



DISABILITY RIGHTS
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Transition to Adulthood

A Guide for Transition Age Individuals with Disabilities and Their Families

Chapter 5 - Healthcare

Chapter 5: Healthcare

When you turn 21, many of the services you used as a child are no longer available to you. You may need to find new health insurance, new healthcare providers, and new resources for getting your personal care items and services, such as assistive technology and personal care assistants. This chapter will discuss ways to get health insurance and where to get healthcare services. Some information in this chapter may change due to the proposed Healthy PA Plan.

Health Insurance

Health insurance options for adults include Medical Assistance (MA), Medicare, and private insurance policies. If you have a disability, it is very likely that you will qualify for MA. Some people with disabilities may also qualify for Medicare. If you do not qualify for either MA or Medicare or both, there are several options for getting private health insurance. This section describes some of the health insurance options for adults.

Understanding the Language:

If you have never been in charge of your own insurance before, you may not be familiar with a lot of the words insurance companies use. Here are some of the words you will see a lot:

- **Premiums:** An insurance premium is the amount of money you may have to pay each month to your insurance company for health coverage.
- **Deductible:** A deductible is the amount of money you may have to spend on your medical expenses before your insurance will start to pay. Deductibles can be annual or per incident.
- **Copayment:** A copayment is a set amount of money that you pay for each medical service. This amount may be different for different services. For example, you may have to pay \$20 for a visit to your regular doctor and \$30 for a visit to a specialist. Not all insurance policies require copayments.
- **Coinsurance:** Coinsurance is the portion of the total cost of a service

that you have to pay. For instance, if you have a coinsurance of 30%, and your doctor charges \$100 per visit, you will have to pay \$30 and your insurance company will pay \$70. Not all insurance policies require coinsurance.

- **Primary Care Physician (PCP):** Your PCP is the doctor that you see for standard checkups. Some insurance policies require you to choose a PCP and get a referral from your PCP anytime you need to see a specialist.
- **Managed Care Plan:** A managed care plan is a type of health insurance that forms contracts with healthcare providers and medical facilities to provide care for members at a reduced cost. The providers who have these contracts become part of the managed care plan's "network."
- **Network:** Your network is usually made up of a group of healthcare providers who have contracts with your health insurance company agreeing to charge a reduced rate for their services. Most insurance plans will give incentives to use "in-network" providers, such as lower copays or coinsurance rates.
- **Out-of-Network:** A healthcare provider that does not have an agreement with your health insurance company is considered "out-of-network." Some insurance plans do not cover any services from out-of-network providers, and some will allow you to see out-of-network providers, but will charge a higher copay or coinsurance.
- **Fee-for-Service (FFS):** FFS is a type of payment system in which healthcare providers, including PCPs, get paid separately for each service, such as an office visit, screening test, or treatment. With a FFS model, patients are not limited to a set network of providers.

Medical Assistance (MA) Programs

Part One – Eligibility and Application Requirements

Standard MA: MA, also known as Medicaid or Medical Assistance, is a free public health insurance program paid for by the Department of Public Welfare (DPW) and the federal government. MA is available for many different groups of people, including individuals with disabilities. In Pennsylvania, the MA available to individuals with disabilities is known as Healthy Horizons. If you receive SSI payments, you automatically qualify

for Healthy Horizons, and if you receive SSDI payments, you qualify for Healthy Horizons if you meet certain income and resource requirements. You don't need to have SSI or SSDI to get Healthy Horizons, though. If your health care professional certifies that you have a disability that will last at least 12 months, you can qualify for Healthy Horizons if you meet the income and resource requirements.

Income: If you do not receive SSI payments, you need to meet the income requirement to qualify for MA. To meet the income requirement, your income must be at or below the Federal Poverty Income Guidelines. In 2014, the Federal Poverty Income Guidelines is \$973 per month for a one person household. MA allows certain deductions from your total income before they compare it to the income requirement. These include a \$65 deduction for all applicants and deductions for Impairment Related Work Expenses (IRWE), which are expenses for things related to your disability that you need in order to be able to work, such as an alteration to your vehicle.

Resources: To meet the resource requirement, individuals need to have under \$2,000 in resources and couples need to have under \$3,000. If you are under 21, you are pregnant, or you are responsible for the care of a child under 21, you do not need to meet the resource requirement.

If you have a disability, but your income is higher than the guidelines, you may still be able to qualify for MA. The first option is to reduce your countable income through the "spenddown" option. To apply for MA under the spenddown option, indicate on your application that you would like to do so. You then have two choices of spenddown programs:

Non Money Payment (NMP) option: The caseworker assigned to your application will tell you your monthly spenddown amount. Each month, you will submit receipts or bills to show that you owe or have paid that amount in medical expenses, including insurance premiums, doctors' visits, and prescription costs. Once you meet your spenddown amount, MA will pay the rest of your medical expenses for that month, including costs for prescriptions and most durable medical equipment.

Medically Needy Only (MNO) option: Your caseworker will give you a spenddown amount for a six-month period. You can include expenses from up to three months before this period in your spenddown, so this may be a good option if you have a lot of old unpaid bills. Once you meet your spenddown amount, MA will pay the rest of your medical expenses for that six-month period. The income limits are higher for MNO than for NMP, but if you get MA under the MNO option, it won't cover prescriptions or durable medical equipment.

If you do not meet the income requirements and are unable to meet the requirements by "spending down" your income, you may be eligible for Medical Assistance for Workers with Disabilities (MAWD) or for MA under a Home and Community-Based Services Waiver (Waiver). Eligibility requirements for MAWD are explained on page 72 and eligibility requirements for Waivers are explained beginning on page 74.

You can apply for MA online, in person, or by mail.

Online: <http://www.compass.state.pa.us/>

In person: Go to your local County Assistance Office (CAO). To find your local CAO, visit

<http://www.dpw.state.pa.us/findfacilsandlocs/countyassistanceofficecontactinformation/index.htm> or call DPW at (800) 692-7462.

By mail: Download the application at

http://services.dpw.state.pa.us/oimpolicymanuals/manuals/bop/ma/PA_600.pdf and mail it to your CAO.

