Health Coverage Renewal Form

06/06/2022
Respond by: 07/11/2022
Case number:

Renew Your Benefits – Due [DATE]

You are currently receiving health coverage through Medicaid/Healthy Montana Kids. Your benefits will end if you do not complete this renewal.

How to complete your renewal

- Call 1-888-706-1535 (TTY: 711). The call is free.
- Go to apply.mt.gov and click Sign In/Create Account.
  To create an account, you will need the case number on the top right of this page.

If neither of the above options are possible, please follow these steps:

1. Answer all the questions on the form.
2. Read the information we have filled in about you and each member of your household. Make sure you give us information about every person living in your household orlisted on your tax return. Add any missing information. Cross out any information that isn't right and write in the correct information.
3. Sign and date the form at the bottom of Section 12.
4. Return the form to us by one of these ways:

- Mail to:
  DPHHS
  PO Box 202925
  Helena, MT 59620-2925
- Fax: 1-877-418-4533
- Drop off at your local OPA: To find anoffice near you, visit https://dphhs.mt.gov/hcsd/OfficeofpublicAssistance

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What happens next

We will review the information you give us and see if you still qualify for Medicaid/Healthy Montana Kids. We will send you a letter with our final decision. 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.

If you no longer qualify, we will tell you at least 10 days before your coverage ends. We will also tell you about other affordable health coverage you might qualify for through HealthCare.gov, and we will send your information to them. We will tell you how you can get help signing up.

1 Your contact information

▼ Review your contact information here

▼ Correct any wrong or missing information here.

Name (first, middle, last & suffix):

Home address: Apartment #:

City (home): State: ZIP code:

Mailing address: Apartment #:

City (mailing): State: ZIP code:

Best phone number to reach you: ☐ Home ☐ Cell ☐ Work

Number:

Other phone number, if you have one: ☐ Home ☐ Cell ☐ Work

Number:

Email address, if you have one:

2 We need information about who files tax returns

You can still renew if you do not file tax returns

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

☐ Yes If yes, answer all of the questions below ☐ No If no, answer the question marked with a star * below

Person 1: Name (first, middle, last & suffix)

If this person is filing a joint return, write the name of the spouse:

If this person will claim dependents, write the names of the dependents:

Person 2: Name (first, middle, last & suffix)

This is a second tax filer in the household
If this person is filing a joint return, write the name of the spouse:

If this person will claim dependents, write the names of the dependents:

* If anyone will be claimed as a dependent on someone else's tax return, write the name of the tax filer and the dependents. Answer only if different than what you reported above or if you did not fill in any information above

Name of tax filer: _____

Name of dependents: _____

_____

3 These are the people in your household who get health coverage and need to renew now

Person 1 [redacted]

☐ Check here if this person is no longer living in the household

☒ DPHHS has this person's Social Security number.

☐ DPHHS does not have this person's Social Security number. Write it in the spaces below.

_ _ _ - _ _ - _ _ _ _

If this person is an immigrant, for their immigration status:

☐ You need to fill in the information below. ☐ You do not need to fill in the information below because DPHHS has it.

☐ Check here if this person has eligible immigration status and fill in the document type: _____

and ID number:_____See Attachment D for more information about eligible immigration status and document types.

Person 2 [redacted]

☐ Check here if this person is no longer living in the household

☒ DPHHS has this person's Social Security number.

☐ DPHHS does not have this person's Social Security number. Write it in the spaces below.

_ _ _ - _ _ - _ _ _ _

If this person is an immigrant, for their immigration status:

☐ You need to fill in the information below. ☐ You do not need to fill in the information below because DPHHS has it.

☐ Check here if this person has eligible immigration status and fill in the document type: _____

and ID number:_____See Attachment D for more information about eligible immigration status and document types.

4 We need more information about people not listed in Section 3

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

Other person: Name (first, middle, last & suffix):

☒ DPHHS has this person's Social Security number.

