Service Agency Name
Service Agency Address Line 1
Service Agency Address Line 2
City, State Zip Code

DEPARTMENT OF HUMAN SERVICES

Primary Client Name
Client Address Line 1
Client Address Line 2
City, State Zip Code

Date & Time Printed
Case Number: XXXXXXXXX

Health Care Renewal Notice

You are getting this notice because it is time to renew coverage for members of your household. This notice tells you the status of your renewal. This notice is for the people listed below.

Health Care Results

[Client Name]- MNsure ID Number: XXXXXXXXX

Effective Date	Action	Coverage Type
[First day of new certification period]	Auto Renewed	[Coverage Type]

[Client Name]'s coverage has been automatically renewed. **[Client Name]** qualifies for **[Coverage Type]** starting **[First day of new certification period]**. Please review the information summary included with this notice. We used this information to renew **[Client Name]**'s coverage. (*Code of Federal Regulations, title 42, sections 435.916(a) and 600.340(e); Minnesota Statutes, sections 256B. 056, subdivision 7a, and 256L.05, subdivision 3a)*

SAMPLE

This page intentionally left blank.

SAMPLE

[Client Name]- MNsure ID Number: XXXXXXXXX

Effective Date	Action	Coverage Type
[First day of new certification period]	Auto Renewed	[Coverage Type]

[Client Name]'s coverage has been automatically renewed. **[Client Name]** qualifies for **[Coverage Type]** starting **[First day of new certification period]**. Please review the information summary included with this notice. We used this information to renew **[Client Name]**'s coverage. (*Code of Federal Regulations, title 42, sections 435.916(a) and 600.340(e); Minnesota Statutes, sections 256B. 056, subdivision 7a, and 256L.05, subdivision 3a)*

[Client Name] - MNsure ID Number: XXXXXXXXX

Effective Date	Action	Coverage Type
[First day of new certification period]	Auto Renewed	[Coverage Type]

[Client Name]'s coverage has been automatically renewed. [**Client Name]** qualifies for **[Coverage Type]** starting **[First day of new certification period]**. Please review the information summary included with this notice. We used this information to renew **[Client Name]**'s coverage.(*Code of Federal Regulations, title 42, section 435.116; Minnesota Statutes, sections 256B.055, subd. 6, and 256B.057, subd. 1(a))*

SAMPLE

Information Summary

This is the information we have about your household. We used this information to renew your coverage. You must tell us if any of the information, including the address listed on the notice, is not correct. Send the updated information to the return address on this notice or contact your case worker. You do not need to do anything if all of this information is correct.

Household Information

Name	Gender	Date of Birth	Marital Status	Pregnant?	Receiving coverage?

Relationships

Name

Residency

Name	Lives in Minnesota?	Plans to make Minnesota home?	Visiting Minnesota for medical care or personal reasons?	Is home address the same as mailing address?	Home address, if different from mailing address

SAMPLE

Social Security Number (SSN)

Name	SSN provided?	If no, has person applied for SSN?

Citizenship Status

Name	United States Citizen?	United States National?

Noncitizen Information

Name	Immigration status (examples: asylee, legal permanent resident, refugee)	Entered US before August 22, 1996?	Lived in US for 5 or more years in a qualified status?	Honorably discharged veteran or active-duty military member?	Spouse or dependent child of an honorably discharged veteran or active-duty military member?

SAMPLE

Expected Tax Filing Information

Name	Expected Tax Status	Tax Relationship	Married Filing Jointly?	Tax dependent of someone outside the household?	Expected to be claimed as a tax dependent by a noncustodial parent?

Name	Had or expects a change in family size?	Had or expects a decrease in annual household income?	Had or expects a change in tax-filing status?	Filed an application for unemployment benefits?	Had or expects a change in the number of people on tax return?