Medical Assistance for Workers with Disabilities (MAWD): MAWD gives you insurance if you have a disability, but your income or resources are too high for you to qualify for MA. The income and resource limits are higher for MAWD than for MA, but you have to pay a premium to get MAWD. The premium will be 5% of your countable income, meaning your income after DPW takes certain deductions. If you qualify for MAWD and pay the premium, you will get the same coverage as people who qualify for MA. To qualify for MAWD, you must meet the following requirements:

- You are between the ages of 16 and 64,
- You have a disability,
- You are employed and getting paid,
- You have \$10,000 or less in countable resources, and
- Your countable income is less than 250% of the Federal Poverty Income Guideline (in 2014, 250% of the Federal Poverty Income Guideline is \$2,431 per month for a one-person household).

To meet the definition of disability, you must:

- Be receiving Social Security Benefits,
- Have received Social Security Benefits in the past 12 months and still meet the SSA's definition of disability, or
- Be declared disabled by the CAO.

If you don't receive SSI or SSDI, the CAO can declare you "presumptively disabled" and give you MAWD as long as you provide information about your disability from one of a variety of sources within three months. This information can come from places such as the Office of Vocational Rehabilitation or your Center for Independent Living. DPW's Medical Review Team will then evaluate your documentation and determine if you can still get MAWD past the three month period. If your impairment no longer meets the definition of disability, you may qualify as a worker with a medically improved disability, as long as medical professionals determine that you still have a severe impairment.

DPW does not have requirements about the type of work you can do or how much you have to work. You can work for only one hour per week and still qualify, and jobs like babysitting or mowing your neighbor's lawn count as work as long as you get paid for it. If you don't get a paystub for the work you do, you can get a letter from your employer. If you are self-employed, you must provide proof of your self-employment. You can do this by submitting the MAWD Self-Employment Form found at (http://services.dpw.state.pa.us/oimpolicymanuals/manuals/bop/ma/PA_1762.pdf) or by submitting other verification, such as a business plan, customer lists, or tax returns. If you are applying for MAWD as a worker with a medically approved disability, you must be working at least 40 hours a month and earning at least minimum wage.

If you are married, your spouse's income and resources count toward the limits, and unlike with MA, you have to meet the resource requirement even if you have a child under 21. Your spouse's income will not count when determining the amount of your monthly premium.

You can apply for MAWD online, in person, or by mail. If you apply online, put in the comments section that you are applying for MAWD. For more details about applying, see the section in this guide on applying for MA (page 72) or go to

<http://www.dpw.state.pa.us/fordisabilityservices/healthcarema/medicallassistancebenefitsforworkerswithdisabilities/index.htm>.

Home and Community-Based Services Waivers (Waivers): In order to live independently, some individuals with disabilities need more services and supports than they can get through MA. Waiver programs support individuals who are at risk of institutionalization, or are leaving institutions, and want to live independently in the community instead.

There are several different Waivers that may be available to young adults with disabilities, and each one has its own functional eligibility criteria.

There are also income and resource requirements that are the same for all Waivers. In 2014, an individual must have an income of less than \$2,163 per month and resources below \$8,000. It is important to know that getting into a Waiver is not an entitlement. This means that even if you qualify for a Waiver, you might not be able to get it. There are limited funds for Waivers and some may have waitlists or be closed to new applicants. However, once you are enrolled in a Waiver, you are entitled to the covered services that you need, within the limits of the Waiver rules.

The following Waivers may be available to you:

Attendant Care Waiver Eligibility criteria:

- Ages 18-59;
- Physical impairment lasting 12 months or longer;
- Capable of directing own care, such as selecting and supervising attendants; and

- Certified by a doctor as needing the level of care and services offered in a nursing facility, other than just room and board.
- Overseen by: Office of Long-Term Living (OLTL)
- To apply: Contact the Independent Enrollment Broker, Maximus, at (877) 550-4227.

COMMCARE Waiver Eligibility criteria:

- Age 21 or older;
- Traumatic Brain Injury that results in substantial functional limitations in at least three of the following: mobility, communication, self-care, learning, self-direction, or capacity for independent living; and
- Certified by a doctor as needing the level of care and services offered in a nursing facility, other than just room and board.
- Overseen by: Office of Long-Term Living (OLTL)
- To apply: Contact the Independent Enrollment Broker, Maximus, at (877) 550-4227.

OBRA Waiver Eligibility criteria:

- Age 18-59;
- Developmental disability (manifested before age 22 and likely to continue indefinitely);
- Substantial functional limitations in at least three of the following: mobility, communication, self-care, learning, self-direction, or capacity for independent living;
- Primary diagnosis that is not mental health or intellectual disability (though these can be secondary diagnoses); and
- Certified by a doctor as needing the level of care of an Intermediate Care Facility for persons with developmental disabilities, meaning there is a high need for habilitation services.
- Overseen by: Office of Long-Term Living (OLTL)
- To apply: Contact the Independent Enrollment Broker, Maximus, at (877) 550-4227.

Independence Waiver Eligibility criteria:

- Age 18-59;
- Physical disability that is likely to continue indefinitely;
- Substantial functional limitations in at least three of the following:

mobility, communication, self-care, learning, self- direction, or capacity for independent living;

- Primary diagnosis that is not mental health or intellectual disability; and
- Certified by a doctor as needing the level of care and services offered in a nursing facility.
- Overseen by: Office of Long-Term Living (OLTL)
- To apply: Contact the Independent Enrollment Broker, Maximus, at (877) 550-4227.

Autism Waiver Eligibility criteria:

- Age 21 or older;
- Autism Spectrum Disorder;
- Significant functional limitations in three or more major life activities, such as communication, learning, mobility, self- care, self-direction, or capacity for independent living;
- Need level of care of Intermediate Care Facility.
- Overseen by: Bureau of Autism Services (BAS)
- To apply: Contact BAS at (866) 539-7689 and leave a message with basic information about the caller and about the person applying for the Waiver.

This is a small waiver. Priority is given to individuals who do not have any kind of long-term care services, such as another Waiver or care in a state hospital or a nursing facility or ICF/ID.

AIDS Waiver Eligibility criteria:

- Age 21 or older;
- Diagnosis of HIV/AIDS; and
- Require hospital or nursing facility level of care.
- Overseen by: Office of Long-Term Living (OLTL)
- To apply: Contact the Independent Enrollment Broker, Maximus, at (877) 550-4227.

Person/Family Directed Support (PFDS) Waiver Eligibility criteria:

- Age 3 or older;
- Diagnosis of an intellectual disability; and

- Needs Intermediate Care Facility level of care, meaning there is a high need for habilitation services.
- Overseen by: Office of Developmental Programs (ODP)
- To apply: Contact ODP at (888) 565-9435.

