



Government Assistance Samples

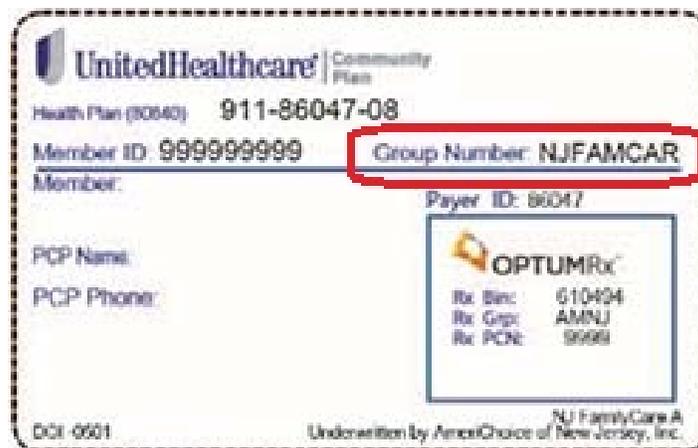
Patients and caregivers if qualified and approved for the state and federal assistance programs listed below for a discounted fee of \$20 for their MMP ID card. Each registration period is valid for 2 years.

- NJ Medicaid Program
- NJ SNAP (Supplemental Nutrition Assistance Program)
 - NJ Temporary Disability Insurance Benefits
 - Supplemental Security Income Benefits (SSI)
 - Social Security Disability Benefits (SSD)
 - Veterans Identification Card
- DD Form 214 (Certificate of Release or Discharge from Active Duty)
 - DD Form 2
 - Medicare

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

Medicaid Samples

We accept either the NJ HBIC card and/or the Medicaid HMO card. This is typically indicated by NJFAMCARE being printed on the card.



The following Horizon HMO cards indicate Medicaid:

Horizon  **Horizon NJ Health**

Horizon Blue Cross Blue Shield of New Jersey

Managed Long Term Services and Supports (MLTSS)

NAME [REDACTED]
MEMBER ID NO: [REDACTED]
PCP [REDACTED]
PHONE [REDACTED]
ISSUE DATE [REDACTED]
EFFECTIVE [REDACTED]

Dental Benefit [REDACTED]
No Copayments [REDACTED]

Pharmacies Group: [REDACTED]
ProCat: HMC

BC/BS Plan Codes 280/780
www.horizonNJhealth.com 000061

Horizon  **Horizon NJ Health NJ FamilyCare**

Horizon Blue Cross Blue Shield of New Jersey
Member License of the Blue Cross and Blue Shield Association
Horizon NJ Health, a product of Horizon HMO
NJST Plan Codes 280/780

NAME [REDACTED]
MEMBER ID NO: YKZ
DOCTOR [REDACTED]
PHONE [REDACTED]
ISSUE DATE [REDACTED]
EFFECTIVE [REDACTED]

Plan:
Dental Benefit [REDACTED]
Emergency \$
PCP Copay \$
Dental Copay \$
Specialist Copay \$
Rx Generic \$
Rx Brand \$

www.horizonNJhealth.com

Horizon  **Horizon Medicare Blue TotalCare (HMO SNP)**

Member Name [REDACTED]
Member ID Number [REDACTED]