SAMPLE

Other Health Insurance Information

Name	Are you enrolled in health insurance through an employer?	Do you have access to health insurance through an employer?	Is employer making changes for new plan year?	Do you have Medicare or other non-employer health insurance?	Type of non-employer health insurance

Information about Health Insurance Available through an Employer

Name	Name of Employer	Are you the employee?	Does the employer offer a plan that meets the minimum value standard for Self-Only Coverage?	How much would the employee pay for Self-Only Coverage?	How often does the amount for coverage have to be paid?

Information about Access to Family Health Insurance Available through an Employer

Name	Name of Employer	Are you the spouse or tax dependent of the employee?	Does the employer offer a plan that meets the minimum value standard for Family Coverage?	How much would the employee pay for Family Coverage?	How often does the amount for coverage have to be paid?

SAMPLE

Income Information

This is the income we have for your household. It includes your taxable income plus any nontaxable foreign earned income, interest income and Title II Social Security benefits. Title II Social Security benefits include retirement, disability and railroad retirement benefits. Supplemental Security Income (SSI) is not Title II income.

Name	Income	Seasonally employed?	Amount	Frequency	Amount of interest received or part of Social Security benefit amount that is tax-exempt?

Name	Stopped working in the last six months?	Had work hours, wages or salary decrease in last six months?

SAMPLE

Income Adjustments

Income adjustments are expenses listed on the front page of a federal tax return that you can subtract from your gross income. Your gross income minus any adjustments is your “adjusted gross income”. For a complete list of allowable income adjustments, see the Adjusted Gross Income section on the 1040 tax form.

Name	Type of Income Adjustment	Amount of Income Adjustment	Frequency of Income Adjustment

Projected Annual Income

Projected annual income (PAI) is the income you expect to receive in [YYYY].

How do you figure out PAI?

1. Start with the income that you will earn in [YYYY]. This is gross income reported on your federal tax return. Do not count income that is not included on the federal tax return. Examples of income that is not included are child support and worker’s compensation.
2. Add nontaxable Social Security, nontaxable interest income and foreign earned income, if applicable.
3. Subtract any adjustments that you will claim on your federal tax return. Some common adjustments are student loan interest and the self-employed health insurance expense.
4. You can use a federal tax return (1040 tax form) as a guide. The income from step 1 is listed in the Income section. The adjustments from step 3 are listed in the Adjusted Gross Income section.

Name	PAI Amount

Other Information

Name	Has ongoing medical bills to meet a spenddown?	Is seeking Medical Assistance payment of long-term-care services to reside in a long-term-care facility?	Is seeking services to help stay in his or her home through a Medical Assistance home and community-based waiver program?

SAMPLE

Name	Has a physical or mental health condition that limits the ability to work or perform daily activities?	Is blind?	Is getting services from the Center for Victims of Torture?	Is in jail or prison?

Full Medical Assistance Determination

Some people may be eligible for Medical Assistance (MA) under different categories. These categories include people with disabilities, people who are blind, people who receive services from the Center for Victims of Torture, people seeking payment of long-term-care services, and people seeking community-based waiver services. In addition, people who have outstanding medical bills at application may qualify for coverage for three months before application, and people with excess income may qualify with a spenddown. We will screen you to see if you may be eligible for MA under a different category, using the information you gave us on this form or when you applied. We will contact you for more information if we think you might qualify. If one of these categories applies to you, but you have not reported information about that, call and tell your worker. If you want us to make a full MA determination for you, call your worker for more information.

Voter Registration

If you want to register to vote in Minnesota, you can complete a voter registration form at sos.state.mn.us.

SAMPLE

How do I use my health care coverage?

If you qualify for Medical Assistance:

- You will get a Minnesota Health Care Programs (MHCP) member ID card showing your Medical Assistance ID number. Give your MHCP member ID card or Medical Assistance ID number to your health care providers.
- If you have medical bills for services received since the date you qualified for coverage, contact the health care provider and ask the provider to bill the State of Minnesota. The provider may be able to pay you back for bills you have already paid.
- You may be enrolled in a health plan. You will get information in the mail about choosing a health plan. Once you are enrolled, the health plan will send you an ID card and information telling you how to get services.

