Redetermination Notice

Dear ,

It is time to see if you or your family is still eligible for your medical benefits. The information you give will be used to determine if you or your family are still eligible for these programs.

Please return the following information to me by to continue benefits for your family. If you do not return this information by your family benefits may end.

Section II: Report Your Changes-
I am reporting the following change(s) (Check the boxes next to each change):

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

_____

_____

☐ **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: _____
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☐ **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

☐ **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:
_____
_____

☐ I have no changes.

_____
Signature Date

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

Thank you,