INSURANCE ASSISTANCE PROGRAM REDETERMINATION

Michigan Department of Health and Human Services

To remain eligible, you must complete this form and return it in 30 days. Failure to return this form in 30 days will result in delay in your insurance payment or cancellation from the insurance assistance program.

1. Recipient Name		2. Address	
3. City	4. State	5. Zip	6. County

7. Social Security Number	8. Date	9. Telephone Number

ANSWER ALL QUESTIONS LISTED BELOW

EMPLOYMENT INCOME Answer all questions that apply to your employment and **submit income verification**.

10. Are you employed or self-employed? ☐ Yes ☐ No ▸ If yes, completed items 11-20 below.				
If you are Currently Working List Employer(s) Name	Number of Hours Per Week	Wages Before Deductions	How Often Paid: Weekly, Every 2 Weeks, Twice a Month, Monthly, Other	Is Health Insurance Available Through Your Employer
11.	12.	13.	14.	15. ☐ Yes ☐ No
16.	17.	18.	19.	20. ☐ Yes ☐ No

OTHER INCOME Check all that apply and **submit income verification**.

21. Do you receive money from:	22. If yes, give monthly amount	23. Who receives?
☐ Social Security Benefits	$	
☐ Veteran's Benefits	$	
☐ Unemployment or Worker's Compensation	$	
☐ Disability Benefits Long Term and Short Term	$	
Do you Receive Money From:		
☐ Child Support	$	
☐ Retirement Benefits	$	
☐ Spouse's Income	$	
☐ Other Income (please explain)	$	
29. If you are currently working and you are eligible for an employer sponsored health insurance, what is the date you will become eligible? (Please list date) _____		

Record Asset Information on Next Page

ASSETS: Check off all that apply and **submit verification. Include assets held jointly.**

ASSET TYPE

30. Do you have any of the following accounts:	31. Name(s) on the Account	32. Name and Address of Bank, Credit Union, Savings	33. Account Number	34. Balance as of Current Date
☐ Checking/Draft Accounts				$
☐ Money Market				$
☐ Savings/Share Accounts				$
☐ Certificates of Deposit (CD)				$
			Amount/Value	Owners
☐ Cash on Hand or in Safe Deposit Box				
☐ Savings Bonds, Stock or Mutual Funds				
☐ IRA, KEOGH, 401K or Deferred Compensation account(s)				
☐ Trust Funds, Land Contracts, Real Estate (not including your home)				
☐ Other Assets (List)				
☐ None (from listed above)				

I certify, under penalty of perjury, that all the information that I have written on this form or told to a caseworker is true.

35. Print Applicant Name	Applicant Signature	Date

Case Manager, if applicable (Print Name)	Agency
Phone Number	Email

Redetermination forms should be mailed to the address below or **faxed** to **517-335-7723**.

Michigan Department of Health and Human Services
Insurance Assistance Program
109 W. Michigan Avenue, 9th Floor
Lansing, MI 48913

If you have any questions, please call 877-342-2437.

This form is issued under authority of 45 CFR 206.10(a)(1)(ii); 42 CFR 435.907l; CFR 273.2(d); and Sections 24, 25, and 59 Act 280 of the Public Acts of 1939, as amended. You must complete this form if you want the agency to consider your re-application for the insurance assistance program.

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