If you qualify for MinnesotaCare:

- **If you have a MinnesotaCare premium:** You must make a full payment for coverage to start. Your coverage starts on the first day of the month after you make your first payment. If you have not gotten it already, you will get your first premium notice in the mail. Send the payment to us as soon as you can.
- **If you do not have a MinnesotaCare premium:** Your coverage will start on the first day of the month after you were approved.
- **You must enroll in a health plan:** You will get information in the mail about choosing a health plan. You may be enrolled in an assigned health plan until we get your enrollment form. Once we get your enrollment form and you are enrolled, the health plan will send you an ID card and information telling you how to get services. You will also get an MHCP member ID card.

What if I have questions about this notice?

Call us if you have questions.

- For questions about Medical Assistance, call your county or tribal agency.
- For questions about MinnesotaCare, call Healthcare Consumer Support at 800-657-3672 or 651-297-3862.
- For general questions about Medical Assistance or MinnesotaCare, call Healthcare Consumer Support at 651-431-2670 or 800-657-3739.

If you have hearing or speech disabilities, contact us using your preferred telecommunications relay service.

You can also visit us in person:

- For in-person help about Medical Assistance, go to your county or tribal agency.
- For in-person help about MinnesotaCare, go to the MinnesotaCare walk-in office. The walk-in office is on the first floor of the Elmer L. Andersen Human Services Building in St. Paul. It is next to the security desk in the lobby.

SAMPLE

Location: Elmer L. Andersen Human Services Building
540 Cedar Street
St. Paul, MN 55101
Hours: 8:00 a.m. to 5:00 p.m., Monday–Friday

SAMPLE

Do I have to pay back the costs of my health care if I am receiving government assistance?

In certain circumstances, federal and state law require the Minnesota Department of Human Services and local agencies to recover costs that the MA program paid for its members. This recovery process is done through Minnesota's MA estate recovery and lien program. Read the following if you are enrolled in MA.

If you are enrolled in MA, then, after you die, Minnesota must try to recover the costs of any long-term services and supports (LTSS) you received at 55 years old or older. LTSS include:

- Nursing home services
- Home and community-based services
- Related hospital and prescription drug costs

Even after you die, Minnesota cannot recover these costs if your spouse survives you, you have a child under 21 years old, or you have a child who is blind or permanently disabled. Once your spouse dies, Minnesota must try to recover your MA LTSS costs from your spouse's estate. However, recovery is further delayed if you still have a child who is under 21 years old, blind, or permanently disabled. Your children do not have to use their assets to reimburse the state for any MA services you received.

Also, Minnesota must try to recover the costs of all MA services an MA member received at any age while permanently living in a medical institution. However, MA members who qualify for services under modified adjusted gross income (MAGI) eligibility criteria are not subject to recovery for services received before the age of 55.

The state may file an MA lien against your real property to recover MA costs before your death, but only if you are permanently living in a medical institution. The state also may file a notice of potential claim, which is a form of lien, against real property to recover MA costs after death. Liens to recover MA costs may be filed against the following:

- Your life estate or joint tenancy interest in real property
- Your real property that you own solely
- Your real property that you own with someone else

You have the right to speak with a legal-aid group or a private attorney if you have specific questions about how MA estate recovery and liens may affect your circumstance and estate planning. The Minnesota Department of Human Services cannot provide you with legal advice. For more information, go to http://mn.gov/dhs/ma-estate-recovery/.

SAMPLE

IMPORTANT APPEAL RIGHTS! READ THIS NOW!

What if I do not agree with the action taken on my health care coverage?

If you think the decision in your health care notice is wrong, you have the right to appeal. An appeal is a legal process where a human services judge holds a hearing and reviews (1) a decision by the Minnesota Department of Human Services (DHS) about MinnesotaCare coverage; or (2) a decision by a county or tribal agency about Medical Assistance coverage. You can learn more about how this works at www.dhs.state.mn.us/appeals/faqs.

