



# Medicaid Unwind

*How to Navigate the Future*



Foundation *for*  
Healthy Communities



# Federally Certified Navigator

- Hi, my name is Adrian Jasion, and I am a Federally Certified Marketplace Navigator and Medicaid Specialist.





# What to Expect

- To keep Medicaid coverage, it is no longer optional to complete redeterminations or respond to Department requests for information about eligibility status.
- ***Failure to complete redeterminations or respond to any DHHS requests for information will result in termination of Medicaid coverage.***
- DHHS has begun to send renewal notices and will continue over the next several months to those who must complete a redetermination or provide information to keep their coverage.
- These notices on **yellow paper** or posted to individuals' NH EASY accounts highlighted in yellow.



# Medicaid Transition – Update cont.

- Per CMS guidance, a state cannot initiate renewal for more than 1/9<sup>th</sup> of its entire caseload in any given month.
- CMS requires states to submit an Eligibility Renewal Distribution Plan to CMS in February.
- NH has developed an Eligibility Renewal Distribution Plan and is refining it in response to the newest requirements and ongoing discussions with CMS.
- CMS requires states to make monthly reports reflecting metrics that monitor state enrollment / edibility activities and trends.



# Medicaid Transition Back to Regular Operations

- Congress has set a time for Medicaid to return to regular eligibility requirements: April 1, 2023.
- The Medicaid transition back to regular operations is now separate (decoupled) from the federal PHE timeline.
- Beneficiaries who have had continuous coverage due to the federal PHE will have to **demonstrate eligibility** to keep their coverage.
- April 1<sup>st</sup> is the beginning of the time in which beneficiaries can lose coverage for failure to renew eligibility and / or



# Unwinding Special Enrollment Period (SEP)

Healthcare.gov recently announced it will allow people who lose Medicaid eligibility to claim a Special Enrollment Period (SEP) for Marketplace coverage between March 31, 2023 and July 31, 2024, as the continuous coverage requirement ends.

- The “Unwinding SEP” will be available in all states using the federal enrollment platform and is optional for SBMs.
- To access the Unwinding SEP, a marketplace-eligible person must submit a new application or update an existing one between 3/31/23 – 7/31/24 and attest to loss of Medicaid coverage during that time period. Consumers will have 60 days after they submit their application to select a plan.
- Coverage starts the first day of the month following plan selection. Consumers who are aware that their Medicaid is ending may report loss of coverage and select a plan up to 60 days prior to the event for coverage as early as the first day of the month following coverage loss.



# Individuals in Protected Status in Medicaid

## Individuals in Protected Status in Medicaid

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# Changes in Enrollment – NH Medicaid

	Feb 28 2019	Feb 29 2020	Feb 28 2021	Feb 6 2023
Standard Medicaid	128,252	127,356	143,182	154,506 (over 20% increase over 2019 figures)
Granite Advantage (Expansion Group)	51,240	51,574	72,392	95,704 (86% increase over 2019 figures)
Total	179,492	178,930	215,574	250,210 (29% increase over



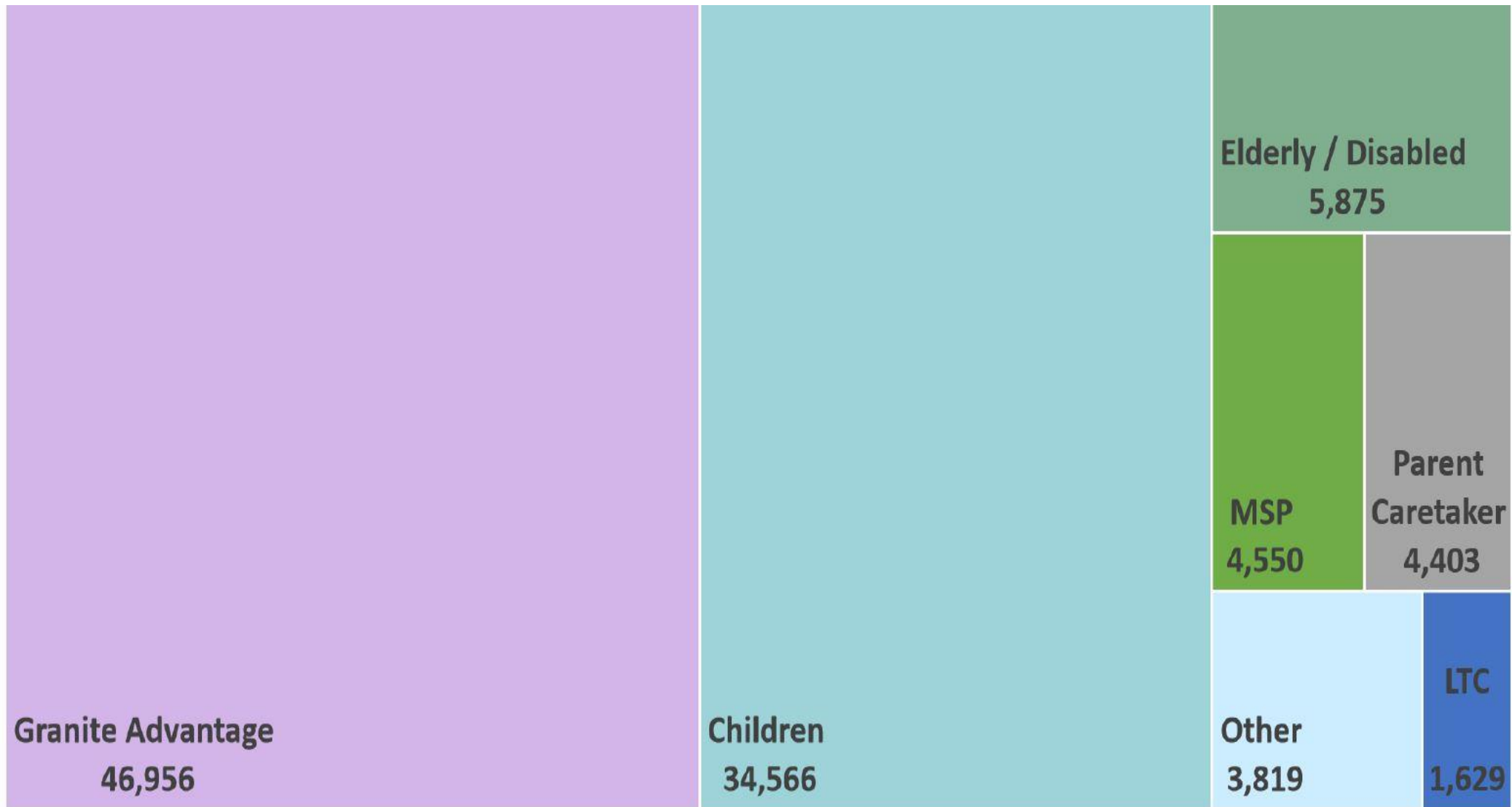


# Medicaid 'Protected Individuals' during COVID PHE

**Protected Individuals** - Individuals who no longer meet eligibility requirements and/or have overdue administrative tasks to complete their redeterminations placing them at risk of losing coverage when the continuous coverage period ends.

