Office of Public Assistance
PO BOX 202925
Helena, Montana 59620-2959

BETTY D HOLT
PO BOX 431
TROY, MONTANA 59935-0431

DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES

GREG GIANFORTE
GOVERNOR

CHARLES BRERETON
DIRECTOR

STATE OF MONTANA

www.dphhs.mt.gov

PO BOX 4210
HELENA, MT 59604-4210

Case #: 642664
Document #: 47465136
Print Date: 08/06/2025
Contact Phone: 1-888-706-1535
Contact Fax: 1-877-418-4533
Contact Website: apply.mt.gov

About Your Case

Dear Betty Holt,

The first part of this letter is a summary of your benefits.

Please report changes according to each program's reporting requirements so your benefits can be determined correctly.

SNAP

There have been no changes to your Supplemental Nutrition Assistance Program (SNAP) benefits.

Health Coverage

Your health coverage information is listed below. Please read this entire letter.

Effective Date	Action	Person(s)	Monthly Charge	Explanation
08/01/2025	Approved	Betty D Holt	$35.00	For more information, please see the **Welcome to Medicaid for Workers with Disabilities (MWD)**, **Your Health Coverage Change Reporting Requirements**, and **Your Cost Share Amount** Section. **Action Needed:** To get benefits, you need to provide more information. Please see **What We Need From You** section.
09/01/2025	Approved	Betty D Holt		For more information, please see the **Change in Health Coverage**, **Change in Health Coverage**, **Your Health Coverage Change Reporting Requirements**, and **Qualified Medicare Beneficiary (QMB) Program Information** Section.

If you have any questions, please call the Montana Public Assistance Helpline at 1-888-706-1535.

Your Health Coverage Benefits

Medicaid for Workers with Disabilities (MWD)

Welcome to the MWD program. You can receive your MWD benefits each month by paying a cost share fee to the State of Montana. The amount of the cost share fee is based on the monthly income of the worker(s) with disabilities only.

Each month, you will receive a purple form called the Montana MWD Cost Share Fee Notification and a pink envelope. Use that envelope to send the form with a check or money order for the exact amount. Once we receive the payment, Medicaid will be opened for that whole month. Please be sure the form that is sent with the payment shows the month that you are requesting coverage. You do not have to pay the cost share for any month that you do not want Medicaid to help with medical costs.

Change in Health Coverage

The Medicare Savings Program coverage for the following people has changed from Specified Low Income Medicare Beneficiary (SLMB) or Qualified Individuals (QI) to Qualified Medicare Beneficiary (QMB):

- Betty D Holt

Your countable monthly income is within the limit for the QMB program. The SLMB or QI program only pay your Medicare Part B premium. In addition to this benefit, the QMB program will also pay Medicare deductibles and co-insurance. The QMB program will only help with medical expenses that are covered by Medicare.

Change in Health Coverage

The following people have a change in their prescription drug coverage. Medicaid will no longer pay for prescriptions (with some exceptions, including benzodiazepines, barbiturates and some prescribed over-the-counter drugs) because you will be eligible for Medicare.

- Betty D Holt

Continued Medicaid eligibility requires that people eligible for Medicare accept and enroll in Medicare Part A and Part B. You will also be eligible for Medicare Part D and should enroll in a prescription drug plan. Coverage under the prescription drug plan will likely begin the month after the month of enrollment. It is important to enroll in a drug plan prior to the date of Part D entitlement to avoid a break in prescription drug coverage.

Failure to enroll in Medicare Part A and/or Part B will cause termination of your Medicaid coverage. Medicaid will no longer pay for your prescriptions even if you do not enroll in a Medicare Part D prescription drug plan.

Your Health Coverage Change Reporting Requirements

You must report changes that might affect your health coverage within 10 days of the change. Changes that must be reported for you and other people in your household are:

- Change of address
- Change in marital status (marriage or divorce)
- Change in household composition (someone moves in/out, becomes pregnant or adopts a child)
- Change in income and expenses

You can report changes by:

- Calling the Montana Public Assistance Helpline at 1-888-706-1535
- Logging into your account at apply.mt.gov

- Faxing new information to 1-877-418-4533 or
- Mailing a letter to:
  DPHHS
  PO Box 202925
  Helena, MT 59620-2925

We are required to see if you still qualify for health coverage any time we find out about a change in your case. If you report a change and we find you no longer qualify for health coverage, we will send you a letter telling you your coverage will be ending and at what date. This letter will include information about other ways you may be able to get health coverage.

If you don't have any changes that affect your eligibility, your coverage will continue for a year.

Qualified Medicare Beneficiary (QMB) Information

Your request for a Medicare Savings Program (MSP) has been approved for the following people:

- Betty D Holt

This coverage will pay premiums, deductibles and co-insurance costs for services covered by Medicare Part A and B. Some services may still require a small cost-share. It may take up to 4 months before your Medicare premium is paid by the MSP.

The first month of QMB eligibility at application is considered a wait month, QMB benefits will not be issued until the second month of eligibility. The wait month is not applicable at renewal.

