HEALTH COVERAGE FOR WORKERS WITH DISABILITIES
PREMIUM NOTICE

Date _____

Name _____
Address _____
_____

Dear _____:

You have been determined eligible for a Medicaid program called "Health Coverage for Workers with Disabilities" (HCWD). North Carolina Law (G.S. 108A-54.1) requires that individuals who participate in HCWD and have countable income greater than two hundred percent (200%) of the Federal Poverty Level (FPL) pay a monthly premium. The premium increases as your income reaches a higher percentage of FPL. Once the premium is paid for a month, your covered medical bills can be paid for that entire month.

Case Id	Client Name	Coverage Month (provide dates)	Amount Due
		Total Amount Due:	**$**

- **Payment is due within 12 days of the date of this letter**
- **Make check payable to "NCDHHS"**
- **Write "HCWD Premium" on memo line of check**
- **Send check or money order to:**
  DHHS Controller
  2019 Mail Service Center
  Raleigh, NC 27699-2019

Check the boxes below to make sure you have enclosed all information needed to process your premium payment.

- ☐ **Enclosed this invoice in envelope**
- ☐ **Enclosed Full Premium (Payment)**
- ☐ **"HCWD Premium" written on memo line of check**
- ☐ **Signed check or money order**

PLEASE NOTE: BENEFITS WILL NOT BE AVAILABLE UNTIL MONTHLY PREMIUM IS PAID IN FULL EACH MONTH. PAYMENTS WILL BE APPLIED TO EARLIEST MONTH DUE. PLEASE DO NOT SEND CASH

If you have any questions concerning this invoice, contact: _____
Caseworker Name

_____
Phone Number

_____
Email