(DHS/Med-QUEST Office Name)
(Address)
(Address)
(Address)

Telephone Number XXX-XXXX
Fax Number XXX-XXXX
Case Number XXXXXXXX
Worker's Name XXXXXXXXXX

(Case Name)
(Case Mailing Address)
(Case Mailing Address)
(Case Mailing Address)

Dear XXXXXXXXXXXXXX,
It is time to renew your Med-QUEST medical assistance. Please review the information below.

A. Attach copies of last month's income, assets, and private health insurance (**even if you check "No"**).

B. If you check YES to any question, please explain your new information next to it.

C. Sign number 12 and **return this form to us by XX/XX/XXXX.** If we do not get the form and copies of income, assets, and private health insurance by this date, your medical assistance may stop. You can mail, fax, or bring them to our office.

Thank you for your time and we look forward to helping you!

YES **NO**

☐ ☐ 1. Do you want to STOP your Med-QUEST medical assistance?

Reason to Stop QUEST or Medicaid:
_____
_____

☐ ☐ 2. Did your name, address, telephone number, or email address change?

XXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXX

Changes (Name, Address, Telephone Number, or Email Address):
_____
_____
_____
_____

☐ ☐ 3. Did any of the people below move out or did anyone move in? If yes, we will contact you.

XXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXX

People Who Moved Out or Moved In:
_____
_____
_____
_____
_____

YES	NO		
☐	☐	4. Did anyone's assets change? Please attach copies of all asset balances on the first day of last month.	Asset Changes—bank accounts, home, jewelry, stocks, etc. (Owner, Type, and Value): ____ ____ ____

OWNER	TYPE	VALUE
XXXXXXXXXXXXXX	XXXXXXXXXXXXXX	$ XXX,XXX.XX
XXXXXXXXXXXXXX	XXXXXXXXXXXXXX	$ XXX,XXX.XX
XXXXXXXXXXXXXX	XXXXXXXXXXXXXX	$ XXX,XXX.XX
XXXXXXXXXXXXXX	XXXXXXXXXXXXXX	$ XXX,XXX.XX
XXXXXXXXXXXXXX	XXXXXXXXXXXXXX	$ XXX,XXX.XX
XXXXXXXXXXXXXX	XXXXXXXXXXXXXX	$ XXX,XXX.XX
XXXXXXXXXXXXXX	XXXXXXXXXXXXXX	$ XXX,XXX.XX

YES	NO		
☐	☐	5. Did anyone's monthly income change? Please attach copies of all income for the past three months. If someone is self-employed, also attach copies of business expenses.	Income Changes (Person's Name, Type, and Monthly Gross Dollar Amount): ____ ____ ____ ____ ____

NAME	TYPE	AMOUNT
XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXX	$ X,XXX.XX
XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXX	$ X,XXX.XX
XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXX	$ X,XXX.XX
XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXX	$ X,XXX.XX
XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXX	$ X,XXX.XX
XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXX	$ X,XXX.XX
XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXX	$ X,XXX.XX
XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXX	$ X,XXX.XX

YES	NO		
☐	☐	6. Did anyone have an accident during the last year? If yes, we will contact you.	Accident (Date and Who Was Involved): ____ ____ ____
☐	☐	7. Was an employed person offered health insurance by the employer for herself or himself?	Health Insurance (Person's Name, Type of Insurance, and Start Date): ____ ____ ____
☐	☐	8. Did anyone get or stop private health insurance?	Private Health Insurance (Person's Name, Type of Insurance, and Start or Stop Date): ____ ____ ____

Questions 9 and 10 are for people who entered a nursing home or started receiving nursing home services in the community during the past year.

YES **NO**

☐ ☐ 9. Did anyone sell, trade, or give away property or other resources/assets—including money—within the past 3 years? Or did they make transfers into a trust within the past 5 years? (If you gave us the information before, you do not have to explain it again).

Sold, Transferred, or Gave Away Assets (Person's Name, Type of Asset, Reason, Transfer Date, Value, and Amount Received from Sale):

_____

_____

_____

_____

_____

_____

☐ ☐ 10. Do you have a spouse and/or dependent family member living with your spouse that has income?

Spouse or Dependent Family Member's Income (Person's Name, Type, and Monthly Gross Dollar Amount):

_____

_____

_____

_____

☐ ☐ 11. Do you have other changes to report?

Other Changes:

_____

_____

_____

12. Please sign below, write the date, and mail, fax, or bring the form to our office.

I certify all the information on this form is correct after making the changes.

Signature: _____ Date _____

PLEASE REMEMBER TO ATTACH COPIES OF ALL INCOME, ASSETS, AND HEALTH INSURANCE AND RETURN THIS FORM TO US BY XX/XX/XXXX