Medical Assistance of Workers with Disabilities
P.O.Box 8052
Harrisburg, PA 17105-8052

RESET FIELDS

pennsylvania
DEPARTMENT OF HUMAN SERVICES

www.dhs.pa.gov/MAWD

INITIAL PREMIUM STATEMENT

CO	RECORD	CAT	GG	DIST
RID:				

Client Name and Address:

Premium Month
Payment Due Date
Premium Amount
Total Amount Due

Eligibility Information

_____ has been determined eligible for Medical Assistance for Workers with Disabilities coverage effective _____. Your monthly premium amount has been determined to be $ _____. Please send a check or money order for the total amount due indicated below along with the voucher in the enclosed postage paid envelope by _____. Failure to submit payment by the date provided could result in termination of Medical Assistance benefits.

Regulations and/or Law: The Ticket to Work and Work Incentives Improvement Act of 1999 (PL 106-170) and Act 2001-77 of June 2001 (P.L. 755)

Premiums for continuing Medical Assistance eligibility that are not paid may result in closing of benefits.

Retroactive Eligibility

You have been determined eligible for retroactive Medical Assistance for Worker with Disabilities coverage for the following months:

Month/Yr			
Premium			

Authorization of Medical Assistance for the Retroactive Period will be processed upon receipt of the Premium Payment.
The total premium amount for this retroactive period is $ _____.

If you have questions about this statement, call your CAO caseworker at _____.

▲ **Retain this portion for your records.**

▼ **Detach and return with payment in the enclosed postage paid envelope.**

INITIAL PREMIUM VOUCHER

Retro	Premium Month	Payment Due Date	Premium Amount	Retro-Premium Due	Total Amount Due

- Make Checks payable to: Commonwealth of PA
- Include RID of Client on check or money order.
- Do not send cash.
- If past due amount has been submitted - Thank you.

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PA 1755 8/17

This concerns important information about health care benefits. If you need help translating it, contact your County Assistance Office.

Esto es en referencia a información importante sobre sus beneficios médicos. Si necesita que se lo traduzcan, comuníquese con la Oficina de Asistencia del Condado.

此內容有關醫療照護福利的重要資訊。如果您須要翻譯協助，請與您當地的縣立救濟單位聯繫。

Tài liệu này liên quan đến tin tức quan trọng về trợ cấp chăm sóc sức khỏe. Nếu quý vị cần được giúp đỡ để phiên dịch nó, xin liên lạc với Văn phòng Giúp đỡ tại Quận quý vị cư ngụ.

នេះជាព័តមានដ៏មានសារសំខាន់ស្តីពីផលប្រយោជន៍នៃការថែទាំសុខភាព ។ប្រសិនបើលោកអ្នកត្រូវការជំនួយបកប្រែព័តមាននេះ សូមទាក់ទងមកការិយាល័យជំនួយការតាមខេត្ត ក្រុងរបស់លោកអ្នក ។

Данные материалы содержат важные сведения о предоставляемом вам медицинском обслуживании. Если вам нужна помощь в их переводе, обращайтесь в Бюро помощи вашего графства (County Assistance Office)

CLIENT RIGHTS

RIGHT TO NON-DISCRIMINATION We may not discriminate on basis of age, sex, race, color, ancestry, disability, religious creed, national origin, sexual preference, life-style, union membership, political belief, or because you applied for and/or received assistance before. If you feel discriminated against by the Department or anyone providing services for the Department, you may file a verbal or written complaint with the Department or the appropriate federal or state agency.	**RIGHT TO APPEAL** You have the right to ask for a Departmental hearing to appeal a decision of or a failure to act by the Department, which affects your benefits, or that you feel is unfair or incorrect. You may file the appeal at the County Assistance Office. At the appeal hearing, you may represent yourself or someone else, such as a lawyer, friend, or relative, may represent you. You may have an agency conference before the hearing.
RIGHT TO CONFIDENTIALITY We keep information you give confidential and use it only to administer the programs you apply for and/or may be eligible for.	**RIGHT TO A WRITTEN NOTICE** We will give you a written notice explaining your benefits. If we deny, change, suspend, or stop benefits, we will explain the reason on the notice. You have 30 days from the date of the notice to ask for a hearing if you disagree with the action taken and/or the reasons given.

CLIENT RESPONSIBILITY

RESPONSIBILITY TO PROVIDE SOCIAL SECURITY NUMBERS

You must provide a Social Security Number (SSN) for each person for whom you are applying. If you do not have a SSN, we will help you apply for one. Refusal or failure to provide a SSN may result in disqualification. We will also ask you to supply a SSN to verify identify and administer our programs. We will use your SSN to prevent duplication in state and federal programs and to get information about income to determine eligibility for benefits.

RESPONSIBILITY TO PROVIDE INFORMATION

You must give true, correct, and complete information. You must cooperate to document or prove the information you give. If you cannot provide proof, you should ask the County Assistance Office to help.

RESPONSIBILITY TO REPORT CHANGES

You must report changes within 7 days. You must report changes in the number of people in your household, address, income or resources. You must report any new employment or changes in employment. You must report any plans to leave the state. If you are not sure if you must report a change, you should report the change. You can report to a County Assistance Office staff person by telephone or by mail.

RESPONSIBILITY TO PAY MONTHLY PREMIUM

You are responsible for the payment of your monthly premium. If you do not pay your premium timely, you may lose your health care coverage.

RESPONSIBILITY TO CONTACT PROVIDERS FOR REFUNDS

If you pay for any medical bills between the date of application and the determination of your eligibility, you are responsible for contacting the provider for a refund.

To Report Changes

Medical Assistance Recipients: Complete the bottom half of this form and return in the self addressed stamped envelope and contact your caseworker.	**Employers:** Complete the bottom half of this form and return in the self addressed stamped envelope.

REMEMBER TO REPORT CHANGES

Report all changes regarding Employment status within 7 days. Changes that must be reported include, but are not limited to:

- ☐ LOSS OF EMPLOYMENT
- ☐ NEW EMPLOYMENT
- ☐ CHANGE IN YOUR ADDRESS
- ☐ REQUEST PAYROLL DEDUCTION

PLEASE CHECK ALL CHANGES THAT APPLY AND ADD BELOW:

EXPLANATION OF CHANGE: