Medicaid Renewal Request for Information Notice

_____ COUNTY DEPARTMENT OF SOCIAL SERVICES (DSS)

Date: _____

To: _____

Address: _____

_____

Case ID No: _____ Worker: _____

*** THIS FORM MUST BE SENT IN BY _____ (30 DAYS FROM ABOVE DATE) OR YOU MAY LOSE YOUR N.C. MEDICAID OR N.C. HEALTH CHOICE ***

Why You Need to Complete This Form
In order to be considered for Medicaid or N.C. Health Choice, you must complete this form. The information will be used to verify that you and your family still qualify. The information is necessary to process your review.
In addition to helping yourself, you can use this form to apply for health insurance coverage for other family members in your house.
Contact _____ County DSS at _____ if you have any questions about filling out this form.

SECTION 1
TELL US ABOUT YOURSELF
Do you expect to file a tax return? Yes ☐ No ☐
Are you a dependent on someone else's tax return? Yes ☐ No ☐
If yes – who?

SECTION 2
TELL US ABOUT YOUR FAMILY ***(include family members and tax dependents living in your house)***
PERSON 1:
Name:
Does this person expect to file a tax return? Yes ☐ No ☐
Does this person expect to be a dependent on someone else's tax return? Yes ☐ No ☐
If yes – who?
Is this person pregnant? Yes ☐ No ☐
If so, what is the expected due date?
Does this person have Medicaid? Yes ☐ No ☐

If this person does not have Medicaid, complete Attachment A to apply for Medicaid.
PERSON 2:
Name:
Does this person expect to file a tax return? Yes ☐ No ☐
Does this person expect to be a dependent on someone else's tax return? Yes ☐ No ☐
If yes – who?
Is this person pregnant? Yes ☐ No ☐
If so, what is the expected due date?
Does this person have Medicaid? Yes ☐ No ☐
To apply for Medicaid for this person complete Attachment A.
PERSON 3:
Name:
Does this person expect to file a tax return? Yes ☐ No ☐
Does this person expect to be a dependent on someone else's tax return? Yes ☐ No ☐
If yes – who?
Is this person pregnant? Yes ☐ No ☐
If so, what is the expected due date?
Does this person have Medicaid? Yes ☐ No ☐
To apply for Medicaid for this person complete Attachment A.
PERSON 4:
Name
Does this person expect to file a tax return? Yes ☐ No ☐
Does this person expect to be a dependent on someone else's tax return? Yes ☐ No ☐
If yes – who?
Is this person pregnant? Yes ☐ No ☐
If so, what is the expected due date?
Does this person have Medicaid? Yes ☐ No ☐
To apply for Medicaid for this person complete Attachment A.
If more space is needed, please attach a separate sheet.

Medicaid Renewal Request for Information Notice

SECTION 3
TELL US MORE ABOUT THE PEOPLE LISTED ON THIS FORM
A. **Income:** Does anyone listed on this form have an income? Yes ☐ No ☐ If yes, complete **Attachment B.**
B. **Living Situation:** Does anyone listed on this form live in a:
☐ Long-term care facility, group home, or nursing home
☐ Private home, but gets at-home medical, personal or health services
☐ Private home, but gets medical, personal or health services in the community (such as adult day care)
If so, please list their names:
Name(s):
C. **Foster Care:** Is anyone listed on this form between the ages of 18 and 26 **and** was in foster care at age 18? Yes ☐ No ☐
If so, please list their names:
Name(s):

SECTION 4	
SIGNATURE	
I am signing this renewal form under penalty of perjury which means I have provided true answers to all the questions to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide untrue information.	
Beneficiary/Authorized Representative*	Date
*The person who completed the form or their legal representative.	

WHERE TO SEND THE INFORMATION	
You can complete the form:	
• In-person at the	County DSS Office (street address)
• By phone at:	
• By mail at:	County DSS Office, (mailing address)

ATTACHMENT A

TO APPLY FOR MEDICAID FOR ANYONE LISTED IN SECTION 2.
Person 1:
A. Name:
B. Social Security Number:
C. Date of Birth:
D. How is this person related to you?
E. This person is : Male ☐ Female ☐
F. This person is a U.S. citizen or U.S. national Yes ☐ No ☐
If yes, skip to "***additional information" below.***
If no, answer question **"G"**:
G. If this person has eligible immigration status:
Document Type:
ID Number:
☐ 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
Additional Information
☐ Check here, if this person lives with at least one child under the age of 19 and is the person taking care of this child.
☐ Check here, if this person is 18 years or younger and has a parent living outside of the house
☐ Check here, if this person wants help paying for medical bills from the last three months
Person 2:
A. Name
B. Social Security Number
C. Date of Birth
D. How is this person related to you?
E. This person is : Male ☐ Female ☐
F. This person a U.S. citizen or U.S. national Yes ☐ No ☐
If yes, skip to "***additional information" below.***

If no, answer question **"G"**
G. If this person has eligible immigration status:
Document Type:
ID Number:
☐ 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
Additional Information
☐ Check here, if this person lives with at least one child under the age of 19 and is the person taking care of this child.
☐ Check here, if this person is 18 years or younger and has a parent living outside of the house
☐ Check here, if this person wants help paying for medical bills from the last three months
If more space is needed, please attach a separate sheet.

ATTACHMENT B

INCOME

Person Receiving Income	Income Type *	Amount Before Taxes	How Often Received	Start Date

If more space is needed to report changes, attach a separate sheet.

Include income from:

Jobs	Foreign Income	Self-Employment
Investment Income or Interest	Alimony	Farming or Fishing Income
Unemployment	Rental or Royal Income	Social Security Benefits
Capital Gains	Retirement / Pension	Scholarship
Title	Alien Sponsor	Lump Sum Amount
American Indian / Alaskan Native Income		

Do <u>not</u> include:

Child Support
Workers Compensation
Supplemental Security Income (SSI)
Veterans Administration (VA) Benefits

C. **Loss of Income:** Was anyone listed on this form receiving income in the last 12 months but no longer is? Yes ☐ No ☐

If yes, who, when and what type?

D. Expenses: Is there anyone in the family deducting expenses from their taxes? Yes ☐ No ☐

If yes, complete Expenses (Deductions) below.

EXPENSES (DEDUCTIONS)

Person Paying Deduction	Deduction Type	Amount	How Often	Start Date

If more space is needed to report changes, please attach a separate sheet.

***Allowable deductions include*:**

Alimony Paid	Health Savings Acct Contributions	Educator Expenses
IRA Contributions	Tuition / Fees	Moving Expenses
Student Loan Interest	Penalty on Early Withdrawals of savings	

***For those who are self-employed, allowable deductions also include*:**

Rent / Royalty Expenses
Certain Business Expenses of Reservists, Performing Artists and Fee Basis Government Officials
Deductible Part of Self-Employment Tax
Domestic Production Activities Deduction
Health Insurance Deduction
SEP, SIMPLE and Qualified Plans

E. Health Insurance: Does anyone listed on this form have other health insurance besides Medicaid and N.C. Health Choice? Yes ☐ No ☐

If so, complete Health Insurance below.

HEALTH INSURANCE

Person Covered	Policy Holder	Policy Number	Insurance Company	Type of Coverage	Start Date

If more space is needed to report changes, please attach a separate sheet.

Voter Registration:

If you are not registered to vote where you live now, would you like to apply to register to vote here today?
__ yes __ no

If you want to register to vote, you can complete a voter registration form at http://www.ncsbe.gov/.