- **Overdue Redetermination** – Individuals who have not completed their renewals will be provided an opportunity to renew based on our State Plan for Prioritizing and Distributing Renewals.
- **Pending Ineligible** – Individuals who have completed a renewal within the past 12-month and subsequently had a change in circumstance (e.g., categorically

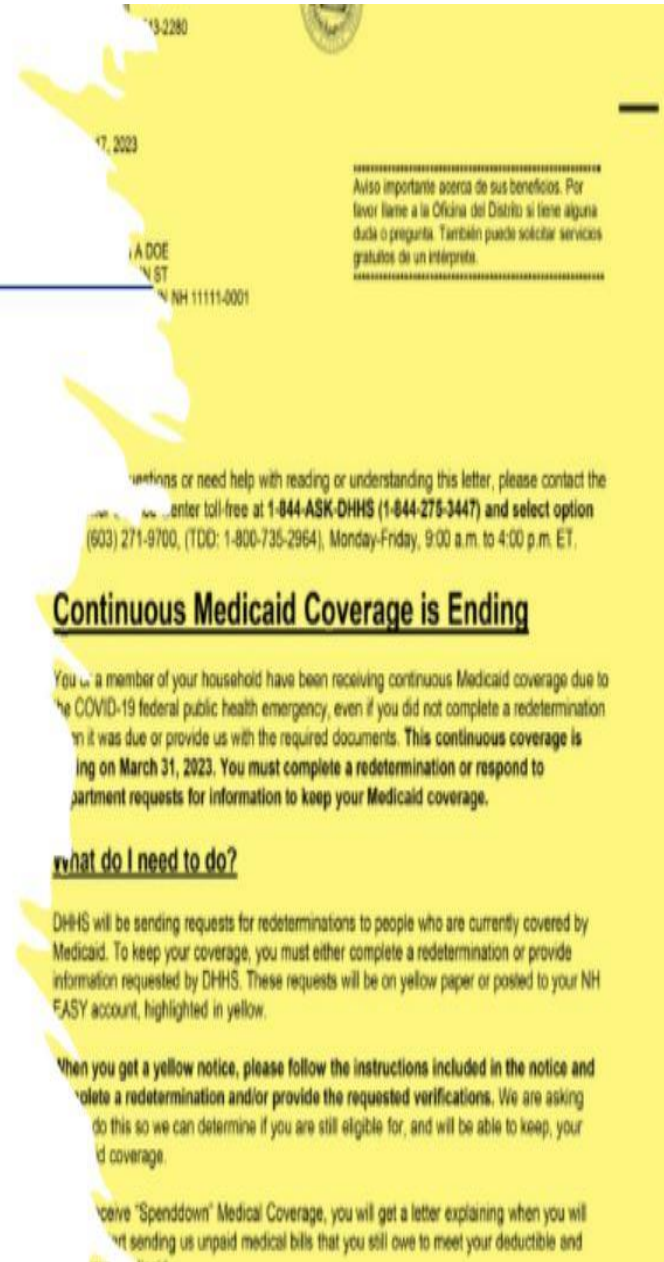






# Sample 'Heads Up' Letter

<https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents2/updatedaddressyellowletter.pdf>





# "Heads Up" End of Continuous Coverage Letter

Bureau of Family Assistance  
Cassamott District Office  
17 Water Street  
Cassamott, NH 03743-2280



NH DEPARTMENT OF  
HEALTH AND HUMAN SERVICES

January 17, 2023

JOHN A DOE  
123 MAIN ST  
SOMETOWN NH 11111-0001

.....  
Ayuda importante acerca de sus beneficios. Por favor llame a la Oficina del Distrito si tiene alguna duda o pregunta. También puede solicitar servicios gratuitos de un intérprete.  
.....

If you have questions or need help with reading or understanding this letter, please contact the Customer Service Center toll-free at **1-844-ASK-DHHS (1-844-275-3447)** and select option #3 or (603) 271-9700, (TDD: 1-800-735-2954), Monday-Friday, 9:00 a.m. to 4:00 p.m. ET.

## Continuous Medicaid Coverage is Ending

You or a member of your household have been receiving continuous Medicaid coverage due to the COVID-19 federal public health emergency, even if you did not complete a redetermination when it was due or provide us with the required documents. **This continuous coverage is ending on March 31, 2023. You must complete a redetermination or respond to Department requests for information to keep your Medicaid coverage.**

### What do I need to do?

DHHS will be sending requests for redeterminations to people who are currently covered by Medicaid. To keep your coverage, you must either complete a redetermination or provide information requested by DHHS. These requests will be on yellow paper or posted to your NH EASY account, highlighted in yellow.

**When you get a yellow notice, please follow the instructions included in the notice and complete a redetermination and/or provide the requested verifications.** We are asking you to do this so we can determine if you are still eligible for, and will be able to keep, your Medicaid coverage.

If you receive "Spindown" Medical Coverage, you will get a letter explaining when you will need to start sending us unpaid medical bills that you still owe to meet your deductible and open your Medicaid.

### Ways to complete your redetermination or provide requested information:

1. **Online:** Through your NH EASY account <https://nheasy.nh.gov> if you do not have an NH EASY account, you can create one today using this same link.
2. **By mail:** Centralized Scanning Unit, PO Box 181, Concord, NH 03302.
3. **In person:** Visit one of our District Offices, locations can be found at <https://www.dhhs.nh.gov/about-dhhs/locations-facilities/locations>

Once you complete your redetermination and/or all requested information is provided, you will receive a notice of decision informing you of the status of your Medicaid eligibility.

### What should I do if I no longer need Medicaid coverage?

If you no longer need Medicaid coverage, you can voluntarily request to end your coverage by using one of the three options above or by calling the Customer Service Center at one of the numbers listed at the top and bottom of this letter.

### Options for those who are no longer eligible for Medicaid:

If you are no longer eligible for Medicaid and still need insurance, you can contact the New Hampshire Navigators to explore other health insurance options. New Hampshire has two Health Insurance Navigators that provide health insurance enrollment assistance in person, virtually, and by phone, at no cost to you.

New Hampshire's Navigators are:

- First Choices Services; 1-877-211-NAVI or (603) 931-3858; <https://acnavigator.com/nh/home>
- Health Market Connect; 1-800-208-5164; <https://hmcnh.com>

You can also visit the Federal Health Insurance Marketplace at <https://www.healthcare.gov/>, or call the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325).

### Need Help?

Visit one of our District Offices in person or contact the DHHS Customer Service Center toll-free at **1-844-ASK-DHHS (1-844-275-3447)** and select option #3 or (603) 271-9700, (TDD: 1-800-735-2954), Monday-Friday, 9:00 a.m. to 4:00 p.m. ET.



