Idaho Department of Health and Welfare

Phone: Fax: (208) 334-6912

Date :
Worker Name :
Case Name :
Case Number :

Medicaid/AABD Cash Re-evaluation

For Mailing Purposes Only
Please remove this page before
returning the attached form.

THIS PAGE IS INTENTIONALLY LEFT BLANK.

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Date :
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Questions? Contact the Department.
State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells how.

Medicaid/AABD Cash Re-Evaluation

You must return this report within 10 days of receiving it, please use the return envelope included with this packet.

The information provided on this form will be used to re-evaluate Medicaid/AABD Cash eligibility for people in your household receiving Medicaid/AABD Cash.

If you want to continue health coverage for all the people receiving **Medicaid/AABD Cash**, follow the steps below. If you do not want to continue health coverage, you do not need to do anything and your health coverage will end on _____
You must provide information about all people in your household when completing this form.

Instructions

- You must provide proof of the information you write on this form. When you send in this form, include documents that can be used as verification of the information provided. IF YOU PROVIDE INCOMPLETE INFORMATION, YOUR CASE WILL CLOSE WITHOUT FURTHER NOTIFICATION.
- Complete this form for all people in your household, even if they do not receive Medicaid health coverage.
- Social Security Numbers and citizenship verification are only needed for household members who are receiving Medicaid benefits.
- Katie Beckett premium payments are optional; choosing not to pay the cost share will not affect eligibility or benefits.

- **PLEASE USE ONLY BLUE OR BLACK INK WHEN COMPLETING THIS FORM.**
- Please remember to sign and date the last page of this form.

IMPORTANT NOTICE: If you need any assistance, please ask. The following services are free:

- Help filling out this form
- Accommodation for a disability
- Language Interpreter. Call 1-800-926-2588 or TDD 208-332-7205

What is your preferred language? Spoken: _____ Written: _____
Do you want an interpreter if you are interviewed? One will be provided at no cost to you. ☐ Yes ☐ No
¿Necesita un Interpréte para su entrevista? Uno estará disponible sin costo alguno para usted ? ☐ Yes ☐ No

If you need to provide more information than space allows, attach extra pages with the necessary information.
You may be required to provide proof to support the information on your application before IDHW can determine your benefits. You may take original documentation to your local IDHW office.

Remember You Must Sign The Last Page

Print

Section 1: Information For All People In Your Household

Please provide your Name and Physical Address:

Name _____ Phone (___) _____

Street _____ City _____ State _____

_____ Zip Code _____ County _____

Mailing Address (if different)

Street _____ City _____ State _____

_____ Zip Code _____ County _____

Daytime Phone - work, home, cell or other (___) _____

If none, with whom can we leave a message? Please provide name and phone number.

Name _____ Phone (___) _____

E-mail _____

Household Information - List all residents in your home, including yourself, newborn babies, and anyone in your household who is residing in a long term care or nursing facility.

Name	Relationship to You	Date of Birth	Country of Birth	US Citizen	Social Security Number
	Self			☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

Is anyone in your household pregnant? ☐ Yes ☐ No If Yes, Who _____ Due Date _____

Is anyone in your home residing in a Nursing Facility? ☐ Yes ☐ No If Yes, Who _____

Nursing Facility Name and Address:

Name _____

Street _____ City _____ State _____

_____ Zip Code _____ County _____

Is anyone in your home receiving or applying for Social Security benefits?

☐ Yes ☐ No If Yes, Who _____

Do any minor children applying for Medicaid have a parent not residing with them?

☐ Yes ☐ No If Yes, Who _____

Does anyone in your household currently have health insurance other than Medicaid or had health insurance within the last 6 months? ☐ Yes ☐ No

If Yes, Who _____ _____

_____ Premium amount $ _____

Policy Holder _____ Insurance Company _____ Phone (___) _____

Policy Number _____ Start Date _____ End Date _____

Please provide a copy of one of the following pieces of documentation to verify health insurance and check the box to indicate which one will be provided: ☐ Copy of Insurance Card ☐ Copy of Health Insurance Policy

If Yes, Who _____ _____

_____ Premium amount $ _____

Policy Holder _____ Insurance Company _____ Phone (___) _____

Policy Number _____ Start Date _____ End Date _____

Please provide a copy of one of the following pieces of documentation to verify health insurance and check the box to indicate which one will be provided: ☐ Copy of Insurance Card ☐ Copy of Health Insurance Policy

Does your family have income: ☐ Yes ☐ No

Income received in the last 30 days. If any income is received monthly or quarterly, provide 6 months of income verification. If income is received annually, provide verification for the last payment. Please list and provide verification of all money received and/or expected by all household members. Include all income from jobs, self-employment, unemployment benefits, Social Security, **S**upplemental **S**ecurity **I**ncome (SSI), Child Support, tips, **V**eterans **A**ffairs (VA), cash gifts, cash loans, income from pensions or trusts, Railroad retirement, rental income on owned property, or retirement funds.

Type of Money Received	Who Earned or Received it?	Employer or Source	Pay Period	Wages $ Per hour	Hours per week	Total Monthly Amount
			☐ Weekly ☐ Annually ☐ Bi-Weekly ☐ Monthly ☐ Semi-Monthly ☐ Quarterly			
			☐ Weekly ☐ Annually ☐ Bi-Weekly ☐ Monthly ☐ Semi-Monthly ☐ Quarterly			
			☐ Weekly ☐ Annually ☐ Bi-Weekly ☐ Monthly ☐ Semi-Monthly ☐ Quarterly			
			☐ Weekly ☐ Annually ☐ Bi-Weekly ☐ Monthly ☐ Semi-Monthly ☐ Quarterly			
			☐ Weekly ☐ Annually ☐ Bi-Weekly ☐ Monthly ☐ Semi-Monthly ☐ Quarterly			

Examples of documents that can be used as verification of income are listed below.