How do I appeal?

You can appeal by submitting your own written request, filling out a DHS appeal form, or getting help by phone or in person. The DHS Appeals Division or your county or tribal agency can help you file your appeal.

1. Internet	2. Phone (for information on filing an appeal)	3. Mail or Fax	4. In person
• Log in to your account at www.mnsure.org • Or fill out the DHS-0033 form at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-0033-ENG and submit it electronically.	• Call your county or tribal agency. • Or call the DHS Appeals Division at 651-431-3600.	• Mail your request to Minnesota Department of Human Services Appeals Division PO Box 64941 St. Paul, MN 55164-0941 • Or fax it to 651-431-7523.	Get appeals help in person at Minnesota Department of Human Services Information Desk 444 Lafayette Road North St. Paul, MN 55155.

SAMPLE

What can I appeal?

You can appeal any of these:

- MNsure, the county or tribal agency, or DHS failed to act on your request about health care coverage.
- MNsure, the county or tribal agency, or DHS processed your request too slowly.
- MNsure, the county or tribal agency, or DHS took an action you do not agree with (examples of actions: denial of Medical Assistance coverage, approval of coverage for a program you do not think you are eligible for, the amount of advanced premium tax credits you qualify for, a change in your MinnesotaCare benefits).

When must I appeal?

If your appeal involves Medical Assistance or MinnesotaCare, you must file your appeal within **30 days** of receiving your health care notice. If you show good cause for not appealing a Medical Assistance or MinnesotaCare action within **30 days**, you may be able to appeal up to **90 days** after the date of your health care notice. See below for more important information about time limits for Medical Assistance and MinnesotaCare appeals.

If your appeal involves QHPs, an advanced premium tax credit or cost-sharing reductions, you must file an appeal within **90 days** after the date of your health care notice.

***Important:** An appeal decision for one household member may affect the eligibility of other household members. Household eligibility may need to be redetermined.

Will my benefits continue during my appeal?

You may be able to continue to get the same benefits you were receiving at the time you got the health care notice. But you may have to file your appeal within a certain time limit:

- For Medical Assistance and MinnesotaCare enrollees, we usually must send you an advance notice 10 days or more before the effective date of an action, or we may send you a notice five days before an action, depending on the situation. Your benefits will automatically continue if you file your appeal by the effective date of the action on the advance health care notice. In a few situations we may send you a notice less than five days before an action, or on the effective date of an action. Your benefits will continue if you file an appeal within 15 days from the date of that health care notice. You must pay your monthly MinnesotaCare premium to get continued coverage during your appeal. Tell DHS in writing if you do not want your benefits to continue.

- For QHP-related appeals, tell MNsure that you want to continue your benefits when you file your appeal.

Important: If you lose your appeal, you may have to pay back the benefits you got while your appeal was pending.

Important: You have the right to apply for Medical Assistance or MinnesotaCare again if your benefits stop.

What if I need a hearing right away?

You have the right to ask for an expedited (sped-up) appeal. If you need a hearing right away, tell MNsure or DHS the reason when you file your appeal. To ask for a sped-up appeal for Medical Assistance or MinnesotaCare, contact the DHS Appeals Office at 800-657-3510 (outstate) or 651-431-3600 (metro).

SAMPLE

What do I do after I file my appeal?

Gather information related to the action you are appealing that you think will prove or explain the reason you think the action was wrong.

You will get a letter telling you the date and time of the appeal hearing. Many hearings are done over the phone.

Continue to report changes (such as the start or stop of a job or changes in who lives with you) within these time frames:

- **30 days** if you have MinnesotaCare, a QHP, an advanced premium tax credit or cost-sharing reductions
- **10 days** if you have Medical Assistance

If you have Medical Assistance, report changes by calling your county or tribal agency. If you have MinnesotaCare, report changes by calling Healthcare Consumer Support at 800-657-3672 or 651-297-3862. If you have a QHP, report changes by calling the MNsure Contact Center at 855-366-7873.