Consolidated Waiver Eligibility criteria:

- Age 3 or older;
- Diagnosis of an intellectual disability; and
- Needs Intermediate Care Facility level of care.
- Overseen by: Office of Developmental Programs (ODP)
- To apply: Contact ODP at (888) 565-9435.

If you have questions about how a Waiver works or how to apply or get on a waiting list, call the agency that oversees that Waiver.

Part Two – MA Benefits

MA Benefits for Adults: If you are under 21 or you are pregnant, there is no limit to your MA benefits, but for all other adults, your MA will be limited to certain services each year, and the amount, duration, and scope of services may also be limited. If you need services beyond the limits, you or your medical provider can contact DPW to request an exception. You can do this before or after you receive the service.

EPSDT: If you are under 21, you qualify for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). This means that you are entitled to almost any medical care you need, if it is something covered by MA. If the MA program or your MA managed care company does not think you need the care, they must send you a notice explaining their decision and telling you how to appeal the decision.

Waiver Benefits: If you have a Waiver, you automatically qualify for MA, and you may be eligible for many additional services not covered by MA that can help you stay in your home or another community-based setting. These extra services can help you fill in the gap when you turn 21 and your MA services become more limited, and many of the Waivers can also

provide extra services before you turn 21. A few of the Waivers, such as Autism and Commcare, are only available after age 21, but most are available earlier (see details in previous section). If a service is covered by EPSDT, your Waiver will not cover it, but the Waiver can be used to supplement EPSDT. This means that if you are in a Waiver, but you are under 21 and still eligible for EPSDT, MA will pay for any services that EPSDT normally covers. You can then use your Waiver to pay for services that are not covered by EPSDT, such as supported employment services or home modifications. Below are some examples of services covered by each Waiver.

Attendant Care Waiver

- Personal assistance services, such as help with bathing and meal preparation;
- Supports coordination;
- Personal emergency response system; and
- Community transition services if you are leaving an institution.

COMMCARE Waiver

- Assistive technology;
- Community integration;
- Counseling;
- Personal assistance services; and
- Service coordination.

OBRA Waiver

- Assistive technology;
- Community integration;
- Residential habilitation in a community home;
- Personal assistance services;
- Home health services (including nursing services); and
- Supported employment services.

Independence Waiver

- Assistive technology;
- Community integration;
- Personal assistance services;

- Home health services (including nursing services); and
- Supports coordination.

Autism Waiver

- Assistive technology;
- Residential habilitation (in a community home);
- Behavioral specialist;
- Community inclusion;
- Family training; and
- Supported employment.

AIDS Waiver

- Home health aide;
- Nutritional consultation;
- Specialized medical equipment and supplies; and
- Personal assistance services.

Person/Family Directed Support (PFDS) Waiver

- Adaptive appliances and equipment;
- Respite care;
- Day habilitation;
- Homemaker services;
- Supports coordination; and
- Supported employment.
- NOTE – services limited to approximately \$30,000 per year.

Consolidated Waiver

- Residential habilitation in a community home;
- Day habilitation;
- Adaptive appliances and equipment;
- Homemaker services;
- Supports coordination;
- Supported employment; and
- Home finding.

When you are approved for a Waiver, you will meet with a Supports Coordinator to develop a care plan. The Supports Coordinator should tell you all the services that are available under that particular Waiver, and then you will work together to decide what services you need and how often you will need them. While you will be included in the assessment of your needs, other people's assessments may be considered as well. You will also develop a budget outlining how much your services will cost. You can bring family members and anyone else you choose to your meeting to help provide input on the services you need. You should ask for all the services you think you will need to live safely in the community. Don't leave anything out, because once you finalize your care plan, it is usually in place for one year and can be difficult to change. If the Waiver program does not approve all the services you think you need, you can file an appeal. Once you finish your care plan, your Supports Coordinator will help find providers for the services you need. Some of the Waivers allow family members to be paid for providing some of the services in your care plan. If this is something you would like, ask your Supports Coordinator if it is an option for you.

Medical Assistance Transportation Program (MATP): If you have MA or MAWD, MATP will help you get to and from your health care services. You can use MATP to get to any health care services that are covered by MA, such as doctors' appointments and the pharmacy. MATP can give you a ride to your services, reimburse you for public transportation costs, or reimburse you for mileage if you use your own car or have someone else drive you. You need to use the least costly method of transportation that you can use. Your MATP provider will tell you which to use, based on the information you give when you register and when you call to request transportation.

If MATP gives you a ride, you will normally be picked up at the curb. If you can't get to the curb because of your disability, you need to tell that to MATP when you call for services. You will then be provided with door-to-door service.

In order to use MATP, you need to register. You can do this by calling the MATP provider for your county. You can find phone numbers for your county's MATP provider at <http://matp.pa.gov/CountyContact.aspx>. When

you call to register, tell your provider about any special needs you have that may affect what kind of transportation you need. For instance, tell the provider if you use a wheelchair or you can't use public transportation.

Part Three – Copayments

Adults over the age of 18 may have to pay a copayment for some MA services. You will pay this copayment directly to the provider. Providers can't refuse to provide services if you are unable to pay the copayment, but they can try to collect it from you later.

Part Four – MA and Other Insurance

MA may be your only insurance, or it may be used to supplement Medicare or private insurance. If you also have Medicare or private insurance, MA will, under many circumstances, cover leftover costs, such as copayments or the cost of services not covered by Medicare or your private insurance. MA can also pay your Medicare premiums but will not ordinarily pay private insurance premiums, unless the state requires you to get private insurance. For more on Medicare, see page 83.

Part Five – Health Plans

MA coverage is usually offered through a variety of health plans. There are a few small categories of people whose MA will be provided directly by DPW. Depending on which county you live in, you will be given a choice of at least two physical health plans. Once you are approved for MA, you will be asked to enroll in a physical health plan and choose a primary care physician. If you don't, a health plan and primary care physician will be chosen for you. Each health plan has its own network of providers, so if you have specific doctors or other healthcare providers that you want to use, you should find out which health plans they are enrolled in before you choose a plan. For behavioral health (mental health) services, there is only one health plan in each county, so you will be automatically assigned to that plan. You can find out more about your options, enroll in a health plan, search for covered doctors, and choose a primary care physician at

<http://www.enrollnow.net>. If you have questions, you can contact Enrollment Services at (800) 440-3989 (voice) or (800) 618-4225 (TTY).

