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

*

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

Date & Time Printed

Due date / Fecha límite / Waqtiga kama danbeysta ah / Hnub tag sij hamn: **[DUE DATE]**

It is time to renew your health care coverage

Es tiempo de renovar su cobertura médica

Waxaaa la joogaa waqtigii aad cusbooneysiin lahayd caymiskaaga caafimaadka

Txog sij hawm rov txuas ntxiv koj daim ntawv kho mob

SAMPLE

Case Number: XXXXXXXX

Household members who need to renew their eligibility:

Member Name	MNsure ID Number	Health Care Program Type
Client's Name	MNsure ID	MA or MCRE

Turn this page over for commonly asked questions.

Commonly asked questions:

What if my renewal form is received after [DUE DATE]?
You may experience gaps in your coverage if your form is received after [DUE DATE].

What if I do not send in my renewal form at all?
If we do not receive your form at all, your coverage will end on [Current certification End Date].

What if I have more questions about the renewal process or my renewal status?

- If you have **Medical Assistance** and have questions about your case, call your county or tribal servicing agency listed on this notice.

- If you have **MinnesotaCare** or have general questions about health care eligibility, call DHS Health Care Consumer Support at 651-297-3862 or 800-657-3672. Our hours of operation are 8:00a.m. – 5:00p.m. Press option 3 to request an interpreter in your preferred language.TTY: Use your preferred relay service.

SAMPLE

Here’s what you need to do:

1. **Review the information** on the included renewal form.
2. **Update** any old or incorrect information. **Fill in** any missing information. **Attach** a sheet of paper if you need more space to write. For help completing this form, scan the code or go to https://mn.gov/dhs/health-care/renewal .

3. **Sign and date** the form.
4. **Mail, fax, or drop off your completed form by [DUE DATE]** to the servicing agency found at the top left of the first page of this notice. Visit https://mn.gov/dhs/renewmycoverage to find out about other ways you can submit your renewal.

Save time now:

Include proofs (Optional): Include copies of income or self-employment proofs (like pay stubs or tax returns) for all household members who have an income. Do not include original documents.

Collecting proofs may be required at a later step. Including proofs now can speed up your processing time.

SAMPLE

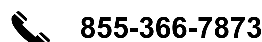
Get additional support:

Get free help completing your renewal by contacting a navigator near you. You can find a navigator who speaks your language. Visit or call:

Obtenga ayuda gratuita contactando a un(a) ayudante cerca de usted. Para encontrar un(a) ayudante que hable su idioma cerca de usted visite la página de internet que se muestra abajo o llame al siguiente número:

Hel caawimaad bilaash ah oo la xariirta cusbooneysiintaada adoo la xariiraya hawl fududeeyaha kuugu dhaw. Waxaad heli kartaa hawl fududeeye ku hadla luuqadaada. Booqo ama wac ilahaan hoose:

Xav tau kev pab dawb txuas ntxiv koj daim ntawv kho mob thov hu rau tus neeg ua ntaub ntawv kho mob nyub ze koj. Koj yuav nrhiav tau tus neeg uas ntaub ntawv kho mob uas nws hais koj hom lus. Thov mus saib los yog hu rau cov chaw muaj kev pab nram qab no:



651-297-3862 or 800-657-3672

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. ဖဲနမ့ၢ်လိဉ်ဘဉ်တၢ်မၤစၢၤကလီလၢတၢ်ကကျိးထံဝဲဒဉ်လံာ်တီလံာ်မီတခါအံၤန့ဉ်, ကိးဘဉ်လီတဲစိနီၣ်ဂံၢ်လၢထးအံၤန့ဉ်တက့ၢ်.

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 (afcelinta) 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 (10-20)

SAMPLE

Renewal Form

This is the information we have about your household. Review the information on this notice, including the address. Tell us if any of the information is not correct and fill in any missing information. To add a new household member or new applicant requesting coverage, call the servicing agency listed in the return address on this notice. See the enclosed Agency Addresses form to get the address and phone number for your servicing agency.

Household Information

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

All this information is correct unless a change is entered below. If you are reporting a pregnancy, please provide the number of unborn child(ren), and the due date.

Relationships

Name

All this information is correct unless a change is entered below:

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

All this information is correct unless a change is entered below:

SAMPLE

Social Security Number (SSN)

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

All this information is correct unless a change is entered below:

Citizenship Status

Name	United States Citizen?	United States National?