☐ DPHHS does not have this person's Social Security Number

Write it here if this person is applying for health insurance coverage:

_ _ _ - _ _ - _ _ _ _

This 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 this person is no longer living in the household.

Date of birth (month/day /year):

This person is: ☐ Male ☒ Female

How is this person related to you? Self

☐ Check here if this person has health coverage

☐ Check here if this person wants health coverage and fill out Attachment A

Other person: Name (first, middle, last & suffix):

☒ DPHHS has this person's Social Security number.

☐ DPHHS does not have this person's Social Security Number

Write it here if this person is applying for health insurance coverage:

_ _ _ - _ _ - _ _ _ _

This 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 this person is no longer living in the household.

Date of birth (month/day /year):

This person is: ☒ Male ☐ Female

How is this person related to you? Spouse of

- [x] Check here if this person has health coverage
- [x] Check here if this person wants health coverage and fill out Attachment A

Other person: Name (first, middle, last & suffix):

- [ ] DPHHS has this person's Social Security number.
- [ ] DPHHS does not have this person's Social Security Number

Write it here if this person is applying for health insurance coverage:

_ _ _ - _ _ - _ _ _ _

This 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 this person is no longer living in the household.

Date of birth (month/day /year):

This person is: ☐ Male ☐ Female

How is this person related to you?

- [ ] Check here if this person has health coverage
- [ ] Check here if this person wants health coverage and fill out Attachment A

Other person: Name (first, middle, last & suffix):

- [ ] DPHHS has this person's Social Security number.
- [ ] DPHHS does not have this person's Social Security Number

Write it here if this person is applying for health insurance coverage:

_ _ _ - _ _ - _ _ _ _

This 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 this person is no longer living in the household.

Date of birth (month/day /year):

This person is: ☐ Male ☐ Female

How is this person related to you?

- [ ] Check here if this person has health coverage
- [ ] Check here if this person wants health coverage and fill out Attachment A

Other person: Name (first, middle, last & suffix):

- [ ] DPHHS has this person's Social Security number.
- [ ] DPHHS does not have this person's Social Security Number

Write it here if this person is applying for health insurance coverage:

_ _ _ - _ _ - _ _ _ _

This 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 this person is no longer living in the household.

Date of birth (month/day /year):

This person is: ☐ Male ☐ Female

How is this person related to you?

- [ ] Check here if this person has health coverage
- [ ] Check here if this person wants health coverage and fill out Attachment A

5 Tell us about other health insurance coverage people have

▶ Include anyone in Sections 3 and 4 with health coverage and anyone who is applying for health insurance coverage. Please update any information about health insurance (other than Medicaid) that is no longer correct, and cross out any information that is no longer valid

▶ If any household members have new health insurance coverage, please provide information below

Name of insurance company:	Policy number:
Address:	Group number:
Policy Holder Name:	
SSN:	

Type of insurance:

☐ Medicare ☐ Tricare ☐ Veteran's health coverage ☐ COBRA Continuation

☐ Group ☐ Individual ☐ Student ☐ Other Health Coverage__________________

Is this insurance provided by an employer? ☐ Yes ☐ No If yes, name of employer:

List everyone who is on this policy:

▶ ☐ Check here if anyone on this form is offered health insurance through a job, even if they are not enrolled in it.
☐ Check here if any of the insurance plans you listed is a state employee benefit plan.

6 Tell us more about the people listed on this form

▶ If anyone who is renewing or applying for health insurance coverage has a medical, mental health, or substance use condition that limits his or her ability to work, go to school, or take care of daily activities (like bathing or dressing), write his or her name here.

Names (first, middle, last & suffix):

Names (first, middle, last & suffix):

▶ If anyone who is renewing or applying for health insurance coverage lives in a long term care facility, group home, or nursing home, or regularly gets medical care, personal care, or health services at home or in another community setting (like adult day care), write his or her name here.