Can I get help with my appeal?

You may speak for yourself at the hearing. You may also have someone else speak for you. You can let us know that you want someone else to speak for you at the hearing when you file your appeal. If your income is below a certain limit, you may be able to get legal advice or help with your appeal from your local legal aid office.

SAMPLE

Civil Rights Notice

CB3 HC-Medical 1-18

Discrimination is against the law. The Minnesota Department of Human Services (DHS) does not discriminate on the basis of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- marital status
- age
- disability
- sex (including sex stereotypes and gender identity)
- political beliefs

Auxiliary Aids and Services: DHS provides auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner to ensure an equal opportunity to participate in our health care programs. Contact the Minnesota Health Care Programs (MHCP) Member Help Desk at dhs.info@state.mn.us or 800-657-3739, or use your preferred relay service.

Language Assistance Services: DHS provides translated documents and spoken language interpreting, free of charge and in a timely manner, when language assistance services are necessary to ensure limited English speakers have meaningful access to our information and services. Contact the Minnesota Health Care Programs (MHCP) Member Help Desk at dhs.info@state.mn.us or 800-657-3739, or use your preferred relay service.

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by a human services agency. You may contact any of the following three agencies directly to file a discrimination complaint.

U.S. Department of Health and Human Services' Office for Civil Rights (OCR)

You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- age
- disability
- sex

Contact the **OCR** directly to file a complaint:

Director, U.S. Department of Health and
Human Services' Office for Civil Rights
200 Independence Avenue SW, Room 509F
HHH Building
Washington, DC 20201
800-368-1019 (voice) 800-537-7697 (TDD)
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Minnesota Department of Human Rights (MDHR)

In Minnesota, you have the right to file a complaint with the MDHR if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- religion
- creed
- sex
- sexual orientation
- marital status
- public assistance status
- disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
Freeman Building, 625 North Robert Street
St. Paul, MN 55155
651-539-1100 (voice) 800-657-3704 (toll free)
711 or 800-627-3529 (MN Relay)
651-296-9042 (fax) Info.MDHR@state.mn.us (email)

DHS

You have the right to file a complaint with DHS if you believe you have been discriminated against in our health care programs because of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- marital status
- age
- disability
- sex (including sex stereotypes and gender identity)
- political beliefs

Complaints must be in writing and filed within 180 days of the date you discovered the alleged discrimination. The complaint must contain your name and address and describe the discrimination you are complaining about. After we get your complaint, we will review it and notify you in writing about whether we have authority to investigate. If we do, we will investigate the complaint.

DHS will notify you in writing of the investigation's outcome. You have the right to appeal the outcome if you disagree with the decision. To appeal, you must send a written request to have DHS review the investigation outcome. Be brief and state why you disagree with the decision. Include additional information you think is important.

If you file a complaint in this way, the people who work for the agency named in the complaint cannot retaliate against you. This means they cannot punish you in any way for filing a complaint. Filing a complaint in this way does not stop you from seeking out other legal or administrative actions.

Contact **DHS** directly to file a discrimination complaint:

Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
651-431-3040 (voice) or use your preferred relay service

651-431-2670 or 800-657-3739

Attention. If you need free help interpreting this document, call the above number.

ያስተውሉ: ካለምንም ክፍያ ይህንን ዶኩመንት የሚተረጉምሎ አስተርጓሚ ከፈለጉ ከላይ ወደተጻፈው የስልክ ቁጥር ይደውሉ።

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊
အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d'une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟ်သူဉ်ဟ်သးဘဉ်တက့ၢ်. ဖဲနမ့ၢ်လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကကျိးထံဝဲဒဉ်လ်ာ် တီလ်ာ်ဓီတခါဆံၤန္ဉာ်,ကိးဘဉ်လီတဲဖိဉ်ါဂ်ါလၢထးဆံၤန္ဉာ်တက့ၢ်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ,
ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

LB2 (8-16)