All this information is correct unless a change is entered below. If citizenship information has changed, please provide the effective date, Naturalization ID number and new name, if available.

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?

All this information is correct unless a change is entered below. If noncitizen information has changed, please provide the date the new status began, the type of document you have, the Alien ID number, and the card number.

SAMPLE

Expected Tax Filing Information – Review the following information and report any tax filing status changes for any member in your household in the box after the tables.

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?

All this information is correct unless a change is entered below:

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

All this information is correct unless a change is entered below. If you are reporting that someone has access to, but is not enrolled in, an employer insurance plan, we will need a completed ***Appendix A: Health Coverage from Jobs*** *with your completed renewal form. Access the appendix at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6696D-ENG or have one mailed to you by calling your county agency or DHS Health Care Consumer Support at 651-297-3862 or 800-657-3672.*

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?

All this information is correct unless a change is entered below. If you are reporting that someone has access to, but is not enrolled in, an employer insurance plan, we will need a completed ***Appendix A: Health Coverage from Jobs*** *with your completed renewal form. Access the appendix at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6696D-ENG or have one mailed to you by calling your county agency or DHS Health Care Consumer Support at 651-297-3862 or 800-657-3672.*

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

All this information is correct unless a change is entered below. If you are reporting that someone has access to, but is not enrolled in, an employer insurance plan, we will need a completed ***Appendix A: Health Coverage from Jobs*** *with your completed renewal form. Access the appendix at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6696D-ENG or have one mailed to you by calling your county agency or DHS Health Care Consumer Support at 651-297-3862 or 800-657-3672.*

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.

How to complete this section: Review all the details for each income source listed on this form. Follow these steps:

1. If the type of income is still current, cross out any details of the income that are not correct and enter the corrections in the space(s) provided in the table.
2. Cross out all income that ended.
3. Cross out duplicate income information (income information listed more than once).

IMPORTANT: If you report a change in income, make sure you review and update all three sections on this form: Income Information, Adjustments to Income and Projected Annual Income.

Name	Income	Seasonally Employed? Yes or No	Amount	How Often? Weekly Bi-weekly Semi-monthly Monthly Yearly	Amount of interest received or part of Social Security benefit amount that is tax-exempt?

SAMPLE

Report new income: Complete this section for any household members that have new income to report that is not listed in the previous table. If you need more space, write “Report new income” on a separate piece of paper and include your case number and the information from the table. Return it with this form.

Name	Income	Seasonally Employed? Yes or No	Amount	How Often? Weekly Bi-weekly Semi-monthly Monthly Yearly	Amount of interest received or part of Social Security benefit amount that is tax-exempt?

Adjustments to Income

Adjustments to income are the types of expenses you would list on Schedule 1 of the 1040 federal tax return. Your gross income minus any adjustments is your "adjusted gross income." For a complete list of allowable adjustments, see the Schedule 1 of the 1040 federal tax return.

How to complete this section: Review all the details for each adjustment listed on this form. Follow the steps below:

1. If the adjustment is still current and correct, do not make any changes.
2. Cross out any detail that is not correct and enter the corrections in the space provided.
3. Cross out all adjustments that ended.

If no changes are made, we will use all of the information in the table to determine eligibility for your household.

Name	Type of Adjustment	Amount of Adjustment	Frequency of Adjustment

Report new adjustments to income: Complete this section if any household members have new adjustments to income not listed in the previous table. If you need more space, write "New adjustments to income" on a separate piece of paper and include your case number and the information from the table. Return it with this form.

Name	Type of Adjustment	Amount of Adjustment	Frequency of Adjustment

SAMPLE

Projected Annual Income

Projected annual income (PAI) is the income you expect to receive in [YYYY]. Eligibility for some health insurance is based on your expected household income for the year you want coverage, not last year's income. You must provide your projected annual income to qualify for the correct program.

How do you figure out PAI?

1. Start with the gross income you will report in [YYYY] on your federal tax return. Do not count income that is not included on a federal tax return. Examples of income that are not included are child support and worker's compensation.
2. Subtract any adjustments to income that you would report on Schedule 1 of your federal tax return.
3. Add any of the following sources of income as part of your PAI. Even though these sources of income may not be taxed when you file your federal tax return, you must add them when projecting your annual income.
   - **Title II Social Security benefits**
   - **Tax-exempt interest income**
   - **Foreign earned income**

We used the information we have on file and calculated the [YYYY] PAI for everyone in your household as shown in the second column of this table. Follow these steps:

1. Answer the question 'Is this amount correct?' by selecting yes or no in the table for each person in your household. You must answer this question for each household member.
2. If the [YYYY] calculated PAI is not correct for any person, enter the amount you expect will be the person's [YYYY] PAI in the New or Correct [YYYY] PAI Amount column.