Names (first, middle, last & suffix):

Names (first, middle, last & suffix):

▶ If anyone who is renewing or applying for health insurance coverage is blind or terminally ill, write his or her name here.

Names (first, middle, last & suffix):

Names (first, middle, last & suffix):

▶ If anyone who is renewing or applying for health insurance coverage is between the ages of 18 and 22 and is also a full-time student, write his or her name here.

Names (first, middle, last & suffix):

Names (first, middle, last & suffix):

▶ If anyone who is renewing or applying for health coverage enrolled for credit in any Montana university system unit, a tribal college, or any other accredited college within Montana offering at least an associate degree, write his or her name here.

Names (first, middle, last & suffix):

Names (first, middle, last & suffix):

▶ If anyone in your household has been discharged from US Military services within the last 12 months, write his or her name here.

Names (first, middle, last & suffix):

Names (first, middle, last & suffix):

▶ If anyone who is renewing or applying for health insurance coverage is between the ages of 18 and 26 and was in foster care at age 18, write his or her name here.

Names (first, middle, last & suffix):

Names (first, middle, last & suffix):

▶ If anyone listed on this form (whether renewing or applying for health insurance coverage or not) is pregnant, write her information below.

Names (first, middle, last & suffix):	How many babies are expected and due date?
Names (first, middle, last & suffix):	How many babies are expected and due date?

▶ If anyone who is renewing or applying for health insurance coverage is disabled, write his or her name here

Names (first, middle, last & suffix):

Names (first, middle, last & suffix):

▶ If anyone who is renewing or applying for health insurance coverage is disabled and under age 22 attending school

Names (first, middle, last & suffix):	Name of the School - How many hours in a week do they attend?
Names (first, middle, last & suffix):	Name of the School - How many hours in a week do they attend?

▶ ☐ Check here if we may forward this application to Children's Special Health Services if a child in your family has been diagnosed with a medical condition (e.g. asthma, cleft palate, diabetes).

Names (first, middle, last & suffix):	Condition(s)

▶ ☐ Check here if you would like information sent to you if a child in your family needs or receives treatment for a Serious Emotional Disturbance (SED).

Names (first, middle, last & suffix):

▶ ☐ Check here if anyone who is renewing or applying for health insurance coverage is an American Indian or Alaska Native, and fill out Attachment B.

7 Tell us about work

▶ Fill in the information below for everyone in your household or on your tax return who has income from a job (not self employed) whether or not they are renewing or applying for coverage. If someone has more than one job, tell us about all jobs. You can tell us about self-employment on the next page.
Make a copy of this page if you need space for more jobs or people. Cross out any information that is not correct about members of your household. Write in any new information.

Job 1 : Name of the person who is working (first, middle, last & suffix):

Employer name: | Employer phone number:

Employer address: | City: | State: | ZIP code:

How often are wages or tips paid? ☐ Hourly ☒ Every two weeks ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Yearly

How much does this person get paid (before taxes)?

Average hours worked each week:

Job 2 ： Name of the person who is working (first, middle, last & suffix):

Employer name: | Employer phone number:

Employer address: | City: | State: | ZIP code:

How often are wages or tips paid? ☐ Hourly ☐ Every two weeks ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Yearly

How much does this person get paid (before taxes)?

Average hours worked each week:

Job 3 ： Name of the person who is working (first, middle, last & suffix):

Employer name: | Employer phone number:

Employer address: | City: | State: | ZIP code:

How often are wages or tips paid? ☐ Hourly ☐ Every two weeks ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Yearly

How much does this person get paid (before taxes)?

Average hours worked each week:

▶ List anyone in your household who has changed jobs or has worked fewer hours in the past four months.

1. Name (first, middle, last & suffix):

☐ This person stopped working ☐ This person is now working fewer hours ☐ This person changed jobs

2. Name (first, middle, last & suffix):

☐ This person stopped working ☐ This person is now working fewer hours ☐ This person changed jobs

▶ If anyone in your household is self-employed, we need to know about their work.
See the instructions below for more information about deductions.
Cross out any information that is not correct about members of your household. Write in any new information

1 Name (first, middle, last & suffix):

Type of work:

Business Name:

How much net income will this person get from self-employment this month? Amount:

▶ Subtract the expenses below from your gross income to get an amount for your net self-employment income.

