

www.dhs.pa.gov/MAWD

INITIAL PREMIUM STATEMENT

CO	RECORD	CAT	GG	DIST	
RID:					
	Premi	um Mon	th		

CI	Client Name and Address:				

Payment Due Date	
Premium Amount	
Total Amount Due	
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 N	Medical Assistance for Worker with [Disabilities coverage for the following	ng 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, contact the Customer Service Center at 1-877-395-8930.

- 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

- $\quad \text{Pay online: } \underline{\text{www.humanservices.state.pa.us/MAWDOnlinePayments}}$
- 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.

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

RID:	
Client Name and Address:	

CAT

RECORD

DIST

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,請與您當地的縣立教 濟單位腦擊。

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

នេះជាពិតមានដ៏មានសារសំខាន់ស្តីពីវេលប្រយោជន៍នៃការថែចាំសុខភាព។ប្រសិនបើលោកអ្នកត្រូវការជំនួយ បកប្រែពិតមាននេះ សូមចាក់ទងការិយាល័យជំនួយការតាមខេត្ត 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	RIGHT TO APPEAL
We may not discriminate on basis of age, sex, race, color, ancestry,	You have the right to ask for a Departmental hearing to appeal a
disability, religious creed, national origin, sexual preference, life-style,	decision of or a failure to act by the Department, which affects your
union membership, political belief, or because you applied for and/	benefits, or that you feel is unfair or incorrect. You may file the appeal
or received assistance before. If you feel discriminated against by the	at the County Assistance Office. At the appeal hearing, you may
Department or anyone providing services for the Department, you may	represent yourself or someone else, such as a lawyer, friend, or
file a verbal or written complaint with the Department or the appropriate	relative, may represent you. You may have an agency conference
federal or state agency.	before the hearing.
RIGHT TO CONFIDENTIALITY	RIGHT TO A WRITTEN NOTICE
We keep information you give confidential and use it only to administer	We will give you a written notice explaining your benefits. If we deny,
the programs you apply for and/or may be eligible for.	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 hear-
	ing 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 by the 10th of the month following the month of change. 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 changes online, through mail, or by calling the Customer Service Center. See the section below on types of changes to report and how to report the change.

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.

REMEMBER TO REPORT CHANGES IN YOUR CIRCUMSTANCES

Report changes by the 10th of the month following the month of change. If you are not sure if you must report a change, you should report the change.

Types of changes to report include:

- · Loss of employment
- New employment
- Change in income or resources
- · Change in your address
- Change in people in your household

How to report changes:

Report changes through your MyCOMPASS account at www.compass.state.pa.us or on the myCOMPASS PA mobile app. If you do not have a MyCOMPASS account, register today.

If you have any questions or would like to report a change by phone, you may call the Customer Service Center at 1-877-395-8930 or for Philadelphia 1-215-560-7226 any time.