Medicaid

Renewal Form

You can get this notification in another language or in large print or another way that's best for you. Call 1-800-XXX-XXXX (TTY: 1-888-XXX-XXXX).

Mary Smith
123 Smith Street
Smithtown, FL 00000

November 5, 2013
Respond by: December 12, 2013
Letter number: 34567

It is time to renew your Medicaid coverage.

You can renew your Medicaid in any one of these ways

- **Renewing online is faster!** Go to **<web address>** and click on Renew My Medicaid
- **By phone:** Just call **1-800-XXX-XXXX** (TTY: 1-888-XXX-XXXX). The call is free.
- **By mail:** Complete this form and mail it to:
  [Medicaid Agency]
  [100 State Street]
  [Anycity, State]
- **In person:** Visit our office at [Medicaid Agency] [100 State Street] [Anycity, State]. Office hours are 8:30 a.m. to 5 p.m. Monday to Friday, and 9:00 a.m. to 12 p.m. on Saturday.

How to complete this renewal form

1. Answer all of the questions on the form.
2. Read the information about you and each member of your household. Add any missing information. If any information has changed, write in the right information.
3. Sign the form on page 9.
4. **Return this form by December 12, 2013**. If you do not return the form by this deadline, you will lose your Medicaid coverage.

What we need

We need information about each person living in your household or listed on your tax return, including:

- those who get Medicaid now,
- those who do not get Medicaid now but would like to apply, ***and***
- others who live in the household and do not get Medicaid but do not want to apply.

We will check your answers using information from computer data sources, including the Internal Revenue Service (IRS), the Social Security Administration, the Department of Homeland Security and others. If the information does not match, we may ask you to send more information.

If you do not qualify for Medicaid

If you do not qualify for Medicaid, [state agency] will check to see if you qualify for other kinds of health coverage. [State agency] may send your information to another program so they can see if you qualify.

1 Your contact information

▼ Review your contact information here.	▼ Correct any wrong or missing information here.		
Ernie Roberts	Name *(first, middle, last & suffix)*		
Home address: 1234 America Ave. Apt. 1A Anywhere, ST 12345	**Home** address		Apartment #
	City *(home)*	State	ZIP code
Mailing address: 5678 Broad St. P.O. Box 6789 Anywhere, ST 12345	**Mailing** address		Apartment #
	City *(mailing)*	State	ZIP code
Phone: Home: 111-222-3333 Other:	Best phone number to reach you: Number:	☐ Home ☐ Cell ☐ Work	
	Other phone number, if you have one: Number:	☐ Home ☐ Cell ☐ Work	

Email address, if you have one:

2 We need information about who files tax returns.

You can still renew if you do not file tax returns.

Will anyone in the household file a **federal tax return** ***next year*** to report income earned ***this year***?

☐ Yes ***If yes,*** answer all of the questions below. ☐ No ***If no,*** answer the question marked with a star ★ below

Person 1: Name (*first, middle, last & suffix)*

If this person is filing a joint return, write the name of the spouse:

If this person will claim dependents, write the names of the dependents:

Person 2: Name (*first, middle, last & suffix)*

This is for a second tax filer in the household

If this person is filing a joint return, write the name of the spouse:

If this person will claim dependents, write the names of the dependents:

★ If anyone will be claimed as a dependent on someone else's tax return, write the name of the tax filer and the dependents. Answer only if different than what you reported above or if you did not fill in any information above.

Name of tax filer: ______________________________

Name of dependents: ______________________________

____

Questions? Call [state agency] at **1-800-XXX-XXXX**. The call is free. (TTY: 1-888-XXX-XXXX). You can call [days and hours of operation]. Or visit **<web address>**.

3 These are the people in your household who get Medicaid and need to renew now

Person 1 Samantha Roberts

☒ The [state agency name] **has** this person's Social Security number.

☐ The [state agency name] **does not** have this person's Social Security number. ***Write it in the spaces below.***

___ ___ ___ – ___ ___ – ___ ___ ___ ___

☐ Check here if this person is no longer living in the household.

If this person is an immigrant, for their immigration status:

☐ You need to fill in the information below. ☒ You **do not** need to fill in the information below because [state Medicaid agency] has it.

☐ Check here if this person has eligible immigration status and fill in the document type: ______________________

and ID number: ______________ . See Attachment D on page 13 for more information about eligible immigration status and document types.

