Washington State Health Care Authority

Apple Health Renewals

Updated October 2014

Agenda

Apple Health Renewal Process

- Auto-Renewal
- Manual Renewal
- How to Process a Renewal in Healthplanfinder
- Other Renewal Info
- Resource Information

Apple Health Renewal Process

Apple Health (Medicaid) Renewals

For individuals receiving Apple Health MAGI Medicaid* through Healthplanfinder:

- 60 days prior to an Apple Health recipient's renewal due date, the Healthplanfinder system captures the individual's original application and determines whether he or she is eligible for auto-renewal

- Individuals will be notified whether they have been auto-renewed or that they could not be auto-renewed and must complete a manual renewal

*MAGI Medicaid: Family, Children, Pregnancy and Adult medical programs

Auto-Renewal Vs. Manual

Auto-Renewal

- Data-match finds household under the Medicaid standard
- No data-match found and income on file under the Medicaid standard
- No additional information needed by recipient
- Recertified for twelve months

Manual

- Data-match finds household above Medicaid standard
- Individual must manually complete their renewal

Auto-Renewal

Auto-Renewal

If the original application is determined to be eligible for auto-renewal:

- The individual will be sent a pre-populated notification (**Healthplanfinder-EE008)** that summarizes their account, household composition, tax filing status, and other application-related information.

- The EE008 notification will inform the individual that their Washington Apple Health determination and enrollment has been renewed for 12 months.

Auto-Renewal

The notification informs the individual they must review the information carefully.

Incorrect information must be corrected by reporting required changes:

- Online at www.wahealthplanfinder.org
- Call Healthplanfinder CSC at 1-855-923-4633
- Make changes to the document received, sign and return via:
  - Mail: PO Box 946, Olympia, WA 98507
  - Fax: 1-855-889-2266

Auto-Renewal:

The EE008 notification informs the individual they have been auto-renewed and will continue receiving Apple Health coverage.

Washington Health Benefit Exchange
521 Capitol Way South
PO Box 657
Olympia, WA 98507

washington healthplanfinder

<<Date>>

<<Individual Name>>
<<Individual Mailing Address>>
<<City, State, Zip Code>>

Application ID:<< Application ID >>

Subject - **Washington Apple Health Renewal**

Dear <<Individual Name>>,

We have reviewed your eligibility and we have renewed Washington Apple Health for:

	Begin Date	End Date
<<Individual Name>>	<<MM/DD/YYYY (Begin Date)>>	<< MM/DD/YYYY (End Date)>>

[Washington Apple Health with Premiums Renewal Tag]

Decision Review

Please review the attached insert listing the information we used to determine you are still eligible for Washington Apple Health.

If the information listed is correct and you would still like Washington Apple Health, you do not need to respond to this letter.

If any of the information is incorrect, report the changes or corrections by doing one of the following:

- **Go online through the <HBEURL>;**
- **Call <HBEPHONE>; or**
- **Make changes on the attached insert, sign, and mail or fax to:**
  <HBEADDRESS1
  HBEADDRESS2
  HBECITY
  HBESTATE
  HBEZIP>

  Fax Number: <HBEFAX>

Appeal Rights

If you disagree with the decisions above you have the right to appeal. See the attached information about your appeal rights. There are deadlines to appeal so you should act quickly.

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EE008

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Washington Health Benefit Exchange
521 Capitol Way South
PO Box 657
Olympia, WA 98507

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<<Date>>

<<Individual Name>>
<<Individual Mailing Address>>
<<City, State, Zip Code>>

Application ID:<< Application ID >>

Subject - **Washington Apple Health Renewal**

Dear <<Individual Name>>,

We have reviewed your eligibility and we have renewed Washington Apple Health for:

	Begin Date	End Date
<<Individual Name>>	<<MM/DD/YYYY (Begin Date)>>	<< MM/DD/YYYY (End Date)>>

[Washington Apple Health with Premiums Renewal Tag]

Decision Review

Please review the attached insert listing the information we used to determine you are still eligible for Washington Apple Health.

If the information listed is correct and you would still like Washington Apple Health, you do not need to respond to this letter.

If any of the information is incorrect, report the changes or corrections by doing one of the following:

- **Go online through the <HBEURL>;**
- **Call <HBEPHONE>; or**
- **Make changes on the attached insert, sign, and mail or fax to:**
  <HBEADDRESS1
  HBEADDRESS2
  HBECITY
  HBESTATE
  HBEZIP>

  Fax Number: <HBEFAX>

Appeal Rights

If you disagree with the decisions above you have the right to appeal. See the attached information about your appeal rights. There are deadlines to appeal so you should act quickly.

Correspondence ID: <<SystemNumber>>
<CORR#>

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521 Capitol Way South
PO Box 657
Olympia, WA 98507

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Current Account Information

Application ID:<< Application ID >>

Please check the information below that we have on file. You can update this information on line. If you choose to reply by mail, please write the information that has changed in the "Updated Information" column.

Head of Household

	Current Information	Updated Information
First Name	<< First Name >>	
Middle Initial	<< Middle Initial >>	
Last Name	<< Last Name >>	
Social Security number	***-**-<< Last Four Digits of SSN >>	
Date of Birth	<< Date of Birth >>	

Physical Address

	Current Information	Updated Information
Address Line 1	<< Address Line 1 >>	
Address Line 2	<< Address Line 2 >>	
City	<< City >>	
State	<< State >>	
County	<< County >>	
Zip Code	<< Zip Code >>	

Mailing Address

	Current Information	Updated Information
Address Line 1	<< Address Line 1 >>	
Address Line 2	<< Address Line 2 >>	
City	<< City >>	
State	<< State >>	
County	<< County >>	
Zip Code	<< Zip Code >>	

Contact Information

	Current Information	Updated Information
Phone Number	<< Phone Number >>	
Alternate Phone Number	<< Alternate Phone Number >>	

Language

	Current Information	Updated Information
Preferred Written Language	<< Written Language >>	
Preferred Spoken Language	<< Spoken Language >>	

Correspondence ID: <<SystemNumber>>
<CORR#>

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If you no longer want coverage for anyone named below, please cross out that name and write why you no longer want coverage for them. If any other information for these household members has changed, please write it in the line below their name.

