

MEDICAID WORK REQUIREMENTS OR COMMUNITY ENGAGEMENT REQUIREMENTS VERIFICATION FORM

Case ID Number: _____

TAKE ACTION TO KEEP YOUR MEDICAID COVERAGE.

We need information to confirm that you meet **work requirements** or **community engagement requirements** for Medicaid. You can meet these requirements by working, participating in work programs, or volunteering/ community service for at least 80 hours each month, or going to school at least half or part-time. A mix of approved work and community engagement activities can count if the combined hours in each activity equal 80 hours in the same month.

Approved activities include:

- Working (including self-employment, seasonal employment, unpaid work or internship)
- Participating in educational programs at least half or part-time
- Participating in a work program
- Volunteering/community service

Some Medicaid members are exempt from these work or community engagement requirements. Exempt members do not have to participate in approved work or community engagement activities.

You are exempt from the work or community engagement requirements if you are:

- Under age 19 or age 65 or older
- A former foster youth under age 26
- Released from incarceration within the last 3 months
- Blind or disabled
- Medically Frail
- A veteran with a total disability rating
- Pregnant or in postpartum coverage
- Participating in substance use disorder (SUD) or alcohol treatment or rehab
- The parent or guardian of a child under age 14
- The parent, guardian, caretaker relative, or family caregiver of a person with a disability
- Meeting Supplemental Nutrition Assistance Program (SNAP) work requirements
- Enrolled in or entitled to Medicare Part A or Part B
- Native American or Alaska Native eligible for Indian Health Service

DEFINITIONS

You may be meeting the work or community engagement requirements if you are working, participating in an educational program, volunteering or participating in a work program.

- **Educational program** means an institution of higher education such as college, community college, proprietary school, vocational school, or university; a program of career or technical education; registered apprenticeships; high school or a program of study leading to a certificate of high school equivalence.
- **Unpaid work** means work, other than community service, that is not for pay. Some, but not all, examples of unpaid work include internships, trial periods for job experience, or caregiving when the individual is not related to nor resides with a dependent child or disabled individual. Unpaid work may benefit an individual or private entity and does not need to benefit the community.
- **Volunteering/community service** means unpaid work, completed voluntarily or because of a mandate by court order, with a structured program that is completed for the direct benefit of the community under the supervision of a public or nonprofit organization. Community service must serve a useful community purpose and does not include activities that directly benefit only specific individuals or activities that are purely recreational. The organization must provide oversight of the activity and have a process in place to track the type of community service, including details on the activity, dates and hours, and a point of contact who can confirm the hours completed.
- **Work program** means a public employment and training program that helps people build skills and find work. These programs are operated or supervised by a state or local government and may include industry or employer training, veterans training, or other federally-supported training. Work programs may include supervised job search and job search training activities, as long as these activities are less than half of the required hours. Work programs may occur as part of an educational program or operate on a stand-alone basis. In Louisiana, most work programs are supervised by Louisiana Works or through Louisiana's American Job Centers.

You may be exempt from meeting the work or community engagement requirements if you are taking care of someone who is not able to care for themselves or if you are medically frail.

- **Caretaker relative and family caregiver** are both trusted adults who provide important daily care to a child or person with a disability. They have different definitions:
 - **Caretaker relative** is a relative of a dependent child or a disabled individual by blood, adoption, or marriage with whom the child or disabled individual is living, and who assumes primary responsibility for the child's or disabled individual's care. A caretaker relative is one of the following: parent; grandparent; sibling (brother or sister); brother-in-law; sister-in-law; step-parent; step-sibling; aunt; uncle; first cousin; niece; or nephew.
 - **Family caregiver** is an adult family member or other individual who has a significant relationship with, and who provides care within a broad range of assistance to, a dependent child or a disabled individual.
- **Medically frail** individuals are those with medical conditions that make it significantly difficult to comply with work or community engagement requirements. This includes individuals who are blind or disabled; with disabling mental disorders; with substance use disorder; with serious or complex medical conditions; or with a physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more activities of daily living.

MEMBER INFORMATION

Complete this section and follow the instructions below.

Member Name: _____

Social Security Number (SSN): _____ Date of Birth: _____
(mm/dd/yyyy)

Case ID Number: _____

HOW ARE YOU MEETING MEDICAID'S WORK OR COMMUNITY ENGAGEMENT REQUIREMENTS?

