Medicaid and Kid Care CHIP

Renewal Form

You can get this notification in another language or in large print or another way that's best for you. Call 1-855-294-2127 (TTY/TDD: 1-855-329-5204).

[PI name]
[Address]
[city, ST zip]

[Date]
Respond by: [Due Date]

It is time to renew your Medicaid or Kid Care CHIP coverage.

You can renew your Medicaid or Kid Care CHIP coverage in any one of these ways

- **Renew online!** Go to www.wesystem.wyo.gov
- **By phone:** Just call **1-855-294-2127** (TTY/TDD: 1-855-329-5204). The call is free.
- **By mail:** Complete this form and mail it to our customer service center:
  2232 Dell Range Blvd., Suite 300
  Cheyenne, WY 82009
- **By fax: 1-855-329-5205**
- **In person:** Visit our office at 2232 Dell Range Blvd., Ste. 300, Cheyenne, WY 82009. Office hours are 7:00 a.m. to 6 p.m. Monday to Friday

How to complete this renewal 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, print the right information. If more space is needed, please attach additional pages.
3. Sign the form on page 8.
4. **Return this form by [DUE DATE]**. If you do not return the form by this deadline, you will lose your Medicaid or Kid Care CHIP coverage.

What we need

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

- those who get Medicaid or Kid Care CHIP now,
- those who do not get Medicaid or Kid Care CHIP now but would like to apply, *and*
- others who 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 send more information.

If you do not qualify for Medicaid

If you do not qualify for Medicaid or Kid Care CHIP, your information may be forwarded to another program so they can see if you qualify.

1 Your contact information

▼ Review your contact information here.

[name]

Home address:

[address]
[city, st zip]

Mailing address:

[address]
city, st zip]

Phone:

Home: [phone number]
Other:

▼ Correct any wrong or missing information here.

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, if you have one:

2 We need information about who files tax returns.

You can still renew even if you did not file 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 a star ★ below

Person 1: 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:

Person 2: Name (*first, middle, last & suffix)*

This is for a second tax filer in the household

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: _____

Name of dependents: _____

_____

3 These are the people in your household who need to renew now

▶ Tell us about anybody else in your household or on your tax return.

Person 1: 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 coverage: _ _ _ – _ _ – _ _ _ _
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?

If this person has Medicaid, check here ☐.
If this person **does not** have Medicaid and wants health insurance coverage, check here ☐ and fill out Attachment A on page 9.

Person 2: 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 coverage: _ _ _ – _ _ – _ _ _ _
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?

If this person has Medicaid, check here ☐.
If this person **does not** have Medicaid and wants health insurance coverage, check here ☐ and fill out Attachment A on page 9.

Person 3 : 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 coverage: _ _ _ – _ _ – _ _ _ _
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?

If this person has Medicaid, check here ☐.
If this person **does not** have Medicaid and wants health insurance coverage, check here ☐ and fill out Attachment A on page 9.

Person 4 : 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 coverage: _ _ _ – _ _ – _ _ _ _
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?

If this person has Medicaid, check here ☐.
If this person **does not** have Medicaid and wants health insurance coverage, check here ☐ and fill out Attachment A on page 9.

Person 5 : 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 coverage: _ _ _ – _ _ – _ _ _ _
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?

If this person has Medicaid, check here ☐.
If this person **does not** have Medicaid and wants health insurance coverage, check here ☐ and fill out Attachment A on page 9.

4 Tell us about anyone who has *other* health insurance coverage

▶ Include anyone you listed in Section 3 and anyone who is applying for health insurance coverage.

Name of insurance company: | Policy number:

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

☐ Employer Sponsored Insurance

List everyone who is on this policy:

Name of insurance company: | Policy number:

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

☐ Employer Sponsored Insurance

List everyone who is on this policy:

▶ If anyone on this form is offered health insurance through a job, check here ☐
If this a State of Wyoming employee benefit plan, check here ☐

5 Tell us more about the people listed on this form

▶ If anyone who is renewing or applying has a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home, write his or her name here.

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

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

▶ If anyone who is renewing or applying for health insurance coverage 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):*

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

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

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

What is the expected delivery date?

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

What is the expected delivery date?

▶ If anyone listed on this form is currently receiving treatment for breast or cervical cancer, write their name here. If so, please provide current verification from your treating provider.

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

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

▶ If anyone who is renewing or applying is an American Indian or Alaska Native, check here ☐
and fill out Attachment B on page 10.

6 Tell us about work

▶ Fill in the information below for anyone in your household who has income from a job (**not** self-employed). You can tell us about **self-employment** on the next page. If someone has more than one job, tell us about **all jobs**. *Make a copy of this page if you need space for more jobs or people. Cross out any information that is **not correct** about members of your household. Write in the new information.*

Job 1: Name of the person who is working (*first, middle, last & suffix):*

Employer name: | **Employer** phone number:

Employer address: | City: | State: | ZIP code:

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

How much does this person get paid (before taxes)?

