Medicaid
Renewal Form

You can get this form in another language or in large print or another way that's best for you. Call [XXX-XXX-XXXX (TTY: XXX-XXX-XXXX)].

Ernie Roberts
5678 Broad St.
P.O. Box 6789
Anywhere, ST 12345

November 5, 2015
Respond by: December 12, 2015
Letter number: 34567

It is time to renew your Medicaid coverage.

You can renew your Medicaid in any one of these four ways

- **Online:** Go to [**web address**]. Click on [web page].
- **By phone:** Call [**XXX-XXX-XXXX** (TTY: XXX-XXX-XXXX)]. The call is free.
- **By mail:** Complete this form and mail it to:
  [State Agency]
  [100 State Street]
  [Anycity, State ZIP]
- **In person:** Visit our office at [State Agency], [100 State Street], [Anycity, State ZIP]. Office hours are 8:30 a.m. to 5:00 p.m. Monday to Friday, and 9:00 a.m. to 12:00 p.m. on Saturday.

Renewing online is faster! Go to [**web address**]. Click on [web page].

How to complete this renewal form

1. Answer all of the questions on the form.
2. Read the information about you and each person in your household or on your tax return. Add any missing information. If any information has changed, write in the right information.
3. **Sign the form in Part 9.**
4. **Return this form by December 12, 2015.** 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***
- those who 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.

Questions? Call [State Agency] at [**XXX-XXX-XXXX** (TTY: XXX-XXX-XXXX)]. The call is free. Or visit [**web address**]. See the top of this page to learn how to **submit** your completed form.

1 Your contact information

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

2 Information about tax returns

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

▶ Review the information below for people in your household who will file a **tax return** *next year* to report income earned *this year*. Cross out anything that is wrong. Write correct information in the space right next to it. Fill in any missing information.

Name
Ernie Roberts

☐ Check here if this person does not plan to file a tax return.

Spouse on tax return	Dependents on tax return
Samantha Roberts	Benjamin Roberts

▶ Fill out the information below if there is a **second tax filer** in the household.

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

▶ Will anyone in your household be claimed as a dependent on **someone else's** tax return? Include only names that do **not** appear above.

☐ Yes ☐ No ***If yes,*** write the name of the dependents and the tax filer.

Name of **dependents** *(first, middle, last & suffix)*

Name of **tax filer** *(first, middle, last & suffix)*

3 People in your household This part shows the information that we have on file for people in your household and on your tax return.

▶ Review the information below. Cross out anything that is wrong. Write correct information in the space right next to it. Fill in any missing information.

Who should be listed in Part 3? Use the list below to be sure everyone in your household and on your tax return is included, even if they aren't renewing or applying for health coverage themselves. If there are new people in your household who aren't listed here, fill in their information in Part 4.

Adults:

- Any spouse
- Any son or daughter under age 21 they live with, including stepchildren
- Any other person on the same federal income tax return (including claimed children over age 21). You don't need to file taxes to get health coverage.

Children under age 21:

- Any parent (or stepparent) they live with
- Any sibling they live with
- Any son or daughter they live with, including stepchildren
- Any other person on the same federal income tax return. You don't need to file taxes to get health coverage.

Name: Ernie Roberts ☐ Check here if this person is no longer living in the household.

This person is: ☒ Male ☐ Female

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

☒ [State Agency] **has** this person's Social Security number.

☐ [State Agency] does **not** have this person's Social Security number. Write it in the spaces below.

___ ___ ___ – ___ ___ – ___ ___ ___ ___

Is this person enrolled in Medicaid? ☐ Yes ☒ No ***If no*** and this person wants to **apply**, fill out **Attachment A**.

☒ This person is a U.S. citizen or U.S. national and does **not** need to fill in the information below.
☐ This person is an immigrant and does **not** need to fill in the information below because [State Agency] has it.
☐ This person is an immigrant and **needs** to fill in the information below.

Document type	Alien or I-94 number	Card number or foreign passport number

See **Attachment D** for more information about eligible immigration status and document types.

Name: Samantha Roberts ☐ Check here if this person is no longer living in the household.

This person is: ☐ Male ☒ Female

Date of birth *(month/day/year)*: **6/8/1975**

☒ [State Agency] **has** this person's Social Security number.

☐ [State Agency] does **not** have this person's Social Security number. Write it in the spaces below.

___ ___ ___ – ___ ___ – ___ ___ ___ ___

Is this person enrolled in Medicaid? ☒ Yes ☐ No ***If no*** and this person wants to **apply**, fill out **Attachment A**.

