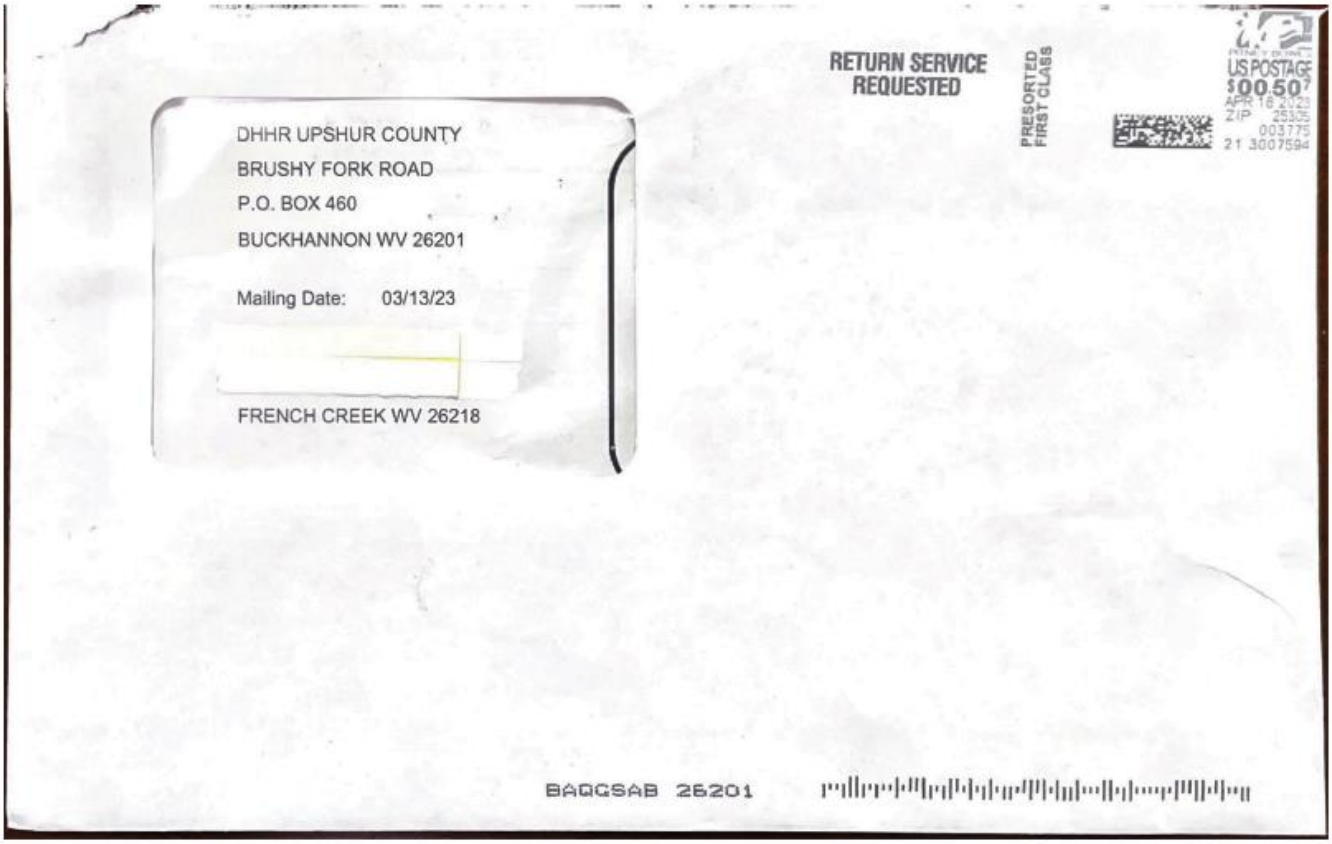
West Virginia
Bureau for Medical Services

Your benefit renewal form will be delivered to your address on file with the Department of Health and Human Resources (DHHR).

To update your mailing address, call 1-877-716-1212, email dhhrbcfchangectr@wv.gov, or visit www.wvpath.wv.gov.

Monitor incoming mail for your renewal from the DHHR.



Continue to page 2.