- Car and truck expenses (for travel during the workday, not commuting)
- Depreciation
- Employee wages and fringe benefits
- Property, liability, or business interruption insurance
- Interest (including mortgage interest paid to banks, etc.)
- Legal and professional services
- Rent or lease of business property and utilities
  Commissions, taxes, licenses and fees

- Advertising
- Contract labor
- Repairs and maintenance
- Certain business travel and meals
- Deductible self-employment taxes
- Cost of self-employed health insurance
- Contributions to a self-employed SEP, SIMPLE, or qualified retirement plan

8 Tell us about other income

▶ Cross out any information that is not correct about members of your household. Write in any new information.

Unemployment	How much?	How often?
Name (first, middle, last & suffix): Source:		☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other

Social Security	How much?	How often?
Name (first, middle, last & suffix):Source:		☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other

Pensions	How much?	How often?
Name (first, middle, last & suffix): Source:		☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other

Retirement accounts	How much?	How often?
Name (first, middle, last & suffix): Source:		☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other

Railroad Retirement Accounts	How much?	How often?
Name (first, middle, last & suffix): Source:		☐ Weekly ☐ Every two weeks ☐ Yearly ■ Monthly ☐ Twice a month ☐ Other

Alimony Received	How much?	How often?
Name (first, middle, last & suffix):		☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other

Farming/Fishing(Profit after business exp)	How much?	How often?
Name (first, middle, last & suffix):		☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other

Rental income or Royalties(Profit after bus exp)	How much?	How often?
Name (first, middle, last & suffix):		☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other

Other income type	How much?	How often?
Name (first, middle, last & suffix):		☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other

▶ If anyone in your household has deductions, tell us what kind. Cross out any information that is not correct. Write in any new information

Alimony paid to someone else	How much?	How often?
Name (first, middle, last & suffix):		☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other

Student loan interest paid	How much?	How often?
Name (first, middle, last & suffix):		☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other

Other deductions	How much?	How often?
Name (first, middle, last & suffix):		☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other

▶ List the names of anyone whose income changes from month to month. Also tell us how much you think their income will be for the year. Make a copy of this page if you need space for more people

1. Name (first, middle, last & suffix):

What do you expect his or her income to be this year? Amount:$ ☐ Check here if you do not know what the income will be this year.

2. Name (first, middle, last & suffix):

What do you expect his or her income to be this year? Amount:$ ☐ Check here if you do not know what the income will be this year.

3. Name (first, middle, last & suffix):

What do you expect his or her income to be this year? Amount:$ ☐ Check here if you do not know what the income will be this year.

9 Tell us about resources

▶ **General Resources** (including bank accounts, cash, property, trusts, life insurance, stocks, etc.)
Please update any resource information that is no longer correct. Cross out any resources that you no longer own, and enter any new resources in the blank lines. Remember to provide current verification of resources listed below.

Applicable For -

Resource Type:

Description:

Owner's Name:	Full Value:	Percent Own:

Resource Type:

Description:

Owner's Name:	Full Value:	Percent Own:

Resource Type:

Description:

Owner's Name:	Full Value:	Percent Own:

▶ **Vehicles** (including cars, trucks, motorcycles, boats, snowmobiles, All Terrain Vehicles (ATV), trailers, campers, etc.)
Please Update any vehicle information that is no longer correct. Cross out any vehicles that you no longer own, and enter any new vehicles in the blank lines.