# PIN Letter

Family Services Specialist  
Bureau of Family Assistance  
Manchester District Office  
1590 Peiner Road  
Manchester NH 03103



NH DEPARTMENT OF  
HEALTH AND HUMAN SERVICES

February 05, 2023

JOHN DOE  
123 MAIN ST  
CONCORD NH 03304

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Aviso importante acerca de sus beneficios. Por favor llame a la Oficina del Distrito si tiene alguna duda o pregunta. También puede solicitar servicios gratuitos de un intérprete.  
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## **Your Medicaid Redetermination is due in April 2023.**

A request to complete your redetermination will be sent to you at least 30 days before it is due. This request will be on **YELLOW** paper. Please read the entire form and follow the instructions. You must complete your redetermination and respond to the Department's requests for information, **by the 15th of your redetermination month to see if you are still eligible for Medicaid.**

**If you do not complete your redetermination or respond to the Department's requests for information by the end of April 2023 your Medicaid will close and your benefits will end.**

Make it "NH EASY" on yourself

Many people use NH EASY because it is a fast and easy way to complete redetermination, upload verifications, and more using their phone, desktop, or tablet.

To activate your personal account, use your PIN and follow the instructions below:

Your PIN: **13KSM**, which is valid for the next (15) days.

Go to the NH EASY URL at <https://nheasy.nh.gov>

From there, select the "Create Account" button and follow the instructions on each screen.

**NH EASY can help you manage your benefits online with these features:**

- Complete redeterminations
- Add new benefits and report changes

- Take pictures of your proofs, upload them, and check on processing status
- Opt in for important text message reminders such as upcoming appointments
- Find important information on your benefit status
- Reschedule appointments if you have a conflict
- "Go Green" to get Notices online, much faster than waiting for "snail mail" delivery
- Enroll in your health plan, if eligible
- Apply for WIC
- Get information about becoming a foster or adoptive parent
- Search for DHHS forms
- Explore other programs and services offered by DHHS.



# Pending Ineligible - Financially Ineligible #1

Bureau of Family Assistance  
Clement District Office  
17 Water Street  
Clarksville, NH 03074-2280



NH DEPARTMENT OF  
HEALTH AND HUMAN SERVICES

February 24, 2023

JOHN A DOE  
123 MAIN ST  
BOWMETOWN NH 11111-0001

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Aviso importante acerca de sus beneficios. Por favor llame a la Oficina del Distrito si tiene alguna duda o pregunta. También puede solicitar servicios gratuitos de un intérprete.  
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## \*\*\*IMPORTANT\*\*\* \*\*IMPORTANT\*\* \*\*IMPORTANT\*\*

You are receiving this letter because we reviewed your case and based on your previously reported wages you are no longer eligible for Medicaid.

If you believe this is incorrect or your income has changed please provide verification of your gross wages by 3/7/2023. This information is needed to determine if you are still eligible for Medicaid. If you do not give us this proof, your medical assistance will end on 3/31/2023.

Gross wages means your pay before deductions. It must include all your tips, bonuses, commissions, overtime, and any other cash or in-kind benefits you got from your employer or through self-employment.

### If you work for someone:

- Enclosed is an Employment Verification form. You may have your employer complete this form or have your employer give us a letter, on letterhead, giving us the hours you worked with your gross wages for the last 4 weeks; OR
- You may give us copies of your last 4 weeks of pay stubs. Your pay stubs must show the week dates, the number of hours worked per week, and your gross wages.

If you are no longer working for the employer you previously reported, you must still have the enclosed form completed by your former employer to verify the employment ended and return it to us.

### If you are self-employed:

- Provide all pages of your most recently filed income tax return, or
- Profit and loss statements for the past 3 months.

Case# 12345678  
ID - CN0006

### Ways to send us the proofs requested:

1. **Online:** Through your NH EASY account <https://theeasy.nh.gov>. If you do not have an NH EASY account, you can create one today using this same link.
2. **By mail:** Centralized Scanning Unit, PO Box 181, Concord, NH 03302.
3. **In person:** Visit one of our District Offices, locations can be found at <https://www.dhsa.nh.gov/about-dhsa/locations-districtoffice/locations>.

If you no longer need Medicaid coverage, you can voluntarily request that your coverage end, using any of the ways above or by calling our Customer Service Center toll-free at 1-844-ASK-DHHS (1-844-275-3447) or (603) 271-9700 and select option #3.

### Options for those who are no longer eligible for Medicaid:

If you are no longer eligible for Medicaid and still need insurance, you can contact the New Hampshire Navigators to explore other health insurance options. New Hampshire has two Health Insurance Navigators that provide health insurance enrollment assistance in person, virtually, and by phone, at no cost to you.

New Hampshire's Navigators are:

- First Choices Services, 1-877-211-NAVY or (603) 931-3858, <https://www.newchoice.com/nh/home>
- Health Market Connect, 1-800-208-5164, <https://hrwvcb.com>

You can also visit the Federal Health Insurance Marketplace at <https://www.healthcare.gov/>, or call the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325).

### Need Help?

If you have questions or need help with reading or understanding this letter, please contact the Customer Service Center toll-free at 1-844-ASK-DHHS (1-844-275-3447) and select option #3 or (603) 271-9700, (TDD: 1-800-735-2964), Monday-Friday, 9:00 a.m. to 4:00 p.m. ET.

Case# 12345678  
ID - CN0006

Page 2 of 2





# Pending Ineligible - Financially Ineligible #2

Bureau of Family Assistance  
Governor's District Office  
17 Water Street  
Concord, NH 03301-3280



NH DEPARTMENT OF  
HEALTH AND HUMAN SERVICES

February 23, 2023

JOHN A DOE  
123 MAIN ST  
SOMETOWN NH 11111-0001

\*\*\*\*\*  
Aviso importante acerca de sus beneficios. Por favor llame a la Oficina del Distrito si tiene alguna duda o pregunta. También puede solicitar servicios gratuitos de un intérprete.  
\*\*\*\*\*

## **\*\*IMPORTANT\*\* \*\*IMPORTANT\*\* \*\*IMPORTANT\*\***

We reviewed your case and your previously reported wages do not match our new income records so we need more information.

You must give the Department proof of your gross wages by 3/6/2023, so we can determine if you are still eligible for Medicaid. If you do not give us this proof, your medical assistance will end on 3/31/2023.

Gross wages means your wages before deductions. It must include all your tips, bonuses, commissions, overtime, and any other cash or in-kind benefits you got from your employer or through self-employment.

### **If you work for someone:**

- Enclosed is an Employment Verification form. You may have your employer complete this form or have your employer give us a letter, on letterhead, giving us the hours you worked with your gross wages for the last 4 weeks; OR
- You may give us copies of your last 4 weeks of pay stubs. Your pay stubs must show the week dates, the number of hours worked per week, and your gross wages.

If you are no longer working for the employer you previously reported, you must still have the enclosed form completed by your former employer to verify the employment ended and return it to us.

### **If you are self-employed:**

- Provide all pages of your most recently filed income tax return, or
- Profit and loss statements for the past 3 months.

