



## West Virginia Medicaid Member Agreement

This Agreement outlines your Rights and Responsibilities as a person in the West Virginia Medicaid Program. It also is about ways you can work with your doctor and other health care providers to become healthier.

### **MEMBER RESPONSIBILITIES**

1. I will follow the requirements of the West Virginia Medicaid program.
2. I will do my best to stay healthy. I will go to health improvement programs as directed by my medical home.
3. I will read the booklets and papers my medical home gives me. If I have questions about them, I will ask for help.

- I will go to my medical home when I am sick.
- I will take my children to their medical home when they are sick.
- I will go to my medical home for check-ups.
- I will take my children to their medical home for check-ups.
- I will take the medicines my health care provider prescribes for me.
- I will show up on time when I have my appointments.
- I will bring my children to their appointments on time.
- I will call the medical home to let them know if I cannot keep my appointments or those for my children.
- I will let my medical home know when there has been a change in my address or phone number for myself or my children.

4. I will use the hospital emergency room only for emergencies.

### **MEMBER RIGHTS**

1. I have the right to pick my medical home. This is where I go for check-ups or when I am sick and where my health care records will be.
2. I have a right to decide things about my health care and the health care of my children. I have a right to see my medical records. I have the right to ask questions about my health care and the health care of my children.
3. I will be treated fairly and with respect. I will get the care and treatment I need as soon as possible. I will not be treated differently because I am in the Medicaid Program.
4. I have a right to know about all laws and rules of the Medicaid Program.

5. I can contact Medicaid or my health plan with any questions about my health care.
6. I have a right to be sent a written notice when West Virginia Medicaid decides to deny or limit my Medicaid eligibility. I have a right to appeal a decision about my eligibility.
7. I have a right to appeal a decision that says I have not kept the member responsibilities in this agreement.

**MEMBER ACKNOWLEDGEMENT**

The information in this paper has been explained to me and I agree to follow this Medicaid Member Agreement.

\_\_\_\_\_  
West Virginia Medicaid Member Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness:

\_\_\_\_\_  
Title:

\_\_\_\_\_  
Location:

\_\_\_\_\_  
Date