Medical Assistance Renewal Notice

It is time to renew your Medicaid/NC Health Choice coverage.
You can renew your Medicaid/NC Health Choice by mail, by phone, or in person.

Please **provide the requested information and complete this renewal form by:**

- Answering all of the questions on the form
- Adding any missing information
- If any information has changed, writing in the right information.
- Signing the form
- **Return this form by**

  If you do not return the form by this deadline, you may lose your Medical coverage

We will check your answers using information from computer data sources, including 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.

By accepting North Carolina Medicaid/NC Health Choice you understand that the information you give will be checked. You agree to help do that and let the Medicaid/NC Health Choice agency get the information it needs to determine eligibility from government agencies, employers, medical providers, and others. Medicaid/NC Health Choice also has the right to seek money you receive from other sources like insurance payments or lawsuits for services Medicaid has paid for you and your other household members that are receiving a Medicaid/NC Health Choice benefit.

Individuals eligible for Medicaid may be eligible for assistance with transportation to medical appointments.

Contact the Department of Social Services if you have questions, need assistance in obtaining verifications, or need assistance completing this form.

If you are NOT registered to vote where you live now, would you like to register to vote here today?
Yes ☐ No ☐

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

If you want to register to vote or to update your registration, you can complete a voter registration form at www.ncsbe.gov/NVRA/01, or ask your caseworker or contact your local DSS for a voter registration form, and if you need help, ask for help to complete the form.

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency. If you would like help filling out the voter registration application form, we will help you. The decision either to see or accept help is yours. You may fill out the application form in private. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Board of Elections, PO Box 27255, Raleigh NC 27611-7255, or you may call the toll free number,
1-866-522-4723.

Your information currently on file is displayed below.

CONTACT INFORMATION

Is your contact information listed below correct? YES ☐ NO ☐

If 'NO' cross out the incorrect information and print the correct information below.

Residential Address

Phone Type **Telephone Number**

Mailing Address

Email Address:

HOUSEHOLD

Is the Household Member information listed below correct? ***YES*** ☐ ***NO*** ☐

If ***'NO'***, cross out the incorrect information and print the correct information below. If someone is no longer in the household, please provide the date he/she moved out.

Name	Relationship	Date of Birth	US Citizen	SSN	Date Moved out

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

Name	Relationship	Date of Birth	Gender

☐ Check here if this person(s) has Medicaid/NC Health Choice

Does the agency have the Social Security number for this person(s)? YES ☐ NO ☐ If no, please provide

NOTE: A 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 the person(s) does not have Medicaid/NC Health Choice and wants to apply for health insurance coverage.

Please fill out Attachment A if this box is checked.

Please provide the Social Security Number for the person(s) applying for health insurance:

TAX FILING INFORMATION

We need information about who files tax returns. You can still renew if you do not file tax returns.

Is the TAX filing Status Information listed below correct? ***YES*** ☐ ***NO*** ☐

If ***'NO'***, cross out the incorrect information and print the correct information below

Name	Tax Filing Status	Married Filing Together	Start Date	End Date

If anyone will be claimed as a dependent on someone else's tax return, write the name of the tax filer and the dependent(s).

Name of Tax Filer	Name of Dependent

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

If yes, Name of tax filer:

PREGNANCY

Is the Pregnancy information listed below correct? ***YES*** ☐ ***NO*** ☐

If ***'NO'***, cross out the incorrect information and print the correct information below.

Name	Due Date	Number Of Unborn	End Date	End Reason

INCOME (Include income from Jobs, Self-employment, Alimony, Unemployment Social Security Benefits, Supplemental Security Income, Retirement, Pension, American Indian Alaskan Native Income, Foreign Income, Investment Income, Interest, Farming or Fishing Income, Rental or Royalty Income, Capital Gains, Scholarship, Title, Lump Sum Amount and Alien Sponsor. Do not include Child Support, Workers Compensation, or VA Benefits.)