Average hours worked each week:

Job 2: Name of the person who is working (*first, middle, last & suffix):*

Employer name: | **Employer** phone number:

Employer address: | City: | State: | ZIP code:

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

How much does this person get paid (before taxes)? **$** _____

Average hours worked each week:

Job 3: Name of the person who is working (*first, middle, last & suffix):*

Employer name: | **Employer** phone number:

Employer address: | City: | State: | ZIP code:

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

How much does this person get paid (before taxes)? **$** _____

Average hours worked each week:

Job 4: Name of the person who is working (*first, middle, last & suffix):*

Employer name: | **Employer** phone number:

Employer address: | City: | State: | ZIP code:

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

How much does this person get paid (before taxes)? **$** _____

Average hours worked each week:

Job 5: Name of the person who is working (*first, middle, last & suffix):*

Employer name: | **Employer** phone number:

Employer address: | City: | State: | ZIP code:

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

How much does this person get paid (before taxes)? **$** _____

Average hours worked each week:

***Section 6** continued on next page ▶▶▶*

6 Tell us about work *(continued)*

▶ If anyone in your household is **self-employed**, we need to know about their work.

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

Type of work:

How much *net income* will this person get from self-employment this month? Amount: **$**_____
Net income means the profits left over after business expenses are paid. For more information about business expenses, see Attachment D on page 12.

2. Name (*first, middle, last & suffix)*:

Type of work:

How much *net income* will this person get from self-employment this month? Amount: **$**_____
Net income means the profits left over after business expenses are paid. For more information about business expenses, see Attachment D on page 12.

7 Tell us about other income

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

Unemployment	**How much?**	**How often?**		
Name (*first, middle, last & suffix):*	**$**	☐ Hourly ☐ Weekly	☐ Every two weeks ☐ Twice a month	☐ Monthly ☐ Yearly
Social Security	**How much?**	**How often?**		
Name (*first, middle, last & suffix):*	**$**	☐ Hourly ☐ Weekly	☐ Every two weeks ☐ Twice a month	☐ Monthly ☐ Yearly
Pensions	**How much?**	**How often?**		
Name (*first, middle, last & suffix):*	**$**	☐ Hourly ☐ Weekly	☐ Every two weeks ☐ Twice a month	☐ Monthly ☐ Yearly
Retirement accounts				
Name (*first, middle, last & suffix):*	**$**	☐ Hourly ☐ Weekly	☐ Every two weeks ☐ Twice a month	☐ Monthly ☐ Yearly

***Section 7** continued on next page ▶▶▶*

7 Tell us about other income *(continued)*

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

Alimony received	**How much?**	**How often?**		
Name (*first, middle, last & suffix):*	$	☐ Hourly ☐ Weekly	☐ Every two weeks ☐ Twice a month	☐ Monthly ☐ Yearly
Farming or fishing *(profit after business expenses)*	**How much?**	**How often?**		
Name (*first, middle, last & suffix):*	$	☐ Hourly ☐ Weekly	☐ Every two weeks ☐ Twice a month	☐ Monthly ☐ Yearly
Rental income or royalties *(profit after business expens es)*	**How much?**	**How often?**		
Name (*first, middle, last & suffix):*	$	☐ Hourly ☐ Weekly	☐ Every two weeks ☐ Twice a month	☐ Monthly ☐ Yearly
Other income Type: _____	**How much?**	**How often?**		
Name (*first, middle, last & suffix):*	$	☐ Hourly ☐ Weekly	☐ Every two weeks ☐ Twice a month	☐ Monthly ☐ Yearly
Other income Type: _____	**How much?**	**How often?**		
Name (*first, middle, last & suffix):*	$	☐ Hourly ☐ Weekly	☐ Every two weeks ☐ Twice a month	☐ Monthly ☐ Yearly

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

Alimony paid to someone else	**How much?**	**How often?**		
Name (*first, middle, last & suffix)*:	$	☐ Weekly	☐ Every two weeks ☐ Twice a month	☐ Monthly ☐ Yearly
Student loan interest paid	**How much?**	**How often?**		
Name (*first, middle, last & suffix)*:	$	☐ Weekly	☐ Every two weeks ☐ Twice a month	☐ Monthly ☐ Yearly
Dependent care expenses	**How much?**	**How often?**		
Name (*first, middle, last & suffix)*:	$	☐ Weekly	☐ Every two weeks ☐ Twice a month	☐ Monthly ☐ Yearly

▶ List the names of anyone whose income **changes** from month to month. Also tell us how much you think their income will be for the year.

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

What do you expect his or her income to be **this** year? Amount: $

2. Name (*first, middle, last & suffix):*

What do you expect his or her income to be **this** year? Amount: $

9 Read and sign this application

Renewal of coverage in future years

▶ Read the statement below and check **one** box.

To make it easier to check my income at renewal time, I give permission to the [state agency] to use income information from my tax returns for the number of years I checked below.