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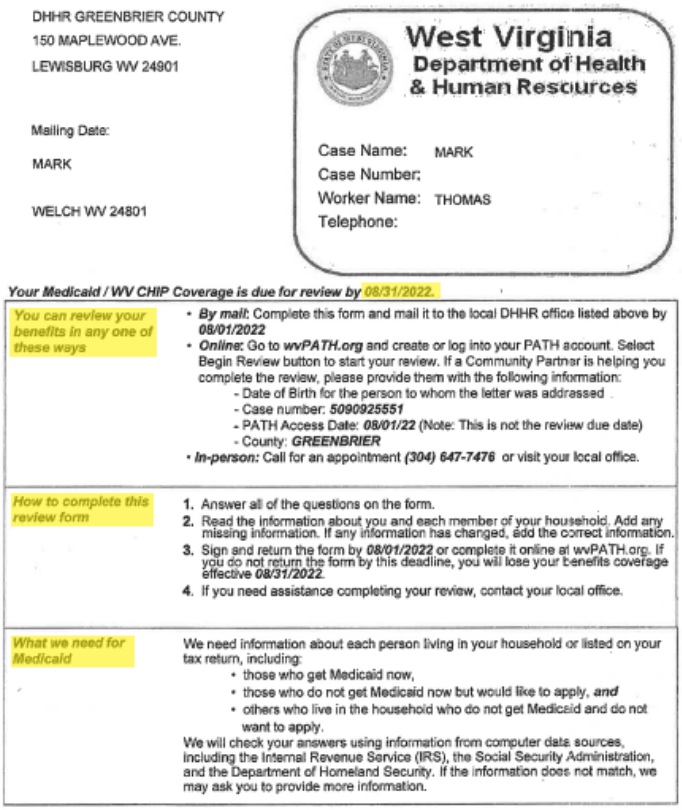
The first page of your form will provide the following:

Your renewal date

How to complete this form

Information Medicaid needs to continue your benefit coverage



DHHR GREENBRIER COUNTY
150 MAPLEWOOD AVE.
LEWISBURG WV 24901

Mailing Date:

MARK

WELCH WV 24801

West Virginia
Department of Health & Human Resources

Case Name: MARK
Case Number:
Worker Name: THOMAS
Telephone:

Your Medicaid / WV CHIP Coverage is due for review by 08/31/2022.

You can review your benefits in any one of these ways

- ***By mail:*** Complete this form and mail it to the local DHHR office listed above by ***08/01/2022***
- ***Online:*** Go to ***wvPATH.org*** and create or log into your PATH account. Select Begin Review button to start your review. If a Community Partner is helping you complete the review, please provide them with the following information:
  - Date of Birth for the person to whom the letter was addressed
  - Case number: ***5090925551***
  - PATH Access Date: ***08/01/22*** (Note: This is not the review due date)
  - County: ***GREENBRIER***
- ***In-person:*** Call for an appointment ***(304) 647-7476*** or visit your local office.

How to complete this review form

1. Answer all of the questions on the form.
2. Read the information about you and each member of your household. Add any missing information. If any information has changed, add the correct information.
3. Sign and return the form by ***08/01/2022*** or complete it online at wvPATH.org. If you do not return the form by this deadline, you will lose your benefits coverage effective ***08/31/2022***.
4. If you need assistance completing your review, contact your local office.

What we need for Medicaid

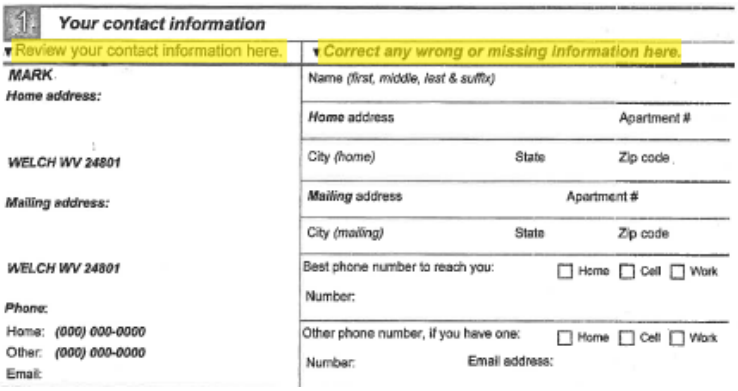
We need information about each person living in your household or listed on your tax return, including:

- those who get Medicaid now,
- those who do not get Medicaid now but would like to apply, ***and***
- others who live in the household who do not get Medicaid and do not want to apply.

We will check your answers using information from computer data sources, including the Internal Revenue Service (IRS), the Social Security Administration, and the Department of Homeland Security. If the information does not match, we may ask you to provide more information.

