FLORIDA

P. 1

January 30 1999

DENISE

SUNRISE FL 33323-2646

RE: ANNUAL RENEWAL NOTICE FOR: DANIEL, STEVEN, CHRISTOPHER
FAMILY ACCOUNT NUMBER: 3591

Dear Dear DENISE ·

Healthy Kids and KidCare looks forward to your continued participation. We are writing to confirm the information on your child(ren)'s record(s) and to verify your monthly payment amount.

We currently have the following information on file:

Household Size:	Number of Children: 3		Number of Adults:	1
Gross Monthly Household Income:	$ 2,080.00			
1st Parent/Guardian:	DENISE		SS#:	-3591
Address:		SUNRISE, FL 33323-2646		
Phone:	Home: -4537		Work:	-7373
2nd Parent/Guardian:			SS#:	
Phone:	Work:			
Emergency Contact:	PHYLLIS			
Phone:	-4537			

PREMIUM AMOUNT: $15.00 **EFFECTIVE MARCH 1, 1999 FOR APRIL 1, 1999 COVERAGE.**

Renewal will take place automatically as long as your child(ren) remain eligible and all applicable premiums have been paid. It is not necessary to call us if the above information is correct.

Enclosed with this letter is an account record status report on each child in your family. To report changes to the information provided in this letter, please contact Healthy Kids and KidCare toll free at 1-800-821-KIDS (5437).

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August 1, 1999

Status Report (Family Record)

Parent Name: **DENISE**
Family Account Number: **23591**

Child(ren)'s Name	Child(ren) SSN	Account Status* October, 1999	Program
DANIEL	-6910	Active	HK
STEVEN	-3904	Active	HK
CHRISTOPHER	-6280	Active	HK

Monthly Payment: $ 15.00

Balance on Account: $ 30.00

If the information on this status report appears inaccurate, please contact us as soon as possible at 1-800-821-KIDS (5437).

*Account Status:

Active	= Insurance coverage for the month listed above.
Cancelled	= Account cancelled effective the first of the month listed above.
Hold	= Non open enrollment.
Inactive	= Account cancelled for more than 2 months.
Pending	= New application awaiting either premium payment or other eligibility verification.
Suspended	= New application which pended without adequate premium or other eligibility verification for over 90 days.
Rejected	= Application rejected during verification of eligibility process.
Payment Overdue	= Payment not received to activate account for month.

Note: This information is accurate as of date listed. The eligibility, balance and payment information is subject to change based on family's continued compliance with eligibility criteria and timely payment.

NOW YOU CAN AFFORD PEACE OF MIND

PeachCare for Kids
Post Office Box 2583
Atlanta, GA 30301-2583
1-877 GA PEACH (427-3224)

GEORGIA

P. 1

June 4, 2001

RE: RENEWAL NOTICE FOR:
FAMILY ACCOUNT NUMBER:

Dear :

PeachCare for Kids looks forward to your continued participation. We are writing to confirm the information on your child(ren)'s record(s) and to verify your monthly payment amount.

We currently have the following information on file:
Gross Household Income/Expenses:

Source	Amount	Period	Person	Employer
Current Employer		Weekly		
Current Employer		Weekly		

1st Parent/Guardian: SS#:
Address:
Phone: Home: Work:
2nd Parent/Guardian: SS#:
Phone: Work:
Emergency Contact:
Phone:

PREMIUM AMOUNT: **$15.00** **EFFECTIVE JULY 1, 2001 FOR AUGUST 1, 2001 COVERAGE.**

Renewal will take place automatically as long as your child(ren) remain eligible and all applicable premiums have been paid. It is not necessary to call us if the above information is correct.

Please remember that you must report any change in your income and circumstances within ten (10)

NOW YOU CAN AFFORD PEACE OF MIND

PeachCare for Kids

Post Office Box 2583
Atlanta, GA 30301-2583
1-877 GA PEACH (427-3224)

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days of becoming aware of change in order to continue to be eligible for PeachCare. To report changes to the information provided in this letter, please contact PeachCare For Kids toll free at 1-877-GA-PEACH (1-877-427-3224).

Please remember, payments are due 30 days in advance. If your payment is late, you may risk cancellation. If your child(ren)'s coverage is cancelled, you will have to pay one month of premium before reinstatement can occur.

You will receive a new payment coupon book within a few weeks. If you have payments due before your payment book arrives, send your payment to this address:

PEACHCARE for Kids Payments
P. O. Box 105864
Atlanta, GA 30348-5864

Thank you for your involvement in your child(ren)'s health.

Sincerely,

PeachCare for Kids

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Nevada ✓ Check Up
Division of Health Care Financing and Policy
1100 E. William Street, Suite 116
Carson City, NV 89701

Nevada ✓ Check Up Annual Redetermination Form

Important. Please read!
Importante. ¡Por favor lea!