☒ This person is a U.S. citizen or U.S. national and does **not** need to fill in the information below.
☐ This person is an immigrant and does **not** need to fill in the information below because [State Agency] has it.
☐ This person is an immigrant and **needs** to fill in the information below.

Document type	Alien or I-94 number	Card number or foreign passport number

See **Attachment D** for more information about eligible immigration status and document types.

Part 3 *continued on next page* ▶▶▶

People in your household (continued)

Name: Benjamin Roberts

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

This person is: ☒ Male ☐ Female

Date of birth *(month/day/year)*: **10/1/2000**

☒ [State Agency] **has** this person's Social Security number.

☐ [State Agency] does **not** have this person's Social Security number. Write it in the spaces below.

___ ___ ___ – ___ ___ – ___ ___ ___ ___

Is this person enrolled in Medicaid? ☒ Yes ☐ No ***If no*** and this person wants to **apply**, fill out **Attachment A**.

☒ This person is a U.S. citizen or U.S. national and does **not** need to fill in the information below.

☐ This person is an immigrant and does **not** need to fill in the information below because [State Agency] has it.

☐ This person is an immigrant and **needs** to fill in the information below.

Document type	Alien or I-94 number	Card number or foreign passport number

See **Attachment D** for more information about eligible immigration status and document types.

4 New people in your household or on your tax return

▶ Include anyone **new** in your household and on your tax return that you did **not** list in Part 3, even if they aren't renewing or applying for health coverage themselves. Make a copy first if you need space for more people.

Are there any **new** people in your household? ☐ Yes ☐ No ***If yes,*** fill in the information below. ***If no,*** go to Part 5.

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

This person is: ☐ Male ☐ Female

Date of birth *(month/day/year)*:

How is this person related to you?

Does this person want to **apply** for Medicaid? ☐ Yes ☐ No ***If yes,*** fill out **Attachment A**.

If this person is applying for Medicaid, we need his or her Social Security number. Write it in the spaces below.

___ ___ ___ – ___ ___ – ___ ___ ___ ___

Even if this person doesn't want coverage, providing the Social Security number speeds up application and renewal for other household members.

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

This person is: ☐ Male ☐ Female

Date of birth *(month/day/year)*:

How is this person related to you?

Does this person want to **apply** for Medicaid? ☐ Yes ☐ No ***If yes,*** fill out **Attachment A**.

If this person is applying for Medicaid, we need his or her Social Security number. Write it in the spaces below.

___ ___ ___ – ___ ___ – ___ ___ ___ ___

Even if this person doesn't want coverage, providing the Social Security number speeds up application and renewal for other household members.

5 Other health insurance coverage

▶ Does anyone renewing or applying for health coverage have **other** health insurance?

☐ Yes ☐ No ***If yes,*** fill in the information below.

Name of insurance company	Policy number	**Name of insurance company**	Policy number
Insurance type: ☐ Medicare ☐ Tricare ☐ Veteran's health coverage ☐ Other insurance: _____		Insurance type: ☐ Medicare ☐ Tricare ☐ Veteran's health coverage ☐ Other insurance: _____	
Is this a state employee benefit plan? ☐ Yes ☐ No		Is this a state employee benefit plan? ☐ Yes ☐ No	
List everyone renewing or applying who is on this policy:		List everyone renewing or applying who is on this policy:	

6 More information about household members

▶ Answer these two questions for **everyone** in your household or on your tax return, whether or not they are renewing or applying for health coverage.

1. Is anyone listed on this form **pregnant**?

☐ Yes ☐ No ***If yes,*** fill in the information below.

Name *(first, middle, last & suffix)*	How many babies are expected?	When is the due date?
Name *(first, middle, last & suffix)*	How many babies are expected?	When is the due date?

2. Is anyone listed on this form an **American Indian or Alaska Native**?

☐ Yes ☐ No ***If yes,*** fill out **Attachment B**.

▶ Answer these four questions for anyone who is **renewing or applying** for health coverage.

1. Does anyone live in a **long term care facility, group home, or nursing home,** or regularly get medical care, personal care, or health services at home or in another community setting (like adult day care)?

☐ Yes ☐ No ***If yes,*** write his or her name below.

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

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

2. Is anyone **blind or terminally ill**?

☐ Yes ☐ No ***If yes,*** write his or her name below.

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

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

3. Is anyone **between the ages of 18 and 22 and also a full-time student**?

☐ Yes ☐ No ***If yes,*** write his or her name below.

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

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

4. Was anyone in **foster care at age 18 or older**?

☐ Yes ☐ No ***If yes,*** write his or her name below.

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

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

7 Income from jobs

▶ Review 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.