Section 1 will have your current contact information on the left.

Please make any changes and corrections on the right side of Section 1.



1 *Your contact information*

▼ Review your contact information here. | ▼ *Correct any wrong or missing information here.*

MARK
Home address:

WELCH WV 24801

Mailing address:

WELCH WV 24801

Phone:
Home: ***(000) 000-0000***
Other: ***(000) 000-0000***
Email:

Name *(first, middle, last & suffix)*

Home address — Apartment #

City *(home)* — State — Zip code

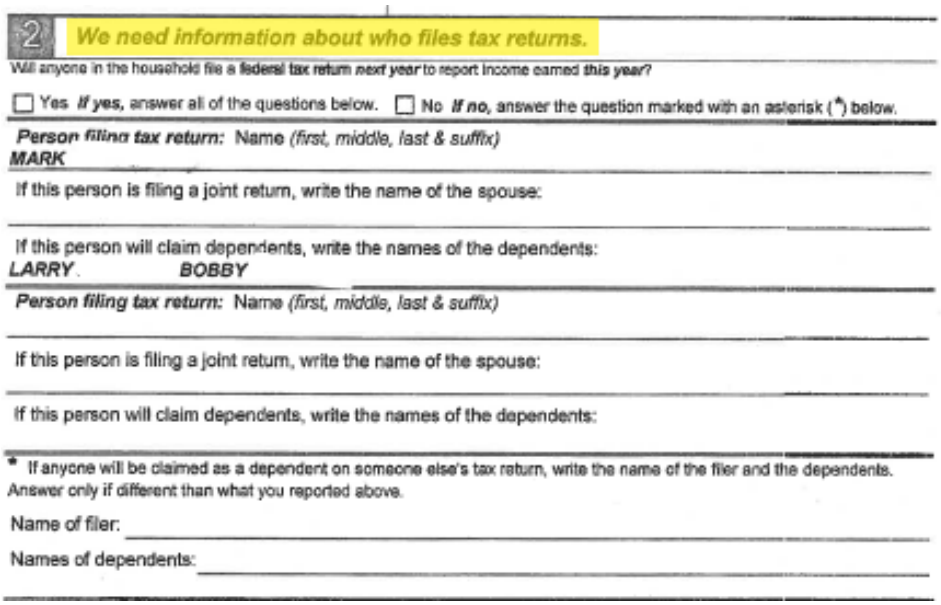
Mailing address — Apartment #

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:

Section 2 asks for information about anyone in the household who will file a federal tax return next year to report income earned this year.



2 We need information about who files 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 an asterisk (*) below.

Person filing tax return: Name *(first, middle, last & suffix)*

MARK

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:

LARRY ***BOBBY***

Person filing tax return: Name *(first, middle, last & suffix)*

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

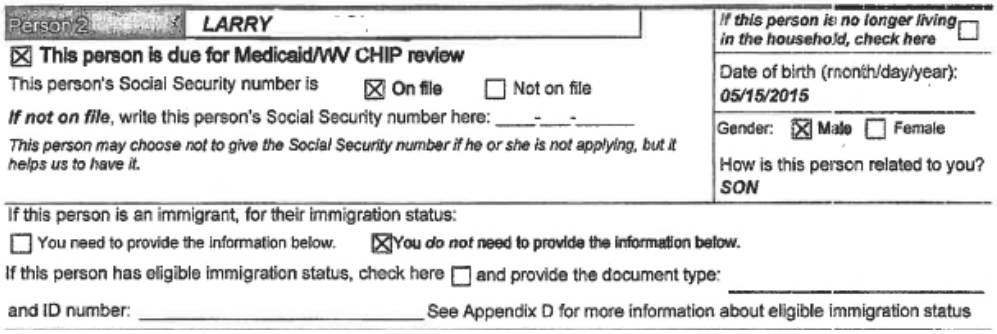
If this person will claim dependents, write the names of the dependents:

* If anyone will be claimed as a dependent on someone else's tax return, write the name of the filer and the dependents. Answer only if different than what you reported above.

Name of filer:

Names of dependents:

Section 3 asks for information about the people in your household.



Person 2 ***LARRY***

☒ **This person is due for Medicaid/WV CHIP review**

This person's Social Security number is ☒ On file ☐ Not on file

If not on file, write this person's Social Security number here: ___-___-____

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.