Part Six – Appeals and Grievances

MA and MAWD: If your application for MA or MAWD is denied, you can appeal to DPW, or if your health plan refuses to cover a medical service, you can appeal to the health plan or to DPW. You should receive a denial letter explaining the reason for the decision. Your denial letter should have instructions on how to file a grievance with your health plan if you have been denied coverage for a service, including how long you have to do so. The denial letter should also have instructions on how to request a fair hearing with DPW, which you must do within 30 days of the decision. If you are appealing because your current services are being terminated, reduced, or changed, you must file your appeal **within 10 days** in order to keep your services while you wait for a decision. If you do not receive a denial letter with instructions, contact your local CAO for assistance. You should send your appeal request by certified mail so you can prove when you sent it and when it was received.

Waivers: If you disagree with a decision related to a Waiver, you can request a fair hearing. There are several reasons why you might want to request a fair hearing. You can request a hearing if:

- Your Waiver application is denied;
- Your Waiver is terminated;
- The services you ask to put in your care plan are denied;
- The services you are getting are terminated, reduced, or changed;
- You are not given a choice of providers for your services or the agency denies your request for a specific provider; or
- There is a delay in putting your Waiver services in place after the Waiver is approved or after you request a change.

When one of these situations occurs, you should receive notice from the state or the agency that made the decision. The notice should have instructions on how to file an appeal. If you do not receive a notice or instructions about appealing, contact the agency you applied to. In most

cases, you must file your appeal **within 30 days** of the date the notice is issued. If you are appealing because your services are being terminated, reduced, or changed, you must file your appeal **within 10 days** of the notice if you want your services to continue during the appeal process.

Always put your appeal request in writing and keep a copy for yourself. If you can, send your appeal by certified mail or request a return receipt so you have proof of when you sent it and when it was received.

If you are unhappy about the provision or timeliness of your services, you have a complaint about program eligibility, or you wish to report abuse, neglect, or exploitation, but you don't think you need a fair hearing, you can file a grievance with the agency that oversees your Waiver. You do not need to file a grievance before you can request a fair hearing.

For the Attendant Care, COMMCARE, OBRA, Independence, or AIDS Waivers, file your grievance with the Office of Long-Term Living (OLTL) by calling their helpline at (800) 757-5042. You will receive an initial response within 1 business day.

For the Autism Waiver, file your grievance with the Bureau of Autism Services (BAS) by calling (866) 539-7689. BAS will resolve your complaint within 30 days and notify you of the resolution in writing.

For the PFDS Waiver or Consolidated Waiver, file your grievance with the Office of Developmental Programs (ODP) by calling their customer service line at (888) 565-9435.

Medicare

Medicare is a health insurance program run by the federal government. Medicare is available to people age 65 and older who receive Social Security Retirement benefits and to people under age 65 who receive Social Security Disability Insurance (SSDI). You can get Medicare as a person with a disability after you have been eligible for SSDI for 24 months. This is not necessarily 24 months after you get your first SSDI check – you may have become eligible for SSDI earlier than that. It doesn't matter

whether you get SSDI based on your own work history or based on your status as a Disabled Adult Child. The waiting period applies in both situations. There is no waiting period for an individual with amyotrophic lateral sclerosis (ALS), however.

Medicare coverage is broken into four Parts. Each Part covers different services and each has its own procedures for enrolling and its own rules about premiums, deductibles, and coinsurance. You can also enroll in a Medigap policy to cover services your Medicare insurance doesn't cover.

Part A: Hospital Insurance

Part A is Medicare's Hospital Insurance. Together, Part A and Part B are known as "Original Medicare." With Original Medicare, you can use any provider who chooses to accept Original Medicare. Part A covers care in a nursing facility, hospital, or hospice. If you are homebound, it will also cover home health services, such as part-time skilled nursing care.

If you have worked long enough (or if you get SSDI as a Disabled Adult Child), Medicare Part A is free. Otherwise, you will have to pay a monthly premium. However, if you are a Qualified Medicare Beneficiary (QMB), you are eligible for a "Buy-In" of Medicare Part A. This means that Medical Assistance will pay your Part A premium. If you are a QMB, Medical Assistance will also pay your Part A deductible and coinsurance. For more details about QMB, see page 85 of this guide.

If you are eligible for Medicare based on your SSDI, you will be automatically enrolled in Medicare Part A. You should get a notice a few months before your 24-month waiting period ends letting you know that your Medicare is about to start.

Part B: Medical Insurance

Part B is Medicare's Medical Insurance. Together, Part A and Part B are known as "Original Medicare." With Original Medicare, you can use any provider who chooses to accept Original Medicare. Part B covers

preventative services, such as your annual physical exam or vaccinations, and medically necessary services or supplies. A service or supply is “medically necessary” if you need it to diagnose or treat a medical condition and it meets the generally accepted standards of medical practice. This could include things like mental health treatment, lab tests, and durable medical equipment, such as wheelchairs and air-fluidized beds. To find out if your service or supply will be covered by Part B, you can search for it at <http://www.medicare.gov/coverage/your-medicare-coverage.html>.

In some areas, Medicare has a Competitive Bidding Program. If you live in this area, you can only get your durable medical equipment from certain providers. For more information, go to: <http://www.medicare.gov/Supplier/static/SupportTab.asp?activeTab=3&viewtype>.

If you are eligible for Medicare based on your SSDI, you will be automatically enrolled in Medicare Part B. Medicare Part B has a monthly premium. In 2014, the premium for most people is \$104.90. Because you have to pay a monthly premium for Part B, you don’t have to enroll in it. You should get a notice a few months before your waiting period ends letting you know that your Medicare coverage is about to start. This notice will include information on how to decline Part B. If you decline Part B, you can sign up for it later. However, there is only a short period of time each year during which you can sign up, and you will probably have to pay a higher premium.

Before you decline Part B, find out if you qualify to have your Part B premium paid by DPW through a Medicare Savings Program (MSP). If you qualify for an MSP, you are eligible for a “Buy-In” of Medicare Part B. This means that DPW will pay your Part B premium. There are three ways to qualify for a Medicare Savings Program:

- **Qualified Medicare Beneficiary (QMB):** To be a QMB, your countable income must be no more than 100% of the Federal Poverty Income Guidelines. In 2014, this means you must have a monthly income of \$973 or less for a one person household. You must also have resources worth no more than \$7,160. If you are under 21, you are pregnant, or you are responsible for the care of a child under 21,

you do not need to meet the resource requirement. Anyone who qualifies for SSI or Healthy Horizons Medical Assistance is a QMB. If you meet the requirements for a QMB, DPW will pay your Part B premium. DPW will also pay your Medicare coinsurance/copayments and deductibles.

