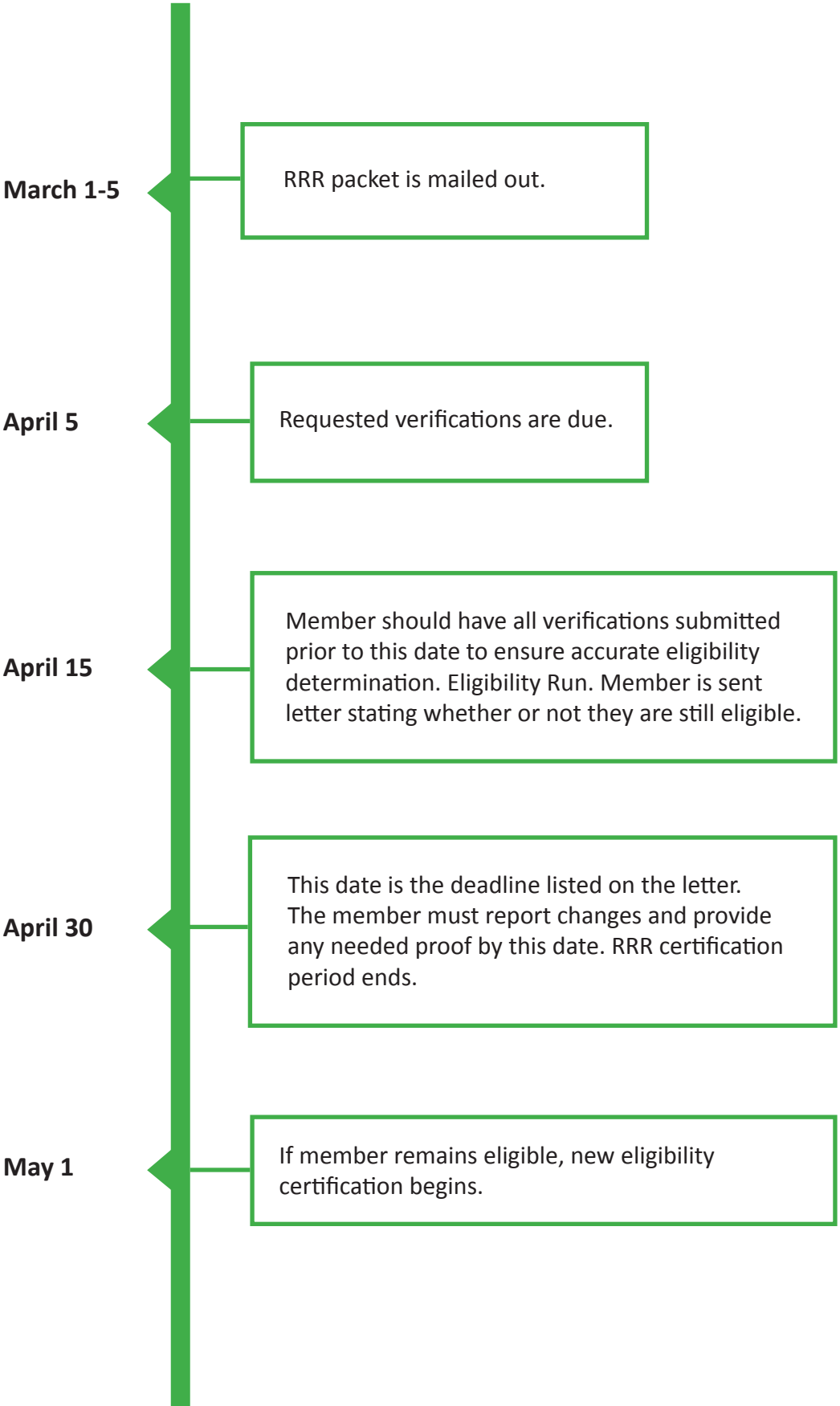