Your Cost Share Amount

The monthly charge amount listed in the Health Coverage Benefit Summary table above is due to a cost share amount. See the table below for details on your cost share. You will receive additional correspondence explaining how you will be charged up to this amount for medical payments before your Health Coverage begins to cover costs.

Individual Name	Cost Share Month	Cost Share Amount
Betty Holt	8/2025	$35.00
Betty Holt	9/2025	$35.00

General Information

Nondiscrimination Statement

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at:

http://www.ascr.usda.gov/complaint filing cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or
(3) email: program.intake@usda.gov

This institution is an equal opportunity provider.

Legal basis for this action is: 42 U.S.C. 1396a(a)(10)(E)(i) and (iv); 42 U.S.C. 1396d (p), ARM 37.82.101, ARM 37.83.201, .202; Current Federal Register publishing poverty standards; P.L. 109-091,43 CFR 423.906,Section 53-6-113(6), 53-6-195, MCA; ARM 37.82.101, 37.82.1002-1007 and 42 USC 1396a(a)(10)(A)(ii)(XIII)

Name: BETTY D HOLT	Case #:642664	Phone: 4062917979	
Address: PO BOX 431	City: TROY	State: Montana	Zip Code: 59935-0431
Address, if different from above:			
Phone, if different from above:			

This letter is your notice that on 08/06/2025, the Department of Public Health and Human Services (DPHHS) made a decision regarding the Health Coverage benefits in your case. If you have any questions about this decision, call the Montana Public Assistance Helpline at 1-888-706-1535.

If you think the decision or amount received is wrong and want someone to review this action, you may request a hearing. You must appeal the decision and request a hearing by 11/04/2025. If you want a hearing AND you would like to continue to receive benefits at the previously authorized level you must request a hearing prior to 08/31/2025 or 10 days from the date of this notice, whichever is later.

IF YOU ARE SATISFIED WITH OUR DECISION AND **DO NOT WANT** A HEARING, PLEASE SKIP THE REMAINDER OF THIS LETTER.

STATE OF MONTANA
DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
OFFICE OF ADMINISTRATIVE HEARINGS
Fax: 406 444-3980
PO Box 202922 Helena MT 59620 2922

HEARING REQUEST

To request a hearing, complete this form and submit it to the Office of Administrative Hearings at the above address.

Oral requests are allowed for **SNAP.** For **SNAP,** you may call the Montana Public Assistance Helpline at 1-888-706-1535 to request a hearing.

I disagree with DPHHS' decision and I request a hearing about my:

- ☐ Supplemental Nutrition Assistance Program (**SNAP**) benefits
- ☐ Temporary Assistance for Needy Families (**TANF**) benefits
- ☐ Health Coverage benefits

I request a hearing because:_____
_____
_____
(Attach a sheet of paper if more room is needed)

_____
Signature (Claimant or Authorized Representative) Date

Name: BETTY D HOLT	Case #:642664	Phone: 4062917979	
Address: PO BOX 431	City: TROY	State: Montana	Zip Code: 59935-0431
Address, if different from above:			
Phone, if different from above:			

Please know that you can have your case presented by a household member or representative, such as legal counsel, a relative, a friend, or other spokesperson. Witnesses can also attend. If you cannot afford an attorney, please call Montana Legal Services Association at 1-800-666-6899 and they may be able to help.

While a hearing decision is pending, if you receive SNAP or Health Coverage benefits, the **benefits may automatically continue at the previously authorized level, as allowable**, unless you tell us you do not want continued benefits. **If the outcome of the hearing is not in your favor, you must repay the amount of continued benefits you received.**

I **DO NOT** want benefits to continue at the previously authorized level for: ☐ SNAP ☐ Health Coverage

TANF cash assistance is different from other programs and **does not continue** unless you tell us you want continued benefits. If you request continued benefits while a hearing decision is pending and the outcome of the hearing is not in your favor, you must repay the amount of continued benefits you received.

I **DO** want my TANF Benefits to continue at the previously authorized level: ☐ Yes ☐ No

DPHHS will contact you with the date and time of your Fair Hearing. You will receive your appointment notice at least 10 days before the appointment.

DPHHS complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-406-444-1386 (TTY: 1-800-833-8503).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-406-444-1386 (TTY: 1-800-833-8503).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-406-444-1386 (TTY: 1-800-833-8503)。

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-406-444-1386 (TTY: 1-800-833-8503) まで、お電話にてご連絡ください。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-406-444-1386 (TTY: 1-800-833-8503).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-406-444-1386 (TTY: 1-800-833-8503).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-406-444-1386 (TTY: 1-800-833-8503).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-406-444-1386 (TTY: 1-800-833-8503) 번으로 전화해 주십시오.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-406-444-1386 (رقم هاتف الصم والبكم: 1-800-833-8503).

เรียน:
ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-406-444-1386 (TTY: 1-800-833-8503).

MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-406-444-1386 (TTY: 1-800-833-8503).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-406-444-1386 (TTY: 1-800-833-8503).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-406-444-1386 (телетайп: 1-800-833-8503).

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-406-444-1386 (TTY: 1-800-833-8503).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-406-444-1386 (TTY: 1-800-833-8503).