- **Specified Low-Income Medicare Beneficiary (SLMB):** To be a SLMB, your countable income must be between 100% and 120% of the Federal Poverty Income Guidelines. For 2014, this means you must have a monthly income between \$973 and \$1,167 for a one person household. You must also have assets worth no more than \$7,160. If you meet the requirements for SLMB, DPW will pay your Part B premium.
- **Qualifying Individual (QI-1):** To be a QI-1, your countable income must be between 120% and 135% of the Federal Poverty Income Guidelines. For 2014, this means you must have a monthly income between \$1,167 and \$1,313 for a one person household. You must also have assets worth no more than \$7,160. If you meet the requirements for QI-1, DPW will pay your Part B premium. Note that, unlike the other MSPs, QI-1 status is not an entitlement. This means that if the state runs out of funding for its QI-1 program, it can start to turn away people who are otherwise eligible. It is therefore important to apply for QI-1 benefits early.

You can apply for a Medicare Savings Program online, in person, or by mail.

Online: <http://www.compass.state.pa.us/>

In person: Go to your local County Assistance Office (CAO). To find your local CAO, visit

<http://www.dpw.state.pa.us/findfacilsandlocs/countyassistanceofficecontactinformation/index.htm> or call DPW at (800) 692-7462.

By mail: Download the model application at

<http://www.socialsecurity.gov/prescriptionhelp/MSP-Model-Application-ENG.pdf> and mail it to your CAO.

Part C: Advantage Plus

Part C, also known as Medicare Advantage Plans, is Medicare coverage offered through a private health insurance company. If you enroll in Part C, you still have Medicare, but you get your Part A and Part B coverage through the private company. If you decide to get Part C coverage, you will have many health plans to choose from. For most Medicare Advantage Plans, you have to use providers who are in the plan's network of providers. If you go to a provider outside of the plan's network, you may have to pay more, or even all, of the costs. Most Medicare Advantage Plans also require a monthly premium. This premium is **in addition to** your Part B premium. However, it may still be worth it to choose a Medicare Advantage Plan, because they often offer different or additional services. Many Medicare Advantage Plans include prescription drug coverage, so you don't need Part D (more about Part D below). The best option for you will depend on what kinds of services you use most often.

There are a few different types of Medicare Advantage Plans. If you have a disability, you may be interested in a Special Needs Plan. A Special Needs Plan is a type of Medicare Advantage Plan that may be available to you if you meet one of the following three requirements: (1) you live in certain institutions, such as a nursing facility, or you require nursing care at home; (2) you are eligible for both Medicare and Medical Assistance; or (3) you have a qualifying chronic condition. Special Needs Plans are specially designed to meet the needs of people in the specific group they cover. So if you have a qualifying condition and choose a Special Needs Plan that is designed to cover that condition, it may provide better coverage for the services you need than other plans do. All Special Needs Plans include Medicare prescription drug coverage. Each insurance company can choose whether to offer Special Needs Plans and what groups to cover, so the Special Needs Plans available vary depending on where you live. For more information about Special Needs Plans, including a list of qualifying conditions, see <http://www.medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-advantage-plans/special-needs-plans-faq.html>.

To find and enroll in a Medicare Advantage Plan, including a Special Needs Plan, use the search tool at <https://www.medicare.gov/find-a-plan/questions/home.aspx>. You can also enroll by contacting the health plan directly or by calling (800) MEDICARE or (800) 633-4227. You can enroll when you first become eligible for Medicare or during one of two enrollment periods offered each year.

Part D: Prescription Drug Plan

Part D is Medicare's Prescription Drug Plan (sometimes called a PDP). Part D coverage is offered through private health insurance companies that are approved by Medicare. Each health plan will set its own costs and will decide which drugs it will cover, so think carefully about your needs before you pick your plan. To find and enroll in a Prescription Drug Plan, use the search tool at <https://www.medicare.gov/find-a-plan/questions/home.aspx>. You can also enroll by contacting the health plan directly or by calling (800) MEDICARE or (800) 633-4227. You can enroll when you first become eligible for Medicare or during one of two enrollment periods offered each year.

You can't get prescription drug coverage through Part C and Part D at the same time. If you are enrolled in a Medicare Advantage Plan (Part C), including a Special Needs Plan, that already has drug coverage and you enroll in Part D, you will be removed from Part C and returned to Original Medicare.

If you have difficulty paying your prescription drug costs, you may be eligible for a Medicare Part D Low-Income Subsidy, also known as "Extra Help." Extra Help can help you pay your Part D premiums, deductibles, and copayments. If you already have Medical Assistance or a Medicare Savings Program, you automatically qualify for the full subsidy and don't need to apply. If you don't have either of these benefits, you must apply for the subsidy.

To be eligible for a full or partial subsidy through Extra Help, your income must be below 150% of the Federal Poverty Income Guidelines (\$1,459/month for a one-person household in 2014) and your assets must be worth no more than \$13,440.

If you qualify for the full subsidy and are a Medicaid Home and Community-Based Services Waiver (Waiver) participant, you should have no prescription drug copays. For more on Waivers, see page 74 of this guide.

For more information about Extra Help, visit - <http://www.ssa.gov/prescriptionhelp/>. To apply online, visit - <https://secure.ssa.gov/i1020/start>. If you would like to apply by mail or in person, call (800) 772-1213 (voice) or (800) 325-0778 (TTY) to request an application or make an appointment.

Medigap: A Medigap policy is an optional supplemental insurance that helps pay for costs your Medicare policy doesn't cover, such as copayments, coinsurance, and deductibles. It may also cover additional services not covered under Original Medicare. You purchase your Medigap policy through an approved private company and you pay a monthly premium. To be eligible for a Medigap policy, you must have Parts A and B.

To find a Medigap policy, visit - <http://www.medicare.gov/find-a-plan/questions/medigap-home.aspx>. If you have Medicare and Medical Assistance, you may not need a Medigap policy, because Medical Assistance may pay for services that Medicare does not cover.

Medicare is a complicated service and all the options can be overwhelming. You can find answers to many of your questions at the U.S Government's official Medicare website, <http://www.medicare.gov/>. If you need more help, each state offers a free counseling service for people with Medicare. This service is called a State Health Insurance Counseling and Assistance Program (SHIP). Pennsylvania's SHIP is called APPRISE and is run by the Pennsylvania Department of Aging. There is a local APPRISE program in each county that is coordinated by that county's Area Agency on Aging. To find contact information for APPRISE in your county, call the APPRISE hotline at (800) 783-7067.