Existing Household Members

Name	Gender	SSN	DOB	Still Need Coverage? (if not, why not)	Residing with HOH	Race(s)
<< Person 1>>	<< >>	***-**-<< Last Four Digits of SSN >>	<< >>	<< >>	<< >>	<< >>
Updated Information for <<Person 1>>?						
<< Person 2>>	<< >>	***-**-<< Last Four Digits of SSN >>	<< >>	<< >>	<< >>	<< >>
Updated Information for <<Person 2>>?						
<< Person 3>>	<< >>	***-**-<< Last Four Digits of SSN >>	<< >>	<< >>	<< >>	<< >>
Updated Information?						

Please add the names of anyone not listed who is new in your home.

New Household Members

Name	Gender	SSN	DOB	Need Coverage	Residing with HOH	Race(s)

Tax Status

<<Last Year>>	<<Current Year>>	<<Next Year>>

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Correspondence ID: <<SystemNumber>>
<CORR#>

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<< Person 1 >>	<< >>	<< >>	<< >>
Updates for Person 1?			
<< Person 2 >>	<< >>	<< >>	<< >>
Updates for Person 2?			
<< Person 3 >>	<< >>	<< >>	<< >>
Updates for Person 3?			

Tax Status for New Household Members

	<<Last Year>>	<<Current Year>>	<<Next Year>>

Relationships

	Current Relationship Status
<< Person 1 >>	<< >>
Updates for Person 1?	
<< Person 2 >>	<< >>
Updates for Person 2?	
<< Person 3 >>	<< >>
Updates for Person 3?	

Relationships for New Household Members

Name	Relationship to Head of Household

Additional Questions
(The Exchange will contact you for additional information)

	Y/N	Updates? (Y/N)
Are all members on this application US citizens?	<< >>	
Is any member on this application affiliated with a tribe?	<< >>	
Is any member on this application currently incarcerated?	<< >>	
Does any member on this application use tobacco products?	<< >>	
Is any member on this application currently pregnant?	<< >>	
Does any member on this application have other health insurance?	<< >>	
Are all members on this application residents of WA?	<< >>	

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Correspondence ID: <<SystemNumber>>
<CORR#>

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Washington Health Benefit Exchange
521 Capitol Way South
PO Box 657
Olympia, WA 98507

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Additional ScreeningQuestions
(The Exchange will contact you for additional information)

	Y/N
Someone in my household needs long-term care services because they are currently living in or expect to move to a medical facility, like a nursing home?	<< >>
Someone in my household needs an in-home care-giver?	<< >>
Someone in my household needs Assisted Living services?	<< >>
Someone in my household needs services through the Division of Developmental Disabilities?	<< >>
Someone in my household needs Hospice care?	<< >>
Do you need a disability determination because of a disabling condition expected to last 12 months or longer or result in death?	<< >>
Do you or someone in your household have any unpaid medical expenses incurred within three months of this application?	<< >>
Do you or someone in your household need coverage due to an emergency hospitalization, cancer or kidney disease?	<< >>

Last Confirmed Income

	Type of Income/Deduction	Monthly Income/Deductions Amount
<< Person 1 >>	<< >>	<< >>
<< Person 2 >>	<< >>	<< >>
<< Person 3 >>	<< >>	<< >>
Total Household Income		<< >>

Income/Deduction Updates including new household members reported

Income	Member with Income/Deduction	Monthly Income/ Deduction Amount	Frequency (such as weekly/monthly)
Wages from employment			
Self-employment			
Dividend payments (stock/shares)			
Rental Income			
Unemployment/ Workers Compensation			
Social Security or Railroad benefits			
Veterans or Military benefits			

Correspondence ID: <<SystemNumber>>
<CORR#>

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Pension, Annuity or IRA income			
Tribal gaming income			
Deductions			
Student tuition and fees			
Health Savings Account contribution			
Alimony/pre-tax retirement contributions/student loan interest/moving costs			
Self-employment Deductions			
Self-employment tax			
Self-employment retirement plan contributions			
Self-employment health insurance premiums			

READ CAREFULLY
I have read and understand the information in this review. I declare, under penalty of perjury, the information I gave in this review is true, correct, and complete to the best of my knowledge.

Primary Applicants Name: << Individuals Name >>

Primary Applicant Signature: _____ Date: _____

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Manual Renewal

Manual Renewal

Example of applications that are not eligible for auto-renewal:

- Automated data-match shows income over the Apple Health (Medicaid) standard

Manual Renewal

If the original application is determined not eligible for auto-renewal:

- The individual will be sent a notification that they must manually renew their Apple Health coverage.

The individual can complete their renewal:

- Online at www.wahealthplanfinder.org
- Call Healthplanfinder CSC at 1-855-923-4633
- Update the renewal document received, sign and return via:
  - Mail: PO Box 946, Olympia, WA 98507; or
  - Fax: 1-855-889-2266

Manual Renewal:

The EE009 notification informs the individual they must manually renew their health care coverage to continue receiving Apple Health.

Washington Health Benefit Exchange
521 Capitol Way South
PO Box 657
Olympia, WA 98507

washington healthplanfinder

<<Date>>

<<Individual Name>>
<<Individual Mailing Address>>
<<City, State, Zip Code>>

Application ID:<<Application ID :

Subject – **Washington Apple Health Renewal Action Required**

Dear << Individual Name >>,

It is time for us to review eligibility for Washington Apple Health. We reviewed your case to see if we could automatically renew Washington Apple Health. We are unable to renew Washington Apple Health for your household using current information that we have and **you need to take action to keep your health care coverage**.

[19-Year Old Age Out]

[Household Action Required]

Appeal Rights

If you disagree with the decisions above you have the right to appeal. See the attached information about your appeal rights. There are deadlines to appeal so you should act quickly.