OFFICE VISIT:  \$0.00
SPECIALIST: \$0.00
EMERGENCY ROOM: \$0.00

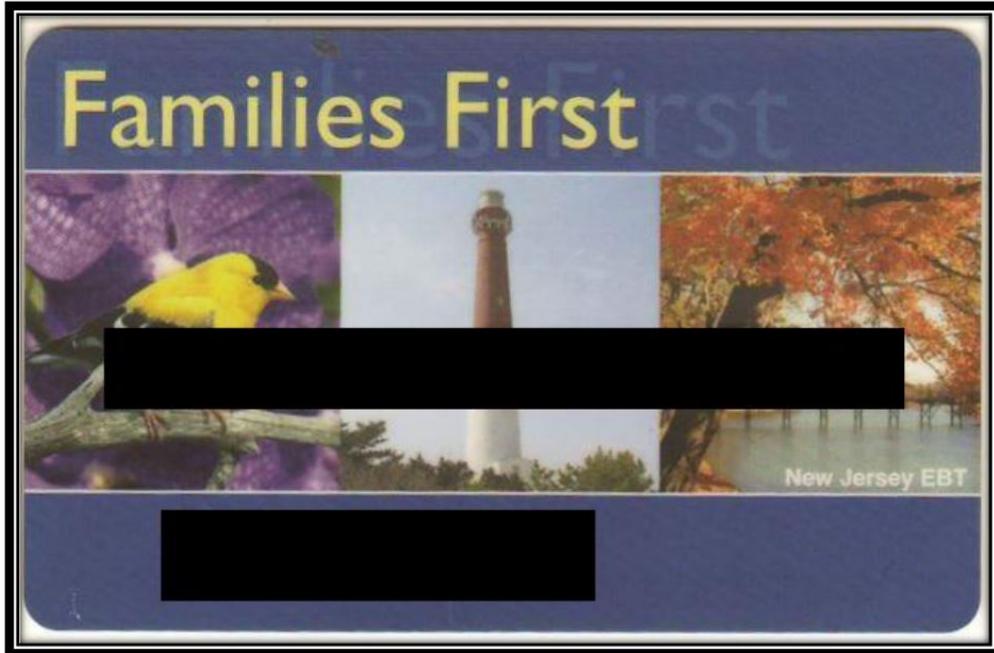
CMS-H3154-020

GROUP NUMBER [REDACTED] RXBIN [REDACTED]
EFFECTIVE DATE [REDACTED] RXPCN [REDACTED]
BC/BS PLAN CODES 280/780 RXGRP [REDACTED]

MedicareRx
Prescription Drug Coverage

NJ SNAP (Supplemental Nutrition Assistance Program)

The MMP will accept the front of your Families First card.



SSI (Social Supplemental Income) & Social Security Disability

Please supply a benefit verification letter dated within the past 90 days. You can obtain this letter by logging into your account or creating an account at www.SSA.gov or by calling SSA at 1-800-772-1213.



Social Security Administration

Date: September 25, 2016

Claim Number: **XXX-XX-XXXX DI or HA**

Name

Street Address

City, State, Zipcode

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 September 2016, the full monthly Social Security benefit before any deductions is

██████████

We deduct ██████████ for medical insurance premiums each month.

The regular monthly Social Security payment is ██████████

(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.

Type of Social Security Benefit Information

You are entitled to monthly disability benefits.

There was no cost of living adjustment in Social Security benefits in December 2015. The benefit amount shown is current as of the date on this letter.

Type of Supplemental Security Income Payment Information

You are entitled to monthly payments as a disabled individual .

There was no cost of living adjustment in Social Security benefits in December 2015. The benefit amount shown is current as of the date on this letter.

From March 1994 to March 1994, 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.)

Information About Supplemental Security Income Payments

Beginning January 2015, the current Supplemental Security Income payment is [REDACTED].

This payment amount may change from month to month if income or living situation changes.

Supplemental Security Income Payments are paid the month they are due. (For example, Supplemental Security Income Payments for March are paid in March.)

Date of Birth Information

The date of birth shown on our records is [REDACTED].

Suspect Social Security Fraud?

Please visit <http://oig.ssa.gov/r> or call the Inspector General's Fraud Hotline at 1-800-269-0271 (TTY 1-866-501-2101).

If You Have Questions

We invite you to visit our web site at www.socialsecurity.gov on the Internet to find general information about Social Security. If you have any specific questions, you may call us toll-free at 1-800-772-1213, or call your local office at 877-600-2852. We can answer most questions over the phone. If you are deaf or hard of hearing, you may call our TTY number, 1-800-325-0778. You can also write or visit any Social Security office. The office that serves your area is located at:

SOCIAL SECURITY
3RD FLOOR
190 MIDDLESEX TRNPIKE
ISELIN, NJ 08830

If you do call or visit an office, please have this letter with you. It will help us answer your questions. Also, if you plan to visit an office, you may call ahead to make an appointment. This will help us serve you more quickly when you arrive at the office.

