficios normales de Medi-Cal, recibirá una notificación por separado con relación a este programa .

Los ordenamientos que requieren esta acción son las secciones _____ del Título 22 del Código de Ordenamientos de California.

_____ (Trabajador(a) de elegibilidad) _____ (Teléfono) _____ (Fecha)