Appeals and Grievances: You have the right to file a grievance or appeal when you don't like something about your Medicare coverage, including when you are denied a service.

Grievances: You can file a grievance if you have a complaint about the services you are getting through your Medicare Advantage Plan or your

Medicare Drug Plan. For instance, you can file a complaint if you think a Medicare service provider has treated you poorly or if your health plan has bad customer service. Where you file your grievance will depend on what you have a complaint about. For details on filing grievances, visit <http://www.medicare.gov/claims-and-appeals/file-a-complaint/complaints.html>.

Appeals: You can file an appeal if you disagree with a decision made by Medicare, your Medicare Advantage Plan, including a Special Needs Plan, or your Medicare Prescription Drug Plan. You can file an appeal if:

- You lose coverage;
- Your health plan denies your request to get a health care service, supply, or prescription drug;
- Your health plan denies your request to pay for a health care service, supply, or prescription drug that you already got; or
- Your plan denies your request to change the amount you have to pay for a prescription drug.

For details on filing an appeal, visit <http://www.medicare.gov/claims-and-appeals/file-an-appeal/appeals.html>.

There are deadlines for filing a grievance or appeal. To find out what the filing deadline is and how to file, check the notice that you receive or contact Original Medicare or your Medicare Advantage Plan. Keep a copy of all notices and everything that you send to Medicare or the Medicare Advantage Plan.

Other Insurance

If you don't qualify for MA or Medicare, you still have options for getting insurance.

Insurance Through Your Parents: Under federal law, if your parents have health insurance that covers dependents, either as an individual or through work, you are eligible to stay on their plan until you turn 26, even if

you don't live with them. Under Pennsylvania law, if you are unmarried and you live in Pennsylvania or are a full-time student, you can stay on your parent's work-based insurance plan until you turn 30. To qualify under Pennsylvania's law, you cannot have any dependents and you cannot be eligible for insurance through your own job or school or through MA or Medicare.

Insurance Through Work: If you have a job, you may be able to get private insurance through your employer's group plan. If an employer offers health insurance to its employees, the employer usually pays part of the premium, so it will probably be a lot less expensive than an individual policy. If your employer offers health insurance, they can't charge you a higher premium or refuse to give you insurance based on your health status or disability. They can restrict insurance for other reasons, though, such as part-time or full-time status and the length of time you've been at the job.

COBRA: COBRA is a program that lets you keep your work-based group health insurance after you leave your job or if you lose your insurance because you reduce your work hours. There are two kinds of COBRA for Pennsylvania residents:

Federal COBRA: Under federal COBRA, you can keep your former employer's group health insurance, but your employer doesn't have to pay for part of it anymore. You pay the entire premium, so it is a lot more expensive. You may also have to pay a small administrative fee. However, since group rates are usually cheaper than individual rates, you will still probably pay less for COBRA than if you get your own private insurance.

You can keep COBRA for up to 18 months, and you may be able to keep it longer if you have a disability. The insurance company can charge you extra during the extended period, though.

You can get COBRA if you are fired or if you leave voluntarily, as long as you aren't fired for gross misconduct. After you lose your coverage, your employer has to give you information telling you how to get COBRA. You

can only get federal COBRA if you worked somewhere with 20 or more employees.

Pennsylvania Mini-COBRA: PA Mini-COBRA is similar to federal COBRA, but you can get it if you worked somewhere with 2-19 employees. Just like with federal COBRA, you have to pay the full premium and any administrative fees. Mini-COBRA only lasts for 9 months.

Within 30 days of the day you lose your group coverage, your employer has to give you information telling you how to get Mini-COBRA. To get Mini-COBRA, you need to have had your employer's group insurance for the whole three month period before you lost coverage. If you become eligible for Medicare or a new employer's group health insurance, you will lose your Mini-COBRA coverage.

Blue Cross Special Care Insurance: Special Care is a limited-benefit insurance program for low-income individuals who do not qualify for MA or Medicare. Special Care is not comprehensive – there's a lot it doesn't cover – but it may be worth it if you don't have other options. Special Care has limits on the number of doctor visits and hospital days you can use each year. It does not cover mental health care or prescription drugs, but it does offer a prescription drug discount card to members. Special Care is "guaranteed issue" insurance, meaning you won't be denied coverage based on a pre-existing condition, but services for pre-existing conditions are subject to a waiting period.

Special Care is offered by all five Blue Cross/Blue Shield companies that serve Pennsylvania. Income limits and monthly premiums vary depending on which company you get your Special Care from. This will depend on the county you live in.

Blue Cross of Northeastern Pennsylvania

Counties Served: Bradford, Carbon, Clinton, Lackawanna, Luzerne, Lycoming, Monroe, Pike, Sullivan, Susquehanna, Tioga, Wayne, Wyoming

Income Limit (2014): \$21,257 for one person

Monthly Premium (2014): \$146.82

Contact: (800) 829-8599 or (866) 280-0486 (TTY)

Apply: Call for an application or print one at
<https://d1tpfj3hind0fx.cloudfront.net/Media/Documents/Non-GroupForms/SpecialCareApp.pdf>.

Mail your application to: Attention: Non-Group
Blue Cross of Northeastern Pennsylvania 19 North Main Street
Wilkes-Barre, PA 18711-0302

Highmark Blue Cross Blue Shield (Western Pennsylvania)

Counties Served: Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Cameron, Centre, Clarion, Clearfield, Crawford, Elk, Erie, Fayette, Forest, Greene, Huntingdon, Indiana, Jefferson, Lawrence, McKean, Mercer, Potter, Somerset, Venango, Warren, Washington, Westmoreland

Income Limit (2014): \$23,550 for one person

Monthly Premium (2014): \$178.40

Contact: (800) 876-7639 or (800) 862-0709 (TTY)

Apply: Call for an application or print one at
https://www.highmarkbcbs.com/pdf/files/enrollment/SpecialCare_HBCBS_AppOnly.pdf.

Mail your application to:
Highmark Blue Cross Blue Shield
P.O. Box 382555 Pittsburgh, PA 15250-8555

Highmark Blue Shield (Central Pennsylvania and the Lehigh Valley)

Counties Served: Adams, Berks, Centre, Columbia, Cumberland, Dauphin, Franklin, Fulton, Juniata, Lancaster, Lebanon, Lehigh, Mifflin, Montour, Northampton, Northumberland, Perry, Schuylkill, Snyder, Union, York

Income Limit (2014): \$22,980 for one person

Monthly Premium (2014): \$151.80

Contact: (888) 269-8412 or (800) 862-0709 (TTY)

Apply: Call for an application or print one at
https://www.highmarkblueshield.com/pdf/files/enrollment/SpecialCare_HBS_AppOnly.pdf.