Social Security Administration

Temporary Disability

NOTICE OF ELIGIBLE DETERMINATIONS - STATE PLAN (D10)				
1. Issued By: New Jersey Department of Labor and Workforce Development Division of Temporary Disability Insurance PO Box 387 Trenton, New Jersey 08625-0387	6. Claimant's S.S. No. XXX-XX-██████	7. Seq. No. 001	8. Date of Claim 03/20/12	9. Claim Rec'd 04/17/12
2. CLAIMANT'S NAME AND ADDRESS: <div style="background-color: black; width: 150px; height: 20px; margin: 5px 0;"></div>			10. Mailing Date 04/20/12	11. Det. No. 001
			12. Exam No. 320	
			13. Claimant's Base Year From: 03/20/11 To: 03/17/12	
3. EIN ██████████ 4. CHG% ██████████			14. Minimum Requirements For Valid Claim Wages = \$ ██████████ or 20 Base Weeks Base Week Amount = \$ ██████████	
5. EMPLOYER'S NAME AND ADDRESS: <div style="background-color: black; width: 150px; height: 15px; margin: 5px 0;"></div>			15. Claimant's Covered NJ Earnings in Base Year A. Wages = \$ ██████████ B. Base Weeks = 52	
			16. Claimant Entitlement: (Payable as eligible periods are established) A. Weekly Benefit Rate: \$ 293.00 B. Max. Benefit Amt: \$ ██████████	
			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 ->)				
<div style="background-color: black; width: 150px; height: 20px; display: inline-block;"></div> 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 HABLE INGLÉS, BUSQUE, DE INMEDIATO, A UNA PERSONA QUE PUEDA INTERPRETAR ESTA DETERMINACION...				