- This is the most recent information that we have on file. Cross out anything that is wrong. Write correct information in the space right next to it. Be sure to include any changes in wages paid or number of hours worked.
- Add any new jobs to the *Income from new jobs* section. If someone has more than one job, tell us about **all** jobs.
- Tell us about self-employment in the *Self-employment income* section.

Job 1

Name of the person who is working
Ernie Roberts

☐ Check here if this person stopped working here.

Employer name
Joe's Body Shop

Amount this person makes in wages and tips (before taxes): **$ 417**

How often:
☐ Hourly ☐ Weekly ☐ Every two weeks
☒ Twice a month ☐ Monthly ☐ Yearly ☐ Other_____

Number of hours this person works each week on average if paid hourly:

Job 2

Name of the person who is working
Samantha Roberts

☐ Check here if this person stopped working here.

Employer name
Main Street Deli

Amount this person makes in wages and tips (before taxes): **$ 10**

How often:
☒ Hourly ☐ Weekly ☐ Every two weeks
☐ Twice a month ☐ Monthly ☐ Yearly ☐ Other_____

Number of hours this person works each week on average if paid hourly: **10**

▶ Income from new jobs

Make a copy first if you need space for more jobs or people.

Has anyone in your household or on your tax return **changed jobs** or **started a new job**? ☐ Yes ☐ No ***If yes,*** complete this section for new jobs.

New job

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

Employer name

Employer phone number

Employer address

City

State

ZIP code

Amount this person makes in wages and tips (before taxes): **$**

How often:
☐ Hourly ☐ Weekly ☐ Every two weeks
☐ Twice a month ☐ Monthly ☐ Yearly ☐ Other_____

Number of hours this person works each week on average if paid hourly:

New job

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

Employer name

Employer phone number

Employer address

City

State

ZIP code

Amount this person makes in wages and tips (before taxes): **$**

How often:
☐ Hourly ☐ Weekly ☐ Every two weeks
☐ Twice a month ☐ Monthly ☐ Yearly ☐ Other_____

Number of hours this person works each week on average if paid hourly:

Part 7 *continued on next page* ▶▶▶

7 Income from jobs (continued)

▶ **Self-employment income** See the instructions below for information on how to get your *net income*. Make a copy first if you need space for more people.

Is anyone in your household or on your tax return **self-employed**? ☐ Yes ☐ No ***If yes,*** complete this section.

Name of the person who is self-employed *(first, middle, last & suffix)*

Type of work:	How much *net income* will this person get from self-employment this month? **$**

Name of the person who is self-employed *(first, middle, last & suffix)*

Type of work:	How much *net income* will this person get from self-employment this month? **$**

▶ **To get your *net income*, subtract the expenses below from your self-employment gross (total) 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 Other income information

▶ Review the information below for everyone in your household or on your tax return.
- Cross out anything that is wrong. Write correct information in the space right next to it. Fill in any missing information.
- You don't need to tell us about child support, veteran's payments or Supplemental Security Income (SSI).

Make a copy first if you need space for more people.

Does anyone in your household or on your tax return get any **other** income?

☒ Yes ☐ No ***If yes,*** complete this section for each type of other income. ***If no,*** go to the *Income changes from month to month* section.

Unemployment	**How much?**	**How often?**
Name *(first, middle, last & suffix)*	**$**	☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other _____
Social Security	**How much?**	**How often?**
Name *(first, middle, last & suffix)*	**$**	☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other _____
Pensions	**How much?**	**How often?**
Name *(first, middle, last & suffix)*	**$**	☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other _____
Retirement accounts	**How much?**	**How often?**
Name *(first, middle, last & suffix)*	**$**	☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other _____

Part 8 *continued on next page* ▶▶▶

8 Other income information (continued)

Alimony received	How much?	How often?
Name Samantha Roberts	**$ 70**	☒ 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 _____

▶ **Income changes from month to month** Make a copy first if you need space for more people.

Is there anyone in your household or on your tax return whose income **changes** from month to month? ☐ Yes ☐ No
If yes, complete this section for each person.

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

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

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

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

▶ **Deductions** *Deductions* are amounts, listed on your tax return, that are subtracted from your income for certain expenses. You shouldn't include child support that you pay, or an expense you subtracted from your self-employment gross income in Part 7.

Does anyone in your household or on your tax return expect to have any **deductions**? ☐ Yes ☐ No
If yes, complete this section for each type of deduction.

