County Office
County Mailing Address

July 16, 2015
Reference Number: Integrated Case #

Consumer's Name
Consumer's Mailing Address

Medical Assistance and MinnesotaCare Renewal Follow-Up Notice
Act Now or Your Coverage Will End

Why am I getting this notice?
We are following up on the renewal of Medical Assistance or MinnesotaCare coverage for you and your household members because we have not received your renewal form.

What do I need to do?
You must complete and sign the enclosed renewal form. You must return it to the agency listed at the top of this notice within 30 days. You and your household members may be eligible for your current program. Or you may be eligible for another health care program.

What happens if I do not return the form within 30 days?
Coverage for all household members needing to renew will end on August 31, 2015. After that date, you will need to reapply if you want coverage.

What if I have questions about my renewal?
If you have questions, call your county at [county phone number].

For MinnesotaCare Members Only

Some MinnesotaCare members have not been getting premium bills. You will get a premium bill, and you will need to pay your premium. We will follow up with you about any past-due premiums.

Reference Number: Integrated Case # Renewal Month

Attention. If you need free help interpreting this document, ask your worker or call the number below for your language.

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اطلب ذلك من مشرفك أو اتصل على الرقم 1-800-358-0377.

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿង របស់អ្នក ឬហៅទូរស័ព្ទមកលេខ 1-888-468-3787 ។

Pažnja. Ako vam treba besplatna pomoć za tumačenje ovog dokumenta, pitajte vašeg radnika ili nazovite 1-888-234-3785.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces nug koj tus neeg lis dej num los sis hu rau 1-888-486-8377.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງຖາມພະນັກງານກໍາກັບການຊ່ວຍເຫຼືອ ຂອງທ່ານ ຫຼື ໂທຣໄປທີ່ 1-888-487-8251.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, hojjettoota kee gaafadhu ykn afaan ati dubbattuuf bilbilli 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, обратитесь к своему социальному работнику или позвоните по телефону 1-888-562-5877.

Digniin. Haddii aad u baahantahay caawimaad lacag-la’aan ah ee tarjumaadda qoraalkan, hawlwadeenkaaga weydiiso ama wac lambarka 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, comuníquese con su trabajador o llame al 1-888-428-3438.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi nhân viên xã hội của quý vị hoặc gọi số 1-888-554-8759.

LBI-0001 (3-13)

This information is available in accessible formats for individuals with disabilities by calling 651-431-2670, toll-free 800-657-3739, or by using your preferred relay service. For other information on disability rights and protections, contact the agency’s ADA coordinator. ADA 12-12

Medical Assistance and MinnesotaCare Renewal Form

This form asks for information we need to know about your household. You must do the following:

- Provide the information the form asks for.
- Sign and date the form.
- Send the form back to this address:
  County Office
  County Mailing Address

You must return this form within 30 days or your coverage will end.

1. **Contact Information:** Give your current home address and phone number. If your mailing address is different from your home address, attach another sheet with the mailing address.

Home Street Address	
City, State, Zip Code	
Telephone Number(s)	

2. **Information about Your Household:** List all members of your household, including yourself. If you need more room, attach another sheet with the information.

Full Name	**Date of Birth (MM/DD/YYYY)**	**Pregnant? (Yes or No)**	**Requesting coverage? (Yes or No)**	**If the person is requesting coverage, provide his or her Social Security number**

3. **Other Health Insurance Information:** List all members of your household, including yourself. Answer the questions for each household member.

Full Name	**Does this person have Medicare or other health insurance that is not provided by an employer? (Yes or No)**	**Does this person have health insurance available through an employer? (Yes or No)**

4. **Current Income Information:** List all income for your household. If you need more room, attach another sheet with the information.
   - Include your taxable income plus any nontaxable foreign earned income, interest income and Social Security benefits. Social Security benefits include retirement, disability and Railroad Retirement benefits.
   - Do not include Supplemental Security Income (SSI).

Full Name	**Type of Income**	**Amount**	**Frequency (How Often)**

5. **Adjustment Information:** List each household member's allowable adjustments.

   Allowable adjustments are the types of expenses that are subtracted from taxable income on the front of the 1040 tax return, like alimony paid or student loan interest. For a full list of allowable adjustments, see lines 23–35 on the 1040 tax form. If you need more room, attach another sheet with the information.

Full Name	Type of Adjustment	Amount	Frequency (How Often)

6. **Projected Annual Income:** Complete this question only if you expect total income for 2015 to be different from what you reported for questions 4 and 5.

   Your projected annual income is your total expected income for 2015. It is the amount of total income you expect to receive in 2015 minus the adjustments you can claim on the front page of the 1040 tax form. If you need more room, attach another sheet with the information.

Full Name	Projected Annual Income

Signature

By signing below, I am saying that I have read and agree to the following:

- I have read and understand the notice of privacy practices and the list of my responsibilities in that notice.
- I have read and understand the "Rights and Responsibilities" section of the notice, including the "Changes" part.
- I have read and understand the "MA Liens and Estate Claims" section of the notice.
- My information will be shared for fraud investigations and audits as stated in the notice of privacy practices.
- My information will be released to the parties listed in the notice of privacy practices to verify eligibility for Minnesota Health Care Programs.
- I give the Medical Assistance (MA) agency our rights to pursue and get any money from other health insurance, legal settlements or other third parties for medical benefits paid by the MA agency. I also give the MA agency the right to pursue and get medical support from a spouse or parent.
- I give permission for the release of my Minnesota Health Care Programs health records to the parties listed in the "MA Authorization for Release (Sharing) of My Medical Information" section of the notice of privacy practices.
- I declare that, under penalty of perjury (not telling the truth), all parts of this form and any updates to information I give during the year are true and correct statements, to the best of my knowledge. I understand what happens to people convicted of perjury. They may be sentenced to prison for up to five years, have to pay a fine of up to $10,000, or both.
- I give permission to use income data from my federal tax returns to renew my eligibility this year.

Sign Below

YOUR SIGNATURE		DATE
SIGNATURE OF AUTHORIZED REPRESENTATIVE	PHONE	DATE

If an enrollee is unable to sign, provide copies of legal documents of conservatorship or power of attorney.