Person 2 Benjamin Roberts

☐ The [state agency name] **has** this person's Social Security number.

☒ The [state agency name] **does not** have this person's Social Security number. ***Write it in the spaces below.***

___ ___ ___ – ___ ___ – ___ ___ ___ ___

☐ Check here if this person is no longer living in the household.

If this person is an immigrant, for their immigration status:

☐ You need to fill in the information below. ☒ You **do not** need to fill in the information below because [state Medicaid agency] has it.

☐ Check here if this person has eligible immigration status and fill in the document type: ______________________

and ID number: ______________ . See Attachment D on page 13 for more information about eligible immigration status and document types.

Person 3 [Name]

☐ The [state agency name] **has** this person's Social Security number.

☐ The [state agency name] **does not** have this person's Social Security number. ***Write it in the spaces below.***

___ ___ ___ – ___ ___ – ___ ___ ___ ___

☐ Check here if this person is no longer living in the household.

If this person is an immigrant, for their immigration status:

☐ You need to fill in the information below. ☐ You **do not** need to fill in the information below because [state Medicaid agency] has it.

☐ Check here if this person has eligible immigration status and fill in the document type: ______________________

and ID number: ______________ . See Attachment D on page 13 for more information about eligible immigration status and document types.

Person 4 [Name]

☐ The [state agency name] **has** this person's Social Security number.

☐ The [state agency name] **does not** have this person's Social Security number. ***Write it in the spaces below.***

___ ___ ___ – ___ ___ – ___ ___ ___ ___

☐ Check here if this person is no longer living in the household.

If this person is an immigrant, for their immigration status:

☐ You need to fill in the information below. ☐ You **do not** need to fill in the information below because [state Medicaid agency] has it.

☐ Check here if this person has eligible immigration status and fill in the document type: ______________________

and ID number: ______________ . See Attachment D on page 13 for more information about eligible immigration status and document types.

Person 5 [Name]

☐ The [state agency name] **has** this person's Social Security number.

☐ The [state agency name] **does not** have this person's Social Security number. ***Write it in the spaces below.***

___ ___ ___ – ___ ___ – ___ ___ ___ ___

☐ Check here if this person is no longer living in the household.

If this person is an immigrant, for their immigration status:

☐ You need to fill in the information below. ☐ You **do not** need to fill in the information below because [state Medicaid agency] has it.

☐ Check here if this person has eligible immigration status and fill in the document type: ______________________

and ID number: ______________ . See Attachment D on page 13 for more information about eligible immigration status and document types.

4 We need more information about people not listed in Section 3 *(page 3)*

▶ Tell us about anybody else in your household or on your tax return.

Other person: Ernie Roberts

☒ The [state agency name] **has** this person's Social Security number.
☐ The [state agency name] **does not** have this person's Social Security number.
Write it here if this person is applying for health insurance coverage:

___ ___ ___ – ___ ___ – ___ ___ ___ ___

This person may choose not to give the Social Security number if he or she is not applying, but it helps us to have it.

☐ Check here if this person is no longer living in the household.

Date of birth (month/day/year): 9/15/1973

This person is: ☒ Male ☐ Female

How is this person related to you?

☐ Check here if this person **has** Medicaid.
☐ Check here if this person **does not** have Medicaid and wants health insurance coverage, and fill out Attachment A on page 10.

Other person: Name (*first, middle, last & suffix):*

☐ The [state agency name] **has** this person's Social Security number.
☒ The [state agency name] **does not** have this person's Social Security number.
Write it here if this person is applying for health insurance coverage:

___ ___ ___ – ___ ___ – ___ ___ ___ ___

This person may choose not to give the Social Security number if he or she is not applying, but it helps us to have it.

☐ Check here if this person is no longer living in the household.

Date of birth (month/day/year):

This person is: ☐ Male ☐ Female

How is this person related to you?

☐ Check here if this person **has** Medicaid.
☐ Check here if this person **does not** have Medicaid and wants health insurance coverage, and fill out Attachment A on page 10.

Other person: Name (*first, middle, last & suffix):*

☐ The [state agency name] **has** this person's Social Security number.
☒ The [state agency name] **does not** have this person's Social Security number.
Write it here if this person is applying for health insurance coverage:

___ ___ ___ – ___ ___ – ___ ___ ___ ___

This person may choose not to give the Social Security number if he or she is not applying, but it helps us to have it.

