

# Family and Children's Medical Benefits Renewal

**This form is for renewal of medical benefits only. To apply for financial or food assistance contact your local DSHS Community Services Office (CSO).**

**To continue medical coverage you must complete a yearly renewal by doing one of the following:**

- **Call the number on the attached letter to complete your renewal by telephone; or**
- **Complete this form and mail it to us with current proof of income.**

**Please Print.**

CLIENT ID NUMBER

FIRST NAME	LAST NAME	MIDDLE INITIAL	DATE OF BIRTH
ADDRESS		CITY	STATE ZIP CODE
MAILING ADDRESS (IF DIFFERENT)		CITY	STATE ZIP CODE
HOME PHONE NUMBER INCLUDE AREA CODE	CELL PHONE NUMBER INCLUDE AREA CODE	EMAIL ADDRESS	

**HOUSEHOLD**

Has anyone moved **into** your home in the past 12 months?    Yes     No

NAME	DATE OF BIRTH	GENDER	SSN
		Female <input type="checkbox"/> Male <input type="checkbox"/>	

U.S. Citizen    Yes     No

Relationship to you

Has anyone moved **out** of your home in the past 12 months?     Yes     No

NAME	DATE MOVED OUT
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Did anyone in the household begin receiving private health insurance in the past 12 months?     Yes     No

If yes, who \_\_\_\_\_

Name of private health insurance \_\_\_\_\_

**All Monthly Earned or Unearned Income for your household.**

Name of person with Income	Employer (Name/Phone) or Income Source	Monthly Income (before taxes or expenses)

**Note: Provide proof of your current income. Proof of earned income is copies of wage stubs, or a statement from your employer. If you are self-employed, you can provide a copy of last year's income tax return. Don't wait to call or return this renewal form because you don't have proof of income.**

**Expenses paid by your household**

Total monthly child care cost you pay so you can work    \$

Total court ordered child support you pay each month    \$