How to Contact Washington Healthplanfinder

Contact us if you have any questions about this letter. Let us know if you need help applying for or accessing your health insurance due to a disability. You can contact us in any of the following ways:

- Online at <HBEURL> ;
- By email at <HBEEMAIL>;
- By calling <HBEPHONE> and <HBETTY>;
- By Fax <HBEFAX>;
- By mail at:

  <HBEADDRESS1
  HBEADDRESS2
  HBECITY
  HBESTATE
  HBEZIP>
- You can drop off an application, renewal form, or any other documents requested by the

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EE009

Washington State Health Care Authority

How to Process a Renewal

Let's process a renewal in Healthplanfinder!

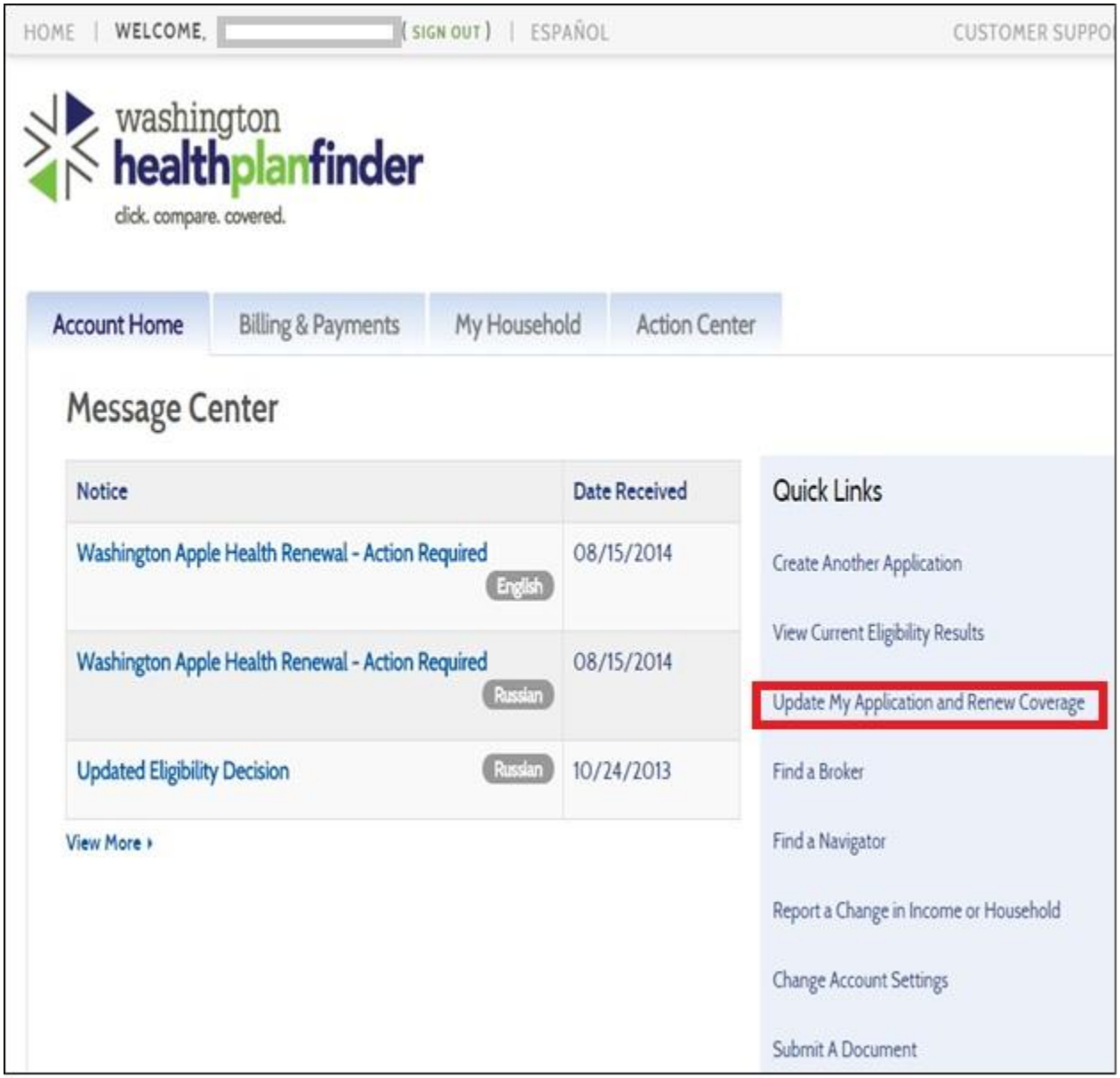
- The following step-by-step process shows how to process an Apple Health renewal in Healthplanfinder (HPF), when an individual has an existing account.

  - Note: Apple Health users are not required to "create an account." Individuals continue to have the option on the "About You" screen to "Skip Account Creation."
  - Account Creation is strongly encouraged to simplify the referral process and locate the account in future visits to Healthplanfinder.

1) Log in to your existing account in HPF.

2) Click on "Update my Application and Renew Coverage" under Quick Links

<u>Note</u>: This option appears 60 days prior to the end date and up to 90 days after coverage has ended for no renewal.



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About You:

3) Information should be prefilled.

- Verify that information is correct.
- Make changes as needed.

FIRST NAME * | M.I | LAST NAME * | SUFFIX

Notice:
Please provide your official name such as the name on your social security card.

SOCIAL SECURITY NUMBER | DATE OF BIRTH *

SOCIAL SECURITY DISCLOSURE

SEX *
- MALE
- FEMALE

WHO ARE YOU APPLYING FOR? *
Myself and Others

DO YOU WANT TO APPLY FOR HEALTH INSURANCE PREMIUM TAX CREDIT, COST-SHARING REDUCTIONS OR WASHINGTON APPLE HEALTH? *
- YES
- NO