Mail your application to:
Highmark Blue Shield
P.O. Box 382051 Pittsburgh, PA 15250-8051

Capital Blue Cross (Central Pennsylvania and the Lehigh Valley)

Counties Served: Adams, Berks, Centre, Columbia, Cumberland, Dauphin, Franklin, Fulton, Juniata, Lancaster, Lebanon, Lehigh, Mifflin, Montour, Northampton, Northumberland, Perry, Schuylkill, Snyder, Union, York

Income Limit (2014): \$22,980 for one person

Monthly Premium (2014): \$211.16

Contact: (800) 962-2242 or (800) 242-4816 (TTY)

Apply: Call for an application or print one at

<https://www.capbluecross.com/NR/ronlyres/0CDF6667-F1A5-49F0-8510-B64EFA3F5929/0/ABC65.pdf>.

Mail your application to:

Capital Blue Cross

P.O. Box 772612 Harrisburg, PA 17177-2612

Health Insurance Marketplace (Marketplace): The Health Insurance Marketplace is a new way to get health insurance that was created by the Affordable Care Act (for more on the Affordable Care Act, see page 95). Through the Marketplace, individuals will be able to complete one application and see a variety of health insurance options available to them. When you complete the application, you'll learn about the plans in your area and find out if you are eligible for lower premiums based on your income. You will also learn if you are eligible for Medical Assistance. Some states will create their own Marketplace (also known as an Exchange), but in Pennsylvania, the Marketplace will be run by the federal government. To learn more about insurance plans available through the Marketplace and apply for coverage, visit <https://www.healthcare.gov/marketplace/individual/>.

Patient Protection and Affordable Care Act (Affordable Care Act): The Affordable Care Act is a federal healthcare reform law that was passed in March 2010. The Affordable Care Act made a lot of changes to healthcare and health insurance law. Some of these changes already happened, and some will happen over the next few years. For instance, beginning in 2014, insurance companies will no longer be able to deny coverage for pre-existing conditions. The Affordable Care Act will make health insurance mandatory for everyone, except those with very low income who cannot find an affordable plan. It also focuses on reducing the costs of health insurance and on improving standards of care. For more information, visit

<http://www.healthcare.gov/law/>.

More Help

If you have more questions about your insurance rights and resources, Pennsylvania and the federal government both have websites to help:

Pennsylvania Insurance Department (PID): PID runs a website providing information about your insurance rights and options in Pennsylvania. You can visit the website at <http://www.pahealthoptions.com/> or contact PID at (877) 881-6388 if you have more questions.

HealthCare.gov: HealthCare.gov (<http://www.healthcare.gov>) is a website created by the federal government to help you find and understand your health insurance options. The website has a lot of information about the Affordable Care Act, the kinds of health insurance you might be eligible for, and how health insurance works. It also has a helpful search engine that lists your health insurance options and can even find information and about private individual insurance plans. To use the search engine, visit <http://finder.healthcare.gov/>.

Finding Healthcare Services

Regardless of whether you have health insurance, finding the services you need can be difficult. The following is a list of resources that can help you find healthcare services that are covered by MA or are free or low-cost. To find healthcare providers that are covered by Original Medicare, visit <http://www.medicare.gov/find-a-doctor/provider-search.aspx>. To find healthcare providers covered by your Medicare Advantage Plan, including a Special Needs Plan, or your private insurance, contact your insurance provider, or visit the health plan's website.

Prescription Drugs

Many health insurance policies do not cover prescription drugs. If it is hard for you to pay for your prescription drugs, there are some programs that can help you. For help finding and applying for these programs, contact the Pennsylvania Patient Assistance Program Clearinghouse at (800) 955-0989. You can also learn about these programs from the Partnership for Prescription Assistance. Visit <https://www.pparx.org/> or call (888) 477-2669 for help. If you don't qualify for one of these programs and still need help, some pharmacies, such as Walmart, Target, and Kmart, offer generic medications at low prices.

Assistive Technology

Assistive technology devices are any items or equipment used to improve or maintain the functional capabilities of a person with a disability. Assistive technology services are services that help you choose, acquire, or use an assistive technology device. Although assistive technology devices can be high-tech, such as complex computer programs and motorized wheelchairs, they do not have to be. For example, assistive technology devices can include canes, walkers, orthopedic shoe inserts, or adapted spoons that are easier to grasp. They also do not need to be designed specifically for individuals with disabilities. Items that are commonly used by individuals without disabilities, such as computers, may be assistive technology devices if they are used to improve or maintain the functional capabilities of a person with a disability.

Medicare and Medical Assistance cover a lot of the assistive technology that you may need. If you are in a Home and Community-Based Services Waiver (Waiver), your assistive technology may also be covered under your Waiver. For more on Waivers, see page 74 of this guide. Private insurance may also cover assistive technology.

If you do not have insurance, or the assistive technology you need is not covered by your insurance, you may be able to get a no- or low-interest loan through the Pennsylvania Assistive Technology Foundation (PATF). PATF offers two types of loans: mini-loans and low-interest loans. Mini-loans range from \$100 to \$1,500 and do not charge interest. For some low-income mini-loan applicants, PATF may provide a grant to cover up to

50% of the amount requested. Low-interest loans start at \$1,500 and have a 3.75% interest rate. If you have good credit, you may be able to borrow up to \$60,000. If you have poor credit or no credit, the PATF Board of Directors may agree to back the loan for you, up to a maximum of \$25,000. For more information and to apply for a loan, visit <http://www.patf.us/>.

If you need help navigating insurance and other funding options, you can contact the Assistive Technology Resource Center (ATRC) that serves your county. ATRCs are part of the Pennsylvania Initiative on Assistive Technology (PIAT), which is a statewide program dedicated to improving access to assistive technology for individuals with disabilities. Every county in Pennsylvania is served by an ATRC, and most services are offered free of charge. ATRCs can help you figure out how to get funding for assistive technology and can help answer any questions you have about assistive technology. ATRCs may also be able to help you find free or inexpensive previously-owned assistive technology. To determine which ATRC serves your county, visit http://disabilities.temple.edu/programs/assistive/atlend/atrc_county.shtml#firstContent.

Contact information for each ATRC can be found at <http://disabilities.temple.edu/programs/assistive/atlend/atrc.shtml#atrc>.