Case# 12345678

### **Ways to send us the proofs requested:**

1. **Online:** Through your NH EASY account <https://ehms.nh.gov>; if you do not have an NH EASY account, you can create one today using this same link.
2. **By mail:** Centralized Scanning Unit, PO Box 161, Concord, NH 03302.
3. **In person:** Visit one of our District Offices, locations can be found at <https://www.dhhs.nh.gov/about-dhhs/locations-facilities/locations>.

Please keep your original documents and give us copies.

Remember, you must report any changes that might affect your medical coverage. You must report the change within 10 calendar days of when the change happens. Please report changes for both you and other people in your household, for example, if someone moves, or if someone's income changes. Or if your household changes, for example, someone in your household marries or divorces, becomes pregnant, or has or adopts a child. Delays in reporting and verifying changes may result in your household getting benefits or services in error. You must pay back any benefits or services received in error, regardless of whether you made a mistake in the information you gave, or if you failed to provide it.

If you are having trouble getting the proofs, don't understand what is needed, or need help getting the proof, contact us before the due date. Our contact information is above.

***If you no longer need Medicaid coverage, you can voluntarily request that your coverage end, using any of the ways above or by calling our Customer Service Center toll-free at 1-844-ASK-DHHS (1-844-275-3447) or (603) 271-9700 and select option #3.***

### **Options for those who are no longer eligible for Medicaid:**

If you are no longer eligible for Medicaid and still need insurance, you can contact the New Hampshire Navigators to explore other health insurance options. New Hampshire has two Health Insurance Navigators that provide health insurance enrollment assistance in person, virtually, and by phone, at no cost to you.

New Hampshire's Navigators are:

- First Choices Services; 1-877-211-NAVI or (603) 931-3650; <https://acnavigator.com/nh/home>.
- Health Market Connect; 1-800-208-5164; <https://hmo.nh.com>

You can also visit the Federal Health Insurance Marketplace at <https://www.healthcare.gov/>, or call the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4326).

### **Need Help?**

If you have questions or need help with reading or understanding this letter, please contact the Customer Service Center toll-free at 1-844-ASK-DHHS (1-844-275-3447) and select option #3 or (603) 271-9700, (TDD: 1-800-735-2964), Monday-Friday, 9:00 a.m. to 4:00 p.m. ET.

Case# 12345678  
ID : CN9596

Page 2 of 2



# Pending Ineligible - Failure to Verify

Department of Health and Human Services  
Bureau of Family Assistance  
PO Box 181  
Concord, NH 03302



NH DEPARTMENT OF  
HEALTH AND HUMAN SERVICES

February 24, 2023

JOHN DOE  
123 MAIN ST  
HOOKSETT NH 03108

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Aviso importante acerca de sus beneficios. Por favor llame a la Oficina del Cliente si tiene alguna duda o pregunta. También puede solicitar servicios gratuitos de un intérprete.  
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If you have questions or need help with reading or understanding this letter, please contact the Medicaid Service Center (NH only) toll-free at **1-844-ASK-DHHS** (1-844-275-3447) or (603) 271-6700 and select option #3, (TDD: 1-800-735-2964), Monday-Friday, 9:00 a.m. to 4:00 p.m. ET.

### IMPORTANT REQUEST FOR INFORMATION. PLEASE READ THIS ENTIRE FORM

You or a member of your household have been receiving continuous Medicaid coverage due to the COVID-19 federal public health emergency, even if you did not complete a redetermination when it was due or provide us with the required documents. **This continuous coverage is ending on March 31, 2023. You must complete a redetermination or respond to Department requests for information to keep your Medicaid coverage.**

**Now that the continuous coverage period is ending, you must respond to all requests from the Department to keep your medical coverage.**

Our records show that as of the date of this letter you failed to provide requested verification. Please provide the proofs listed in the box below. If you do not understand what is needed, or need help getting them, please contact us. Our contact information is listed at the top and bottom of this letter.

The individual(s) listed below are pending ineligible.

John Doe

Program	Reason
Granite Adv.	You did not give us enough information or proof for us to decide if you are eligible.

Case# 12345678  
ID: CN006

Telephone: (603) 271-0790 or (800) 952-3345 (NH Only)  
TDD Access: (603) 735-2964 (NH Only)

Failure to provide the proofs listed in the box below by **March 6, 2023** will result in the termination of your medical coverage. If you do not understand what is needed, or need help getting them, please contact us. Our contact information is listed at the top and bottom of this letter.

We did not receive proof of:	Examples of what to send	For the following people:
Net profit/loss of self-employment	Fed/state tax returns with all schedules, business records	John Doe

You must give us the proofs shown above before the end of the continuous coverage period.

There are four ways to send us the proofs requested or to make updates to the information you told us:

- 1. Online:** Go to <https://nheasy.nh.gov> and make the updates using your NH EASY account. The majority of individuals use NH EASY because it is a fast and easy way to complete redetermination, upload verifications, and more using their phone, desktop or tablet. If you don't have an account, you can create one at <https://nheasy.nh.gov>.
- 2. By mail:** Send a copy to the Central Scanning Unit, PO. Box 181, Concord, NH 03302.
- 3. In person:** Bring a copy to any District Office that is convenient to you.
- 4. By phone:** Call (603) 271-6700 or 1-844-275-3447 (ASK-DHHS) (NH Only).

If you do not want to keep getting medical assistance, please let your District Office know.

Remember, you must report any changes that might affect your medical coverage. You must report the change within 10 calendar days of when the change happens. Please report changes for both you and other people in your household, like if someone moves, if someone's income changes, or if your household changes. For example, someone in your household marries or divorces, becomes pregnant, or has or adopts a child. Delays in reporting and verifying changes may result in your household getting benefits or services in error. You must pay back any benefits or services received in error, regardless of whether you made a mistake in the information you gave, or failed to give, to us.

Case# 12345678  
ID: CN006

Page 2 of 3





Family Services Specialist  
Bureau of Family Assistance  
Manchester District Office  
1050 Perimeter Road  
Manchester NH 03103



**NH DEPARTMENT OF  
HEALTH AND HUMAN SERVICES**

February 03, 2023

JOHN DOE  
123 MAIN ST  
CONCORD NH 01234

\*\*\*\*\*  
Aviso importante acerca de sus beneficios. Por favor llame a la Oficina del Distrito si tiene alguna duda o pregunta. También puede solicitar servicios gratuitos de un intérprete.  
\*\*\*\*\*

**Your Medicaid Redetermination is due in April 2023.**

A request to complete your redetermination will be sent to you at least 30 days before it is due. This request will be on YELLOW paper. Please read the entire form and follow the instructions. You must complete your redetermination and respond to the Department's requests for information, by the 15th of your redetermination month to see if you are still eligible for Medicaid.

If you do not complete your redetermination or respond to the Department's requests for information by the end of April 2023 your Medicaid will close and your benefits will end.

Make it "NH EASY" on yourself

Many people use NH EASY because it is a fast and easy way to complete redetermination, upload verifications, and more using their phone, desktop, or tablet.

To activate your personal account, use your PIN and follow the instructions below:

Your PIN: **13KSM**, which is valid for the next (15) days.

Go to the NH EASY URL at <https://nheasy.nh.gov>

From there, select the "Create Account" button and follow the instructions on each screen.

