Member Name _____ **Member Medicaid #**_____

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

I will follow the requirements of the West Virginia Medicaid program.

- **I will do my best to stay healthy. I will go to health improvement programs as directed by my medical home.**
- **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.**
- **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 or Responsible party Date

_____

Witness: Title:

Location: _____

Date

4/26/06 GW