☐ Check here if this person is no longer living in the household.

Date of birth (month/day/year):

This person is: ☐ Male ☐ Female

How is this person related to you?

☐ Check here if this person **has** Medicaid.
☐ Check here if this person **does not** have Medicaid and wants health insurance coverage, and fill out Attachment A on page 10.

5 Tell us about *other* health insurance coverage people have

▶ Include anyone in Sections 3 and 4 with Medicaid and anyone who is applying for health insurance coverage.

Name of insurance company:

Policy number:

Type of insurance: ☐ Medicare ☐ Tricare ☐ Veteran's health coverage ☐ Other insurance ____________________

List everyone who is on this policy:

Name of insurance company:

Policy number:

Type of insurance: ☐ Medicare ☐ Tricare ☐ Veteran's health coverage ☐ Other insurance ____________________

List everyone who is on this policy:

▶ ☐ Check here if anyone on this form is offered health insurance through a job, even if they are not enrolled in it.
☐ Check here if any of the insurance plans you listed is a state employee benefit plan.

6 Tell us more about the people listed on this form

▶ If anyone who is renewing or applying for health insurance coverage has a medical, mental health, or substance use condition that limits his or her ability to work, go to school, or take care of daily activities (like bathing or dressing), write his or her name here.

Name (*first, middle, last & suffix):*

Name (*first, middle, last & suffix):*

▶ If anyone who is renewing or applying for health insurance coverage lives in a long term care facility, group home, or nursing home, or regularly gets medical care, personal care, or health services at home or in another community setting (like adult day care), write his or her name here.

Name (*first, middle, last & suffix):*

Name (*first, middle, last & suffix):*

▶ If anyone who is renewing or applying for health insurance coverage is blind or terminally ill, write his or her name here.

Name (*first, middle, last & suffix):*

Name (*first, middle, last & suffix):*

▶ If anyone who is renewing or applying for health insurance coverage is between the ages of 18 and 22 and is also a full-time student, write his or her name here.

Name (*first, middle, last & suffix):*

Name (*first, middle, last & suffix):*

▶ If anyone who is renewing or applying for health insurance coverage is between the ages of 18 and 26 and was in foster care at age 18, write his or her name here.

Name (*first, middle, last & suffix):*

Name (*first, middle, last & suffix):*

▶ If anyone listed on this form (whether renewing or applying for health insurance coverage or not) is pregnant, write her information below.

Name (*first, middle, last & suffix):*	How many babies are expected?
Name (*first, middle, last & suffix):*	How many babies are expected?

▶ ☐ Check here if anyone who is renewing or applying for health insurance coverage is an American Indian or Alaska Native, and fill out Attachment B on page 11.

7 Tell us about work

▶ Fill in the information below for everyone in your household or on your tax return who has income from a job (**not** self-employed) whether or not they are renewing or applying for coverage. If someone has more than one job, tell us about **all jobs**. You can tell us about **self-employment** on the next page. *Make a copy of this page if you need space for more jobs or people. Cross out any information that is* ***not correct*** *about members of your household. Write in any new information.*

Job 1: Name of the person who is working (*first, middle, last & suffix*): Ernie Roberts

Employer name: Joe's Body Shop

Employer phone number: 123-456-7890

Employer address: 123 Main St, Anywhere, ST 01234 City: State: ZIP code:

How often are wages or tips paid? ☐ Hourly ☐ Every two weeks ☐ Monthly ☐ Weekly ☒ Twice a month ☐ Yearly

How much does this person get paid (before taxes)? $ 417

Average hours worked each week:

Job 2: Name of the person who is working (*first, middle, last & suffix*):

Employer name:

Employer phone number:

Employer address: City: State: ZIP code:

How often are wages or tips paid? ☐ Hourly ☐ Every two weeks ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Yearly

How much does this person get paid (before taxes)? $ ______________________

Average hours worked each week:

Job 3: Name of the person who is working (*first, middle, last & suffix*):

Employer name:

Employer phone number:

Employer address: City: State: ZIP code:

How often are wages or tips paid? ☐ Hourly ☐ Every two weeks ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Yearly

