Exemption Form

Use this form to state that you have a Healthy Michigan Plan (HMP) exemption. This means you may be excused from:

- HMP work requirements, **and/or**
- MI Health Account payments

Exemptions can last up to one year. Some exemptions can be renewed. Once you tell us about an exemption, Michigan Department of Health and Human Services (MDHHS) will send you a letter with the date the exemption ends.

HEALTHY MICHIGAN PLAN

You must mail this form by **January 31, 2020**.

If you need help filling out this form, call the Beneficiary Help Line at **1-800-642-3195**. (TTY: 1-866-501-5656)

1 Tell us about yourself. Print clearly.

Fill out all information. Use one form for each person. *(Must fill in all fields with *)*

*First name	*Last name			*Date of birth
*Address	*City	*State	*ZIP Code	Telephone number
Beneficiary ID number	You can find your **Beneficiary ID number** on the top left of the letter that came with this form.			

2 Tell us about your reasons to be excused. *(check **all** that apply)*

Check the box next to each reason that applies to you.

- You can claim **any** of the following reasons to be excused from **work requirements**.
- **Medically frail** can excuse you from **MI Health Account payments.**

☐ I am **pregnant** or was pregnant in the last 2 months (Due date_____)

☐ I am **medically frail** due to one or more of the following:

- Physical, mental, or emotional condition that limits a daily activity, like bathing
- Physical, intellectual, or developmental disability that makes it hard to do daily living activity
- Physical, mental, or emotional condition that needs to be checked often
- Disability based on Social Security criteria (SSDI)
- Chronic substance use disorder (SUD)
- Serious and complex medical condition, or special medical needs
- Am in a nursing home, hospice, or get home help services
- Am homeless
- Am a survivor of domestic violence

Reasons to be excused continued on the back ▶

*Reasons to be excused continued (check **all** that apply)*

- ☐ I am the **main caretaker for a family member under 6** (One parent per household)
- ☐ I am a **full-time student**
- ☐ I am **under age 21 and was in Michigan foster care**
- ☐ I was in **prison or jail** in the last 6 months
- ☐ I get **State of Michigan unemployment benefits**
- ☐ I get **temporary or permanent disability payments** from a private insurer or the government
- ☐ I have a **medical condition that limits work**, approved by a doctor
- ☐ I am **caring for a dependent with a disability and doctor's order for full-time care** (One claim per household)
- ☐ I am **caring for a person who cannot make decisions for themselves**
- ☐ I have **good cause** because I or a close family member:
  - Has a serious illness, **or**
  - Is hospitalized, **or**
  - Has a disability that meets the government definition

3 Sign below

You or your authorized representative or legal guardian must sign below.
The signature means the information on this form is true.

HMP member signature		
▶		Date
Or signature of authorized representative (AR) or legal guardian		
Printed name of AR or legal guardian	Telephone number	Relationship to beneficiary
Signature of AR or legal guardian ▶		Date

4 Return completed form by January 31, 2020

Mail to: MDHHS Special Processing Office
Suite 1405
PO Box 30800
Lansing, MI 48909

Or fax to: 1-517-432-6079

Only use this form until January 31, 2020. Starting February 1, 2020, go to **Michigan.gov/MIBridges**. Or call **1-833-895-4355** (TTY: 1-866-501-5656).

MDHHS Michigan Department of Health & Human Services