

# **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 plan at any time and return to regular Medicaid coverage if I continue to meet the eligibility requirements for another Medicaid covered group.

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 plan. I understand that I must establish at least one Work Incentive (WIN) account at a bank or other financial institution to be eligible for this work incentive plan and that I must deposit all earned income into a WIN account. Through the WIN account, I can have earnings in 2009 of up to \$44,100. If I am going to save some of my earnings, I must keep it in a WIN account, where I can save up to \$30,478 in 2009.

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 employment or loss of employment. I further agree to provide any required documentation regarding my employer, employment status, earned income and WIN account(s).

\_\_\_\_\_  
Print Full Name

\_\_\_\_\_-\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date