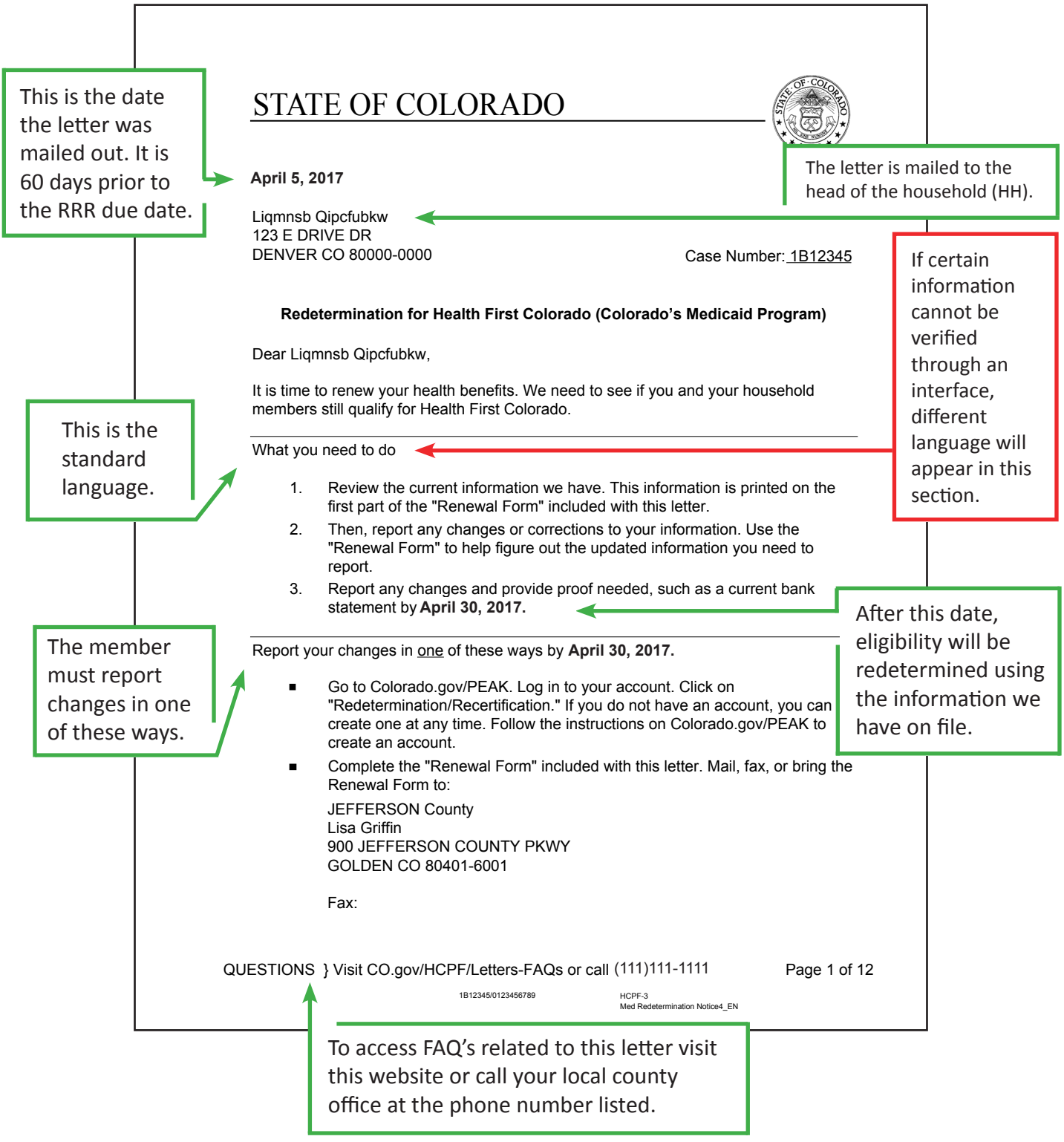
# RRR Desk Aid Timeline