- Wage stubs (for the last 30 days)
- Payments from pensions, annuities or lease agreements
- A statement of how your family meets expenses if you are reporting no income
- Award letters
- Contracts
- Court orders for child support not collected through Idaho
- If you have started a job less than 30 days ago, provide a statement from your employer to verify your anticipated gross pay per month as well as how often your are paid.

Is anyone in your household self-employed?

☐ Yes ☐ No If Yes, Who _____ Business start date _____

If Yes, Who _____ Business start date _____

Examples of Self-Employed individuals include independent, contractors, baby-sitters, daycare providers, home-based business owners, or people managing rental property. Self-Employment operations include S Corporations, partnerships, and Limited Liability Companies.

Examples of documents that can be used as verification of self-employment income are listed below.

- Federal tax returns, including all schedules. Provide both personal AND business tax returns for each business (S Corps, partnerships and LLCs must provide personal returns and the Schedule K-1 *only*)
- Income and expense records for new businesses when past tax returns have not been filed. Please include all income and expenses for the last 12 months or since the business start date.
- Contracts

Do any of your household members have money withheld from their earnings by court order, including money withheld for child support? Attach verifications of the court order.

☐ Yes ☐ No If Yes, Whose income is withheld? _____ Monthly Amount Withheld $ _____

☐ Yes ☐ No If Yes, Whose income is withheld? _____ Monthly Amount Withheld $ _____

Section 2: Property

This section needs to be completed if there are any adults or disabled children in your household receiving Medicaid.

List each car, truck, motorcycle, trailer, boat, snowmobile, or other recreational vehicle owned by members of your household.

Owner	Year	Make	Model	Value

Other than the home you live in, what other resources (land or property) do you own, and what is their value?

_____ _____ _____

Have you gifted, sold or transferred any resources/property? _____

Print

List everyone in your household who has a savings account, stocks, bonds, mutual funds, Individual Retirement Accounts, trusts, checking accounts, miller trust accounts, nursing home accounts, CD's, life insurances designating face value and cash value, burial funds, burial plots, funeral home documents, life estate documents, or real property (home, land, etc.).

- Most recent Bank Statements
- Certificates of Deposit
- Trust documents- including Miller Trusts
- Burial Fund documents
- Current value of Stocks/Bonds-including number of shares
- Life Insurance Policies
- Funeral Home Documents

Owner's Name	Type of Account	Name of Bank or Institution	Account Number	Balance or Monetary Value

Section 3: Expenses

This section needs to be completed if there are any adults in your household receiving Medicaid

Please list and provide verification of other expenses including housing expenses (rent, property insurance, property tax) or medical expenses (health insurance, prescriptions, dental, or eye glasses):

Type of Expense _____ cost _____

Type of Expense _____ cost _____

Type of Expense _____ cost _____

List child care applicable household expenses:

My child care expenses for _____ are $ _____ per month.

_____ are $ _____ per month.

_____ are $ _____ per month.

These child care expense is due to : ☐ Work ☐ Work Search

Equal Opportunity for Applicants

In accordance with federal law and U.S. Department of **H**ealth and **H**uman **S**ervices (HHS) policy. The Idaho Department of Health and Welfare is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, contact HHS at the following address and/or telephone numbers:

U.S. Department of Health and Human Services
Room 506 F
200 Independence Ave.
SW Washington, D.C. 20210

ocrcomplain@hhs.gov
202.619.0403 (voice)
202.619.3257 (TTY)

Rights and Responsibilities

I UNDERSTAND THAT....

- I could be sanctioned and required to return any benefits my children receive if my information is not true. Sanctions may include administrative, civil or criminal actions against me, including prosecution.
- I consent to the gathering, use and disclosure of my information by Idaho Department of Health and Welfare. I understand the information is needed for the purpose of providing benefits or services, obtaining payment for my benefits or services, and for normal business operations of the Department.
- I have the right to revoke this consent, in writing, at any time except to the extent the Department has already used and disclosed my information in reliance on this consent. If I revoke this consent, the Department may not provide further benefits or services.
- I understand that I will be notified of the right to appeal Department decisions and I can contact the Department for information on the appeal process.
- I have read and understand the plan choices and that I might be responsible for paying part of the cost of my child's health plan.
- My signature certifies that the citizenship status marked on page 2 is correct for each child applying.
- By applying for benefits for a minor child, a child support case must be opened, when applicable.
- If a third party is responsible for my child's disease or injury, I give the Idaho health plan any rights I may have, or may acquire in the future, to be compensated by the responsible party for any medical benefits I receive for my children.
- My Signature or the signature of my representative authorizes State offices to communicate with insurance companies related to my child's medical assistance.
- I have the right to choose a Healthy Connections Primary Care Doctor for my children, to request referrals for services, and to change the doctor/clinic if my circumstances change.
- If my children are determined eligible for an Idaho health plan, I choose the plan that is based on their health needs, unless I tell the Self Reliance worker otherwise.

Signature

MUST BE COMPLETED

Signature and Certification:

Under penalty of perjury, I swear or affirm the information I provide is true and complete.

Signature: _____ Phone: (___) _____ Date: _____

Signature: _____ Phone: (___) _____ Date: _____

Print