If this person is no longer living in the household, check here ☐

Date of birth (month/day/year): ***05/15/2015***

Gender: ☒ Male ☐ Female

How is this person related to you? ***SON***

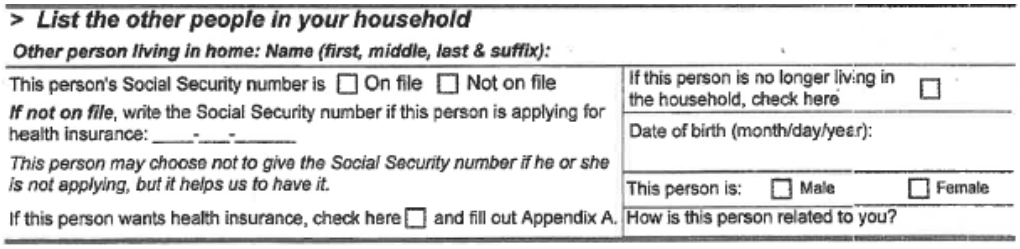
If this person is an immigrant, for their immigration status:

☐ You need to provide the information below. ☒ **You *do not* need to provide the information below.**

If this person has eligible immigration status, check here ☐ and provide the document type:

and ID number: _____ See Appendix D for more information about eligible immigration status

Other people in your household:



> List the other people in your household

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

This person's Social Security number is ☐ On file ☐ Not on file

If not on file, write the Social Security number if this person is applying for health insurance: ___-___-____

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.

If this person wants health insurance, check here ☐ and fill out Appendix A.

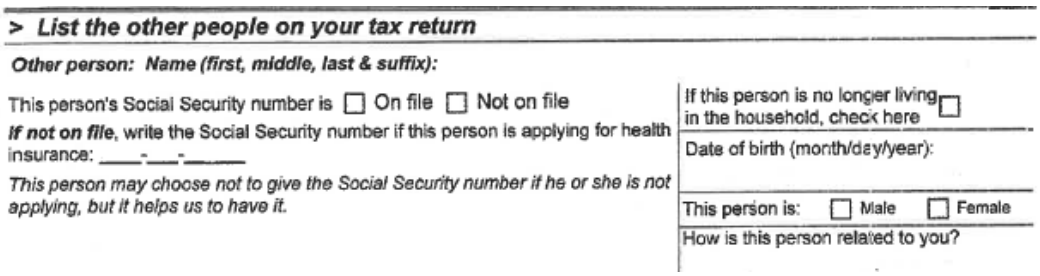
If this person is no longer living in the household, check here ☐

Date of birth (month/day/year):

This person is: ☐ Male ☐ Female

How is this person related to you?

Other people on your tax return:



> List the other people on your tax return

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

This person's Social Security number is ☐ On file ☐ Not on file

If not on file, write the Social Security number if this person is applying for health insurance: ___-___-____

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.

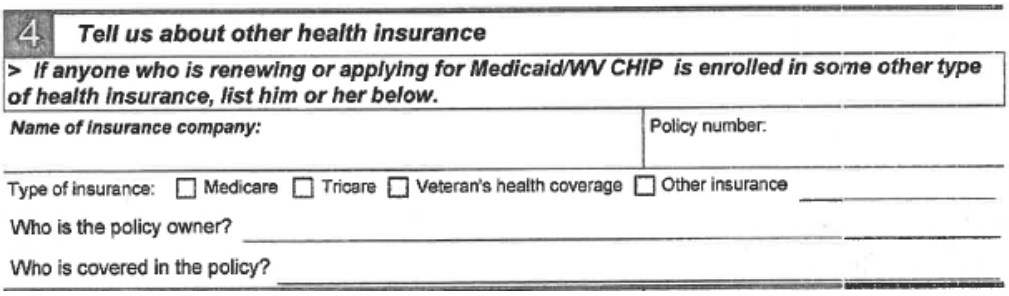
If this person is no longer living in the household, check here ☐

Date of birth (month/day/year):

This person is: ☐ Male ☐ Female

How is this person related to you?

Section 4 asks for information about any other health insurance you or members of your household may be enrolled in.