Applicable For -

Vehicle Year/Make/Model/Type:

Vehicle Use:	Owner's Name:

Full Value:	Percent Own:	Amount Owed:

Vehicle Year/Make/Model/Type:

Vehicle Use:	Owner's Name:

Full Value:	Percent Own:	Amount Owed:

Vehicle Year/Make/Model/Type:

Vehicle Use:	Owner's Name:

Full Value:	Percent Own:	Amount Owed:

▶ **Resources Transferred**

Question	Yes	No
1. Did you or your spouse sell, trade, or give away money, vehicles, property (including your home) or anything of value in the past 60 months?	☐	☐
2. Did you or your spouse transfer any assets to a trust in the past 60 months?	☐	☐
3. Did you or your spouse forgive a debt owed to you in the past 60 months?	☐	☐

If you answered "Yes" to any question, please explain:

10 Tell us about expenses

▶ **Child Support, Dependent Care, and Alimony Expenses That You Pay** Please update any expenses that are no longer correct, and cross out any expenses that are no longer paid. This includes any payments made for a dependent outside of the home. Enter any new expenses in the blank lines provided.

Applicable For -

Type of Expense:

Who Pays Expense:	Who is it Paid For:

Amount:	How Often Paid:	Date Last Paid:

▶ **Shelter and Utility Expenses That You Pay** Please update any shelter and utility expenses that are no longer correct, and cross out any expenses that are no longer paid. Enter any new shelter/utility expenses in the blank lines provided.

Applicable For -

Type of Expense:

Who Pays Expense:

Amount:	How Often Paid:	Date Last Paid:

▶ **Blind and Disabled Expenses That You Pay** Please update expenses that are no longer correct, and cross out any expenses that are no longer paid. Enter any new expenses in the blank lines provided.

Applicable For -

Type of Expense:

Who Pays Expense:

Amount:	How Often Paid:	Date Last Paid:

▶ **Medical Expenses That You Pay** Please update expenses that are no longer correct, and cross out any expenses that are no longer paid. Enter any new expenses in the blank lines provided.

Applicable For -

Type of Expense:

Who Pays Expense:

Amount:	How Often Paid:	Date Last Paid:

11 Tell us about Medicare

▶ **Medicare Information** this includes information about enrollment in Medicare Part A, Part B, or Railroad Retirement coverage.
Please update any Medicare information that is no longer correct, and cross out any information that is no longer valid. Enter information about any new Medicare coverage in the blank lines provided.

Applicable For - Who is Enrolled:	Medicare Number:
Type of Coverage:	Medicare Status:

Read and sign this application

Read the statement below and check one box.

To make it easier to check my income at renewal time for coverage in future years, other than health coverage, I give permission to the Marketplace to use income information from my tax returns for the number of years I checked below.

Yes, I give the Marketplace permission to check my income on tax returns for (check one box):

☐ 5 years (the longest time) ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year

☐ No, I do not give permission to use my tax returns.

▶ Your rights and responsibilities

- I am signing this renewal form under penalty of perjury. That means that have provided true answers to all the questions on this form to the best of my knowledge, and I know that I may be subject to penalties under federal law if I provide false or untrue information.
- I know that I must tell DPHHS if anything changes and is different from what I wrote on this form. I can call 888-706-1535 to report any changes. I understand that a change in my information might affect whether someone in my household qualifies for coverage.
- If I think DPHHS has made a mistake, I can appeal its decision. To appeal means to tell someone at DPHHS that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting DPHHS at 888-706-1535.

Voter's Registration
If you are not registered to vote where you live now, would you like to register to vote? ☐ Yes ☐ No

If you do not check Yes or No, we will assume you have decided not to register to vote at this time. If you would like help filling out a voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. Applying to register or declining to register to vote will not affect your eligibility or benefits

If you believe that someone has interfered with your right to:

1. register to vote, or
2. decline to register to vote, or
3. privacy in deciding whether to register or in applying to register to vote, you may file a complaint with the Secretary of State, PO Box 202801, Helena MT 59620-2801.

