

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

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

(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. 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? 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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

XXXXXXXXXXXXXXXXXXXXXXXXX      XXXXXXXXXXXXXXXXXXXXXXXX  
XXXXXXXXXXXXXXXXXXXXXXXXX      XXXXXXXXXXXXXXXXXXXXXXXX  
XXXXXXXXXXXXXXXXXXXXXXXXX      XXXXXXXXXXXXXXXXXXXXXXXX  
XXXXXXXXXXXXXXXXXXXXXXXXX      XXXXXXXXXXXXXXXXXXXXXXXX  
XXXXXXXXXXXXXXXXXXXXXXXXX      XXXXXXXXXXXXXXXXXXXXXXXX  
XXXXXXXXXXXXXXXXXXXXXXXXX      XXXXXXXXXXXXXXXXXXXXXXXX  
XXXXXXXXXXXXXXXXXXXXXXXXX      XXXXXXXXXXXXXXXXXXXXXXXX

YES NO

4. Did anyone's assets change? Please attach copies of all asset balances on the first day of last month.

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

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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.

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

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**