How much does this person get paid (before taxes)? $ ______________________

Average hours worked each week:

Job 4: Name of the person who is working (*first, middle, last & suffix*):

Employer name:

Employer phone number:

Employer address: City: State: ZIP code:

How often are wages or tips paid? ☐ Hourly ☐ Every two weeks ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Yearly

How much does this person get paid (before taxes)? $ ______________________

Average hours worked each week:

Job 5: Name of the person who is working (*first, middle, last & suffix*):

Employer name:

Employer phone number:

Employer address: City: State: ZIP code:

How often are wages or tips paid? ☐ Hourly ☐ Every two weeks ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Yearly

How much does this person get paid (before taxes)? $ ______________________

Average hours worked each week:

Section 7 *continued on next page* ▶▶▶

7 Tell us about work *(continued)*

▶ List anyone in your household who has **changed jobs** or has **worked fewer hours** in the past four months.

1. Name (*first, middle, last & suffix*):

☐ This person stopped working ☐ This person is now working fewer hours ☐ This person changed jobs

2. Name (*first, middle, last & suffix*):

☐ This person stopped working ☐ This person is now working fewer hours ☐ This person changed jobs

▶ If anyone in your household is **self-employed**, we need to know about their work.
See the instructions for more information about deductions.

1. Name (*first, middle, last & suffix*):

Type of work:

How much *net income* will this person get from self-employment this month? Amount: $ ____________________

2. Name (*first, middle, last & suffix*):

Type of work:

How much *net income* will this person get from self-employment this month? Amount: $ ____________________

▶ Subtract the expenses below from your gross income to get an amount for your net self-employment income.

- Car and truck expenses (for travel during the workday, not commuting)
- Depreciation
- Employee wages and fringe benefits
- Property, liability, or business interruption insurance
- Interest (including mortgage interest paid to banks, etc.)
- Legal and professional services
- Rent or lease of business property and utilities
- Commissions, taxes, licenses and fees
- Advertising
- Contract labor
- Repairs and maintenance
- Certain business travel and meals
- Deductible self-employment taxes
- Cost of self-employed health insurance
- Contributions to a self-employed SEP, SIMPLE, or qualified retirement plan

8 Tell us about other income

▶ *Cross out any information that is **not correct** about members of your household. Write in any new information.*

Unemployment	**How much?**	**How often?**
Name (*first, middle, last & suffix*): Samantha Roberts	$ 70	☒ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other______
Social Security	**How much?**	**How often?**
Name (*first, middle, last & suffix*):	$	☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other______
Pensions	**How much?**	**How often?**
Name (*first, middle, last & suffix*):	$	☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other______
Retirement accounts		
Name (*first, middle, last & suffix*):	$	☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other______

***Section 8** continued on next page* ▶▶▶

8 Tell us about other income *(continued)*

▶ *Cross out any information that is* ***not correct*** *about members of your household. Write in any new information.*

Alimony received	**How much?**	**How often?**
Name (*first, middle, last & suffix):*	$	☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other_______
Farming or fishing *(profit after business expenses)*	**How much?**	**How often?**
Name (*first, middle, last & suffix):*	$	☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other_______
Rental income or royalties *(profit after business expenses)*	**How much?**	**How often?**
Name (*first, middle, last & suffix):*	$	☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other_______
Other income Type: ___________	**How much?**	**How often?**
Name (*first, middle, last & suffix):*	$	☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other_______
Other income Type: ___________	**How much?**	**How often?**
Name (*first, middle, last & suffix):*	$	☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other_______

▶ If anyone in your household has **deductions**, tell us what kind.

Alimony paid to someone else	**How much?**	**How often?**
Name (*first, middle, last & suffix):*	$	☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other_______
Student loan interest paid	**How much?**	**How often?**
Name (*first, middle, last & suffix):*	$	☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other_______
Other deductions	**How much?**	**How often?**
Name (*first, middle, last & suffix):*	$	☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other_______

▶ List the names of anyone whose income **changes** from month to month. Also tell us how much you think their income will be for the year. *Make a copy of this page if you need space for more people.*

1. Name (*first, middle, last & suffix):*

What do you expect his or her income to be **this year**? Amount: $ ☐ Check here if you do not know what the income will be **this year**.