It's easy! You have to sign & return this form to Nevada Check Up by June 01, 2001 ONLY if you have changes to your information.
Failure to report CHANGES may result in DISENROLLMENT from the Nevada Check Up program. Audits will be conducted randomly on samples of Nevada Check Up families.

¡Esta facil! Necesitamos firme y devuelva esta forma a Nevada Check Up para el 06/01/2001 si SOLAMENTE usted tiene cambios.
Si falla al reportar cambios, puede resultar en desenrolamiento del programa de Nevada Check Up. Auditorias al azar serán conducidas.

Lea bien esta información. Haga los cambios necesario si necesita ayuda, llamenos a Nevada Check Up al 1 (800) 360-6044 extension 8.

FAMILY ID NUMBER / NUMERO de IDENTIFICACION de la FAMILIA:

Date Printed
4/23/01 2:00 02 PM

DEAR :

It is the time of year when we need to update our records with any changes in your household.

HEAD OF HOUSEHOLD / JEFE DE FAMILIA:

Current Information / Información Actual:	Changes / Cambios:
Full Name:	
SSN:	
DOB:	
Home Phone:	
Residence:	
Mailing:	
Family members living at this address:	

OTHER ADULTS / OTROS ADULTOS:

Full Name:	
SSN:	
DOB:	

CHILDREN / NIÑOS:

Child's Name:	
SSN:	
DOB:	

Gender:

Ethnicity:

US Citizen/Resident Alien:

Child has Special Needs:

ADAN'S CURRENT NEVADA CHECK UP ENROLLMENT INFORMATION

Currently covered by Nevada Check Up Insurance:

Type of Coverage:

Name of HMO:

Child's Name:

SSN:

DOB:

Gender:

Ethnicity:

US Citizen/Resident Alien:

Child has Special Needs:

JENNIFER'S CURRENT NEVADA CHECK UP ENROLLMENT INFORMATION

Currently covered by Nevada Check Up Insurance:

Type of Coverage:

Name of HMO:

EMPLOYMENT* / EMPLEO *: (Only report changes / Solamente reporte cambios)

Name of Employed:

Employer:

Work Phone:

How often Paid:

Gross Pay:

Gross Pay Per Year:

*If your EMPLOYMENT information or OTHER INCOME has changed:

You must provide proof of income by attaching copies of the two most recent pay stubs from each job.
If you are self employed you must provide a copy of your most recent federal tax return.
If you have no employment information, then you must provide proof of your income and the source(s) where you receive it.

OTHER INCOME* / OTRO INGRESO*: (Only report changes / Solamente reporte cambios)

OTHER INFORMATION / OTRA INFORMACIÓN:

Is anyone in the household pregnant? Yes: ________ No: ________

If yes, what is the name of the pregnant mother? ________________________ What is the due date? ________________________

List the payments made for child care for anyone working in your household.

Name of Person(s) Paying for Child Care	Name of Child	Name of Provider	Cost of Child Care
			$_______.____ Per
			$_______.____ Per

HEALTH PLAN CHOICES / OPCIONES DE PLANES DE SALUD**:

Once a year Nevada Check Up allows you to change your current Health Maintenance Organization (HMO). It is not necessary for you to change if you are happy with your current HMO. If you choose to change your HMO, it will be effective August 01, 2001.
****Si le gustaría puede cambiar de plan de salud.**

If you would like to change your child's HMO, please mark an "X" next to the HMO you would like. Please refer to the "Name of HMO" under your child's "current Nevada Check Up enrollment information" to see which HMO you currently have.

☐ **Health Plan of Nevada (20)**
Participant Services: (702) 242-7317
Service Area: Clark County zip codes: 89005, 89006, 89009, 89012, 89014-89016, 89030-89033, 89036, 89052, 89053, 89101-89104, 89106-89110, 89112-89135, 89137, 89139, 89141-89149, 89154, 89156, 89160, 89170, 89173, 89177, 89180, 89185, 89193 & 89199

☐ **NevadaCare(South) (25)**
Participant Services: (702) 474-7241
Service Area: All zip codes in Clark County

☐ **United Health Care Of Nevada (30)**
Participant Services: (800) 224-3429
Service Area: All zip codes in Clark County

☐ My child no longer needs the Nevada ✓Check Up program. Please disenroll from your program.