4 Tell us about other health insurance

> *If anyone who is renewing or applying for Medicaid/WV CHIP is enrolled in some other type of health insurance, list him or her below.*

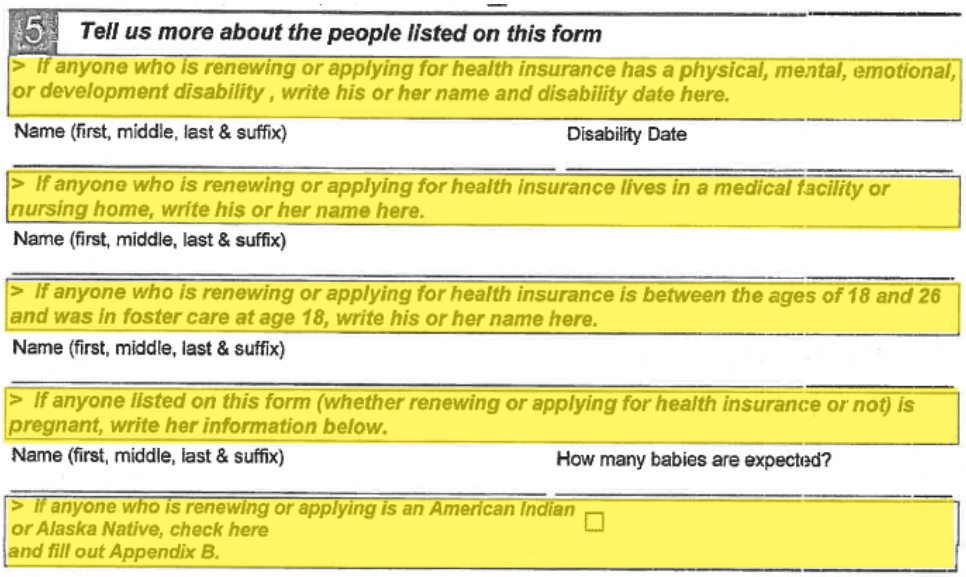
Name of insurance company: | Policy number:

Type of insurance: ☐ Medicare ☐ Tricare ☐ Veteran's health coverage ☐ Other insurance

Who is the policy owner?

Who is covered in the policy?

Section 5 asks for additional information about other household members included in earlier sections of the renewal form. Please review all five questions in this section.



5 Tell us more about the people listed on this form

> *If anyone who is renewing or applying for health insurance has a physical, mental, emotional, or development disability , write his or her name and disability date here.*

Name (first, middle, last & suffix) Disability Date

> *If anyone who is renewing or applying for health insurance lives in a medical facility or nursing home, write his or her name here.*

Name (first, middle, last & suffix)

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

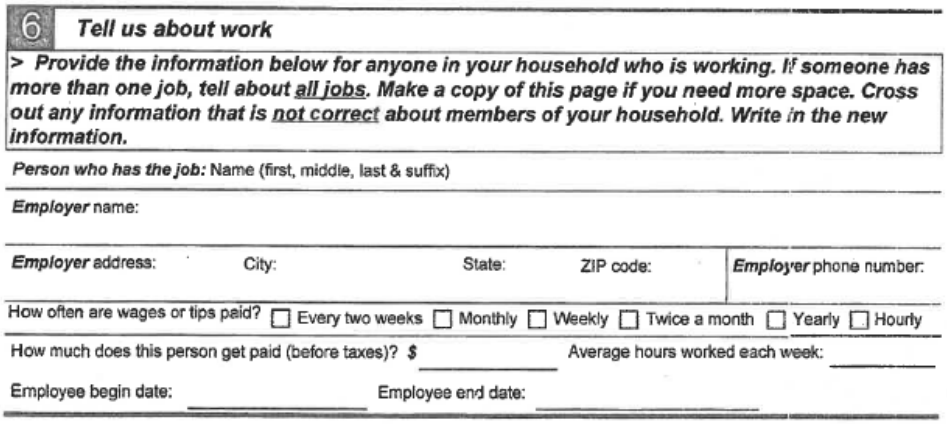
Name (first, middle, last & suffix)

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

Name (first, middle, last & suffix) How many babies are expected?

> *If anyone who is renewing or applying is an American Indian or Alaska Native, check here and fill out Appendix B.* ☐

Section 6 asks for information from anyone in your household who is working. If someone has more than one job, please include information about each job. Please make a copy of this page if you need additional space. Cross out any information that is incorrect.