# RRR Letter Desk Aid



This is the date the letter was mailed out. It is 60 days prior to the RRR due date.

STATE OF COLORADO

The letter is mailed to the head of the household (HH).

**April 5, 2017**

Liqmnsb Qipcfubkw
123 E DRIVE DR
DENVER CO 80000-0000

Case Number: 1B12345

If certain information cannot be verified through an interface, different language will appear in this section.

**Redetermination for Health First Colorado (Colorado's Medicaid Program)**

Dear Liqmnsb Qipcfubkw,

It is time to renew your health benefits. We need to see if you and your household members still qualify for Health First Colorado.

This is the standard language.

What you need to do

1. Review the current information we have. This information is printed on the first part of the "Renewal Form" included with this letter.
2. Then, report any changes or corrections to your information. Use the "Renewal Form" to help figure out the updated information you need to report.
3. Report any changes and provide proof needed, such as a current bank statement by **April 30, 2017.**

After this date, eligibility will be redetermined using the information we have on file.

The member must report changes in one of these ways.

Report your changes in one of these ways by **April 30, 2017.**

- Go to Colorado.gov/PEAK. Log in to your account. Click on "Redetermination/Recertification." If you do not have an account, you can create one at any time. Follow the instructions on Colorado.gov/PEAK to create an account.
- Complete the "Renewal Form" included with this letter. Mail, fax, or bring the Renewal Form to:

  JEFFERSON County
  Lisa Griffin
  900 JEFFERSON COUNTY PKWY
  GOLDEN CO 80401-6001

  Fax:

QUESTIONS } Visit CO.gov/HCPF/Letters-FAQs or call (111)111-1111

Page 1 of 12

1B12345/0123456789

HCPF-3
Med Redetermination Notice4_EN

To access FAQ's related to this letter visit this website or call your local county office at the phone number listed.

After eligibility is redetermined the member will receive a Notice of Action (NOA). The NOA will let them know the current eligibility status of all household members.

- Call JEFFERSON County at (303) 271-4610/ State Relay: 711 and tell them you are calling about renewal of your health benefits.

What happens next

- We will check to see if you and your household still qualify for Health First Colorado.
- We will contact you if we need anything else from you to help us make our decision.
- After **February 05, 2017**, we will send you another letter to tell you if you still qualify for Health First Colorado.

Report changes by **February 05, 2017.**

- You may get two renewal notices, for the same or different benefits. If you get more than one renewal notice, report any changes on both notices. You may need to report some changes twice to make sure we get all the information we need for you and your household members.
- To maintain your benefits, you are required to report changes. If you have changes and **do not** report them, you may have to pay back medical payments paid by Health First Colorado.

Thank you,

County Department of
Human Services

There will be a step 1 for each household member.

## Renewal Form

**Step 1:** Review the current information we have for Liqmnsb Qipcfubkw

Member's name: Liqmnsb Qipcfubkw

Member's date of birth: **01-19-1984**

Asking for Health First Colorado or CHP+: Yes

Address:
123 E DRIVE DR
DENVER CO 80000-0000

Files federal taxes:

Living with both parents, but parents do not expect to file a joint tax return:

Expects to be claimed by a non-custodial parent (the parent the child **does not** live with most nights):

Expects to be claimed as a dependent on someone else's tax return:

Employed: Yes

Employer: PLACE OF BUSINESS INC

Income type: WAGE - CDLE

Amount: $997.20

How often: Quarterly

Self-employed: No

Amount:

How often:

Unearned income (non-work income, such as child support or Social Security): Yes

Income type: SSI

Amount: $636.23

How often: Monthly

Expenses: Yes

Type: SSA/SSI Adjustment

Amount: $0.00

Resources: No

Type:

Value:

Amount owned:

Income from roomers/boarders: No

Amount:

How often:

The step 2 section is where changes in the household need to be reported.

