

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

A. If you check NO to all the questions, all information is correct, and you do not have new information, do not return this form. However, if a change occurs in the future, you must call or write to Med-QUEST within 10 days of when you learn of the change.

B. If you check YES to any question, please explain your new information next to it, sign number 11, and return this form to us by XX/XX/XXXX. You can mail, fax, or bring it 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?

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

XXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXX

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

People Who Moved Out or Moved In:

XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXX

4. Did anyone's assets change?

Asset Changes—bank accounts, home, jewelry stocks, etc. (Owner, Type, and Value):

OWNER	TYPE	VALUE
XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	\$ XXX,XXX.XX
XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	\$ XXX,XXX.XX
XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	\$ XXX,XXX.XX
XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	\$ XXX,XXX.XX
XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	\$ XXX,XXX.XX
XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	\$ XXX,XXX.XX
XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	\$ XXX,XXX.XX

YES NO

5. Did anyone's monthly income change?

NAME	TYPE	AMOUNT
XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	\$ X,XXX.XX
XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	\$ X,XXX.XX
XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	\$ X,XXX.XX
XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	\$ X,XXX.XX
XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	\$ X,XXX.XX
XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	\$ X,XXX.XX
XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	\$ X,XXX.XX

Income Changes (Person's Name, Type, and Monthly Gross Dollar Amount):

6. Did your child care expenses change?

PAYER	CHILD	COST
XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	\$ XXXXXX
XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	\$ XXXXXX
XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	\$ XXXXXX
XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	\$ XXXXXX

Child Care Expense Changes (Payer, Child's Name, and Monthly Dollar Amount):

7. Did anyone have an accident during the last year? If yes, we will contact you.

Accident (Date and Who Was Involved):

8. 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):

9. Did anyone get or stop private health insurance?

NAME	TYPE
XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX

Private Health Insurance (Person's Name, Type of Insurance, and Start or Stop Date):

10. Do you have other changes to report?

Other Changes: _____

11. If there is a change, 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 _____

YOU DO NOT NEED TO RETURN THIS FORM OR CONTACT OUR OFFICE IF YOU DID NOT CHANGE OR ADD INFORMATION