DAB01 (Rev 4/5/11) D10020



12042000618

0006195972

Veterans Documents

DD-214 (example below) can be requested at

<https://www.archives.gov/veterans/military-service-records>

LEGEND: Insert N/A to the items below which are not applicable

PERSONAL DATA	1. LAST NAME - FIRST NAME - MIDDLE NAME		2. SERVICE NUMBER		3. a. GRADE, RATE OR RANK		b. DATE OF BIRTH (Day, Month, Year)				
	4. DEPARTMENT, COMPONENT AND BRANCH OR CLASS				5. PLACE OF BIRTH (City and State or Country)			6. DATE OF BIRTH DAY MONTH YEAR			
	7a. RACE		b. SEX	c. COLOR HAIR	d. COLOR EYES	e. HEIGHT	f. WEIGHT	8. U.S. CITIZEN <input type="checkbox"/> YES <input type="checkbox"/> NO		9. MARITAL STATUS	
TRANSFER OR DISCHARGE DATA	10a. HIGHEST CIVILIAN EDUCATION LEVEL ATTAINED				b. MAJOR COURSE OR FIELD						
	11a. TYPE OF TRANSFER OR DISCHARGE				b. STATION OR INSTALLATION AT WHICH EFFECTED						
	c. REASON AND AUTHORITY						d. EFFECTIVE DATE	DAY	MONTH	YEAR	
SELECTIVE SERVICE DATA	12. LAST DUTY ASSIGNMENT AND MAJOR COMMAND				13a. CHARACTER OF SERVICE			b. TYPE OF CERTIFICATE ISSUED			
	14. SELECTIVE SERVICE NUMBER		15. SELECTIVE SERVICE LOCAL BOARD NUMBER, CITY, COUNTY AND STATE						16. DATE INDUCTED DAY MONTH YEAR		
	17. DISTRICT OR AREA COMMAND TO WHICH RESERVE TRANSFERRED										
SERVICE DATA	18. TERMINAL DATE OF RESERVE OBLIGATION DAY MONTH YEAR		19. CURRENT ACTIVE SERVICE OTHER THAN BY INDUCTION a. SOURCE OF ENTRY <input type="checkbox"/> ENLISTED (First Enlistment) <input type="checkbox"/> ENLISTED (Prior Service) <input type="checkbox"/> REENLISTED <input type="checkbox"/> OTHER:				b. TERM OF SERVICE (Years)		c. DATE OF ENTRY DAY MONTH YEAR		
	20. PRIOR REGULAR ENLISTMENTS		21. GRADE, RATE, OR RANK AT TIME OF ENTRY INTO CURRENT ACTIVE SERVICE		22. PLACE OF ENTRY INTO CURRENT ACTIVE SERVICE (City and State)						
	23. HOME OF RECORD AT TIME OF ENTRY INTO ACTIVE SERVICE (Street, RFD, City, County and State)				24. STATEMENT OF SERVICE		YEARS	MONTHS	DAYS		
	25 a. SPECIALTY NUMBER AND TITLE		b. RELATED CIVILIAN OCCUPATION AND D.O.T. NUMBER		a. CREDITABLE FOR BASIC PAY PURPOSES	(1) NET SERVICE THIS PERIOD	(2) OTHER SERVICE	(3) TOTAL (Line (1) + Line (2))			
					b. TOTAL ACTIVE SERVICE						
					c. FOREIGN AND/OR SEA SERVICE						
	26. DECORATIONS, MEDALS, BADGES, COMMENDATIONS, CITATIONS AND CAMPAIGN RIBBONS AWARDED OR AUTHORIZED										
	27. WOUNDS RECEIVED AS A RESULT OF ACTION WITH ENEMY FORCES (Place and date, if known)										
	28. SERVICE SCHOOLS OR COLLEGES, COLLEGE TRAINING COURSES AND/OR POST-GRADUATE COURSES SUCCESSFULLY COMPLETED				29. OTHER SERVICE TRAINING COURSES SUCCESSFULLY COMPLETED						
	SCHOOL OR COURSE a.		DATES (From - To) b.		MAJOR COURSES c.						
VA DATA	30. a. GOVERNMENT LIFE INSURANCE IN FORCE <input type="checkbox"/> YES <input type="checkbox"/> NO				b. AMOUNT OF ALLOTMENT			c. MONTH ALLOTMENT DISCONTINUED			
	31. a. VA BENEFITS PREVIOUSLY APPLIED FOR (Specify type)							d. A CLAIM NUMBER			
AUTHENTICATION	32. REMARKS										
	33. PERMANENT ADDRESS FOR MAILING PURPOSES AFTER TRANSFER OR DISCHARGE (Street, RFD, City, County and State)					34. SIGNATURE OF PERSON BEING TRANSFERRED OR DISCHARGED					
	35. a. TYPED NAME, GRADE AND TITLE OF AUTHORIZING OFFICER					35. b. SIGNATURE OF OFFICER AUTHORIZED TO SIGN					

VA ID Card



DD Form 2

****DD Form 1173 and DD 1173-1 will not be accepted****

****Front and Back of ID will be required****



Medicare Documents

 **MEDICARE HEALTH INSURANCE**

Name/Nombre
JOHN L SMITH

Medicare Number/Número de Medicare
1EG4-TE5-MK72

Entitled to/Con derecho a
PART A
PART B

Coverage starts/Cobertura empieza
03-03-2016
03-03-2016

 **MEDICARE PPO**

MA 20 PPO MEMBER SINCE 2005 RX

ID HE*****
NAME TEST TEST
RxBIN 610502 RxPCN MEDDAET
GRP#: XXXXXX
ISSUER (80840)

MedicareRx
Prescription Drug Coverage X

DR	20	ER	60
SP	20	HO	260
AS	0		

CMS- H5521 802

 Medicare Solutions 

Health Plan (80840): **911-87726-04**

Member ID: 999999999-99 Group Number: 15500

Member:
SUBSCRIBER BROWN

Payer ID: PEEHIP
87726

MedicareRx
Prescription Drug Coverage X

RxBin:	610097
RxPCN:	9999
RxGrp:	COS

Copay: PCP \$13 ER \$35
Spec \$18

H2001 PBP# 816 UnitedHealthcare Group Medicare Advantage (PPO)
Medicare limiting charges apply.

Any questions regarding the documents that will be accepted for Government Assistance please call the Medicinal Marijuana Program at (609) 292-0424 Monday through Friday 8am -5pm.