Telephone number: 1-406-444-7911

- I understand that if I do not qualify for health coverage, DPHHS will send my information to the Marketplace so they can see if I qualify. DPHHS will check my 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, DPHHS may ask me to send more information.
- I understand that, after my death, DPHHS can file a claim against my estate to recover money that the state paid for coverage provided to me. This process must happen if I am in a medical institution and not expected to return home, or if I am 55 years of age or older and the state pays for my nursing facility services, home and community based services, or related hospital and prescription drug services. The amount recovered by the DPHHS will not be more than the amount Medicaid paid for my care.
- I understand that when I send in this form, it means I have permission from everyone whose information is on the form to submit their information to DPHHS and receive any communications about their eligibility and enrollment.
- I understand that DPHHS is authorized to collect information on this form, and other supporting information including Social Security numbers, under the Patient Protection and Affordable Care Act (Public Law No. 111-148), as amended by the Health Care Education Reconciliation Act of 2010 (Public Law 111-152) and the Social Security Act.
- I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, marital status or disability. I can file a complaint of discrimination by visiting hhs.gov/ocr/office/file.

☐ Please check if you are interested in receiving a discount on your telephone bills if you are approved for Medicaid.

▶ Sign and date below. If you want an authorized representative or want to change the authorized representative you have now, fill out Attachment C.

☐ Check here if you are an authorized representative.Sign below and fill out Attachment C.

Signature of household contact or authorized representative:	Date:

Attachment A

People applying for health coverage for the first time
For people listed in Section 4

Tell us about anyone in your household who wants to apply for health coverage. Do not answer these questions for people who already have health coverage. If more than two people are applying, make a copy of this page.

Name of the person applying: Name (first, middle, last & suffix)

▶ Tell us about citizenship

Is this person a U.S. citizen or U.S. national?
☐ Yes If yes, go to "Tell us more information about this person"
☐ No If no, answer all of the questions below.

☐ Check here, if this person has eligible immigration status and fill in the document type:_____and ID number:_____See Attachment D for more information about eligible immigration status and document types.

☐ 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.

▶ Tell us more information about this person

☐ Check here, if this person lives with at least one child under the age of 19, and is the main person taking care of this child.
☐ Check here, if this person is 18 years or younger and has a parent living outside of the household.
☐ Check here, if this person wants help paying for medical bills from the last three months.

▶ Tell us about race and ethnicity. You may choose not to answer these questions. This answer will not be used to make a decision about your eligibility, but will help determine your out-of-pocket expense.

If this person is Hispanic/Latino, check all that apply:
☐ Mexican ☐ Mexican American
☐ Chicano/a ☐ Puerto Rican
☐ Cuban ☐ Other _____

What is this person's race? Check all that apply:
☐ White ☐ Asian Indian ☐ Korean ☐ Guamanian or Chamorro
☐ Black or African American ☐ Chinese ☐ Vietnamese ☐ Samoan
☐ Filipino ☐ Other Asian ☐ Other Pacific Islander
☐ American Indian or Alaska native ☐ Japanese ☐ Native Hawaiian ☐ Other_____

Name of the person applying: Name (first, middle, last & suffix)

▶ Tell us about citizenship

Is this person a U.S. citizen or U.S. national?
☐ Yes If yes, go to "Tell us more information about this person"
☐ No If no, answer all of the questions below.

☐ Check here, if this person has eligible immigration status and fill in the document type:_____and ID number:_____See Attachment D for more information about eligible immigration status and document types.

☐ 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.

▶ Tell us more information about this person

☐ Check here, if this person lives with at least one child under the age of 19, and is the main person taking care of this child.
☐ Check here, if this person is 18 years or younger and has a parent living outside of the household.
☐ Check here, if this person wants help paying for medical bills from the last three months.

▶ Tell us about race and ethnicity. You may choose not to answer these questions. This answer will not be used to make a decision about your eligibility, but will help determine your out-of-pocket expense.