**NH EASY can help you manage your benefits online with these features:**

- Complete redeterminations
- Add new benefits and report changes

Telephone: (999) 567-8900 or (123) 456-7890 (NH Only)  
TDD Access: 789234616277 (NH Only)

- Take pictures of your proofs, upload them, and check on processing status
- Opt in for important text message reminders such as upcoming appointments
- Find important information on your benefit status
- Reschedule appointments if you have a conflict
- "Go Green" to get Notices online, much faster than waiting for "snail mail"
- Enroll in your health plan, if eligible
- Apply for WIC
- Get information about becoming a foster or adoptive parent
- Search for DHHS forms
- Explore other programs and services offered by DHHS.



Bureau of Family Assistance  
Claremont District Office  
17 Water Street  
Claremont, NH 03743-2280



NH DEPARTMENT OF  
HEALTH AND HUMAN SERVICES

January 17, 2023

JOHN A DOE  
17 NOWHERE ST  
SOMETOWN NH 11111-0001

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Aviso importante acerca de sus beneficios. Por favor llame a la Oficina del Distrito si tiene alguna duda o pregunta. También puede solicitar servicios gratuitos de un intérprete.  
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If you have questions or need help with reading or understanding this letter, please contact the Customer Service Center toll-free at **1-844-ASK-DHHS (1-844-275-3447)** and **select option #3** or (603) 271-9700, (TDD: 1-800-735-2964), Monday-Friday, 9:00 a.m. to 4:00 p.m. ET.

## Continuous Medicaid Coverage is Ending

You or a member of your household have been receiving continuous Medicaid coverage due to the COVID-19 federal public health emergency, even if you did not complete a redetermination when it was due or provide us with the required documents. **This continuous coverage is ending on March 31, 2023. You must complete a redetermination or respond to Department requests for information to keep your Medicaid coverage.**

### What do I need to do?

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**When you get a yellow notice, please follow the instructions included in the notice and complete a redetermination and/or provide the requested verifications.** We are asking you to do this so we can determine if you are still eligible for, and will be able to keep, your Medicaid coverage.

If you receive "Spenddown" Medical Coverage, you will get a letter explaining when you will need to start sending us unpaid medical bills that you still owe to meet your deductible and open your Medicaid.

Case# 12345678  
ID : CN9996

### Ways to complete your redetermination or provide requested information:

- 1. Online:** Through your NH EASY account <https://nheasy.nh.gov> if you do not have an NH EASY account, you can create one today using this same link.
- 2. By mail:** Centralized Scanning Unit, PO Box 181, Concord, NH 03302.
- 3. In person:** Visit one of our District Offices, locations can be found at <https://www.dhhs.nh.gov/about-dhhs/locations-facilities#locations>

Once you complete your redetermination and/or all requested information is provided, you will receive a notice of decision informing you of the status of your Medicaid eligibility.

### What should I do if I no longer need Medicaid coverage?

If you no longer need Medicaid coverage, you can voluntarily request to end your coverage by using one of the three options above or by calling the Customer Service Center at one of the numbers listed at the top and bottom of this letter.

### Options for those who are no longer eligible for Medicaid:

If you are no longer eligible for Medicaid and still need insurance, you can contact the New Hampshire Navigators to explore other health insurance options. New Hampshire has two Health Insurance Navigators that provide health insurance enrollment assistance in person, virtually, and by phone, at no cost to you.

New Hampshire's Navigators are:

- First Choices Services; 1-877-211-NAVI or (603) 931 3858; <https://acanavigator.com/nh/home>
- Health Market Connect; 1-800-208-5164; <https://hmcnh.com>

You can also visit the Federal Health Insurance Marketplace at <https://www.healthcare.gov/>, or call the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325).

### Need Help?

Visit one of our District Offices in person or contact the DHHS Customer Service Center toll-free at **1-844-ASK-DHHS (1-844-275-3447)** and **select option #3** or (603) 271-9700, (TDD: 1-800-735-2964), Monday-Friday, 9:00 a.m. to 4:00 p.m. ET.

Case# 12345678  
ID : CN9996

Page 2 of 2





# Documentation Discussion


- Patient has a yellow letter that states they must provide verification of income.
- The yellow letters will state what additional documentation is needed.
- If a patient presents for care and you learn that their Medicaid was terminated within the last 90 days, the patient has the opportunity to provide the missing documentation (and resume coverage) and does not have to complete an entirely **new** Medicaid application.





# NH Easy Website

NEW HAMPSHIRE DEPARTMENT OF HEALTH AND HUMAN SERVICES 1-844-ASK-DHHS

 [MY ACCOUNT](#) [SERVICES](#) [FORMS](#) [FAQs](#) [SIGN IN](#)


## BUILDING PARTNERSHIPS. PROMOTING WELL BEING.


[APPLY NOW](#) Apply now for Cash, Medical, SNAP (Food Assistance), Child Care, Medicare Beneficiary and Long Term Care Assistance


[CREATE ACCOUNT](#) Create an account so you can view and manage benefits online

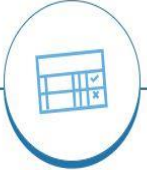
[Feedback](#)


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 **COVID-19 GROUP**  
Provides a limited Medicaid benefit for certain COVID-19 related

 **DO I QUALIFY?**  
Quickly check if you might be eligible for DHHS Services

 **HEALTH PLANS**  
An easy way to determine which Care Management plans your provider

 **GRANITE ADVANTAGE**

 **CUSTOMER SERVICE**  
Need to speak with someone?  
Call 1-844-ASK-DHHS





# Medicaid Coverage & Continuous Enrollment

NH Department of Health & Human Services (DHHS)  
Bureau of Family Assistance (BFA)

BFA Form 800R  
01/20

## APPLICATION FOR CONTINUED ELIGIBILITY FOR FINANCIAL, MEDICAL, CHILD CARE, AND SNAP (FORMERLY FOOD STAMP) BENEFITS

We want you to keep getting your benefits on time and in the right amounts, but we need your help. On a regular basis, we must review your eligibility for the benefits you are getting now. You must complete this Application for Continued Eligibility if you want to find out if you are eligible to continue to get your benefits. We will accept this Renewal Application even if you only fill in your name, address, and signature. However, we will be able to figure out if you can continue to get your benefits much quicker if you complete this entire Renewal Application.

- This page tells you how to complete this Renewal Application. The back of this page, ✓CHECKLIST OF REQUIRED PROOF, tells you what kinds of proof you must give us before we can tell you if you will continue to be eligible. *Keep this page for your records.*
- The booklet is the actual Renewal Application. Please complete this booklet, attach copies of as many of the required proofs as you can, put your proofs and the Renewal Application in the enclosed envelope, and mail it so it reaches us no later than the 15<sup>th</sup> of next month.

If you have any questions, call your District Office right away for help.