2. Name (*first, middle, last & suffix):*

What do you expect his or her income to be **this year**? Amount: $ ☐ Check here if you do not know what the income will be **this year**.

3. Name (*first, middle, last & suffix):*

What do you expect his or her income to be **this year**? Amount: $ ☐ Check here if you do not know what the income will be **this year**.

9 Read and sign this application

Renewal of coverage in future years

▶ Read the statement below and check **one** box.

To make it easier to check my income at renewal time, I give permission to the [state agency] to use income information from my tax returns for the number of years I checked below.

I understand that the [state agency] will send me a letter with the income information they have. I can make changes to it. I can also change my mind and not allow the [state agency] to check this information.

Yes, I give permission to check my income on tax returns for (check one box):

☐ 5 years (the longest time) ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year

☐ No, I do not give permission to use my tax returns.

Your rights and responsibilities

- I am signing this renewal form under penalty of perjury. That means that I have provided true answers to all the questions on this form to the best of my knowledge, and I know that I may be subject to penalties under federal law if I provide false or untrue information.
- I know that I must tell [state agency] if anything changes and is different from what I wrote on this form. I can call XXX-XXX-XXXX or visit [web address] to report any changes. I understand that a change in my information might affect whether someone in my household qualifies for coverage.
- I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting hhs.gov/ocr/office/file.
- If I think [state agency] has made a mistake, I can appeal its decision. To appeal means to tell someone at [state agency] that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting [state agency] at XXX-XXX-XXXX. Someone from [state agency] will explain anything about this application to me if I need that.
- I understand that if I do not qualify for Medicaid, [state agency] will check to see if I qualify for other kinds of health coverage. [State agency] may send my information to another program so they can see if I qualify. [State agency] will check my answers using information from computer data sources, including the Internal Revenue Service (IRS), the Social Security Administration, the Department of Homeland Security and others. If the information does not match, [state agency] may ask me to send more information.
- I understand that, after my death, [state agency] can file a claim against my estate to recover money that the state paid for coverage provided to me. This process must happen if I am in a medical institution and not expected to return home, or if I am 55 years of age or older and the state pays for my nursing facility services, home and community based services, or related hospital and prescription drug services. The amount recovered by the [state agency] will not be more than the amount Medicaid paid for my care.
- I understand that when I send in this form, it means I have permission from everyone whose information is on the form to submit their information to [state agency] and receive any communications about their eligibility and enrollment.
- I understand that [state agency] is authorized to collect information on this form, and other supporting information including Social Security numbers, under the Patient Protection and Affordable Care Act (Public Law No. 111-148), as amended by the Health Care Education Reconciliation Act of 2010 (Public Law 111-152) and the Social Security Act.

▶ Sign and date below. If you want an authorized representative or want to change the authorized representative you have now, fill out Attachment C on page 12.

☐ Check here if you are an authorized representative. Sign below and fill out Attachment C on page 12.

Signature of household contact or authorized representative:	Date:

Questions? Call [state agency] at **1-800-XXX-XXXX**. The call is free. (TTY: 1-888-XXX-XXXX). You can call [days and hours of operation]. Or visit **<web address>**.

Attachment A

People applying for Medicaid for the first time

For people listed in Section 4, Page 4

Tell us about anyone in your household who wants to apply for Medicaid. **Do not answer** these questions for people **who already have Medicaid**. *If more than two people are applying, make a copy of this page.*

Name of person applying: Name (*first, middle, last & suffix*)

▶ Tell us about citizenship

Is this person a U.S. citizen or U.S. national? ☐ Yes ***If yes,*** go to "Tell us more information about this person"
☐ No ***If no,*** answer all of the questions below.

☐ Check here, if this person has eligible immigration status and fill in the document type: ______________________

and ID number: ______________. See Attachment D on page 13 for more information about eligible immigration status and document types.

☐ Check here, if this person has lived in the U.S. since 1996.
☐ Check here, if this person, his or her spouse, or a parent is a veteran or an active duty member in the U.S. military.

▶ Tell us more information about this person

☐ Check here, if this person lives with at least one child under the age of 19, and is the main person taking care of this child.
☐ Check here, if this person is 18 years or younger and has a parent living outside of the household.
☐ Check here, if this person wants help paying for medical bills from the last three months.