I understand that the [state agency] will send me a letter with the income information they have. I can make changes to it. I can also change my mind and not allow the [state agency] to check this information.

Yes, I give permission to check my income on tax returns for (check one box):

☐ 5 years (the longest time) ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year

☐ No, I do not give permission to use my tax returns.

Your rights and responsibilities

▶ Read the statements below.

- I am signing this renewal form under penalty of perjury. That means that I have provided true answers to all the questions on this form to the best of my knowledge, and I know that I may be subject to penalties under federal law if I provide false or untrue information.
- I must tell the Wyoming Department of Health if anything changes and is different from what I wrote on this form. I can call the Customer Service Center at 1-855-294-2127 or visit www.wesystem.wyo.gov to report any changes. I understand that a change in my information might affect whether someone in my household qualifies for coverage.
- I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting hhs.gov/ocr/office/file.
- If I think Wyoming Medicaid or Kid Care CHIP has made a mistake, I can appeal its decision. To appeal means to tell someone at the Wyoming Department of Health that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting Customer Service Center at 1-855-294-2127. Someone from the Customer Service Center will explain anything about this application to me if I need that.
- I understand that if I do not qualify for Medicaid or Kid Care CHIP, the Wyoming Department of Health may send my information to another program so they can see if I qualify.

▶ Sign and date below. If you want an authorized representative or want to change the authorized representative you have now, fill out Attachment C on page 11.

If you are an authorized representative, check here ☐, sign below, and fill out Attachment C on page 11.

Signature of household contact or authorized representative: Date:

Attachment A

People applying for the first time

To help you fill out Section 3, page 3

Tell us about anyone in your household who wants to apply for Medicaid. **Do not answer** these question for people **who already have Medicaid or Kid Care CHIP**. *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,*** go to "Tell us more information about this person"
☐ No ***If no,*** answer all of the questions below.

If this person has eligible immigration status, check here ☐ and fill in the document type: _____
and ID number: _____. See Attachment D on page 12 for more information about eligible immigration status and document types.

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 18, 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
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander
- ☐ Other

Attachment B

American Indian or Alaska Native family member (AI/AN) *To help you fill out Section 5, page 6*

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

2. 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

Attachment C — Assistance with completing this application

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.
- Do you want an authorized representative? ☐ Yes ☐ No

If yes, you want an authorized representative, answer the questions below.

We show that you chose this person as your authorized representative:	Do you still want this person to be your authorized representative?
Not applicable	☐ Yes ☐ No ***If yes,*** has any of his or her information changed? ☐ Yes ☐ No

If your authorized representative's information has **changed**, or if you would like a **different** authorized representative, please write the new information here:

Name of authorized representative:

Address: Apartment # City State ZIP code

Phone number: ☐ Home ☐ Cell ☐ Work ☐ Other

Number:

By signing, you allow this person to sign your renewal form, to get information about this renewal form, and to act for you with this agency.

Your signature: Date:

Attachment D

Helpful information about immigration statusand document types, and self-employment business expenses *To help you fill out Section 3, page 3 and Section 6, page 6*

Eligible immigration status list

▶ If you see the person's status below, go back to Section 3, page 3 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 Arrivals (DACA) is not an eligible immigration status for applying for health insurance
- Applicant for Special Immigrant Juvenile Status
- Applicant for Adjustment to LPR Status
- Applicant for Asylum
- Applicant for Withholding of Deportation or 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

Immigration document types

▶ Eligible non-citizens applying for health coverage also need to list their immigration document. Below are some common types. If the document you have is not listed, you can still write its name. If you are not sure, or you have an eligible status but no document, call 1-800-123-4567 so we can help.

- Permanent Resident Card (I-551, also known as Green Card)
- Temporary I-551 Stamp (on passport or I-94, I-94A)
- Immigrant Visa (with temporary I-551 language)
- Employment Authorization Card (EAD or I-766)
- Arrival/Departure Record (I-94 or I-94A)
- Arrival/Departure Record in foreign passport (I-94)
- Foreign passport
- Reentry Permit (I-327)
- Refugee travel document (I-571)
- Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20)
- Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)
- Notice of Action (I-797)
- Other document with an Alien Number or I-94 number, or other document showing you have an eligible immigration status listed above

Self-employment business expenses

▶ You can subtract the business expenses listed below from your gross income to get an amount for your net self-employment income.

- Car and truck expenses (for travel during the workday, not commuting)
- Depreciation
- Employee wages and fringe benefits
- Property, liability, or business interruption insurance
- Interest (including mortgage interest paid to banks, etc.)
- Legal and professional services
- Rent or lease of business property and utilities
- Commissions, taxes, licenses and fees
- Advertising
- Contract labor
- Repairs and maintenance
- Certain business travel and meals
- Deductible self-employment taxes
- Cost of self-employed health insurance
- Contributions to a self-employed SEP, SIMPLE, or qualified retirement plan