RACE
Thai
Unreported
Vietnamese
White

HISPANIC ORIGIN
Not Spanish/Hispanic

ARE YOU AN AMERICAN INDIAN OR ALASKAN NATIVE? *
- YES
- NO

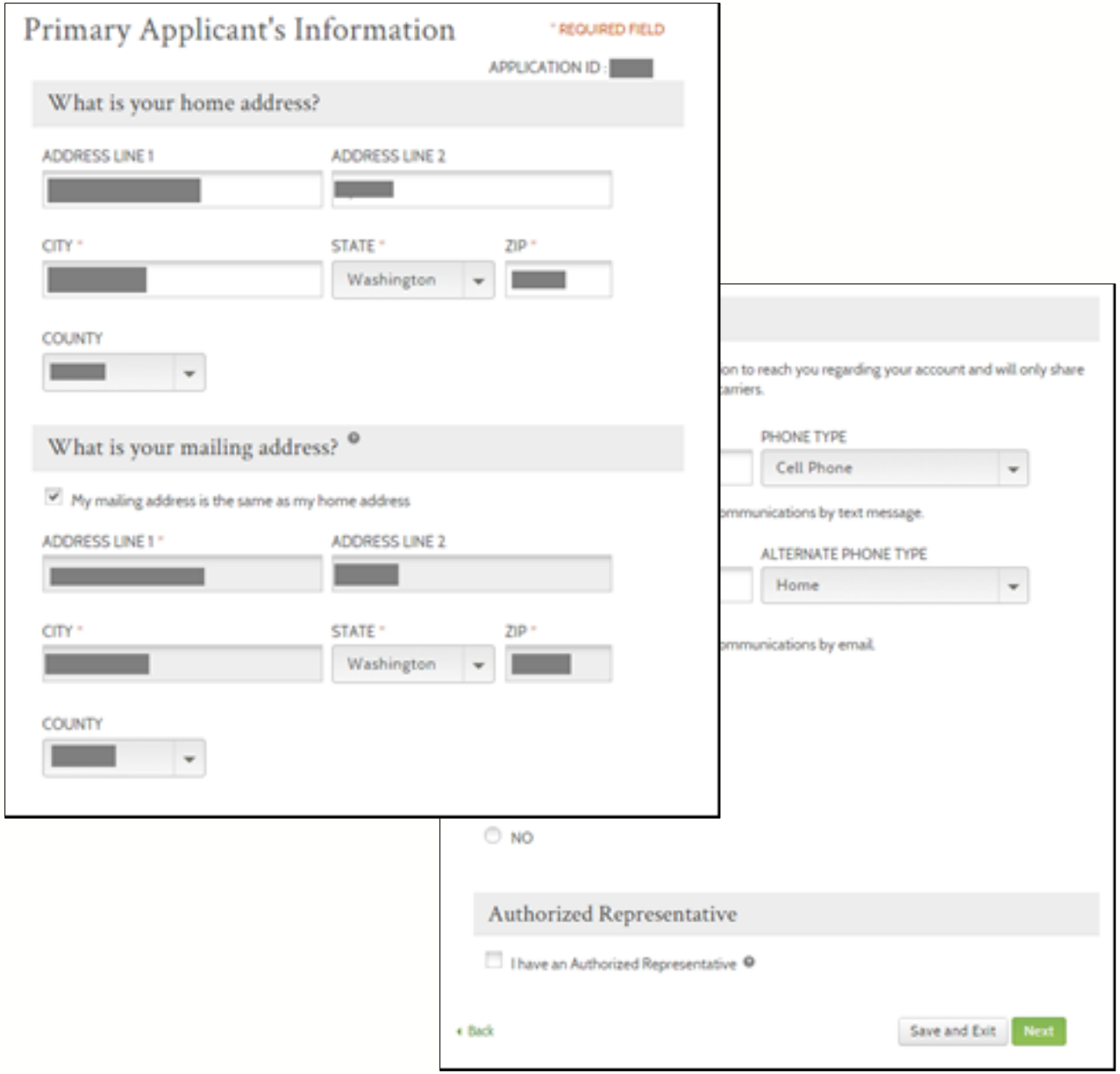
Yes, I have read the Washington Healthplanfinder Privacy Policy*

Next

Primary Applicant's Information:

4) Information should be prefilled.

- Verify that information is correct.
- Make changes as needed.



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Primary Applicant's Taxes:

5) Information should be prefilled.

- Verify that information is correct.
- Make changes as needed.

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Other Household Members or Tax Dependents:

6) Information should be prefilled.

- This is where household members can be added/removed.
- Verify that information is correct. Make changes as needed.

Do you have other household members or tax dependents?

Note: All household and tax dependents must be listed, even if they do not need health care coverage

Name	Sex	Social Security Number	Date of Birth (MM/DD/YYYY)	Applying for Coverage	Living in Same Home as [redacted]	Edit	Remove
[redacted]	Male	XXX-XX-[redacted]	[redacted]	Yes	N/A		
[redacted]	Female	XXX-XX-[redacted]	[redacted]	Yes	Yes		
[redacted]	Female	XXX-XX-[redacted]	[redacted]	Yes	Yes		
[redacted]	Female	XXX-XX-[redacted]	[redacted]	Yes	Yes		
[redacted]	Male	XXX-XX-[redacted]	[redacted]	Yes	Yes		
[redacted]	Male	XXX-XX-[redacted]	[redacted]	Yes	Yes		

