ARIZONA DEPARTMENT OF ECONOMIC SECURITY (DES)
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM(AHCCCS)

CUSTOMER: XXXXXX	DATE: XX/XX/XX XX	HEAPLUS PERSON ID: XXXXXXXXXXXX	APPLICATION ID: XXXXXXXXXXXX

<INSERT CUSTOMER NAME>
<INSERT MAILING ADDRESS>

OTHER IDS USED BY AHCCCS OR DES
AHCCCS ID : XXXXXX
AZTECS Case ID : XXXXXX

Call 1-855-HEA-PLUS (432-7587) if you have any questions or need help.

Medical Assistance Renewal

Dear <INSERT MEMBER NAME>

Please read this entire letter. We are sending this letter to let you know it is time to renew Medical Assistance coverage for:

- <INSERT CUSTOMER NAME> (Birthdate: XX/XX/XXXX; Person ID: XXXXXXXXXX;AHCCCS ID: XXXXXXX)

You must complete your renewal by XX/XX/XXXX.

This letter tells you:

- The actions you must take to renew.
- About additional proof of information you need to give us; and.
- Information you previously gave us or current information we have been able to verify through federal and state electronic sources.

We have included in this letter a Medical Assistance Renewal Summary form. This summary form may be used as your renewal application. You do not need to turn in a separate renewal application if you complete and return this form to us by your renewal due date.

Based on this information we were not able to determine if you continue to be eligible.

It is important that you review all the information. On the form you will be able to indicate:

- If the information is correct.
- Changes that have happened. When you report changes on the form you must give us proof of the changes.

If you have questions or need help, you can call 1-855-HEA-PLUS (432-7587).

If you get Cash Assistance or Nutrition Assistance, you may get a separate letter for those benefits.

There are several ways for you to complete the renewal and give us information:

- Log in or create an account on the Health-e-Arizona Plus website at **http://www.healthearizonaplus.gov/** and complete the renewal online as well as upload or emailverification for your case; or
- You can complete the attached form and:
- Fax it using the attached fax coversheet. The fax coversheet has a barcode that identifies your case; or
- Mail it to: Department of Economic Security, P.O. Box 19009, Phoenix, AZ 85005-9009; or
- Take it to an eligibility office. To find an office near you call 1-855-HEA-PLUS (432-7587).

Our records show you do not have a Health-e-Arizona Plus account. A Health-e-Arizona Plus account will allow you to:

- See applications that have been submitted;
- See decision letters;
- Submit documents online; and
- Report changes online.

To help you set up a Health-e-Arizona Plus account, an Application Access Code has been created for you.

Your Application Access Code is:
XXXXXX

The Application Access Code will expire when you create a Health-e-Arizona Plus account. If you want to create a Health-e-Arizona Plus account and see your information, here is what you need to do:

1. Visit the Health-e-Arizona Plus website at www.healthearizonaplus.gov.
2. Click on "Create Account" on the home page and follow the steps.
3. Look under the "I Want To…" section on the left side of your Health-e-Arizona Plus account. Click on "Enter Application Access Code to Access Existing Application."
4. Enter the six digit Application Access Code (found above on this letter).

If you have any questions regarding your Health-e-Arizona Plus account you can call us toll free at 1-855-HEA-PLUS (1-855-432-7587).

CUSTOMER:	DATE:	HEA PLUS PERSON ID:	APPLICATION ID:
<INSERT CUSTOMER NAME>	XX/XX/XX	XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXX

Medical Assistance Renewal Summary

MAIN CONTACT INFORMATION

This is the current information we have on record or verified through electronic sources.			
HOME PHONE	WORK OR OTHER PHONE (XXX) XXX-XXXX	E-MAIL ADDRESS	
CELL PHONE		MESSAGE/EMERGENCY PHONE	
STREET ADDRESS	CITY	STATE AZ	ZIP XXXXX-XXXX
MAILING ADDRESS	CITY	STATE AZ	ZIP XXXXX-XXXX
IN CARE OF:			
This person has a visual impairment that requires an accommodation for printed letters			

☐ CHECK HERE IF NO CHANGE.			
If different, please give us new contact information.			
HOME PHONE	WORK OR OTHER PHONE	E-MAIL ADDRESS	
CELL PHONE		MESSAGE/EMERGENCY PHONE	
STREET ADDRESS	CITY	STATE	ZIP
MAILING ADDRESS IF DIFFERENT	CITY	STATE	ZIP
IN CARE OF:			
ENROLLED IN ADDRESS CONFIDENTIALITY PROGRAM (ACP) ☐ Yes ☐ No	ACP APT #	DATE OF ISSUANCE	DATE OF EXPIRATION

HOUSEHOLD MEMBERS

This is the current information we have on record or verified through electronic sources.		
NAME	RELATIONSHIP TO YOU	DATE OF BIRTH

☐ CHECK HERE IF NO CHANGE.
If different, tell us who has moved in or out.