## HOW TO COMPLETE THIS RENEWAL APPLICATION

- PLEASE READ EVERYTHING CAREFULLY AND FOLLOW ALL INSTRUCTIONS!
- Fill out Sections 1 through 8 on the next page for each person who is getting assistance. If you get medical assistance, also complete Section 8.
- The Supplemental Nutrition Assistance Program (SNAP formerly Food Stamps) allows special income deductions. If you get SNAP benefits, you can claim more deductions from your income by filling out Section 7. See the shaded sections for special SNAP information. We will not be able to give you deductions that you do not tell us about and prove.
- When you have finished filling out this Renewal Application, sign and date it in the spaces provided on the bottom of the last page and mail the Renewal Application, along with copies of as many of the proofs discussed below as you can, in the enclosed pre-addressed, postage-paid envelope. Return it as soon as possible, but no later than the 15<sup>th</sup> of next month. It is important that we receive your completed Renewal Application by the 15<sup>th</sup> so that if you are eligible for continued benefits, your benefits will continue without interruption.

## PROOFS WE WILL NEED TO DECIDE YOUR ELIGIBILITY

- YOU MUST GIVE US PROOF OF ALL INCOME RECEIVED BY EVERYONE IN YOUR HOUSEHOLD, even if your household's income has not changed since the last time you gave us this proof.
- If anything else has changed, such as your address, who lives in your home, or if your expenses have gone up or down, please tell us about these changes.
- This could affect eligibility or, if you get cash or SNAP benefits, the amount you get each month.
- The ✓CHECKLIST OF REQUIRED PROOF on the back of this page tells you what kinds of proof we need. PLEASE GIVE US ONLY COPIES OF ORIGINAL DOCUMENTS — NO ORIGINALS WILL BE RETURNED.

## WHAT WILL HAPPEN NEXT

- When we get your completed Renewal Application and all required proofs, we will review the information you tell us, and let you know if you are still eligible for the benefits you are getting now and if there are any changes.
- If we have questions or need any other information, we will contact you and tell you what we need. If we do need other proofs, you will have at least 10 days to provide them.
- If you need help getting the proofs, or you don't understand what we need, contact us right away.
- If you want to apply for any new benefits, do not use this form. Contact us for more information if you want to apply for new benefits.
- If on your application you tell us you want to "Go Green," you will get all future notifications from us through your NH EASY account. Going Green means your notices are paperless — you get your notices electronically. This means you get your notices faster than through "snail mail." Your notices and letters from us will be visible on one screen. Plus, you are helping the environment! After you Go Green, we will email you any time you have a notice using the email address you give to us. Go to [www.nheasy.nh.gov](http://www.nheasy.nh.gov) for more information.

PLEASE TURN THE PAGE — IMPORTANT INFORMATION IS ON THE BACK! BFA SR 20-07 (NA)

## ✓CHECKLIST OF REQUIRED PROOF

Use this page to check for all the proofs you need to give us.

NOT GIVING US ALL THE PROOFS WE ASK FOR CAN CAUSE YOUR BENEFITS TO GO DOWN OR EVEN END!

### Proof of Household Income

Please give us ONE proof of income for EACH type of income that is received by anyone living with you:

#### Salaried or Hourly Employees

- Copies of pay stubs for the last 4 weeks.
- A letter from the employer on company letterhead stating hours worked & gross wages earned for the most recent 4 weeks, or our BFA Form 756, which is available from your worker or online.

#### Self-employed Individuals

- Most recent federal income tax forms and all supporting schedules, e.g., Schedules C or E, or
- Other records, such as a recent Profit and Loss Statement, proof of earnings and expenses.

#### Other Kinds of Income

- Copy of any letter, bank statement, or check stub that clearly shows the gross amount of any benefits received, such as Social Security, SSI, Unemployment, VA, Worker's Compensation, disability, etc.
- Child/spousal support or educational income you get.
- All documents showing income you get from rent, royalties, interest, dividends, roomers/boarders in your home, money from friends/relatives, etc.

### Proof of Expenses You Want to Claim

With proof we may be able to subtract some other kinds of expenses from your income.

- Court-Ordered Child or Spousal Support — Give us one copy of the court order signed by a court official or a letter from the court or your attorney confirming the amount/frequency, plus proof of payment.
- Impairment Related Work Expenses - Cancelled checks or receipts for home/workplace modifications, special work or medical equipment, etc. which enable a disabled person to work.
- Legal Wage Garnishments - Pay stub itemizing the garnished amount, or a statement from your employer on company letterhead verifying the amount/frequency.
- Other Expenses — Proof of Taxes, child care, transportation, mandatory deductions, cost of special clothes, educational or medical costs.

### Proof of NH Residence/Student Status

Give us a copy of any ONE of the following that shows your current street address:

- Lease, rental agreement, or rent receipt; or
- Electric, cable, heating fuel, telephone bill; or
- Property tax bill, car registration, or library card; and
- If a student, proof of attendance and status.

### Proof of Resources You Own

Give us ONE copy of any of the following that you have:

- Most recent checking and saving statements.
- Most recent statements showing the current value of CDs, IRAs, trusts, annuities, Christmas Club accounts, stocks/bonds and any other interest-bearing accounts or instruments.
- Current face and cash values of life insurance policies other than term insurance.
- Registrations for all vehicles, boats, snowmobiles, ATVs, motorcycles, etc., owned by members of the household.

### Special SNAP Income Deductions

If you give us proof, we can also deduct some additional expenses that you pay out of your own pocket. Give us ONE copy of:

- Child or Adult Care Expenses  
Receipts that verify you paid someone to care for your child or to care for a disabled adult in your home so you could go to work or training.

#### Medical Expenses (for elderly or disabled individuals only)

- Health insurance premium bills or receipts.
- Bills or receipts for doctors, hospital visits, prescriptions (medical marijuana is not allowed), medical supplies, eyeglasses/contacts, dentures, hearing aids, or any other medical supplies or expenses.

#### Housing and Utility Expenses

- Rent, mortgage payments, or property tax receipts.
- Heat, cooking fuel, electricity, water, sewage, phone, internet (including mobile data) or trash collection receipts.
- Proof that you currently get NH Fuel Assistance (FA) or have received FA or more than \$20 in the last 12 months.

PLEASE GIVE US COPIES ONLY! ORIGINALS WILL NOT BE RETURNED.

ATTACH ADDITIONAL SHEETS OF PAPER IF THERE IS NOT ENOUGH ROOM ON THE FORM TO WRITE EVERYTHING.

If you have trouble getting any information, call us as soon as possible. We will help you get the proofs you need or will tell you if there are other kinds of proof that we can accept instead.