Add Member

Back

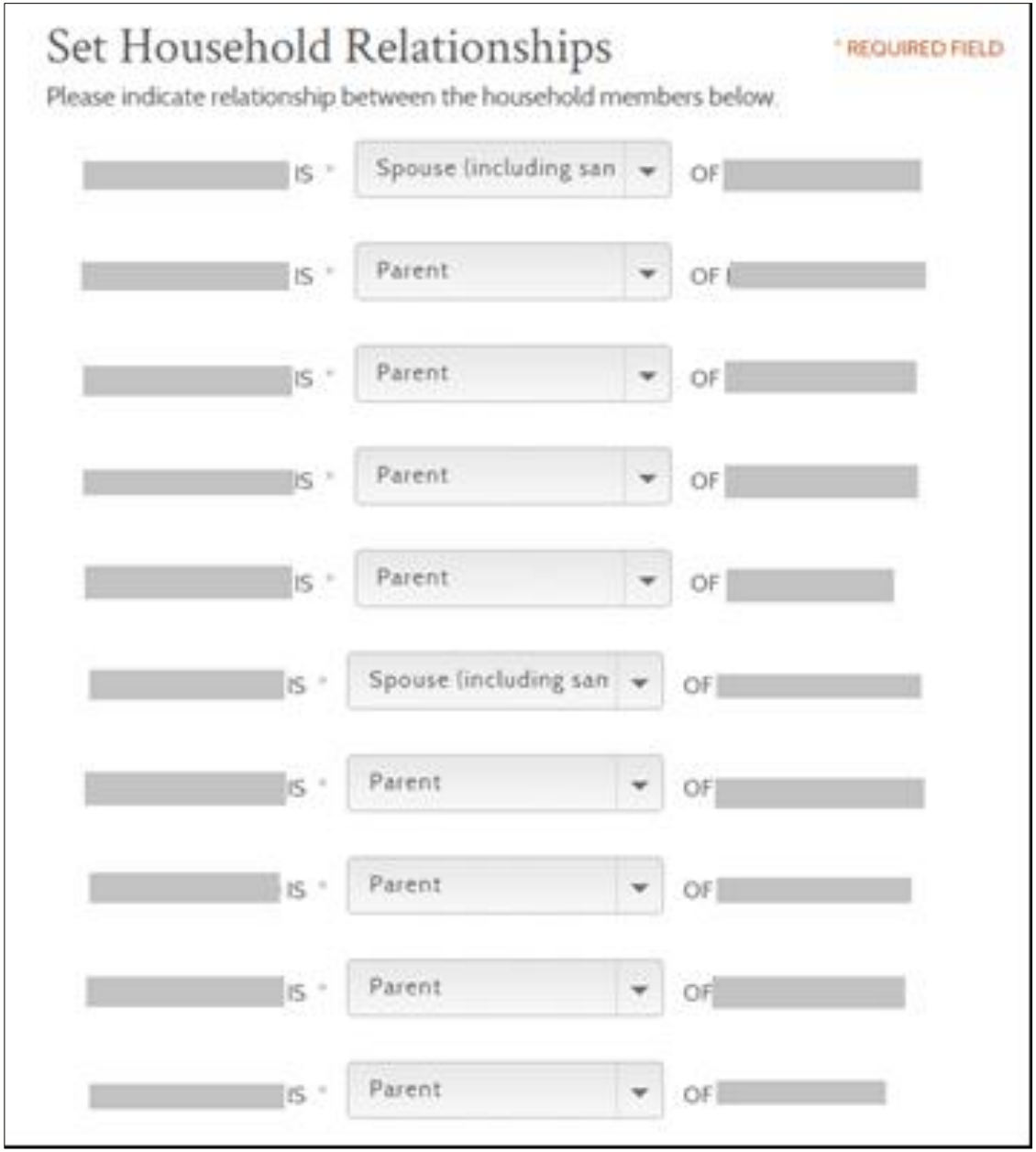
Save and Exit

Next

Set Household Relationships:

7) Information should be prefilled.

- Verify that information is correct.
- Make changes as needed.



Additional Questions:

8) Information should be prefilled.

- This is where to report a pregnancy or any changes in health insurance.
- Verify that information is correct. Make changes as needed.

Additional Questions

* REQUIRED FIELD

Answers to these questions are necessary to process your application.
Please respond to the questions below and only select the applicable household members.
Note: The only names that will appear are for the individuals that you indicated you wanted enrolled in coverage.

Is every member on this application a U.S. citizen (including naturalized or derived citizenship) or U.S. national? *	YES	NO
Is any household member on this application currently incarcerated? *	YES	NO
Has any household member on this application regularly used tobacco products in the past 6 months? *	YES	NO
Is any household member on this application currently pregnant? *	YES	NO
Does any household member on this application currently have health insurance? *	YES	NO
Have any of your children lost health insurance within the last four months? *	YES	NO
Are all household members on this application residents of the State of Washington? *	YES	NO

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Save and Exit | Next

Additional Screening Questions:

9) Information should be prefilled.

- LTC and retroactive coverage requests are updated here.
- Verify that information is correct. Make changes as needed.

Additional Screening Questions

* REQUIRED FIELD

Long Term Care Coverage

If you or someone in your household needs long-term care or Hospice services, please answer the following questions

Someone in my household needs long-term care services because they are currently living in or expect to move to a medical facility, like a nursing home? *	YES	NO
Someone in my household needs an in-home care-giver? *	YES	NO
Someone in my household needs Assisted Living services? *	YES	NO
Someone in my household needs services through the Division of Developmental Disabilities? *	YES	NO
Someone in my household needs Hospice care? *	YES	NO
Do you need a disability determination because of a disabling condition expected to last 12 months or longer or result in death? *	YES	NO

Unpaid Medical Expenses Coverage

Do you or someone in your household have any unpaid medical expenses incurred within three months of this application? *	YES	NO

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Save and Exit | Next

Household Income and Deductions:

10) Information should be prefilled.

- Report any income changes.
- Verify that information is correct. Make changes as needed.

Household Income

* REQUIRED FIELD

This section helps us determine the amount of your households income to determine if you are eligible for free or low cost health coverage including Washington Apple Health.

Please answer the following questions for each household member as accurately as you can. Only enter information about the types of income we ask for. You will have an opportunity to review the income we have calculated at the end of the questions.

Please include income of all individuals age 14 and older.

Household Income

Are you or someone in your household currently employed? * YES NO

Are you a public employee (do you work for a municipal, city, county, state government? Or as an employee of a public education system?) * YES NO

Are you or someone in your household currently self-employed? * YES NO

Have you or someone in your household received: dividend payments from companies in which you hold stock, shares or ownership, interest payments (both taxable and tax-exempt), capital gains or losses, farm income or losses, or income from partnerships, S corporations, trusts, etc., other than what you reported above for self employment? * YES NO

Do you or someone in your household receive income from renting a home or royalties that was not included in your self-employment income? * YES NO

Do you or someone in your household expect to receive unemployment income this month? * YES NO

Do you or someone in your household receive social security or railroad retirement benefits? * YES NO

Do you or someone in your household receive an annuity or pension (including military retirement that is not disability related) or IRA distribution income? * YES NO

Do you or someone in your household receive alimony/spousal support, foreign earned income, other claimable gains or losses, or Economic Development funds from tribes (for example, per capita distributions from gaming)? * YES NO

Deductions

You are being asked additional questions regarding deductions the IRS may allow you. These deductions may lower the amount of your countable income. If you do not want to answer these questions, you may still qualify for free or low cost health insurance through Washington Healthplanfinder.