6 Tell us about work

> *Provide the information below for anyone in your household who is working. If someone has more than one job, tell about all jobs. Make a copy of this page if you need more space. Cross out any information that is not correct about members of your household. Write in the new information.*

Person who has the job: Name (first, middle, last & suffix)

Employer name:

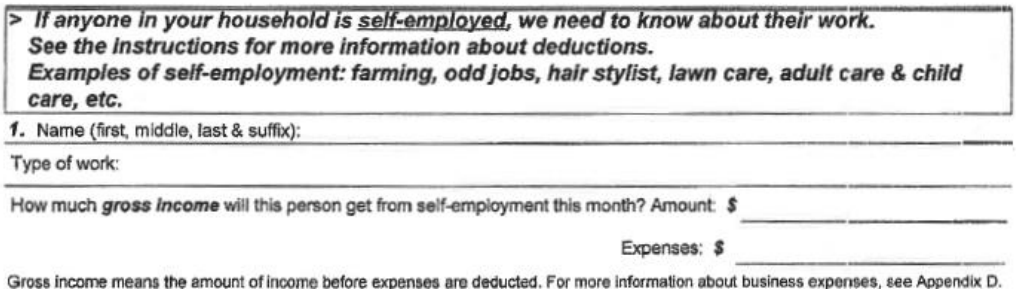
Employer address: City: State: ZIP code: | *Employer* phone number:

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

How much does this person get paid (before taxes)? $ Average hours worked each week:

Employee begin date: Employee end date:

Section 6 also includes a space for anyone in your household who is self-employed.



> ***If anyone in your household is self-employed, we need to know about their work.***
> ***See the instructions for more information about deductions.***
> ***Examples of self-employment: farming, odd jobs, hair stylist, lawn care, adult care & child care, etc.***

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

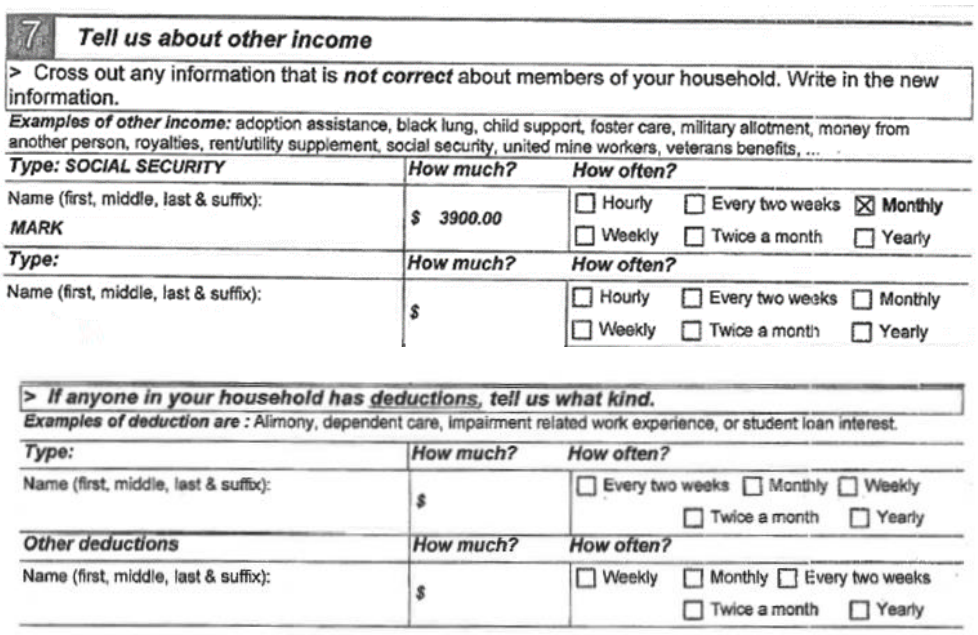
Type of work:

How much ***gross income*** will this person get from self-employment this month? Amount: $

Expenses: $

Gross income means the amount of income before expenses are deducted. For more information about business expenses, see Appendix D.

Section 7 asks for information on other income and if anyone in the household has deductions. Please cross out any information that is incorrect and write in new information.



7 Tell us about other income

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

Examples of other income: adoption assistance, black lung, child support, foster care, military allotment, money from another person, royalties, rent/utility supplement, social security, united mine workers, veterans benefits, ...