If you think you might benefit from an assistive technology device, but would like to try it out before you invest in one for yourself, your ATRC can arrange a device demonstration to show you exactly how the device works. Device demonstrations are available to people with disabilities and their families. If you want to spend more time getting to know an assistive technology device, you may be able to borrow the device temporarily from Pennsylvania's Assistive Technology Lending Library. The Lending Library is a free service that allows you to try an assistive technology device for a short period to help you decide if you would like to buy one. To use the Lending Library, first search the inventory to see if the equipment you want is available. To search the Lending Library's inventory of available equipment, visit http://www.ioddev.org/search_inventory.php. Then visit http://www.ioddev.org/complete_request.php to complete and submit the loan request form. Some popular items may have waiting lists. For information about borrowing and returning equipment from the Lending Library, visit

<http://disabilities.temple.edu/programs/assistive/atlend/borrow.shtml>.

Mental Health

Mental Health/Intellectual Disabilities (MH/ID) Offices: Every county in Pennsylvania is served by an MH/ID Office, though not every county uses this name. MH/ID offices do not provide mental healthcare services, but they can assess your need for treatment, and then refer you to local providers and provide funding for some services. The MH/ID office can also help figure out if you are eligible for assistance paying for services. To get assistance, call (800) 692-7462 or find contact information for your local MH/ID office at <http://www.mhdspa.org/Pages/Local-Contacts.aspx>.

Medical Assistance Behavioral Health Plans: If you have Medical Assistance (MA), some mental health and substance abuse treatment services are covered by a managed care behavioral health plan. Each county has one. The behavioral health plan in your county can direct you to mental health services near you that are covered by your MA. To find the phone number of your county's behavioral health plan, visit https://www.enrollnow.net/PASelfService/en_US/behav.html.

Pennsylvania Network of Care: The Pennsylvania Network of Care is a website for consumers of mental health services. It is a great resource if you are looking for services in your county, or if you just want more information about mental health conditions and treatments. Visit <http://pa.networkofcare.org/> and select your county from the dropdown menu.

Substance Abuse and Mental Health Services Administration (SAMHSA): SAMHSA is a federal agency created to help improve mental health care. SAMHSA has a useful search engine on its website that allows you to search for mental health services near you. This website can be especially helpful if you don't have insurance and need to find low-cost services or services with sliding scale fees. If you click "select services" on the search page, you can search for services with specific requirements. Go to <http://findtreatment.samhsa.gov/MHTreatmentLocator/faces/addressSearch.jspx> to search for services. You can also call SAMHSA's Treatment

Referral Routing Service at (800) 662-HELP (4357). The referral service is available 24 hours a day, 365 days a year.

Health Resources and Services Administration (HRSA): See “physical health” section (below).

Pennsylvania Association of Community Health Centers (PACHC): See “physical health” section (below).

Medicare.gov: See “physical health” section (below).

Physical Health:

Pennsylvania Dental Association (PDA): The PDA keeps a list of free and low-cost dental clinics in Pennsylvania. This is a great resource, because many insurance plans, including Medicare and MA for adults, provide limited or no dental coverage. To find a clinic near you, go to http://www.padental.org/Online/Public/Dental_Clinic_Directory/Online/Directory/Clinic_Directory.aspx?hkey=d5107b48-f2c6-4320-a75a-54add3393cbe.

Health Resources and Services Administration (HRSA): HRSA is part of the U.S. Department of Health and Human Services. HRSA gives grants to health clinics so the clinics can provide reduced fee services to people who need them. Some HRSA-supported clinics also offer mental health services. To find an HRSA-supported clinic, visit http://findahealthcenter.hrsa.gov/Search_HCC.aspx.

Pennsylvania Association of Community Health Centers (PACHC): The PACHC represents Pennsylvania’s Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC). FQHCs and RHCs provide primary health care with fees based on your ability to pay. FQHCs often offer dental and behavioral health care as well, but most RHCs do not. There are currently more than 200 FQHCs located in both rural and urban areas in 44 of Pennsylvania’s counties and 59 RHCs in rural areas. To search for a health center by county, visit

http://www.pachc.com/health_find.html. For a detailed list of health centers, including the services each provides, visit <http://www.pachc.com/pdfs/CHC%20Directory%202011.pdf>.

Medicare.gov: The U.S. Government's official Medicare website has search engines to help you find doctors, hospitals, and other providers that are covered by Original Medicare. There is also a search engine to find suppliers of covered medical items, such as durable medical equipment. You can find links to each of these search engines at <http://www.medicare.gov/forms-help-and-resources/find-doctors-hospitals-and-facilities/quality-care-finder.html>.

Medical Assistance Providers: To find a doctor or other provider who is covered by your MA health plan, visit <https://www.enrollnow.net/PASelfService/faces/search.xhtml>. Contact your County Assistance Office case manager or your Home and Community-Based Waiver service/supports coordinator if you need help finding a provider.

Health Clinic Search Engines

Several websites offer search engines to help you find free and low-cost health clinics. You can generally find both mental and physical health services on these websites. A few of these websites are listed here:

- NeedyMeds: http://www.needy meds.org/free_clinics.taf
- Partnership for Prescription Assistance:
http://www.pparx.org/en/prescription_assistance_programs/free_clinic_finder
- Free Medical Search:
<http://www.freemedicalsearch.org/sta/pennsylvania>
<http://www.freedentalcare.us/st/pennsylvania>

Contact Information

If you need more information or need help, please contact Disability Rights Pennsylvania (DRP) at 800-692-7443 (voice) or 877-375-7139 (TDD). The

email address is: intake@disabilityrightspa.org.

The mission of Disability Rights Pennsylvania is to advance, protect, and advocate for the human, civil, and legal rights of Pennsylvanians with disabilities. Due to our limited resources, Disability Rights Pennsylvania cannot provide individual services to every person with advocacy and legal issues. Disability Rights Pennsylvania prioritizes cases that have the potential to result in widespread, systemic changes to benefit persons with disabilities. While we cannot provide assistance to everyone, we do seek to provide every individual with information and referral options.

IMPORTANT: This publication is for general informational purposes only. This publication is not intended, nor should be construed, to create an attorney-client relationship between Disability Rights Pennsylvania and any person. Nothing in this publication should be considered to be legal advice.

PLEASE NOTE: For information in alternative formats or a language other than English, contact Disability Rights Pennsylvania at 800-692-7443, Ext. 400, TDD: 877-375-7139 or intake@disabilityrightspa.org.