MEDICAID WORKS
Agreement

I, _____, want to enroll in ***MEDICAID WORKS***, the
PRINT ENROLLEE NAME
work incentive plan for individuals with disabilities through the Virginia Medicaid program. I understand that this is a voluntary option and that I may leave the program at any time and return to regular Medicaid coverage if I continue to meet the eligibility requirements for another Medicaid covered group. I further understand that while enrolled in ***MEDICAID WORKS***, I will have a different health benefit plan, which includes all standard Medicaid benefits plus personal assistance services, instead of the standard Medicaid benefit plan usually provided to Medicaid enrollees that does not include personal assistance services. I may choose to discontinue the ***MEDICAID WORKS*** benefit plan at any time and return to the standard Medicaid benefit plan.

I know that I must be employed to be enrolled in ***MEDICAID WORKS*** and that a monthly premium payment may be required to continue to participate in this program. I understand that I must establish at least one Work Incentive (WIN) account (a regular checking or savings account) at a bank or other financial institution to be eligible for this work incentive plan. I must deposit all of my earned income into a WIN account and I am able to use this income as needed. If I am going to save some of my earnings, I also must keep it in a WIN account, where I can accumulate up to $41,399 (effective January 1, 2021).

I can have annual earnings of up to $75,000 if I deposit my earned income into my WIN account. If I receive a monthly SSDI payment and the amount increases due to work and/or a cost-of-living adjustment (COLA), I understand that I must deposit the amount of this increase into my WIN account if the new SSDI payment amount exceeds the unearned income limit of 138% of the federal poverty level. In addition, if I become unemployed and receive income from unemployment insurance payments, I must deposit all of these payments into my WIN account in order to remain eligible for ***MEDICAID WORKS*** during the six-month safety net or “grace” period.

I agree to the above requirements for ***MEDICAID WORKS*** and to inform my eligibility worker about changes that may affect my coverage, including but not limited to, change of address, change in income, change in employment or loss of employment. I further agree to provide any required documentation regarding my employer, employment status, earned income and WIN account(s). If I choose to discontinue enrollment in ***MEDICAID WORKS*** or in the benefit plan provided in this program, I will inform my eligibility worker.

_____	_____
Print Full Name	Social Security Number
_____	_____
Signature	Date

Prepared by the Virginia Department of Medical Assistance Services, revised July 1, 2021