

**MBI-WPD
Grace Period Approval
Medical Improvement Group- Medical Condition**

Date: _____

Case Name: _____

Dear Consumer:

This letter confirms the approval of your request for a grace period in the Medicaid Buy-In program for Working People with Disabilities (MBI-WPD) due to a change in your medical condition that:

- does not allow you to work, or
- does not allow you to fulfill the requirements of the Medical Improvement group to work at least 40 hours per month or to work for at least the federally required minimum wage.

This grace period is effective _____ through _____. Your participation in the MBI-WPD program means that your Medicaid coverage will continue unchanged during this grace period.

If there is a change in your medical condition such that:

- you can return to work, or
- you can work at least 40 hours per month or work for at least the federally required minimum wage,

you must notify us immediately and submit documentation of employment, for example a copy of your first pay stub. At that time, you will no longer be in a grace period as you will, once again, be considered an actively employed participant in the MBI-WPD program.

You are allowed up to six months grace period in a twelve-month period. If you have not used the full six months by the end of the effective date stated above and you require an extension of this grace period, you must request an extension in writing. You must document your medical condition with a letter from your physician.

Please contact me if you have any further questions.

Sincerely,