If this person is Hispanic/Latino, check all that apply:
☐ Mexican ☐ Mexican American
☐ Chicano/a ☐ Puerto Rican
☐ Cuban ☐ Other _____

What is this person's race? Check all that apply:
☐ White ☐ Asian Indian ☐ Korean ☐ Guamanian or Chamorro
☐ Black or African American ☐ Chinese ☐ Vietnamese ☐ Samoan
☐ Filipino ☐ Other Asian ☐ Other Pacific Islander
☐ American Indian or Alaska native ☐ Japanese ☐ Native Hawaiian ☐ Other_____

☐ If anyone applying for Medicaid has medical bills from the last three months, send the medical bills to DPHHS, PO Box 202925, Helena, MT 59620-2925. Medicaid may help pay past bills.

Questions? Call the Montana Public Assistance Helpline at 1-888-706-1535. The call is free. (TTY: 711). You can call Monday - Friday, 8:00am - 5:00pm Mountain Time.

MONTANA DPHHS Healthy People. Healthy Communities.

Attachment B	American Indian or Alaska Native family member (AI/AN) To help you fill out Section 6

Tell us about your American Indian or Alaska Native family member(s)

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They may not have to pay co-pays and may get special monthly enrollment periods.

If more than two people are American Indian or Alaska Native, make a copy of this page.

1. Name (first, middle, last & suffix):

Has this 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

List any income that includes money from these sources:	How much income?$
• Payments from a tribe for natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance • Money from tribally managed gaming income	How often? ☐ Weekly ☐ Twice a month ☐ Every two weeks ☐ Yearly ☐ Monthly

2. Name (first, middle, last & suffix):

Has this 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

List any income that includes money from these sources:	How much income?$
• Payments from a tribe for natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance • Money from tribally managed gaming income	How often? ☐ Weekly ☐ Twice a month ☐ Every two weeks ☐ Yearly ☐ Monthly

Attachment C — Assistance with completing this application

An authorized representative is a trusted friend, partner, relative or lawyer you choose to sign your renewal form, get information about this renewal form, and act for you with this agency.

If you have an authorized representative now, please answer these questions.

We show that you chose this person as your authorized representative:	Do you still want this person to be your authorized representative? ☐ Yes ☐ No If yes, has any of his or her information changed? ☐ Yes ☐ No

If your authorized representative's information has changed, or if you would like a different authorized representative, please write the new information here:

Name of authorized representative:

Address: Apartment # City State ZIP code

Phone number: ☐ Home ☐ Cell ☐ Work ☐ Other

Number:

By signing, you allow this person to sign your renewal form, to get information about this renewal form, and to act for you with this agency.

Your signature:	Date:

If you do not have an authorized representative and want one, please answer these questions.

☐ Check here if you want an authorized representative. Answer the questions below.

Address: Apartment # City State ZIP code

Phone number: ☐ Home ☐ Cell ☐ Work ☐ Other

Number:

By signing, you allow this person to sign your renewal form, to get information about this renewal form, and to act for you with this agency.

Your signature:	Date:

Attachment D

Helpful information about immigration status and document types to help you fill out Section 3

