

Renewal Notice

Denail Care &



Denai Care Denai Kidoare t's Time to Renew Your

Here is what you need to do:

- 1. Read this form and make sure this information is correct.
- Cross out any old information and write in your new information.
- 3. If you have any questions about your outside of Anchorage or 269-5777 in benefits, please call us at 1-888-804-6330 Anchorage.



delayed if the completed renewal form is not received before your Denali Care/Denali KidCare coverage ends. Your new Denali Care/Denali KidCare card may be



Medical Assistance Manual Section 5005-7 supports this action.



	Home	Home
	Phone	Home Address:
	Home Phone Number:	Ġ
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Please Print Clearly If more space is needed, attach a separate sheet

IS THE INFORMATION SHOWN ABOVE CORRECT?

Yes
No If no, please show changes in boxes below:

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DENALI CARE/DENALI KIDCARE SYSTEM:

CURRENT HOUSEHOLD AND OTHER INSURANCE INFORMATION SHOWN IN THE

If a person listed below no longer lives in your home, please draw a line through their name and write the date they moved out. Report new people living in your home in the gold boxes under Reporting Changes in Your Household section below. Please fill in Social security Number for those applying for assistance.

	Name	A COLOR OF THE COLOR OF T	Social Security Number	Relationship to you

KETOKIIZA CHAZGEVIZ KOCK HOCVEHOLD:

To request medical coverage for any household members not currently receiving Denail. Care or Denail KidCare, please provide the following information:	hold members following infor	not currer mation:	itly receiving Dena		Complete only for household m Denall Care/Denall KidCar	nly fo I Care	r hous Denal	ehold i KidC	mem are c	plete only for household members needing Denali Care/Denali KidCare coverage	
Last Name, First Name, Middle Initial	Relationship to you	Does this person need coverage?	If yes, please list Social Security Number*	Date of Birth	Are both Parents Ilving in the	Gender M/F (Race optional)	US A	farital Status	Are both Gender Race US Marital Allen ID Numbert Full-time Parents (M / F Toptional V / Nr Status (If Applicable) Y / N None? Y / N	Full-time Student? Y/N
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*Required only for those who will be receiving coverage through Denall Care/Denall KidCare.

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☐ Yes ☐ No If yes, please list their names:	OTHER INFORMATION: Are there any new household members covered by Tribal or Indian Health Service?
se list their names:_	ON: Are there any
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E) PREGNANCY INFORMATION:

If anyone in the household is pregnant, please complete the following:

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HEALTH INSURANCE CHANGES

S S Did any household members begin receiving employer-provided or personal health insurance, Medicare, TRICARE, or VA Benefits in the last six months?

| Yes | No | If yes, please complete the following:

Name of person(s) covered	Name of insurance company, address, city, state	Insurance compar	y Start Group Policy holder(s) Circle all types of coverage date number Social Security No.
			Major Medical - Dental - Vision - Höspita Student Only - Worker's Comp. ≟Other
			Major Medical - Dental - Vision - Hospital Student Only - Worker's Comp. Other

ద్ద Did anyone in your household have health insurance cancelled or stopped within the last 12 months? □ Yes □ No If yes, please complete the following:

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INCOME INFORMATION AND CHANGES:

The Denali Care/Denali KidCare system shows the following people receive income in your household. If a person listed is no longer employed, if the amount of income has changed, or if there have been other changes in employment or income, please draw a line through this pre-printed information and write the reason for change. Make other changes by completing the information in the gold box below

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If the information listed in the blue box above has changed, or if there are new people living in the household receiving income not shown in the blue box, please complete the income information in the *gold* box below. Income includes wages, tips, self-employment income, dividends and interest, and any other earned or unearned income.

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Rights and Responsibilities

Social Security Number

Social Security Numbers (SSN) are required, in accordance with 42 CFR 435.910, only for those who will be receiving coverage through Denali Care/Denali KidCare. Social Security Numbers are matched with the records of other agencies such as the Social Security Administration, Internal Revenue Service, Department of Labor etc., to verify eligibility.