**Step 2:** Report any changes in your information

Please check all boxes that apply to your changes. For each box you check, write the information we need. If there is no change, leave it blank.

☐ Name change

Old Name: New Name:

☐ New phone number:

☐ New address

Street address Apartment #

City State ZIP

☐ Someone has been added to my household

Name:

Date of birth: Date added to my household:

How is this person related to you? This person is my:

Does this new person in your household need health coverage? ☐ Yes ☐ No

- If no, do they have other health coverage? ☐ Yes ☐ No

What is their Social Security number or Taxpayer ID?

If they do not have a Social Security number, have they applied for one? ☐ Yes ☐ No

- If yes, fill in their application date:

Is this person a newborn child? ☐ Yes ☐ No

Does this person file federal taxes? ☐ Yes ☐ No

Is this person living with both parents, but the parents do not expect to file a joint tax return? ☐ Yes ☐ No

Does this person expect to be claimed by a non-custodial parent? (the parent the child **does not** live with most nights) ☐ Yes ☐ No

Does this person expect to be claimed as a dependent on someone else's tax return? ☐ Yes ☐ No

▶ Report any changes in your information (Step 2 continued)

Please check all boxes that apply to your changes. For each box you check, write the information we need. If there is no change, leave it blank.

Does this person have a medical, physical, mental, or developmental condition that has lasted, or is expected to last, more than 12 months, including blindness?

☐ Yes ☐ No

Does this person have a medical, physical, mental, or developmental condition that causes them to regularly need help with some or all of their self-care activities (such as bathing, dressing, eating, using the bathroom)?

☐ Yes ☐ No

Does this person need to move to a nursing home, acute care, hospital, group home, mental health institution or long-term care facility within the next 30 days, or do they need in-home health care to stay in their home?

☐ Yes ☐ No

---

☐ Someone has left my household

(For example, legal separation, divorce, death, adult child moved)

Name:

Date of birth: Date left my household:

How is this person related to you? This person is my:

---

☐ Someone in my household is pregnant

Pregnant individual's name: Due date:

Number of babies expected:

---

☐ Someone in my household has a new job

Name:

Employer:

Income type: Amount: How often: ☐ Daily ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Twice a Month ☐ Yearly

Is this a seasonal job? ☐ Yes ☐ No

Is this a job that pays commissions or tips? ☐ Yes ☐ No

---

Based off member feedback, the pay frequency was broken out into multiple choice options.

▶ Report any changes in your information (Step 2 continued)

Please check all boxes that apply to your changes. For each box you check, write the information we need. If there is no change, leave it blank.

☐ Someone in my household got another job, in addition to their first job

Name:

Employer:

Income type: Amount: How often: ☐ Daily ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Twice a Month ☐ Yearly ☐ Other

Is this a seasonal job? ☐ Yes ☐ No

Is this a job that pays commissions or tips? ☐ Yes ☐ No

---

☐ Income at a current job changed for someone in my household

Name:

New amount: How often: ☐ Daily ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Twice a Month ☐ Yearly ☐ Other

Is this a seasonal job? ☐ Yes ☐ No

Is this a job that pays commissions or tips? ☐ Yes ☐ No

---

☐ Someone in my household lost or quit a job

Name:

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☐ Someone in my household is self-employed

Name:

Amount: How often: ☐ Daily ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Twice a Month ☐ Yearly ☐ Other

Please submit proof of income from self-employment for this month or last month with this form, such as a copy of a profit and loss statement, a business ledger, a contract, or a bank statement.

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▶ Report any changes in your information (Step 2 continued)

Please check all boxes that apply to your changes. For each box you check, write the information we need. If there is no change, leave it blank.

☐ Unearned income for someone in my household has changed

Name:

Income type:

☐ Social Security ☐ Unemployment ☐ Alimony or spousal support

☐ Other:

New amount:

How often:

☐ Daily ☐ Weekly ☐ Every 2 weeks
☐ Monthly ☐ Twice a Month
☐ Yearly ☐ Other

Please send proof of changes to unearned income.

