Notice Regarding Acceptance of Other Benefits

Date
County
SS No
Case No
SS Claim No

Part A

To be eligible for Medicaid or State Supplementary Assistance, an applicant or recipient or certain spouses of persons in medical institutions must apply for and take any steps necessary to receive payment from other possible sources. You must indicate the status of your application for other cash benefits for which you may be eligible by completing Part B of the form and returning it by _____. Failure to do so will result in denial or cancellation of your Medicaid or State Supplementary Assistance. See Employees' Manual 8-C "Benefits From Other Sources" and 6-B "Nonfinancial Eligibility."

It appears you may be entitled to receive _____

_____

_____ benefits.

The name and address of the agency you must contact is:

Agency		Telephone	
Street	City	State	Zip Code

If you have any questions please call:

Case Worker		Telephone	
DHS County Office	City	State	Zip Code

Part B

Please check the box below which best explains your status in regard to the benefit identified in Part A above. Sign and return one copy to your county office.

☐ I applied for the benefits on _____ (date) and the decision is pending.

☐ I will apply for the above benefits and provide verification that an application has been made within 30 days from the date of this notice.

☐ I refuse to apply for or accept the above benefits.

☐ I have applied for the above benefits and entitlement was denied. Attached is a copy of the Notice of Denial.

Signature of Applicant or Recipient	Date