Is the income information listed below correct? ***YES*** ☐ ***NO*** ☐

If ***'NO'*** cross out the incorrect information and print the correct information below. Please include new income sources if applicable.

Person Receiving Income	Income Type	Gross Amount	Frequency	Start Date	End Date

DEDUCTIONS (Allowable deductions include: Alimony Paid, Educator Expenses, Tuition/Fees, Student Loan Interest, Health Savings Account Contributions, IRA Contributions, Moving Expenses, and Penalty on Early Withdrawal of Savings. For those with Self Employment, 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, and SEP, SIMPLE, and Qualified Plans.)

Is the Deduction information listed below correct? ***YES*** ☐ ***NO*** ☐

If ***'NO'***, cross out the incorrect information and print the correct information below.

Person Paying Deduction	Deduction Type	Amount	Frequency	Start Date	End Date

MEDICAL INSURANCE

Is the Medical Insurance information listed below correct and complete? Y*ES* ☐ ***NO*** ☐

*If **'NO'**, cross out the incorrect information and print the correct information below. If any other household member has health insurance not listed below, provide information in the space provided.*

Person Covered	Policy Holder	Policy Number	Insurance Company	Start Date	End Date

☐ Check here if anyone on this form is offered health insurance through a job, even if they are not enrolled in it.

Tell us more about the people listed on this form

Please provide the name and check if any of the below applies for anyone who is renewing or applying for coverage

Age 65 or older Name(s): ____

Disabled Name(s): ____

Blind Name(s): ____

Requires assistance with daily activities (like bathing or dressing): Name(s): ____

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

SIGNATURE

I (print name)_____, certify that the information/answers I have given on this renewal are complete and correct to the best of my knowledge. I also certify that the citizenship status information I provided is correct. I understand I can be penalized by law if I commit perjury by purposely giving false information on this renewal or fail to report changes.

Your Social Security Number and all other information you give will be subject to verification by federal, state, and localagencies. By signing this renewal, you are authorizing a release of information to conduct computer matches, program reviews, and audits with U.S. Citizenship and Immigration Services (formerly INS) and other federal and state agencies. Your Social Security Number may be disclosed to other Federal and State agencies for official examination, and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law.

_____

Signature or Mark of Customer Date

_____

Signature of Authorizing Representative Date

NEW APPLICANT

Tell us about anyone in your household who wants to apply for Medicaid/NC Health Choice.

Do not answer these questions for people who are already receiving Medicaid/NC Health Choice.

If more than one person is applying, please make a copy of this page.

Name of person applying:

(First) (Middle) (Last) (Suffix)

1. Is this person a US Citizen or US National? ***YES*** ☐ ***NO*** ☐
   If no, Are you lawfully present in the United States? ***YES*** ☐ ***NO*** ☐
   If yes, please provide your supporting document type and ID:
   Document: _____ ID: _____
   ☐ Check here, if this person has lived in the US Since 1996.
   ☐ Check here, if this person, his or her spouse, or a parent is a veteran or an active duty member in the US Military.
2. Does this person live with at least one child under age of 19, and is the main person taking care of the child? ***YES*** ☐ ***NO*** ☐
3. Is this person age 18 years or younger and has a parent living outside of the household? ***YES*** ☐ ***NO*** ☐
4. Is this person an American Indian or Alaska Native? ***YES*** ☐ ***NO*** ☐
   If yes, are you part of a federally recognized tribe? ***YES*** ☐ ***NO*** ☐
   Tribe name:
   _____
   Has is 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*** ☐
5. Is this person age 65 or older? ***YES*** ☐ ***NO*** ☐
6. Is this person disabled? ***YES*** ☐ ***NO*** ☐
7. Is this person blind? ***YES*** ☐ ***NO*** ☐
8. Does this person require assistance with daily activities? (ex: bathing or dressing) ***YES*** ☐ ***NO*** ☐
9. Does this person want help paying for medical bills from the last three months? ***YES*** ☐ ***NO*** ☐
   If yes, please list the month(s) you have a medical bill:
   _____