# Medicaid Coverage & Continuous Enrollment

APPLICATION FOR CONTINUED ELIGIBILITY FOR FINANCIAL, MEDICAL, CHILD CARE, AND SNAP (FORMERLY FOOD STAMP) BENEFITS					
<b>1. ABOUT YOU AND WHERE YOU LIVE:</b> Please tell us who you are and where you live.					
Name (First, Middle Initial, Last)		Mailing Address (if Different from Street Address)			
Street Address (House/Apt. #, Street, City, State, Zip Code)		Home Phone	Work Phone	Cell / MSG	
Email address:		DO YOU WANT TO GO GREEN? <input type="checkbox"/> YES <input type="checkbox"/> NO			
<p><small>WE WILL ACCEPT YOUR APPLICATION EVEN IF YOU ONLY FILL IN YOUR NAME, ADDRESS, AND SIGNATURE. HOWEVER, WE WILL BE ABLE TO FIGURE OUT IF YOU CAN CONTINUE TO GET BENEFITS MUCH QUICKER IF YOU COMPLETE THIS ENTIRE APPLICATION. IF YOU NEED HELP COMPLETING THIS APPLICATION, PLEASE SIGN ON THE BACK OF THIS PAGE IN THE SPACE PROVIDED AND THEN MARK THE BOX LOCATED UNDER THE SIGNATURE AREA WITH A CHECK. THEN RETURN THE APPLICATION TO US AS SOON AS POSSIBLE.</small></p>					
<b>2. ABOUT THE PEOPLE YOU LIVE WITH:</b> Start with yourself and list ALL of the people living with you.					
Name (First, MI, Last)	Gender	DOB (mm/dd/yyyy)	SSN	Relation to You	Student? If Y, put grade
	<input type="checkbox"/> F <input type="checkbox"/> M			SELF	<input type="checkbox"/> N <input type="checkbox"/> Y
	<input type="checkbox"/> F <input type="checkbox"/> M				<input type="checkbox"/> N <input type="checkbox"/> Y
	<input type="checkbox"/> F <input type="checkbox"/> M				<input type="checkbox"/> N <input type="checkbox"/> Y
	<input type="checkbox"/> F <input type="checkbox"/> M				<input type="checkbox"/> N <input type="checkbox"/> Y
Did any individual move in since your last review?		<input type="checkbox"/> Y <input type="checkbox"/> N	If yes, list his/her name and date s/he moved in:		
<b>3. ABOUT YOUR JOB AND INCOME:</b> Tell us how much gross income you and your household members have. Include all money you get from working, SSI/SSA, VA, child support, unemployment, friends, family, etc.					
Name of Person Receiving Money	Name of Agency, Employer, or Individual that Provides the Money	Gross Amount Received	How Often?		
		\$			
		\$			
		\$			
		\$			
<b>4. ABOUT ALL YOUR ASSETS:</b> Please tell us about everything you and the people you live with have. (Use another sheet if necessary)					
How much total cash money does your household have? \$	Savings Accounts: \$	Other Accounts: \$	Annuities/Bonds/Trusts: \$		
Do you or anyone living with you own or pay for a house, lot, or land other than where you live? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Do you or anyone living with you sell, trade, or give away any cash or property? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Do you or anyone living with you have life insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Tell us about all the cars, trucks, or other vehicles your household owns:					
1. Year/Make/Model:	Amount owed:	2. Year/Make/Model:	Amount owed:		
	\$		\$		
<b>5. ABOUT YOUR MEDICAL COVERAGE</b>					
Do you or any household member have health insurance other than Medicaid (such as private insurance, dental, vision, or prescription coverage)? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, Insurer/Policy #:					

<b>6. ABOUT YOUR EXPENSES:</b> We may be able to subtract some expenses from your income when we figure out your eligibility and benefit amounts. Please tell us about your monthly expenses.					
Court-ordered child or spousal support (enter the amount of the order):					
<input type="checkbox"/> Child Support: \$	<input type="checkbox"/> Spousal Support: \$	<input type="checkbox"/> Wage garnishment (only if paid): \$			
<input type="checkbox"/> Care for a dependent child or adult in the household who needs care while I am working (only if paid): \$			<input type="checkbox"/> Other legally required expenses (only if paid): \$		
<b>7. SPECIAL SNAP INCOME DEDUCTIONS</b>					
Monthly Rent/Mortgage	Heat	Utilities	Telephone	Property Taxes	Home Insurance
\$	\$	\$	\$	\$	\$
Do you currently get NH Fuel Assistance (FA) OR have you gotten FA of more than \$20 in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, you may be eligible for more SNAP benefits.					
Does any elderly or disabled member of your household have monthly medical costs, such as doctors' bills or receipts, medicine, medical insurance, transportation, home care, etc., that they pay out of their own pocket? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, write the name of the person who has the medical expenses: _____					
List the kinds of monthly medical expenses: _____					
Tell us the cost of the person's medical expenses each month: \$ _____					
<b>TO GET A DEDUCTION FOR ANY OF THE EXPENSES YOU ARE CLAIMING, YOU MUST TELL US ABOUT AND PROVIDE PROOF OF THESE EXPENSES.</b> We will not call you or send you any further notice to get this information from you. By not giving us proof or by not answering these questions, you are saying that your household does not want to get a deduction for these unreported or unverified expenses. Failure to tell us about or verify any of these expenses means that you may get less Food Stamp benefits each month.					
<b>8. ABOUT YOUR FEDERAL TAX FILING STATUS:</b> Only complete this section if you get Medical Assistance (MA). If you do not get MA, you can skip down to Section 9 below.					
First, please tell us your federal tax filing information: (You don't need to file taxes to get health coverage.)					
Your Full Name (first, middle initial, and last):					
Do you plan to file a federal income tax return NEXT YEAR?					
<input type="checkbox"/> Yes. If yes, please answer questions a – e. <input type="checkbox"/> No. If no, skip to question d.					
a. Will you file jointly with a spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, name of spouse: _____					
b. Will you claim any dependents on your tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, list name(s) of dependents: _____					
c. Do any of these dependents live with someone else? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, how many dependents live with someone else? _____					
Please list their name(s): _____					
d. Are you required to file a federal income tax return next year? <input type="checkbox"/> Yes <input type="checkbox"/> No					
e. Will you be claimed as a dependent on someone's tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, please list the name of the tax filer: _____					
How are you related to the tax filer? _____					
Next, please tell us about your family: Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. Attach an extra sheet of paper, if needed, to include everyone.					
<b>DO Include:</b>			<b>You DON'T have to include:</b>		
<ul style="list-style-type: none"> <li>Your spouse</li> <li>Your children under 21 who live with you</li> <li>Your unmarried partner if you have children in common or if he or she needs health coverage</li> <li>Anyone you include on your tax return, even if they don't live with you</li> <li>Anyone else under 21 who you take care of and lives with you</li> </ul>			<ul style="list-style-type: none"> <li>Your unmarried partner who doesn't need health coverage if you have no children in common</li> <li>Your unmarried partner's children</li> <li>Your parents who live with you, but file their own tax return (if you're over 21)</li> <li>Other adult relatives who file their own tax return</li> </ul>		



# Medicaid Coverage & Continuous Enrollment

NH Department of Health & Human Services (DHHS)  
Bureau of Family Assistance (BFA)

BFA Form 800R  
01/20

Person 2 Name (first, middle initial, and last): \_\_\_\_\_

Does PERSON 2 plan to file a federal income tax return NEXT YEAR?  
 Yes. If yes, please answer questions a – e.     No. If no, skip to question d.