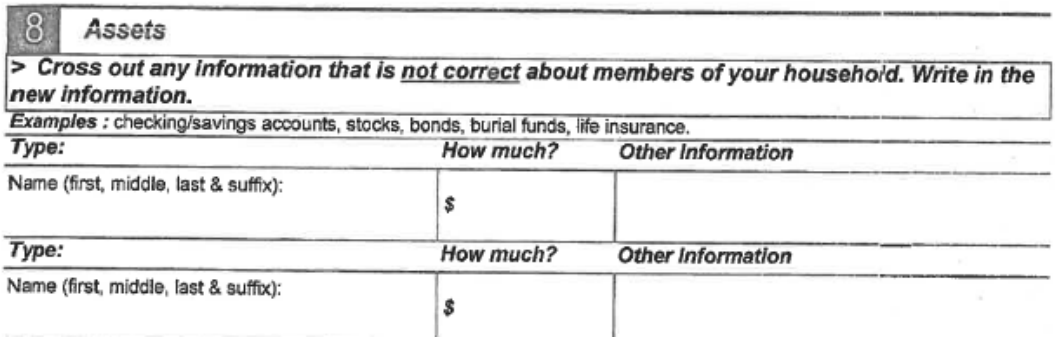
Type: SOCIAL SECURITY	***How much?***	***How often?***
Name (first, middle, last & suffix): ***MARK***	$ 3900.00	☐ Hourly ☐ Every two weeks ☒ **Monthly** ☐ Weekly ☐ Twice a month ☐ Yearly
Type:	***How much?***	***How often?***
Name (first, middle, last & suffix):	$	☐ Hourly ☐ Every two weeks ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Yearly

> ***If anyone in your household has deductions, tell us what kind.***

Examples of deduction are : Alimony, dependent care, impairment related work experience, or student loan interest.

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

Section 8 asks for information on additional assets, such as checking/savings accounts, stocks, bonds, burial funds, or life insurance.



8 Assets

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

Examples : checking/savings accounts, stocks, bonds, burial funds, life insurance.

Type:	***How much?***	***Other Information***
Name (first, middle, last & suffix):	$	
Type:	***How much?***	***Other Information***
Name (first, middle, last & suffix):	$	

Section 9 lists your rights and responsibilities. Please read the statements carefully.

You can elect to renew your eligibility automatically in this section.

Yes, renew my eligibility automatically for the next:

☐ 5 years (the maximum number of years allowed), or for a shorter number of years.

☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ Don't use information from tax returns to renew my coverage.

After reading all of the statements, please sign and date the renewal form on page 11.

X _____ _____

Signature of Household Member or Authorized Representative **Date**

Please complete, sign and return this entire form to the address on the first page by the due date.

Appendix A should be filled out about anyone in your household who wants to apply for health coverage. You may make a copy of the page if more than two people are applying.

<u>DO NOT</u> answer these questions for people who already have health coverage.

Appendix A

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 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, answer all of the questions below.***

☐ No **If no,** *go to "Tell us more information about this person"*

If this person ***is not*** a U.S. citizen or U.S. national, but has eligible immigration status check here, ☐

and write the document type: _____ and ID number: _____

See Appendix D for more information about eligible immigration status.

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, check here ☐

> Tell us more information about this person

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, check here ☐

> Tell us about race and ethnicity. You may choose not to answer these questions.

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

☐ American Indian or Alaska Native ☐ Filipino ☐ Other Asian ☐ Other Pacific Islander

☐ Japanese ☐ Native Hawaiian ☐ Other

Appendix B is for American Indian or Alaska Native family members.

Appendix B

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:

- 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

How much income? $

How often?

☐ Weekly ☐ Twice a month ☐ Every two weeks ☐ Yearly ☐ Monthly

Appendix C is for if you choose a trusted friend, partner, or lawyer to sign your renewal form as an authorized representative, to obtain information about your renewal, and act on your behalf.

Appendix C

You can choose an authorized representative

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

Appendix D is a list of eligible immigration statuses. If you see a household member's status listed, go back to Section 2 and check the box for Yes.

Appendix D

Eligible immigration status list

> If you see the person's status below, go back to the question and check the Yes box.