▶ Tell us about race and ethnicity. *You may choose not to answer these questions.*

If this person is Hispanic/Latino, check all that apply:

☐ Mexican ☐ Mexican American
☐ Chicano/a ☐ Puerto Rican
☐ Cuban ☐ Other ____________

What is this person's race? Check all that apply:

☐ White ☐ Asian Indian ☐ Korean ☐ Guamanian or Chamorro
☐ Black or African American ☐ Chinese ☐ Vietnamese ☐ Samoan
☐ American Indian or Alaska Native ☐ Filipino ☐ Other Asian ☐ Other Pacific Islander
☐ Japanese ☐ Native Hawaiian ☐ Other ____________

Name of person applying: Name (*first, middle, last & suffix*)

▶ Tell us about citizenship

Is this person a U.S. citizen or U.S. national? ☐ Yes ***If yes,*** go to "Tell us more information about this person"
☐ No ***If no,*** answer all of the questions below.

☐ Check here, if this person has eligible immigration status and fill in the document type: ______________________

and ID number: ______________. See Attachment D on page 13 for more information about eligible immigration status and document types.

☐ Check here, if this person has lived in the U.S. since 1996.
☐ Check here, if this person, his or her spouse, or a parent is a veteran or an active duty member in the U.S. military.

▶ Tell us more information about this person

☐ Check here, if this person lives with at least one child under the age of 19, and is the main person taking care of this child.
☐ Check here, if this person is 18 years or younger and has a parent living outside of the household.
☐ Check here, if this person wants help paying for medical bills from the last three months.

▶ Tell us about race and ethnicity. *You may choose not to answer these questions.*

If this person is Hispanic/Latino, check all that apply:

☐ Mexican ☐ Mexican American
☐ Chicano/a ☐ Puerto Rican
☐ Cuban ☐ Other ____________

What is this person's race? Check all that apply:

☐ White ☐ Asian Indian ☐ Korean ☐ Guamanian or Chamorro
☐ Black or African American ☐ Chinese ☐ Vietnamese ☐ Samoan
☐ American Indian or Alaska Native ☐ Filipino ☐ Other Asian ☐ Other Pacific Islander
☐ Japanese ☐ Native Hawaiian ☐ Other ____________

★ If anyone applying for Medicaid has medical bills from the last three months, send the medical bills to <Billing Office>, [Medicaid Agency], [100 State Street], [Anycity, State]. Medicaid may pay past bills, even if you already paid them yourself.

Attachment B

American Indian or Alaska Native family member (AI/AN) *To help you fill out Section 6, page 5*

Tell us about your American Indian or Alaska Native family member(s)

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They may not have to pay co-pays and may get special monthly enrollment periods.

If more than two people are American Indian or Alaska Native, make a copy of this page.

1. Name (*first, middle, last & suffix):*

Has this person ever received a service from the Indian Health Service, a tribal health program, or urban Indian health program?

☐ Yes ☐ No

If no, does this person qualify to get these services?

☐ Yes ☐ No

List any income that includes money from these sources:	How much income? **$**
■ Payments from a tribe for natural resources, usage rights, leases, or royalties ■ Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) ■ Money from selling things that have cultural significance	How often? ☐ Weekly ☐ Twice a month ☐ Every two weeks ☐ Yearly ☐ Monthly

2. Name (*first, middle, last & suffix):*

Has this person ever received a service from the Indian Health Service, a tribal health program, or urban Indian health program?

☐ Yes ☐ No

If no, does this person qualify to get these services?

☐ Yes ☐ No

List any income that includes money from these sources:	How much income? **$**
■ Payments from a tribe for natural resources, usage rights, leases, or royalties ■ Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) ■ Money from selling things that have cultural significance	How often? ☐ Weekly ☐ Twice a month ☐ Every two weeks ☐ Yearly ☐ Monthly

Attachment C — Assistance with completing this application

An authorized representative is a trusted friend, partner, or lawyer you choose to sign your renewal form, get information about this renewal form, and act for you with this agency.

▶ If you have an authorized representative now, please answer these questions.

We show that you chose this person as your authorized representative:	Do you still want this person to be your authorized representative?
Not applicable	☐ Yes ☐ No ***If yes,*** has any of his or her information changed? ☐ Yes ☐ No

If your authorized representative's information has **changed**, or if you would like a **different** authorized representative, please write the new information here:

Name of authorized representative:

Address:	Apartment #	City	State	ZIP code

Phone number: ☐ Home ☐ Cell ☐ Work ☐ Other
Number:

By signing, you allow this person to sign your renewal form, to get information about this renewal form, and to act for you with this agency.