a. Will PERSON 2 file jointly with a spouse?     Yes  No  
 If yes, name of spouse: \_\_\_\_\_

b. Will PERSON 2 claim any dependents on their tax return?     Yes  No  
 If yes, list name(s) of dependents: \_\_\_\_\_

c. Do any of these dependents live with someone else?     Yes  No  
 If yes, how many dependents live with someone else? \_\_\_\_\_  
 Please list their name(s): \_\_\_\_\_

d. Is PERSON 2 required to file a federal income tax return next year?     Yes  No

e. Will PERSON 2 be claimed as a dependent on someone's tax return?     Yes  No  
 If yes, please list the name of the tax filer: \_\_\_\_\_  
 How is PERSON 2 related to the tax filer? \_\_\_\_\_

---

Person 3 Name (first, middle initial, and last) \_\_\_\_\_

Does PERSON 3 plan to file a federal income tax return NEXT YEAR?  
 Yes. If yes, please answer questions a – e.     No. If no, skip to question d.

a. Will PERSON 3 file jointly with a spouse?     Yes  No  
 If yes, name of spouse: \_\_\_\_\_

b. Will PERSON 3 claim any dependents on their tax return?     Yes  No  
 If yes, list name(s) of dependents: \_\_\_\_\_

c. Do any of these dependents live with someone else?     Yes  No  
 If yes, how many dependents live with someone else? \_\_\_\_\_  
 Please list their name(s): \_\_\_\_\_

d. Is PERSON 3 required to file a federal income tax return next year?     Yes  No

e. Will PERSON 3 be claimed as a dependent on someone's tax return?     Yes  No  
 If yes, please list the name of the tax filer: \_\_\_\_\_  
 How is PERSON 3 related to the tax filer? \_\_\_\_\_

---

Person 4 Name (first, middle initial, and last) \_\_\_\_\_

Does PERSON 4 plan to file a federal income tax return NEXT YEAR?  
 Yes. If yes, please answer questions a – e.     No. If no, skip to question d.

a. Will PERSON 4 file jointly with a spouse?     Yes  No  
 If yes, name of spouse: \_\_\_\_\_

b. Will PERSON 4 claim any dependents on their tax return?     Yes  No  
 If yes, list name(s) of dependents: \_\_\_\_\_

c. Do any of these dependents live with someone else?     Yes  No  
 If yes, how many dependents live with someone else? \_\_\_\_\_  
 Please list their name(s): \_\_\_\_\_

d. Is PERSON 4 required to file a federal income tax return next year?     Yes  No

e. Will PERSON 4 be claimed as a dependent on someone's tax return?     Yes  No  
 If yes, please list the name of the tax filer: \_\_\_\_\_  
 How is PERSON 4 related to the tax filer? \_\_\_\_\_

## 9. PLEASE READ THE STATEMENTS BELOW, SIGN, & RETURN THIS APPLICATION BEFORE THE 15<sup>TH</sup> OF NEXT MONTH.

Do you expect any changes to any information on this form in the near future?     No     Yes

If yes, please explain: \_\_\_\_\_

BY SIGNING MY NAME BELOW, I AGREE TO EACH OF THE FOLLOWING STATEMENTS:

- I understand that if I choose to Go Green, this means that I will get future notifications from BFA through my NH EASY account, and will no longer get paper notices. BFA will email me when I have these notices using the email address I gave above. I understand that if I do not want to go paperless, I can go back to getting paper notices through my NH EASY account or by writing to my caseworker.
- All of the information I have provided on this Application is true to the best of my knowledge. I understand and agree to give proof of my statements as requested. I also understand and give permission to DHHS to contact other persons or organizations to get additional proofs of my eligibility and understand that the information I have provided will be used in computer matching with other agencies and that information obtained through matching programs may be used to determine and redetermine continued eligibility for and/or amount of my benefits.
- I understand that I must report any changes in my circumstances within 10 days of when the change occurs, or as instructed by my caseworker.
- I understand that deprivation of parental support and care is a condition of eligibility for FANF. Additionally, if I get FANF because of deprivation due to continued absence of a parent, my signature below also means that I certify the continued absence of all responsible parents associated with my FANF case, and I agree to immediately notify DHHS if any responsible parent returns to my home.
- I understand that if either my spouse or I are requesting long-term care services (Nursing Facility or Home and Community-Based Care), any annuity purchased or modified by my spouse or me on or after February 8, 2006 will be considered a transfer of assets for less than fair market value unless the State is named the beneficiary for at least the amount of Medicaid paid for long-term care services.
- I understand that DHHS may share my SSN and the SSN of my spouse or household member(s) that I have provided with contracted third parties to verify my income and resource eligibility.
- If I am not satisfied with the decision on my application, I may request an appeal within 30 days for cash and Medicaid, or within 90 days for Food Stamps, from the date of the Notice of Decision, by contacting the District Office or DHHS, Administrative Appeals Unit, State Office Park South, 105 Pleasant St., Concord, NH 03301-6521. Telephone 1-800-852-3345, extension 4292. I can choose to have an attorney or other person represent me at an Administrative Appeal. DHHS will not pay for the cost of any legal services. I understand that there is free and reduced cost legal services available in NH.

Signature of Recipient \_\_\_\_\_

Date \_\_\_\_\_

If someone helped you complete this form, that individual must sign below:

Printed Name & Title \_\_\_\_\_

Signature \_\_\_\_\_

Telephone # \_\_\_\_\_

I Need Help Completing This Form.    Nondiscrimination Statement

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs. The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form](#), (AD-3027), found online at: [How to File a Complaint](#), and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights    (2) fax: (202) 690-7442; or  
 1400 Independence Avenue, SW; Washington, D.C. 20250-9410    (3) email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the [State Information/Hotline Numbers](#) (click the link for a listing of hotline numbers by State); found online at: [SNAP Hotline](#).

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7897 (TTY). This institution is an equal opportunity provider.





# Who can we refer patients too who no longer qualify for Medicaid

- First Choice- 1-877-211-Navi
- Healthcare.gov







## Contact Me for Assistance

- I am available to bring my knowledge and years of experience to your hospital and community by providing free service to your consumers in helping obtain Marketplace insurance <https://www.healthcare.gov> or Granite Advantage Medicaid. I look forward to working with you and your consumers.
- Feel free to reach out to me and set up an appointment, as I am eager to help at [ajasion@healthynh.org](mailto:ajasion@healthynh.org) or by phone at 603-415-4256. Thank you





## LOOKING FOR HEALTH INSURANCE FOR YOU OR YOUR FAMILY?

You and your children may be eligible for free or low-cost health insurance through Medicaid, CHIP, or the Health Insurance Marketplace.

To see if you & your family are eligible, call Adrian Jasion, Health Insurance Navigator, at the Foundation for Healthy Communities at (603) 415-4256 or email [ajasion@healthynh.org](mailto:ajasion@healthynh.org)

*Through our free, grant-funded program, we can help people in New Hampshire identify the right insurance options available to them. If you're looking for health insurance for you and your family, call us today.*





# Q and A

- Does anyone have questions