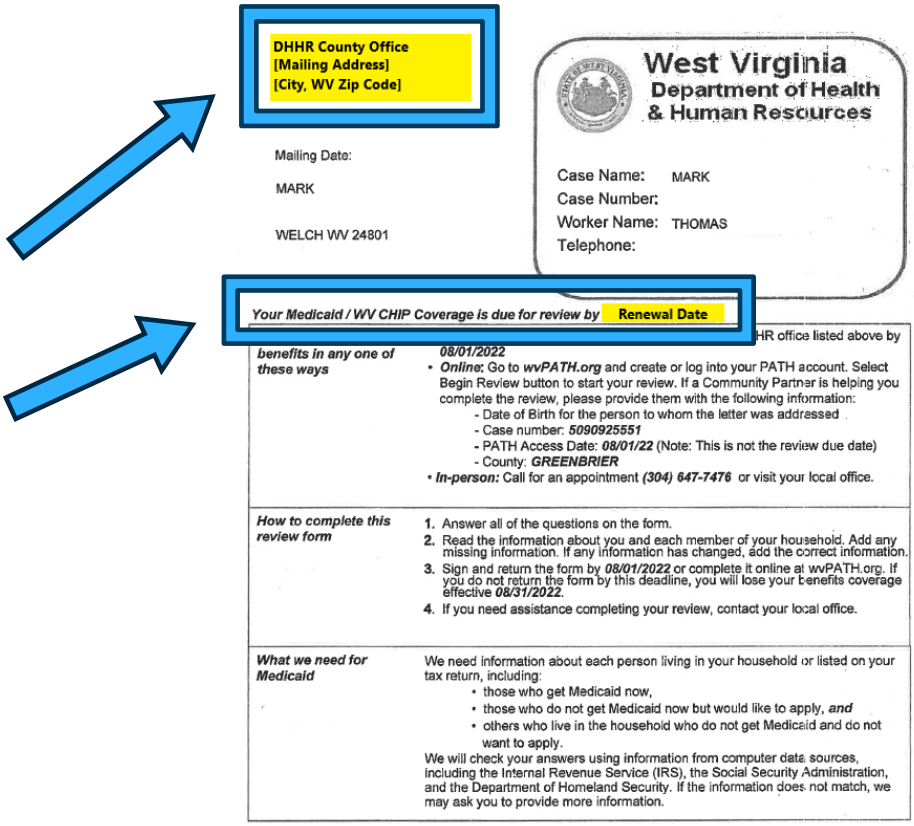
- Lawful Permanent Resident (LPR or Greencard holder)
- Asylee
- Refugee
- Cuban or Haitian entrant
- Paroled into the U.S.
- Conditional entrant granted before 1980
- Battered spouse, child and parent
- Victim of Trafficking and his/her spouse, child, sibling or parent
- Granted Withholding of Deportation 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 A)
- Applicant for Special Immigrant Juvenile Status
- Applicant for Adjustment to LPR Status
- Applicant for Asylum
- Applicant for Withholding of Deportation of 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

This completes the renewal form.

Please verify the form includes your signature on page 11.

Return the entire form to the address listed on page 1. County office addresses can also be found [at this link](#).

Mail your form by the review date listed on page 1.



DHHR County Office
[Mailing Address]
[City, WV Zip Code]

Mailing Date:

MARK

WELCH WV 24801

West Virginia
Department of Health & Human Resources

Case Name: MARK
Case Number:
Worker Name: THOMAS
Telephone:

Your Medicaid / WV CHIP Coverage is due for review by Renewal Date

HR office listed above by

benefits in any one of these ways

08/01/2022

- ***Online:*** Go to ***wvPATH.org*** and create or log into your PATH account. Select Begin Review button to start your review. If a Community Partner is helping you complete the review, please provide them with the following information:
  - Date of Birth for the person to whom the letter was addressed
  - Case number: ***5090925551***
  - PATH Access Date: ***08/01/22*** (Note: This is not the review due date)
  - County: ***GREENBRIER***
- ***In-person:*** Call for an appointment ***(304) 647-7476*** or visit your local office.

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1. Answer all of the questions on the form.
2. Read the information about you and each member of your household. Add any missing information. If any information has changed, add the correct information.
3. Sign and return the form by ***08/01/2022*** or complete it online at wvPATH.org. If you do not return the form by this deadline, you will lose your benefits coverage effective ***08/31/2022***.
4. If you need assistance completing your review, contact your local office.

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- those who get Medicaid now,
- those who do not get Medicaid now but would like to apply, ***and***
- others who live in the household who do not get Medicaid and do not want to apply.

We will check your answers using information from computer data sources, including the Internal Revenue Service (IRS), the Social Security Administration, and the Department of Homeland Security. If the information does not match, we may ask you to provide more information.