▶ Eligible immigration status list

If you see the person's status below, go back to Section 3 and check the Yes box

- Lawful Permanent Resident (LPR or Greencard holder)
- Asylee
- Refugee
- Cuban or Haitian entrant
- Paroled into the U.S.
- Conditional entrant granted before 1980
- Battered spouse, child and parent
- Victim of Trafficking and his/her spouse, child, sibling or parent
- Granted Withholding of Deportation or Withholding of Removal, under the immigration laws and under the Convention against Torture (CAT)
- Individual with Non-immigrant Status (includes worker visas,student visas, and citizens of Micronesia, the Marshall Islands, and Palau)
- Temporary Protected Status (TPS) and Applicant for Temporary Protected Status (TPS)
- Deferred Enforced Departure (DED)
- Family Unity beneficiary
- Deferred Action Status (Deferred Action for Childhood
- Arrivals (DACA) is not an eligible immigration status for applying for health insurance
- Applicant for Special Immigrant Juvenile Status
- Applicant for Adjustment to LPR Status
- Applicant for Asylum
- Applicant for Withholding of Deportation or Withholding of Removal, under the immigration laws or under the Convention against Torture (CAT)
- Registry Applicants (with Employment Authorization)
- Order of Supervision (with Employment Authorization)
- Applicant for Cancellation of Removal or Suspension of Deportation (with EAD Employment Authorization)
- Applicant for Legalization under IRCA (with Employment Authorization)
- Legalization under the LIFE Act (with Employment Authorization)
- Lawful Temporary Resident
- Member of a federally-recognized Indian tribe or American Indian Born in Canada
- Resident of American Samoa
- Administrative order staying removal issued by the Department of Homeland Security

▶ Immigration document types

People who are not citizens, but who are eligible to apply for health insurance coverage, must put their immigration documents and ID numbers on Section 3. A list of documents and ID numbers is below. If your document type is not listed, you can write the document name. If you have questions, or are eligible but have no document, call 1-888-706-1535.

Permanent Resident Card (I-551, also known as Green Card)
- Alien registration number
- Card number

Temporary I-551 Stamp (on passport or I-94, I-94A)
- Alien registration number

Immigrant Visa (with temporary I-551 language)
- Alien registration number
- Passport number

Employment Authorization Card (EAD or I-766)
- Alien registration number
- Card number
- Expiration date
- Category code

Arrival/Departure Record (I-94 or I-94A)
- I-94 number

Arrival/Departure Record in foreign passport (I-94)
- I-94 number
- Passport number
- Expiration date
- Country of issuance

Foreign passport
- Passport number
- Expiration date

Country of issuance Reentry Permit (I-327)
- Alien registration number

Refugee travel document (I-571)
- Alien registration number

Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20)
- Alien registration number or an I-94 number
- Description of the type or name of the document

Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)
- SEVIS ID

Notice of Action (I-797)
- Alien registration

number or an I-94 number

Other
- Alien registration number or an I-94 number
- Description of the type or name of the document

You can also list these documents or statuses:

- Document indicating a member of a federally recognized Indian tribe or American Indian born in Canada This is considered an eligible immigration status for Medicaid/HMK, but not for a Qualified Health Plan [QHP]
- Office of Refugee Resettlement (ORR) eligibility letter (if under 18)
- Document indicating withholding of removal
- Administrative order staying removal issued by the Department of HomelandSecurity (DHS)
- Certification from U.S. Department of Health and Human Services (HHS)Office of Refugee Resettlement (ORR)
- Cuban/Haitian entrant
- Resident of American Samoa

Questions? Call the Montana Public Assistance Helpline at 1-888-706-1535. The call is free. (TTY: 711). You can call Monday - Friday, 8:00am - 5:00pm Mountain Time.

DPHHS complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-406-444-1386 (TTY: 1-800-833-8503).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-406-444-1386 (TTY: 1-800-833-8503).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-406-444-1386 (TTY: 1-800-833-8503)。

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-406-444-1386 (TTY: 1-800-833-8503) まで、お電話にてご連絡ください。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-406-444-1386 (TTY: 1-800-833-8503).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-406-444-1386 (TTY: 1-800-833-8503).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-406-444-1386 (TTY: 1-800-833-8503).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-406-444-1386 (TTY: 1-800-833-8503) 번으로 전화해 주십시오.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-406-444-1386 (رقم هاتف الصم والبكم: 1-800-833-8503).

เรียน:
ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-406-444-1386 (TTY: 1-800-833-8503).

MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-406-444-1386 (TTY: 1-800-833-8503).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-406-444-1386 (TTY: 1-800-833-8503).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-406-444-1386 (телетайп: 1-800-833-8503).

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-406-444-1386 (TTY: 1-800-833-8503).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-406-444-1386 (TTY: 1-800-833-8503).