☐ Income from roomers/boarders has changed

New amount:

How often:

☐ Daily ☐ Weekly ☐ Every 2 weeks
☐ Monthly ☐ Twice a Month
☐ Yearly ☐ Other

☐ Expenses have changed for someone in my household

Name:

Expense type:

☐ Child care ☐ Dependent elder care ☐ Child support ☐ Medical
☐ Prescriptions ☐ Health insurance premiums ☐ Shelter ☐ Trust fees
☐ Other:

The expense is for:

The expense is paid by:

Amount:

How often:

☐ Daily ☐ Weekly ☐ Every 2 weeks
☐ Monthly ☐ Twice a Month
☐ Yearly ☐ Other

☐ My household's vehicles have changed

▶ Report any changes in your information (Step 2 continued)

Please check all boxes that apply to your changes. For each box you check, write the information we need. If there is no change, leave it blank.

Owner's name:

Year/Make/Model: Value:

Please send proof of changes to vehicles.

☐ My household's resources have changed

Owner's name: Value:

Resource type:

☐ Bank accounts ☐ Trust accounts ☐ Life insurance/Burial policies

☐ Properties ☐ Annuities ☐ Promissory notes ☐ Stocks ☐ Other:

Please send proof of changes to resources.

☐ Someone in my household gave away or sold resources

Owner's name:

Resource type:

Date given away or sold: Value:

☐ Immigration status for someone in my household changed

Name:

Please explain:

☐ Someone in my household is enrolled in other health insurance

Name:

Please explain:

☐ Someone in my household is now a full-time student

Name:

▶ Report any changes in your information (Step 2 continued)

Please check all boxes that apply to your changes. For each box you check, write the information we need. If there is no change, leave it blank.

☐ Additional information to help explain my renewal changes (optional)

Please explain:

COLORADO PEAK*Health*

**Want fast and easy access to your Health First Colorado (Colorado's Medicaid Program) benefits information on the go? Download the free PEAK*Health* app to manage your Health First Colorado benefits.**

## Language Assistance

| | |
|---|---|
| Español | ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-221-3943 (State Relay: 711). |
| Tiếng Việt | CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-221-3943 (State Relay: 711). |
| 繁體中文 | 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 1-800-221-3943（State Relay: 711）。 |
| 한국어 | 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-221-3943 (State Relay: 711) 번으로 전화해 주십시오. |
| Русский | ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-221-3943 (телетайп: 711). |
| አማርኛ | ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል: ወደ ሚከተለው ቁጥር ይደውሉ 1-800-221-3943 (መስማት ለተሳናቸው: 711). |
| العربية | ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-221-3493(رقم هاتف الصم والبكم: 117). |
| Deutsch | ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-221-3943 (State Relay: 711). |
| Français | ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-221-3943 (ATS : 711). |
| नेपाली | ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ। फोन गर्नुहोस् 1-800-221-3943 (टिटिवाइ: 711). |
| Tagalog | PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-221-3943 (State Relay: 711). |
| 日本語 | 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。1-800-221-3943（State Relay: 711）まで、お電話にてご連絡ください。 |
| Oroomiffa | XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-221-3943 (State Relay: 711). |
| فارسی | توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-221-3943 (State Relay: 711) تماس بگیرید. |
| Polski | UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-221-3943 (State Relay: 711). |

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Colorado Medical Assistance Program

# NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

As a Colorado Medical Assistance Program client, some of your health information is collected and maintained by the State of Colorado, Department of Health Care Policy and Financing. The Department is required by law to maintain your privacy and the security of your health information and to provide you with this Notice of Privacy Practices. This Notice describes how your health information may be used and shared, and explains your privacy rights. The Department is required to follow the terms of this Notice. We may, however, change our privacy practices and the terms of this Notice in the future, and those changes may affect all health information maintained by the Department. If our privacy practices change, we will prominently post our revised Notice on our web site and provide the revised notice to you at reenrollment. The most recent version of our Notice is available on the Department's web site at http://www.colorado.gov/hcpf.