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 deduction Type:	**How much?**	**How often?**
Name *(first, middle, last & suffix)*	**$**	☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other _____
Other deduction Type:	**How much?**	**How often?**
Name *(first, middle, last & suffix)*	**$**	☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other _____

9 Read and sign this application

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** (TTY: 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** (TTY: XXX-XXX-XXXX)]. Someone from [State Agency] will explain anything about this application to me if I need that.
- 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 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 for certain long term care services provided to me. [State Agency] must do this 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 [State Agency] from my estate after my death will not be more than the amount Medicaid paid for my care.
- 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.

Is anyone renewing or applying for health coverage incarcerated (detained or jailed)?

☐ Yes ☐ No ***If yes,*** what is the person's name?_____

Renewal of coverage in future years: Read the statements below and choose.

To make it easier to renew, I give permission to [State Agency] to use updated income information from my tax returns for the next **5** years.

☐ Yes ☐ No ***If no,*** check **one** box below.

I give permission to [State Agency] to use income information from my tax returns for the next:

☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ Do not use my tax information. I understand that this may delay my Medicaid renewal.

You can change this choice at any time by contacting [State Agency].

▶ Sign and date below

If you want an authorized representative or want to change the authorized representative you have now, fill out **Attachment C**.

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

Signature of household contact or authorized representative ▶	Date

Attachment A

People applying for Medicaid

Use with Part 3 and Part 4.

▶ Fill out Attachment A for people who are listed in Part 3 and Part 4 who are **applying for Medicaid for the first time**. Do not include people who already have Medicaid. Make a copy first if you need space for more people.

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

1. Tell us about this person's citizenship.

Is this person a U.S. citizen or U.S. national? ☐ Yes ☐ No ***If yes,*** go to number 2. ***If no,*** answer all of the questions below.

Does this person have eligible immigration status? ☐ Yes ☐ No ***If yes,*** please provide information about his or her document.

Document type	Alien or I-94 number	Card number or foreign passport number

See **Attachment D** 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.

2. Tell us more 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.

If this person is Hispanic/Latino, check all that apply. *You may choose not to answer this question:*

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

What is this person's race? Check all that apply. *You may choose not to answer this question:*

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

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

1. Tell us about this person's citizenship.

Is this person a U.S. citizen or U.S. national? ☐ Yes ☐ No ***If yes,*** go to number 2. ***If no,*** answer all of the questions below.

Does this person have eligible immigration status? ☐ Yes ☐ No ***If yes,*** please provide information about his or her document.

Document type	Alien or I-94 number	Card number or foreign passport number

See **Attachment D** 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.

2. Tell us more 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.

If this person is Hispanic/Latino, check all that apply. *You may choose not to answer this question:*

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

What is this person's race? Check all that apply. *You may choose not to answer this question:*

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

Attachment B

American Indian or Alaska Native household members (AI/AN) Use with Part 6.

▶ Tell us about people in your household or on your tax return who are American Indians or Alaska Natives. Make a copy first if you need space for more people.

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.

Person 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

Certain money received may not be counted for Medicaid. List any income (amount and how often) reported in Part 8 that includes money from these sources:

- 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

Income source	How much?	How often?
	$	☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other _____
	$	☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other _____

Person 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

Certain money received may not be counted for Medicaid. List any income (amount and how often) reported in Part 8 that includes money from these sources:

- 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

Income source	How much?	How often?
	$	☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other _____
	$	☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other _____

Attachment C Authorized representative

▶ If you have an authorized representative now, please answer these questions. An authorized representative is someone you choose to sign this renewal form and act for you with this agency. The authorized representative may receive notices about you from the [State Agency].

We show that you chose this person as your authorized representative:

No authorized representative chosen

Do you still want this person to be your authorized representative?
☐ 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 below.

Name of authorized representative

Address | Apartment # | City | State | ZIP code

Phone number: ☐ Home ☐ Cell ☐ Work ☐ Other

Number:

Sign and date

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.

Do you want an authorized representative? ☐ Yes ☐ No ***If yes,*** answer the questions below.

Name of authorized representative

Address | Apartment # | City | State | ZIP code

Phone number: ☐ Home ☐ Cell ☐ Work ☐ Other

Number:

Sign and date

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

Immigration status and documents

Use with Part 3 and Attachment A.

▶ Eligible immigration status list

If you see the person's status below, go back to Part 3 or Attachment A 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 or 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 documents

People who are not citizens, but who are eligible to apply for health insurance coverage, must put their immigration documents, ID numbers, and card numbers in Part 3 and Attachment A. A list of documents, ID numbers, and card numbers is below. If your document is not listed, you can write its name. If you have questions, or are eligible but have no document, call [**XXX-XXX-XXXX** (TTY: XXX-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 or Haitian entrant
- Resident of American Samoa