If you or someone in your household is a student attending a college of higher education, do you pay tuition or other school related fees? * YES NO

Do you or someone in your household contribute monthly to a Health Savings Account? * YES NO

Do you or someone in your household have any of the following expenses: alimony/spousal support, student loan interest, educator expenses, moving costs since January of the current year, domestic production activities, penalty on early withdrawal of savings, pre-tax retirement account payments (excluding Roth IRA contributions), or certain claimable business expenses of reservists, performing artists, or fee-basis government officials? For each of these categories, please provide the amount that the IRS would allow you to subtract from total income to calculate your adjusted gross income. * YES NO

‹ Back Save and Exit Next

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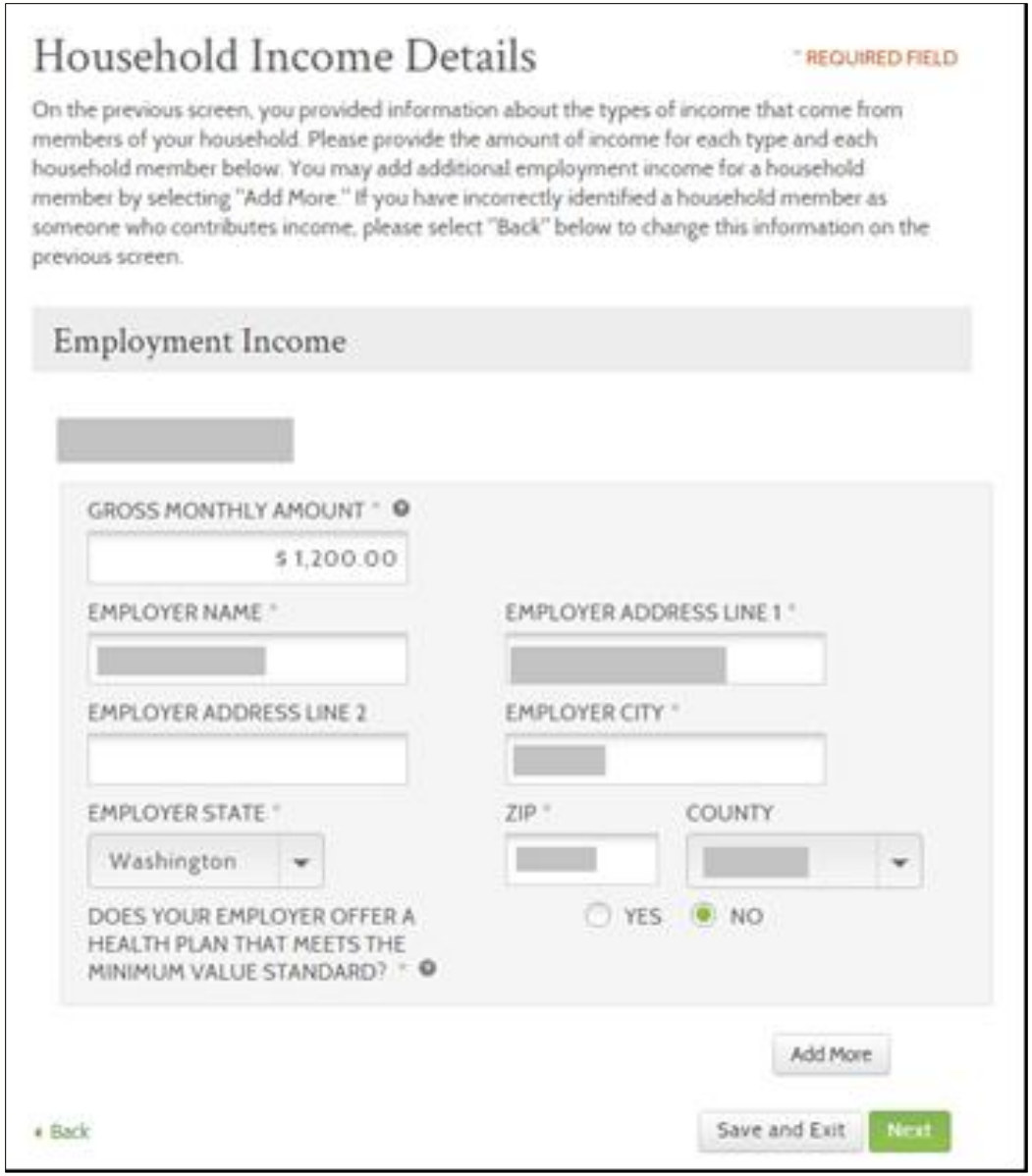
Household Income Details:

11) Information should be prefilled.

- Update income information.
- Verify that information is correct. Make changes as needed.



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Application Review and Additional Screening Questions:

12) Information should be prefilled.

- Opportunity for final review.
- Verify that information is correct.

Application Review

Please review the information you have provided so far in your application. You may make changes to any area where there is an edit option. Selecting the edit option will take you back to that section of the application. Selecting 'Next' from this screen takes you to the signature page so you can submit this application.

Please review the information you have entered before you submit your application.

Primary Account Holder

First Name
Middle Initial
Last Name
Social Security Number XXX-XX-
Date of Birth
Sex Male
Email

Edit

Physical Address

Address Line 1
Address Line 2
City
State WA
ZIP

Additional Screening Questions

Name	Long Term Care Services	In-home care-giver	Assisted Living Care Services	Divison of Developmental Disabilities Services	Hospice Care	Medical Personal Care Services	Unpaid Medical Expenses	Emergency Hospitalization
	No	No	No	No	No	No	No	
	No	No	No	No	No	No	No	
	No	No	No	No	No	No	No	
	No	No	No	No	No	No	No	
	No	No	No	No	No	No	No	
	No	No	No	No	No	No	No	

Edit

Back

Next

Primary Applicant's Signature:

13) Submitting the application.