"Check box to disenroll" Reason for disenrollment: ______________________________

I hereby apply for Nevada Check Up services and certify all of the information contained herein is true and correct to the best of my knowledge and that no facts have been omitted. I understand that verification of the information is necessary and may be obtained upon request. I understand that I may be asked to provide additional information. I further understand the law provides penalties for person(s) hiding facts or not telling the truth. I will report, within 30 days the following information for my child: 1) child moves out of state, 2) becomes eligible for Medicaid, 3) gets other health insurance, 4) dies, or 5) becomes a resident or inmate of a public institution for more than 30 days.

The Department of Human Resources, Division of Health Care Financing and Policy, provides services WITHOUT DISCRIMINATION OF ANY KIND due to race, national origin, color, gender, religion, age, disability, or sex as required by federal regulations.

I hereby authorize the Department of Human Resources to make any investigation concerning the information supplied on this application necessary to establish or continue eligibility for the Nevada Check Up program. I hereby authorize and consent to the release of any and all information concerning me and my family to the Department of Human Resources by the holder of the information, regardless of the manner of form held, including, without limitation, information made confidential by law or otherwise. I hereby release the holder of such information from liability, if any, resulting from the disclosure of the required information. I authorize the Department of Human Resources or provider agency to contact my employer to obtain wage and health insurance information. A reproduced copy of the authorization legally constitutes an original copy.

SIGNATURE: ______________________________ **DATE:** ____________________

Nevada Check Up Program
1100 E. William Street, Suite 116
Carson City, NV 89701
(775) 687-4176 ext. 5
Para Español (775) 687-4176 ext. 8
Statewide Toll Free 1-(800) 360-6044

SOUTH CAROLINA

MEDICAID PASSIVE REVIEW FORM

FROM:

Date: **06/29/2001**
WorkerÃ: **AT26**
Telephone: **803 231-2155**
BGÃ:

TO:

RE: PARTNERS FOR HEALTHY CHILDREN RENEWAL NOTICE

Dear:

Partners for Healthy Children look forward to your continued participation. We are writing to see if there have been any changes in your income or changes in the family members who live with you.

Please answer the following questions. If all of the answers are no, you do not need to do anything. If any of the answers are yes, please fill in the information and sign below, and mail this letter to your local Department of Social Services (DSS) office, at the address above, within 30 days from the date of this letter.

1. Has your income changed in the past year? Yes or No
   If the answer is yes, how did it change? From $________ to $________
   Provide copies of pay stubs for the last four weeks or other proof of your earnings.
2. Have any family members moved in or out of your home in the past year? Yes or no
   If yes, did they ___ move in or did they ___ move out?
   Please list this person(s) name and how this person(s) is related to you?
   ____
   ____
3. If you pay for care for children under 12 and/or dependent adults, is the number you pay for fewer now than a year ago? Yes or no
   If yes, how many children under age 12 and dependent adults do you pay for?
   Children under 12 ____ dependent adults ____

If there have been any changes, fill in the information and sign and return this letter to your local DSS office within 30 days. If there are no changes, DO NOT RETURN THIS LETTER. If you have any questions, you can call your local DSS office.

Signed: ______________________________ Date: ______________

CHIP Renewal Information

MAR 2003

This is the one that goes out when we have not received info about a new job.
xxx are fields that are preprinted from our system.

UTAH

HEALTH-BUREAU OF ELIG SERVICES
6671 S REDWOOD RD
SUITE 110
WEST JORDAN UT 84084-7488

Mailing Address
[redacted]
[redacted]
[redacted] UT 84118-4767

(801) [redacted]

Return Address
HEALTH-BUREAU OF ELIG SERVICES
6671 S REDWOOD RD
SUITE 110
WEST JORDAN UT 84084-7488

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)
Annual Renewal

YOUR CHIP ID#: **XXXXXXX** **Your CHIP Representative's phone number: (XXX) XXX-XXXX**

To renew your child(ren)'s benefits for another 12 months, please circle "yes" or "no" whether any of the following information has changed in the past 12 months. Please answer all questions.

1. Have you had any change in your household size? YES NO
   Current children receiving benefits: XXXXX XXXXXX
   XXXX XXXXX
   XXXXXX XXXXXX

   Other members in the household: XXXX XXXXXXX
   XXXXXXX XXXXX

2. Has any adult in the household changed employers in the past 12 months? YES NO

3. Do any of your children have health insurance? YES NO

4. Do your children have health insurance available, even if you have not currently purchased it? YES NO
   (not including CHIP or Medicaid)

5. Has there been any change in yours or your spouses' household income from that listed below? YES NO

Person	$ Dollar Amount	Type of Income
XXXXXX XXXXX	$ XXXXX	XXXXXXXXXX

If you answered "yes" to ANY of these questions, you MUST CONTACT the eligibility office by Date auto in PACMIS.

To report changes over the phone, call WORKER NAME at (XXX) XXX-XXXX to renew your child(ren)'s benefits.

