ATTACHMENT XVI

FAMILY HEALTH PLUS
INITIAL ENROLLMENT PERIOD ENDING

CASE NAME (And C/O Name if Present) AND ADDRESS		
DATE	**UNIT OR WORKER NAME**	**UNIT/WORKER PHONE #**

NAME _____ CIN _____

NAME _____ CIN _____

You are now a member of _____ health plan as part of the Family Health Plus program. When you joined this health plan, you were told that you must stay in this plan for 12 months. Those 12 months will be up on **_____.**

Enclosed with this letter are facts about the Family Health Plus health plans you can choose from in your county. If you would like to join a different health plan or if you have any questions, please call the Managed Care Unit at the number listed above.

If you do not wish to pick a different health plan, you will stay in the health plan you are in now, and how you get your health care will stay the same.