Your signature:	Date:

▶ If you do not have an authorized representative and want one, please answer these questions.

☐ Check here if you want an authorized representative. Answer the questions below.

Name of authorized representative:

Address:	Apartment #	City	State	ZIP code

Phone number: ☐ Home ☐ Cell ☐ Work ☐ Other
Number:

By signing, you allow this person to sign your renewal form, to get information about this renewal form, and to act for you with this agency.

Your signature:	Date:

Attachment D

Helpful information about immigration status and document types, and self-employment business expenses *To help you fill out Section 3, page 3*

Eligible immigration status list

▶ If you see the person's status below, go back to Section 3, page 3 and check the Yes box.

- Lawful Permanent Resident (LPR or Greencard holder)
- Asylee
- Refugee
- Cuban or Haitian entrant
- Paroled into the U.S.
- Conditional entrant granted before 1980
- Battered spouse, child and parent
- Victim of Trafficking and his/her spouse, child, sibling or parent
- Granted Withholding of Deportation or Withholding of Removal, under the immigration laws and under the Convention against Torture (CAT)
- Individual with Non-immigrant Status (includes worker visas, student visas, and citizens of Micronesia, the Marshall Islands, and Palau)
- Temporary Protected Status (TPS) and Applicant for Temporary Protected Status (TPS)
- Deferred Enforced Departure (DED)
- Family Unity beneficiary
- Deferred Action Status (Deferred Action for Childhood
- Arrivals (DACA) is not an eligible immigration status for applying for health insurance
- Applicant for Special Immigrant Juvenile Status
- Applicant for Adjustment to LPR Status
- Applicant for Asylum
- Applicant for Withholding of Deportation or Withholding of Removal, under the immigration laws or under the Convention against Torture (CAT)
- Registry Applicants (with Employment Authorization)
- Order of Supervision (with Employment Authorization)
- Applicant for Cancellation of Removal or Suspension of Deportation (with EAD Employment Authorization)
- Applicant for Legalization under IRCA (with Employment Authorization)
- Legalization under the LIFE Act (with Employment Authorization)
- Lawful Temporary Resident
- Member of a federally-recognized Indian tribe or American Indian Born in Canada
- Resident of American Samoa
- Administrative order staying removal issued by the Department of Homeland Security

Immigration document types

▶ People who are not citizens, but who are eligible to apply for health insurance coverage, must put their immigration documents and ID numbers on Section 3, page 3. A list of documents and ID numbers is below. If your document type is not listed, you can write its name. If you have questions, or are eligible but have no document, call 1-800-XXX-XXXX.

Permanent Resident Card (I-551, also known as Green Card)
- Alien registration number
- Card number

Temporary I-551 Stamp (on passport or I-94, I-94A)
- Alien registration number

Immigrant Visa (with temporary I-551 language)
- Alien registration number
- Passport number

Employment Authorization Card (EAD or I-766)
- Alien registration number
- Card number
- Expiration date
- Category code

Arrival/Departure Record (I-94 or I-94A)
- I-94 number

Arrival/Departure Record in foreign passport (I-94)
- I-94 number
- Passport number
- Expiration date
- Country of issuance

Foreign passport
- Passport number
- Expiration date

Country of issuance Reentry Permit (I-327)
- Alien registration number

Refugee travel document (I-571)
- Alien registration number

Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20)
- Alien registration number or an I-94 number
- Description of the type or name of the document

Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)
- SEVIS ID

Notice of Action (I-797)
- Alien registration number or an I-94 number

Other
- Alien registration number or an I-94 number
- Description of the type or name of the document

You can also list these documents or statuses:

- Document indicating a member of a federally recognized Indian tribe or American Indian born in Canada *This is considered an eligible immigration status for Medicaid, but not for a Qualified Health Plan [QHP]*
- Office of Refugee Resettlement (ORR) eligibility letter (if under 18)
- Document indicating withholding of removal
- Administrative order staying removal issued by the Department of Homeland Security (DHS)
- Certification from U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR)
- Cuban/Haitian entrant
- Resident of American Samoa