

**MBI-WPD
Sample Grace Period Letter
For
Medical Condition**

Address/Letterhead

Date

Dear _____:

This letter will confirm 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. This grace period is effective _____ through _____. Your participation in the MBI-WPD program means that your Medicaid coverage will not be interrupted during this grace period.

When there is again a change in your medical condition such that you can return to work, you must notify the local Department of Social Services in writing and submit verification of employment, i.e. 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.

If you are unable to return to work by _____, and require an extension of this grace period, you will be required to request the extension in writing and document your medical condition with a letter from your physician. Remember that for the MBI-WPD program, no more than six months grace period may be allowed in a twelve month period.

Please contact me if you have any further questions.

Sincerely,

Signature