Name	PAI Amount	Is this amount correct?	New or Correct [YYYY] PAI Amount

SAMPLE

Other Information

Review each question below. If the answer is yes for you or anyone in your household, use the box below to explain which question the answer is yes for. Also write the name of the person answering yes.

- Stopped working or had hours, wages or salary decrease in the last six months?
- 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 a person stay in his or her home through a Medical Assistance home and community-based waiver program?
- 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.

Renewing Coverage in the Future

Each year, MNsure and DHS match data to verify and renew eligibility for help paying for health coverage. We need consent to use information from tax returns to verify and renew your financial assistance for coverage. If you do not give consent to use this information, your financial assistance cannot be verified during the year and renewed. You can change your consent at any time. **If you do not check a box, you are agreeing to the use of your information for 5 years**.

I agree to the use of tax return information to verify and renew my eligibility for help paying for health coverage for:

☐ 5 years

☐ 4 years

☐ 3 years

☐ 2 years

☐ 1 year

☐ Do not use information from tax returns to renew my eligibility for help paying for health coverage.

SAMPLE

By signing below:

I received and reviewed the Notice of Privacy Practices and the Notice of Rights and Responsibilities. I know that I must report changes to the information listed on this renewal form.

I understand that if I am providing information on behalf of other people in my household, I must have consent to provide and view information about all the people that I have listed on this renewal form and agree to safeguard their information.

I declare under the penalties of perjury that this renewal form has been examined by me and to the best of my knowledge is a true and correct statement of every material point. I understand that a person convicted of perjury may be sentenced to imprisonment of not more than five years or to payment of a fine of not more than $10,000, or both. I understand that there may be other penalties for not telling the truth.

Additional Agreements for Medical Assistance and MinnesotaCare:

- **If anyone on this renewal form is eligible for Medical Assistance or MinnesotaCare**, I consent to the release of my Minnesota Health Care Programs health records to the parties listed in the Consent for Sharing of Medical Information section of the Notice of Rights and Responsibilities.
- **If anyone on this renewal form is eligible for Medical Assistance**, I give the Medical Assistance agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties.
- **If I am a parent that is eligible for Medical Assistance**, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell the agency, and I may not have to cooperate. I give to the Medical Assistance agency the rights to medical support paid for my children.
- **If anyone on this renewal form is eligible for Medical Assistance,** I have read and understand that the state may claim repayment for the cost of medical care, or the cost of the premiums paid for care, from my estate or my spouse's estate.
- **If anyone on this renewal form is eligible for Medical Assistance**, I agree and understand that my information, and information about me shared from third parties, will be shared for fraud prevention investigations as stated in the Notice of Privacy Practices.
- **If I or anyone in my household already receives Medical Assistance or MinnesotaCare,** I understand that the state may stop or change benefits because of the information I give on this form. I understand that the state may make changes without 10 days' advance notice. However, the state will send written notice no later than the effective date of the change.

If an enrollee is unable to sign, provide copies of legal documents of conservatorship or power of attorney.

SAMPLE

YOUR SIGNATURE	PHONE	DATE
SIGNATURE OF AUTHORIZED REPRESENTATIVE	PHONE	DATE

For certified application counselors, navigators, in-person assisters, agents, and brokers only.

Complete this section if you are a certified application counselor, navigator, in-person assister, agent or broker filling out this renewal form for somebody else.

DATE (MM/DD/YYYY)	NAME OF ENROLLEE (First Name, Middle Name, Last Name, Suffix)
NAME OF ASSISTER (First Name, Middle Initial, Last Name, Suffix)	ASSISTER PHONE NUMBER
ORGANIZATION NAME	ASSISTER ID NUMBER

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 or general questions about Medical Assistance, call DHS Health Care Consumer Support at 651-297-3862 or 800-657-3672.

You can get free help from a Navigator. To find a Navigator in your area who speaks your preferred language, go to https://www.mnsure.org and click “Assister Directory” under Find Free Help.

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

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