CUSTOMER:	DATE:	HEA PLUS PERSON ID:	APPLICATION ID:
<INSERT CUSTOMER NAME>	XX/XX/XXXX	XXXXXXXXXXXX	XXXXXXXXXXX

NAME	RELATIONSHIP TO YOU	DATE OF BIRTH	DATE MOVED OUT	DATE MOVED IN	DO YOU WANT BENEFITS FOR THIS PERSON?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

STUDENT INFORMATION

This is the current information we have on record or verified through electronic sources.

NAME	SCHOOL NAME	ENROLLMENT	EXPECTED GRADUATION DATE

☐ CHECK HERE IF NO CHANGE.

If different, tell us what has changed.

NAME	SCHOOL NAME	ENROLLMENT	EXPECTED GRADUATION DATE
		☐ FULL TIME ☐ HALF TIME ☐ LESS THAN HALF TIME ☐ NO LONGER ENROLLED	
		☐ FULL TIME ☐ HALF TIME ☐ LESS THAN HALF TIME ☐ NO LONGER ENROLLED	
		☐ FULL TIME ☐ HALF TIME ☐ LESS THAN HALF TIME ☐ NO LONGER ENROLLED	

FEDERAL TAX FILING STATUS

This is the current information we have on record. This includes dependents who may not be living with you.

NAME	TAX FILING STATUS	NAMES OF DEPENDENTS CLAIMED

☐CHECK HERE IF NO CHANGE.

If different, tell us about any changes to a person's federal tax filing status.

NAME	EXPECTED FILING STATUS FOR CURRENT TAX YEAR XXXX	NAMES OF DEPENDENTS YOU WILL CLAIM
	☐MARRIED – FILING JOINTLY WITH	
	☐MARRIED – FILING SEPARATELY ☐QUALIFYING WIDOW(ER) ☐HEAD OF HOUSEHOLD ☐SINGLE ☐CLAIMED AS A DEPENDENT BY	
	☐NOT A TAX FILER	
	☐MARRIED – FILING JOINTLY WITH	
	☐MARRIED – FILING SEPARATELY ☐QUALIFYING WIDOW(ER) ☐HEAD OF HOUSEHOLD ☐SINGLE ☐CLAIMED AS A DEPENDENT BY	
	☐NOT A TAX FILER	
	☐MARRIED – FILING JOINTLY WITH	
	☐MARRIED – FILING SEPARATELY ☐QUALIFYING WIDOW(ER) ☐HEAD OF HOUSEHOLD ☐SINGLE ☐CLAIMED AS A DEPENDENT	

CUSTOMER:	DATE:	HEA PLUS PERSON ID:	APPLICATION ID:
<INSERT CUSTOMER NAME>	XX/XX/XX	XXXXXXXXXXXX	XXXXXXXXXXX

	BY ______________ ☐NOT A TAX FILER	
	☐MARRIED – FILING JOINTLY WITH ______________ ☐MARRIED – FILING SEPARATELY ☐QUALIFYING WIDOW(ER) ☐HEAD OF HOUSEHOLD ☐SINGLE ☐CLAIMED AS A DEPENDENT BY ______________ ☐NOT A TAX FILER	

INCOME (Does not include SELF-EMPLOYMENT)

This is the current information we have on record or verified through electronic sources.			
PERSON	SOURCE	GROSS AMOUNT	HOW OFTEN PAID
Total Monthly Gross Income counted:			

☐CHECK HERE IF NO CHANGE.

CUSTOMER:	DATE:	HEA PLUS PERSON ID:	APPLICATION ID:
<INSERT CUSTOMER NAME>	XX/XX/XX	XXXXXXXXXXXX	XXXXXXXXXXX

You must tell us what has changed or is different in income listed above. Some income sources may have appeared more than once. It is important that you tell us if any income sources are incorrect or listed more than once. If you do not tell us, all the income will be counted.

CHANGE 1

PERSON	EMPLOYER OR SOURCE OF INCOME	WHAT IS THE CHANGE?	DATE INCOME STARTED	DATE INCOME STOPPED
		☐ Started ☐ Stopped ☐ Never Received ☐ Different		

HOW OFTEN RECEIVED	AMOUNT RECEIVED EACH PERIOD	HOURS WORKED PER WEEK

CONTACT PERSON WHO CAN VERIFY YOUR INCOME	PHONE NUMBER

☐ CHECK HERE IF NO CHANGE.

You must tell us what has changed or is different in income listed above. Some income sources may have appeared more than once. It is important that you tell us if any income sources are incorrect or listed more than once. If you do not tell us, all the income will be counted.