If you would like to mail or FAX this renewal form, then please cross out any incorrect information below, write in the correct information, sign below and mail it to the return address listed above, or FAX it to (XXX) XXX-XXXX.

Please note, income guidelines increase annually, so if there was a change in your income, you may still be eligible for CHIP benefits.

I verify that with the noted changes made all information is true and correct. ______________________
Signature

If you answered "no" to ALL these questions, you do not need to return this form or contact the office. Your child(ren)'s CHIP benefits will be renewed for another 12 months. Please remember, you are required at this time to report any changes that may affect your child(ren)'s CHIP eligibility. Knowingly providing false information, or failure to report a change, may result in administrative, civil, or criminal action.

Si necesita ayuda en español, por favor llame al *worker phone #*. Los beneficios de CHIP terminarán el *date*, si no responde.

CHIP Renewal Information

MAR 2003

This is the form that goes out when we have received info that the person has changed jobs, so we require the form to be returned.

UTAH

HEALTH-BUREAU OF ELIG SERVICES
6671 S REDWOOD RD
SUITE 110
WEST JORDAN UT 84084-7488

Mailing Address
[redacted]
[redacted]
[redacted] UT 84118-4767

(801) [redacted]

Return Address
HEALTH-BUREAU OF ELIG SERVICES
6671 S REDWOOD RD
SUITE 110
WEST JORDAN UT 84084-7488

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)
Annual Renewal

YOUR CHIP ID#: **XXXXXXX** **Your CHIP Representative's phone number: (XXX) XXX-XXXX**

Your child(ren)'s CHIP benefits will terminate on <date> if this annual renewal is not completed by <date>

To renew your child(ren)'s benefits for another 12 months, please circle "yes" or "no" whether any of the following information has changed in the past 12 months. Please answer all questions.

1. Have you had any change in your household size? YES NO
   Current children receiving benefits: XXXXX XXXXXX
   XXXX XXXXX
   XXXXXX XXXXXX

   Other members in the household: XXXX XXXXXXX
   XXXXXXX XXXXX

2. Has any adult in the household changed employers in the past 12 months? YES NO

3. Do any of your children have health insurance? YES NO

4. Do your children have health insurance available, even if you have not currently purchased it? (not including CHIP or Medicaid) YES NO

5. Has there been any change in yours or your spouses' household income from that listed below? YES NO

Person	$ Dollar Amount	Type of Income
XXXXXX XXXXX	$ XXXXX	XXXXXXXXXX

To report changes over the phone, call WORKER NAME at (XXX) XXX-XXXX to renew your child(ren)'s benefits.

If you would like to mail or FAX this renewal form, then please cross out any incorrect information below, write in the correct information, sign below and mail it to the return address listed above, or FAX it to (XXX) XXX-XXXX.

Please note, income guidelines increase annually, so if there was a change in your income, you may still be eligible for CHIP benefits.

I verify that with the noted changes made all information is true and correct. ______________________
Signature

Si necesita ayuda en español, por favor llame al *worker phone #*. Los beneficios de CHIP terminarán el *date* , si no responde.

This is the notice we sent when we receive a new hire alert. If the person doesn't respond, we can discontinue coverage. If they complete the bottom section, we can treat it as a renewal and certify another 12 months.

UTAH

NEW HIRE ALERT OR INCOME CHANGE NOTICE

Title: New Employment - Information Needed (ALEC)

We have received new employment information for ______________________________.
Please fill out the health insurance questions on this form and send it to this office or call your worker at ____________________, by ______________________________. If you do not do this, your Children's Health Insurance Program (CHIP) will be closed effective ____________________.

****

Health Insurance Information

Can your children enroll in health insurance through your employer? Yes / No (circle one)
If yes, when can they enroll? ______________________________

Please call your worker immediately if your children have been enrolled, or are going to be enrolled in Health Insurance.

****

To allow us to do a renewal and extend your CHIP coverage for another 12 months, please answer the following questions. If you do not give us the information, we will not be able to extend your coverage. Instead, we will review your eligibility during ____________________.

Company Name: ______________________________
Company Address: ______________________________
Company Phone: ______________________________

My job is (circle one): Full-Time / Part-Time / Temporary
If temporary, when will it end? ______________________________
List your wage, piece rate, or salary: Wage $____________ per hour / Piece Rate $____________
Salary $____________________per month.
How many hours do you normally work each week? ______________________________
How often are you paid (Circle one)? Weekly / Every 2 weeks / Once per month / Twice per month / Other (Explain) ______________________________
What day of the week or month is your paycheck available? ______________________________
Do you receive tips, commissions, or bonuses? Yes / No
If yes, explain ______________________________

The above action is based on CHIP Policy, Section 804