I am meeting work or community engagement requirements by participating in a total of 80 hours or more per month (completed in the same month) in one or more of the following activities (*check all that apply and complete all sections that apply. **Section G** on page 10 must also be completed*):

- ☐ Working (including seasonal work, unpaid work, or self-employment). Working includes full time work, part time work or unpaid work such as an internship. If checked, complete **Section A** on page 4.
- ☐ Education (at least half or part-time). Education means attending an institution of higher education such as college, community college, proprietary school, vocational school, or university; a program of career or technical education; a high school or high school equivalent program. If checked, complete **Section B** on page 5.
- ☐ Participating in a work program. A work program is supervised by a state or local government and may include industry or employer training, veterans training, or other federally-supported training. If checked, complete **Section C** on page 6.
- ☐ Volunteering or participating in community service. Volunteering or participating in community service means unpaid work in a structured program for the benefit of the community. If checked, complete **Section D** on page 7.
- ☐ I am a caretaker relative or family caregiver. This means you are taking care of someone who is not able to care for themselves. If checked, complete **Section E** on page 8.
- ☐ I am medically frail. This means you are unable to work because of a medical condition. If checked, complete **Section F** on page 9.

IMPORTANT REMINDER:

Complete all sections that apply to you.
Section G must also be completed.

SECTION A: WORKING

Complete this section if you have worked, including self-employment or seasonal work.

Attach **one or more** of the following **OR** have your **employer** complete this section:

- Recent pay stubs
- Employer letter verifying hours worked
- Self-employment records (such as invoices, ledgers, or tax records)

EMPLOYMENT INFORMATION:

Employer's Name: _____

Employer's Address: _____

Employer's Phone Number: _____

What was the hourly pay rate for the Medicaid member named on page 3? \$_____ / hour

How frequently were they paid?

☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly ☐ Self-employed ☐ Unpaid work

Was this seasonal work? ☐ Yes ☐ No

List the average number of hours the they worked for each month:

JAN: _____ FEB: _____ MAR: _____ APR: _____ MAY: _____ JUN: _____

JUL: _____ AUG: _____ SEPT: _____ OCT: _____ NOV: _____ DEC: _____

A work supervisor must complete and sign below to certify the information above is true and accurate.

Supervisor's Name: _____ Phone Number: _____

Supervisor's Signature

Date (mm/dd/yyyy)

If you have **additional work** information, **copy this page** and attach the completed copy to the form.

You can also visit mymedicaid.la.gov to report information about your work through the self service portal or the EMMY tool.

SECTION B: EDUCATION

Complete this section if you attended school or participated in an education program, including part-time education.

Have your school's **registrar, financial aid office**, or an **academic advisor, faculty member** or **instructor** complete this section.

"School" includes high school, trade school, HiSET (formerly GED programs), community college, academic programs, private college, or a two or four year university.

SCHOOL INFORMATION:

School's Name: _____

School's Address: _____

The Medicaid member named on page 3 was:

☐ Enrolled **full-time**

In which months were they enrolled? *(check all that apply)*

☐ JAN ☐ FEB ☐ MAR ☐ APR ☐ MAY ☐ JUN ☐ JUL ☐ AUG ☐ SEPT ☐ OCT ☐ NOV ☐ DEC

☐ Enrolled **half** or **part-time**

In which months were they enrolled? *(check all that apply)*

☐ JAN ☐ FEB ☐ MAR ☐ APR ☐ MAY ☐ JUN ☐ JUL ☐ AUG ☐ SEPT ☐ OCT ☐ NOV ☐ DEC

☐ Enrolled **LESS** than **half** or **part-time** for _____ hours per term

Are these credit hours or classroom hours? ☐ Credit hours ☐ Classroom hours

In which months were they enrolled? *(check all that apply)*

☐ JAN ☐ FEB ☐ MAR ☐ APR ☐ MAY ☐ JUN ☐ JUL ☐ AUG ☐ SEPT ☐ OCT ☐ NOV ☐ DEC

A school official must complete and sign below to certify the information above is true and accurate:

School Official's Name: _____

School Official's Title: _____

E-mail Address: _____ Phone Number: _____

School Official's Signature

Date (mm/dd/yyyy)

If you have **additional education** information, **copy this page** and attach the completed copy to the form.

SECTION C: WORK PROGRAMS

Complete this section if you have participated in a work program.

Have a member of your **work program staff**, your **instructor**, or your **training coordinator** complete this section.

Work programs are operated or supervised by a state or local government and may include industry or employer training, veterans training, or other federally-supported training. Work programs may include supervised job search and job search training activities, as long as these activities are less than half of the required hours. In Louisiana, work programs are supervised by Louisiana Works or through Louisiana's American Job Centers.

