Health Coverage for Workers with Disabilities
(County Letterhead)

Date _____

Recipient _____

Address _____

_____

Application Number _____

We have determined that you are eligible for Health Coverage for Workers with Disabilities (HCWD). Because your income is above 150% of the federal poverty level, State law requires payment of an enrollment fee to obtain HCWD coverage. The enrollment fee is $50 and must be paid by _____, or your application will be denied. If we must deny the application because of failure to pay the enrollment fee, you will have to file a new application to obtain health care coverage.

Mail or bring this letter with your enrollment fee to _____
_____.

Your payment must be paid in full by: _____ cash, _____money order, _____ or certified check. Partial payments will not be accepted.

_____
Income Maintenance Caseworker

Telephone Number _____

Official Use Only

Date of Payment _____

Amount Paid _____

_____
Signature of Collector

Copy to: Applicant
County File
Collector