Redetermination Notice

Dear [4],

It is time to see if you or your family are still eligible for your medical benefits.
Please review the current information we have in **Section I below**. If there are changes, please complete **Section II** and return the information to us by [due date].

If you do not have changes, do not do anything. We will check to see if you are still eligible for benefits with the information in Section I.

You must Report Your Changes. If you have changes and don't report them, you may have to pay back medical payments paid by Medicaid if you are not eligible for benefits.

Section I: Your Information on File-

Information below is to be prepopulated

[Client's name, medical program and income information]

Aged, blind, disabled or Long-Term Care clients-
The things you own, other than your home, like bank accounts, life insurance policies, stocks, and a second vehicle are not more than $2,000 or $3,000 if married.

Medicare Savings Program clients-
The things you own, other than your home, like bank accounts, life insurance policies, stocks, and a second vehicle are not more than $8,180 or $13,020 if married.

For Low Income Subsidy Program clients-
The things you own, other than your home, like bank accounts, life insurance policies, stocks, and a 2nd vehicle are not more than $12,640 (or $25,260 if married).

Section II: Report Your Changes-

☐ I have no changes. (If you do not have changes, do not do anything)

I am reporting the following change(s) (Check the boxes next to each change):

☐ **Change of address or phone number:**

____

____

SAMPLE

☐ **Pregnancy:**

- Pregnant woman's name: _________________________________ Due date: ___________

* Please send a pregnancy statement signed by a medical professional including the expected due date.

☐ **Person leaving my home:**

- Name: ______________________________________ Date of birth: ___________
- Date left my home:____
- Relationship of this person to you:____

☐ **Person added to my home:**

- Name: ______________________________________ Date of birth: _____________

*If this person is requesting Medical Assistance, please include the information below.

- Social Security number or date applied:____________________________________
- Date entered my home:____
- Relationship of this person to you:____

☐ **Changes to work-for example, new job, change in hours, lost job, new self-employment.**

- Name: ____
- Type of employment change: ____
- Gross amount received this or last month: $ _______________________________________
- Date received:____

*If anyone is currently self employed, please send a copy of a profit and loss statement or business ledger from this or last month

☐ **Changes to non-work income – for example, child support, social security, unemployment, gifts/cash.**

- Name: ____
- Gross monthly amount received:
  $____
- Date received: ____
- Type of income: ____
-

☐ **Changes to Health Maintenance Organization (HMO):** For CHP+ clients only)

- Choice:
  ____
- For information on HMO's visit www.ChpPlus.org or call 1-800-359-1991

SAMPLE

☐ **Changes to vehicle:** For Adult Medicaid, Long Term Care, Medicare Savings Program, and Low Income Subsidy Program clients

- Owners Name: ____
- Make/Model: _________________________Year: _________________________Value:_________

☐ **Changes to resources:** For Adult Medicaid, Long-Term Care, Medicare Savings Program, Low Income Subsidy Program clients

- Name:____
- What type: _________________________Dollar value: ____________________________

☐ **Sold or gave away any resources:** For Adult Medicaid, Long-Term Care, Medicare Savings Program, Low Income Subsidy Program clients)

- Name: ____
- Date: _________________________Type: ___________________Value:______________

☐ **Other changes: For example,: Social Security Number for a newborn, name change, marriage, divorce, change in immigration status, or school attendance**

Please explain:

____

____

____

Signature Date

If you have any questions, please call me right away.

Thank you,
[Worker Name and Contact Information]

SAMPLE