WORK PROGRAM INFORMATION:

Program's Name: _____

Program's Address: _____

The Medicaid member named on page 3 has participated:

☐ **Full-time** in the program for an average of _____ hours per month

In which months did they participate? *(check all that apply)*

☐ JAN ☐ FEB ☐ MAR ☐ APR ☐ MAY ☐ JUN ☐ JUL ☐ AUG ☐ SEPT ☐ OCT ☐ NOV ☐ DEC

☐ **Half or part-time** in the program for an average of _____ hours per month

In which months did they participate? *(check all that apply)*

☐ JAN ☐ FEB ☐ MAR ☐ APR ☐ MAY ☐ JUN ☐ JUL ☐ AUG ☐ SEPT ☐ OCT ☐ NOV ☐ DEC

As part of the work program, have they participated in a supervised job search? ☐ Yes ☐ No

If **YES**, what was the average number of hours per month they spent in a supervised job search? _____
(Up to 39 hours per month can count toward work and community engagement requirements.)

In which months did they participate in a supervised job search? *(check all that apply)*

☐ JAN ☐ FEB ☐ MAR ☐ APR ☐ MAY ☐ JUN ☐ JUL ☐ AUG ☐ SEPT ☐ OCT ☐ NOV ☐ DEC

A program official must complete and sign below to certify the information above is true and accurate:

Program Official's Name: _____

Program Official's Title: _____

E-mail Address: _____ Phone Number: _____

 Program Official's Signature

 Date (mm/dd/yyyy)

If you have **additional work program** information, **copy this page** and attach the completed copy to the form.

SECTION D: VOLUNTEERING/COMMUNITY SERVICE*Complete this section if you have volunteered for community service.*

Have a **representative of the organization** where you volunteer complete this section.

Community service means unpaid work, completed voluntarily or because of a mandate by court order, with a structured program that is completed for the direct benefit of the community under the supervision of a public or nonprofit organization.

COMMUNITY SERVICE ORGANIZATION INFORMATION:

Organization's Name: _____

Organization's Address: _____

List the average number of hours the Medicaid member named on page 3 volunteered for each month:

JAN: _____ FEB: _____ MAR: _____ APR: _____ MAY: _____ JUN: _____

JUL: _____ AUG: _____ SEPT: _____ OCT: _____ NOV: _____ DEC: _____

An organization official must complete and sign below to certify the information above is true and accurate:

Organization Official's Name: _____

Organization Official's Title: _____

E-mail Address: _____ Phone Number: _____

Organization Official's Signature_____
Date (mm/dd/yyyy)

If you have **additional volunteering/community service** information, **copy this page** and attach the completed copy to the form.

SECTION E: CARETAKER RELATIVE/FAMILY CAREGIVER

Complete this section if you are caring for another individual who has a disability or illness.

I certify that I, _____, have a significant relationship with and am the
(print your name)

☐ Caretaker Relative ☐ Family Caregiver (check the box that applies to you)

for _____, who needs care because (check all that apply):
(print the name of the cared for individual)

- ☐ Physical disability or mobility problem
- ☐ Intellectual or development disability
- ☐ Serious mental health condition
- ☐ Serious illness (cancer, HIV, Parkinson's, end-stage renal disease, etc.) or injury that prevents you from working.
- ☐ Organ transplant or transplant waiting list
- ☐ Substance use disorder
- ☐ Other: _____

Your Signature

Date (mm/dd/yyyy)

SECTION F: MEDICALLY FRAIL

Complete this section if you are unable to work due to a medical condition.

I certify that I, _____, am unable to meet work and community
(print your name)
engagement requirements due to the following disabling condition(s) (check all that apply):

- ☐ Physical disability or mobility problem
- ☐ Intellectual or development disability
- ☐ Serious mental health condition
- ☐ Serious illness (cancer, HIV, Parkinson's, end-stage renal disease, etc.) or injury that prevents you from working.
- ☐ Organ transplant or transplant waiting list
- ☐ Substance use disorder
- ☐ Other: _____

How long will you be unable to meet work and community engagement requirements?

☐ Permanently ☐ Temporarily

Your Signature

Date (mm/dd/yyyy)

SECTION G: READ AND SIGN

The Medicaid member must complete this section.

Signing this document is an attestation that, to the best of my knowledge, the information on this form is true and accurate. I understand that falsifying or omitting information may result in an investigation by Medicaid Program Integrity and/or the Louisiana Attorney General's Office or any other state or federal agency over Medicaid funds resulting in jail time and/or a recoupment of paid claims.

Member/Authorized Representative's Name: _____

Case ID Number: _____

Member/Authorized Representative's Signature

Date (mm/dd/yyyy)

RETURNING THIS FORM:

Return the completed form by the due date listed on your notice using one of the following methods:

- **Online:** Visit the website at mymedicaid.la.gov
- **Email:** MyMedicaid@la.gov
- **In Person:** Find a Medicaid office near you at ldh.la.gov/directory/category/medicaid-regional-offices
- **By Fax:** 1-877-523-2987
- **By Mail:** P.O. Box 91283, Baton Rouge, LA 70821-9278

If you need help please call the toll-free number at 1-888-342-6207 as soon as possible.