Citizensnip

Citizenship information is required only for those who will be receiving Denali Care/Denali KidCare

I understand that:

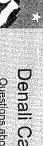
- I must report the following changes within 10 days; changes in physical and mailing addresses; a household member moves into or out of the home; change in state residency; anyone starts or stops a job, has a change in rate of pay or their employment status; change in health insurance coverage; change in unearned income; and change in pregnancy.
- state for the value of any continued benefits I received while waiting for a fair hearing decision if the hearing decision is not in my favor. I can request a fair hearing if I do not agree with the decision made on this renewal form. I can make this request in person to any State of Alaska Public Assistance office. I understand that I may be required to repay the
- Denali Care/Denali KidCare eligibility will not be affected by race, color, age, religious creed, national origin, sex, disability or political belief.
- I may have to prove eligibility for Denali Care/Denali KidCare and that my situation is subject to verification by the Department and other state or federal agencies.
- By applying for and receiving Denali Care/Denali KidCare coverage, I assign to the State of Alaska all rights to any medical support or other third party payment for medical care.
- It is my responsibility to cooperate with Child Support Services Division in obtaining medical support and establishing paternity for each child who has a parent absent from the home unless it is determined by the State that I do not need to cooperate.
- > My records will be kept confidential and will not be used for unauthorized purposes.
- > I may be restricted to one physician, dentist and pharmacy if Denali Care/Denali KidCare coverage is misused.
- ٧ I must not knowingly withhold information or give false information in order to obtain Denali Care/Denali KidCare coverage and that in doing so I may be prosecuted for unsworn falsification and/or fraud I may also be liable for repaying in cash the value of the benefits received.
- > I must cooperate in obtaining and providing information regarding third party health insurance coverage.
- When I sign the renewal form for health coverage and use Denali Care/Denali KidCare, I consent to release medical records and information about myself and other people upon whose behalf I am applying to the Department of Health and Social Services or its designee. Upon request, any person who has medical records and information or the custody of such records shall release those records to the Department or its designee

Statement of Truth and Authorization for Release of Information Authorized Representative (Optional): If signing as authorized representative, please complete section below. complete to the best of my knowledge. I have read or have had read to me and understand my rights and responsibilities. this renewal form regarding the persons in my home for whom I am applying for Denali Care/Denali KidCare coverage, including income, citizenship, and all other items that pertain to eligibility are true and KidCare and will not be released to any other person or agency outside the Department of Health and Social Services. Under penalty of perjury or unsworn falsification, I certify that the statements made on I authorize the release of information requested by the Department of Health and Social Services or its agents. The requested information will be used solely in the administration of Denali Care/Denali The following person is acting as an authorized representative on behalf of the applicant An authorized representative is someone you name in writing who may act on behalf of your household. This person must be age 18 or older. Even though an authorized representative may sign and submit this renewal form on your behalf, please review the renewal form yourself. SIGNATURE OF WITNESS, IF SIGNED WITH AN X SIGNATURE OF APPLICANT OR AUTHORIZED REPRESENTATIVE NAME OF PERSON (PLEASE PRINT DATE DATE SIGNATURE OF OTHER ADULT IN HOUSEHOLD DAYTIME OR MESSAGE PHONE NUMBER OF PERSON SIGNATURE OF WITNESS, IF SIGNED WITH AN X DATE DATE



Please review this renewal form very carefully and be sure that all required information has been included. If you are self-employed, you may send a copy of your most recent federal income tax form and/or business records.

If you are not sure what to send or if you have questions regarding this renewal form, please call your local Public Assistance office at the number located on page 2 of this renewal form.



Denali Care & Denali KidCare

Questions about your coverage? Please call the Medicaid Recipient Hotline at 1-800-780-9972.



State of Alaska, Department of Health and Social Services

The State of Alaska does not discriminate against any person on the basis of race, color, national origin, religious creed, political belief, disability or age in admission to or participation in its programs.