CHANGE 2

PERSON	EMPLOYER OR SOURCE OF INCOME	WHAT IS THE CHANGE?	DATE INCOME STARTED	DATE INCOME STOPPED
		☐ Started ☐ Stopped ☐ Never Received ☐ Different		

HOW OFTEN RECEIVED	AMOUNT RECEIVED EACH PERIOD	HOURS WORKED PER WEEK

CONTACT PERSON WHO CAN VERIFY YOUR INCOME	PHONE NUMBER

CUSTOMER:	DATE:	HEA PLUS PERSON ID:	APPLICATION ID:
<INSERT CUSTOMER NAME>	XX/XX/XX	XXXXXXXXXXXX	XXXXXXXXXXX

SELF-EMPLOYMENT INCOME

This is the current information we have on record.			
PERSON	TYPE [Rental or Franchise Type selection or Self-Employment]	ANNUAL GROSS AMOUNT	TOTAL ANNUAL EXPENSES

Total Annual Gross Income Counted:			
Total Annual Self-Employment Expenses:			

☐CHECK HERE IF NO CHANGE.				
You must tell us what has changed or is different in the income and expenses listed above. It is important that you tell us if any income sources are incorrect or have changed. If you do not tell us, all the income listed above will be counted.				
CHANGE 1				
PERSON	TYPE	WHAT IS THE CHANGE?	DATE INCOME STARTED	DATE INCOME STOPPED
		☐Started ☐Stopped ☐Different		

ANNUAL GROSS AMOUNT	ANNUAL EXPENSE AMOUNT	SOLE OWNER?
		☐Yes ☐No

Household Has No Income

If your household has no income, please tell us how you meet your needs?

☐Living with family or friends
☐Using money from savings and checking accounts
☐Working odd jobs: $___________(Monthly Amount)
☐Living off credit cards
☐ Getting loans from people
Name of Lender:____________________Telephone #:_____________Amount of help: $_________
☐Having someone give you money
Name of Giver:_____________________Telephone #:_____________Amount of help: $_________
☐ Having someone pay bills directly
Name of Payer:_____________________Telephone #:_____________Amount of help: $_________
☐ Working in exchange for rent
Name of Landlord:___________________Telephone #:_____________Amount of help: $_________
☐ Other ____

CUSTOMER:	DATE:	HEA PLUS PERSON ID:	APPLICATION ID:
<INSERT CUSTOMER NAME>	XX/XX/XX	XXXXXXXXXXXX	XXXXXXXXXXX

INCOME DEDUCTIONS

These are adjustments to your income that are allowed when filing Federal taxes:

- Educator Expenses;
- Business Expenses of Reservists;
- Performing Artists;
- Fee-Basis Government Officials;
- Health Savings Account Deduction;
- Moving Expenses;
- Deductible Self-Employment Tax;
- Self-Employed Simplified Employee Pension;
- SIMPLE and Qualified Plans;
- Self-Employed Health Insurance Deductions;
- Penalty on Early Withdrawal of Savings;
- Alimony Paid;
- IRA Deduction;
- Student Loan Interest;
- Tuition and Fees;
- Domestic Production Activities;

This is the current information we have on record or verified through electronic sources.		
PERSON	TYPE	ANNUAL AMOUNT OR BY MONTH

☐CHECK HERE IF NO CHANGE.		
If different, tell us about changes in expenses.		
PERSON	TYPE	ANNUAL AMOUNT OR BY MONTH
		Annual Amount: $___________ Or By Month: Jan 20XX: $___________ Feb 20XX: $___________ Mar 20XX: $___________ Apr 20XX: $___________ May 20XX: $___________ Jun 20XX $___________ July 20XX: $___________ Aug 20XX: $___________ Sep 20XX: $___________ Oct 20XX: $___________ Nov 20XX: $___________ Dec 20XX: $___________

OTHER HEALTH INSURANCE (NOT INCLUDING MEDICARE OR AHCCCS)

This is the current information we have on record or verified through electronic sources.		
PERSON INSURED	INSURANCE COMPANY NAME	POLICY/GROUP NUMBER

☐ CHECK HERE IF NO CHANGE.

If different, tell us about changes.		
PERSON INSURED	INSURANCE COMPANY NAME	POLICY/GROUP NUMBER

I swear under penalty of perjury that the statements and documents provided about myself and persons in my home, that relates to my eligibility for benefits, is true and correct to the best of my knowledge, and that I have not withheld any information. I swear under penalty of perjury that any photocopied information I have provided are the same as the original documents.

Printed Name	Signature	Date

CUSTOMER:	DATE:	HEA PLUS PERSON ID:	APPLICATION ID:
<INSERT CUSTOMER NAME>	XX/XX/XX	XXXXXXXXXXXX	XXXXXXXXXXX

Voter Registration

Applying to register to vote or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

☐ Yes ☐ No

If you do not check either box, you will be considered to have decided not to register to vote at this time.

If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the State Election Director, Secretary of State's Office, 1700 West Washington, Phoenix, AZ 85007, 602-542-8683.

You may also get a voter registration form at https://www.azsos.gov/elections/voting-election/register-vote-or-update-your-current-voter-information.