PERMITTED USES AND SHARING OF YOUR HEALTH INFORMATION:

**Treatment:** We will use and share your health information to ensure you are provided medical treatment and services. For example, the Department may share your health information with a doctor or hospital that is providing you health care. If you are part of the Department's Accountable Care Collaborative (ACC), we will share your information with our Regional Care Collaborative Organizations (RCCOs) to attain the objectives of the ACC to improve clients' health and reduce costs.

**Payment:** We will use and share your health information to pay for your medical treatment and services. For example, your doctor may send health information about you to the Department when billing the Department for your health care services.

**Health Care Operations:** We will use and share your health information for Department operations that are authorized by law. For example, the Department may share your health information with an outside contractor to coordinate your care, resolve disputes, or audit the compliance of our providers with regulations. We may also share your information with another state or federal agency to fulfill our mission of providing coordinated benefits to you.

**Communications:** We may use your health information to communicate with you about health care programs and health care choices.

# Colorado Medical Assistance Program

**Legal Requirements:** We will share health information about you when required to do so by federal or state law.

**To Avoid Harm:** We may use or share your health information to prevent a serious threat to your health and safety or the health and safety of others such as in abuse, neglect, or domestic violence situations, or for law enforcement purposes.

**Research:** Under certain circumstances, we may share your health information for research purposes.

**Public Health:** We may share your health information with public health agencies to prevent or control the spread of diseases.

**Health Oversight Activities:** We may share your health information with a health oversight agency for activities authorized by law. These activities may include, for example, audits, investigations, and inspections.

**Lawsuits and Disputes:** We may share your health information in response to a valid judicial or administrative order.

**Coroners, Medical Examiners, Funeral Directors and Organ Procurement Organizations/Entities:** Consistent with applicable law, we may share your health information with a coroner, medical examiner, or funeral director so that they may carry out their duties, or with appropriate personnel for the purpose of facilitating organ, eye or tissue donation and transplantation.

**Workers Compensation:** We may share your health information with programs that provide benefits for work-related injuries or illness.

**National Security and Intelligence Activities and Specialized Government Functions:** We may share your health information with authorized federal officials for activities related to national security and special investigations or for military and veterans activities.

**Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may share your health information with the correctional institution or law enforcement official for the purposes of health care or safety.

**Marketing and Sale of Health Information:** We will not use or disclose your health information for marketing purposes (with limited exceptions), or sell your health

information, without your written Authorization.

**Other uses and disclosures not described in this Notice will be made only with your written authorization.**

YOUR HEALTH INFORMATION RIGHTS:

**Right to See and Get a Copy of Your Health Information:** You may see and get a copy of your health information and billing records by making a written request to the Department's Privacy Officer. We can only provide those records that were created for or on behalf of the Department. The Department need not provide psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.

**Right to be Notified Following a Breach of Your Unsecured Health Information:** The Department is required by law to notify you following a breach of your unsecured health information. This notice will describe the circumstances of what happened and the information that was inappropriately used or disclosed. You may receive this notice in the mail, or if you have elected to receive communications from the Department by email, through an email sent to the email address that we have on file for you.

**Right to Request that We Correct Your Health Information:** If you feel that the health information we have provided to you is incorrect or incomplete, you may ask us to amend the information by making a written request to the Department's Privacy Officer. In certain cases, the Department may deny your request to amend your information.

**Right to a List of Disclosures Made of Your Health Information:** You have the right to a list of those instances in which we have shared your health information, other than for treatment, payment, and health care operations, or other than when you specifically authorized the Department to share your information. Your request must be in writing to the Department's Privacy Officer.

**Right to Request that Your Health Information be Communicated in a Confidential Manner:** You may request that we contact you in a specific way, for example, home or office phone, or to send mail to a different address. The Department will consider all reasonable requests, and will agree to your request if you tell us you would be in danger if we did not.

**Right to Request that We Not Use or Share Your Health Information:** You have the right to request that we not use or share your health information for treatment,

payment, or health care operations. This would include your right to request that we not share your information with persons involved in your care except when specifically authorized by you. Your request must be in writing to the Department's Privacy Officer, and we will consider your request but we are not legally required to agree to it.

**Right to a Copy of the Notice:** You may ask us for a paper copy of this Notice at any time and we will provide it to you.

FOR MORE INFORMATION OR TO REPORT A PROBLEM:

If you have questions about your privacy rights, would like additional information about something in this Notice, or would like to file a complaint because you believe your privacy rights have been violated, you may contact the Department's Privacy Officer at:

Privacy Officer/State of Colorado/Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203-1818
303-866-4366

You may also file a complaint with the Secretary of the United States Department of Health and Human Services at:

Secretary/U.S. Department of Health and Human Services
Office of Civil Rights; 200 Independence Avenue, SW
Washington, DC 20201
Or by visiting: http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

THE DEPARTMENT WILL NOT TAKE AWAY YOUR BENEFITS OR RETALIATE AGAINST YOU IN ANY WAY IF YOU FILE A PRIVACY COMPLAINT.

This Notice is effective as of September 20, 2013.

***Pg. 1: This section may change depending on the information needed about the individual.**

**Scenario 3: Self-Employment**

**If we need proof of self-employment income, the directions will say:**

**Use this model below.**

1. Review the current information we have about you and your household members. This information is printed on the first part of the "Renewal Form" included with this letter.
2. Then, report any changes or corrections to your information. Our records show that we need more information about the amount of income from self-employment you or someone else in your household receives and how often you receive it. Use the "Renewal Form" to figure out if there is other updated information you need to report.
3. Report changes and updated information, including proof of self-employment income, by June 2017.

**Scenario 4: Unearned Income**

**What you need to do**

1. Review the current information we have about you and your household members. This information is printed on the first part of the "Renewal Form" included with this letter.
2. Then, report any changes or corrections to your information. Our records show that we need more information about the amount of unearned income, such as private pensions or child support, you or someone else in your household receives and how often you receive it. Use the "Renewal Form" to figure out if there is other updated information you need to report.
3. Report changes and updated information, including proof of unearned income, by June 1, 2017.

**Scenario 5: Earned Income**

**What you need to do**

1. Review the current information we have about you and your household members. This information is printed on the first part of the "Renewal Form" included with this letter.
2. Then, report any changes or corrections to your information. Our records show that we need more information about the amount of earned income from employment you or someone else in your household receives and how often you receive it. Use the "Renewal Form" to figure out if there is other updated information you need to report.
3. Report changes and updated information, including proof of earned income, by June 1, 2017.

**Scenario 6: Resources**

**What you need to do**

1. Review the current information we have about you and your household members. This information is printed on the first part of the "Renewal Form" included with this letter.
2. Then, report any changes or corrections to your information. Our records show that we need more information about the value of resource(s), such as bank accounts, you or someone else in your household own. Use the "Renewal Form" to figure out if there is other updated information you need to report.
3. Report changes and updated information, including proof of the value of the resource(s), by June 1, 2017.

**Scenario 7: Multiple Combos of Blurbs Above**

**What you need to do**

1. Review the current information we have about you and your household members. This information is printed on the first part of the "Renewal Form" included with this letter.
2. Then, report any changes or corrections to your information. Our records show that we need more information about the amount of income you or someone else in your household receives and how often you receive it. Use the "Renewal Form" to figure out if there is other updated information you need to report.
3. Report changes and updated information, including proof of income (earned and/or unearned), by June 1, 2017.