- Certify that you understand your rights and responsibilities.
- E-sign the application.

Primary Applicant's Signature

* REQUIRED FIELD

I have agreed to submit this application electronically. By signing this application electronically, I certify under penalty and false swearing that my answers are correct and complete to the best of my knowledge.

I also certify that:

- I understand the questions and statements within this application.
- I understand the penalties for giving false information or breaking the law.
- I understand that the Washington Healthplanfinder may contact other persons or organizations on my behalf.
- I understand that an electronic signature has the same legal effect and can be enforced in the same way as a written signature.

☐ By checking this box and signing my name below, I confirm that I am completing e-signing this application on the applicant's behalf. *

☐ In order to simplify the application redetermination process, I authorize Washington Healthplanfinder to obtain my updated federal tax information for a period of no more than five years. I can change my consent any time through Washington Healthplanfinder.

☐ I have read the Rights & Responsibilities *

FIRST NAME *	MIDDLE INITIAL	LAST NAME *
Eg. John	Eg. A	Eg. Smith

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Submit My Application

Eligibility Results/ Household Summary:

14) Review the final results.

- Eligibility Results
- Household Summary

Eligibility Results

Congratulations! We received and reviewed your application and determined the following individuals will receive the health care coverage listed below:

Coverage for 2014

Name	Program	Status	Eligibility Start Date	Eligibility End Date	Reason
	Washington Apple Health Family Coverage	Approved	10/01/2013		
	Washington Apple Health for Kids Coverage	Approved	12/01/2013		
	Washington Apple Health for Kids Coverage	Approved	12/01/2013		
	Washington Apple Health Family Coverage	Approved	10/01/2013		
	Washington Apple Health for Kids Coverage	Approved	12/01/2013		
	Washington Apple Health for Kids Coverage	Approved	12/01/2013		

Washington Apple Health

The following household members are eligible for Washington Apple Health

You will receive a letter telling you, which managed care plan you are enroll

You will also receive instructions and a "Healthy Options Medical Benefit Bo more information about your benefits and plans available in your area. Call Health at 1-800-562-3022 if you need help.

Name

Household Summary

Below is the summary of plan(s) selected for your household.

Coverage	Name(s)	Coverage Start Date	Coverage End Date	Your Monthly Cost
Washington Apple Health		10/01/13	09/30/15	$ 0.00
Washington Apple Health		10/01/13	09/30/15	$ 0.00
Washington Apple Health		12/01/13	09/30/15	$ 0.00
Washington Apple Health		12/01/13	09/30/15	$ 0.00
Washington Apple Health		12/01/13	09/30/15	$ 0.00
Washington Apple Health		12/01/13	09/30/15	$ 0.00

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Next

Other Renewal Info

Lost your Healthplanfinder User Name or Password?

How to recover your HPF user name or password

- The following step-by-step process shows how to obtain your forgotten user name or password in Healthplanfinder.

HPF Home Page:

1) Click either link at bottom right.

- Forgot your username?
- Forgot your password?

- Our first example is "Forgot my User Name?"

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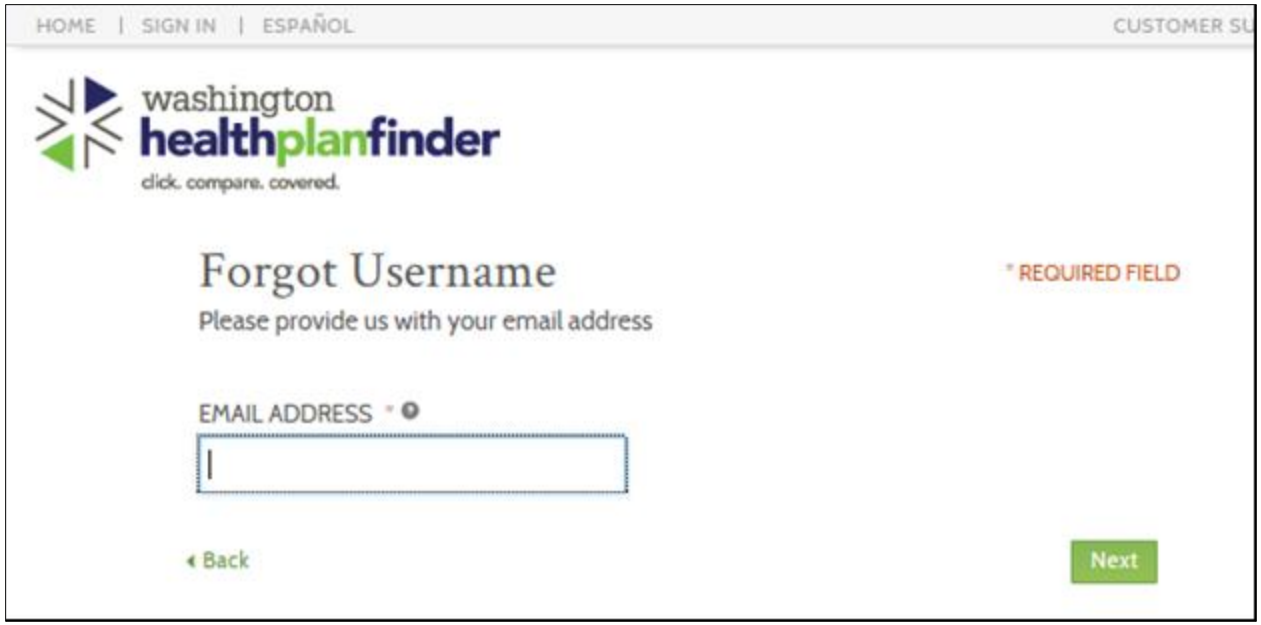
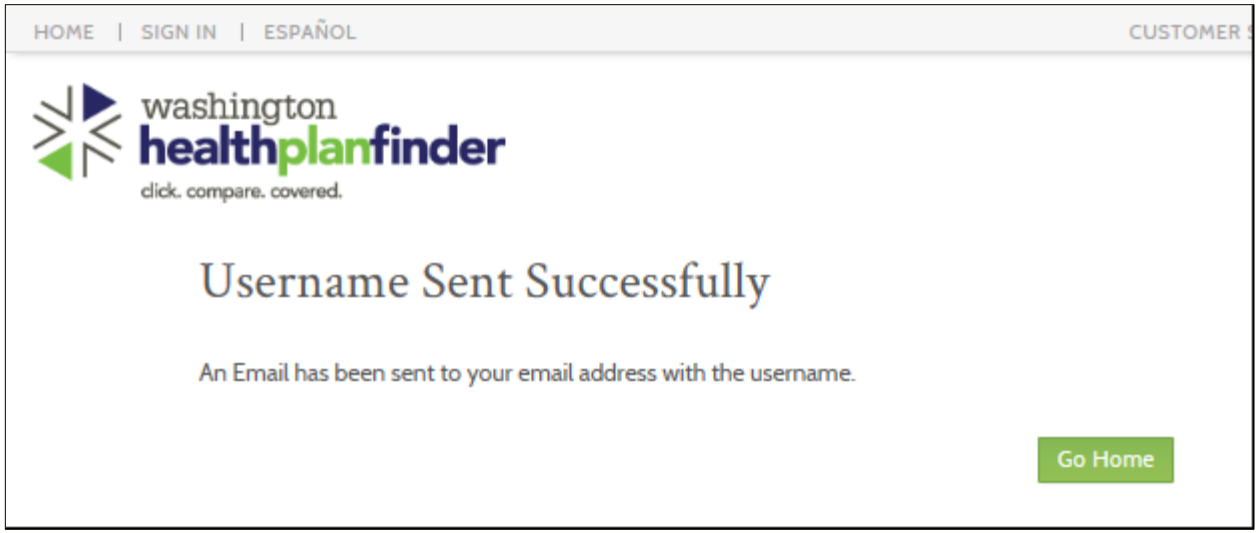
Forgot User Name:

2) Provide an email address and click next.

- User name is sent to you via email.





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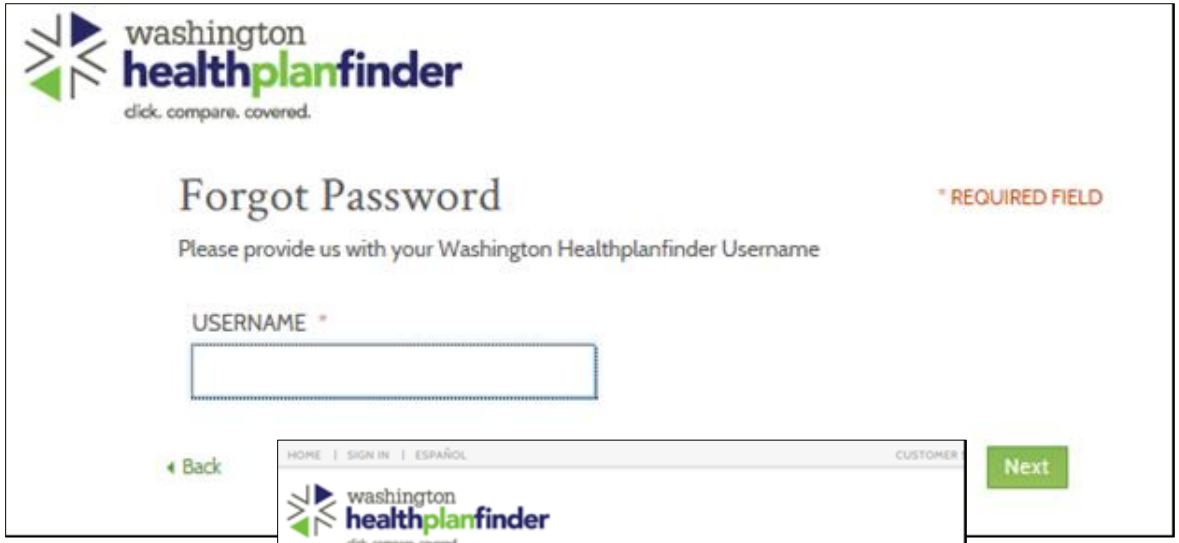
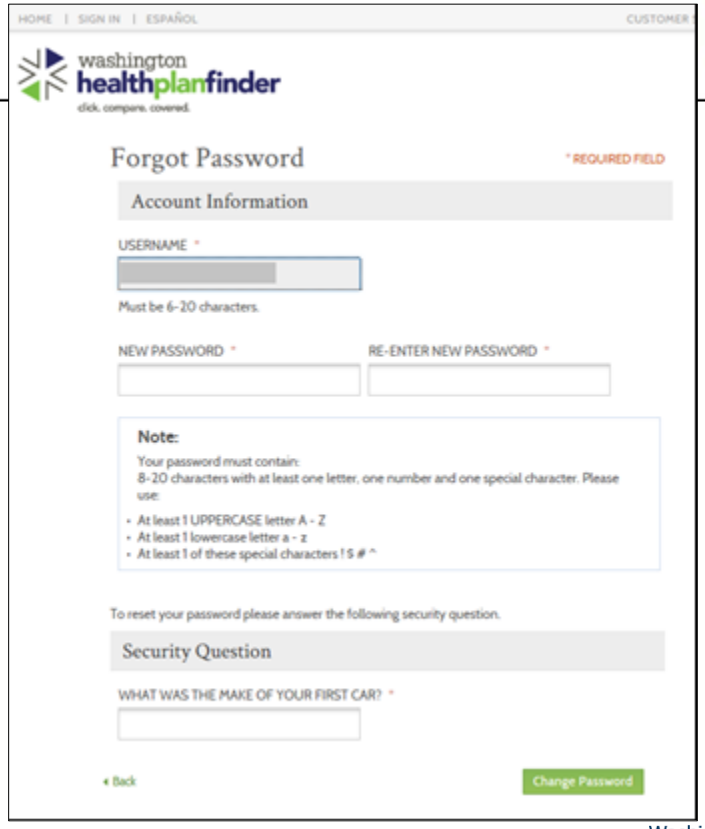
Forgot Password:

3) Provide your user name and click next.

- The Forgot Password screen will prompt you to create a new password.



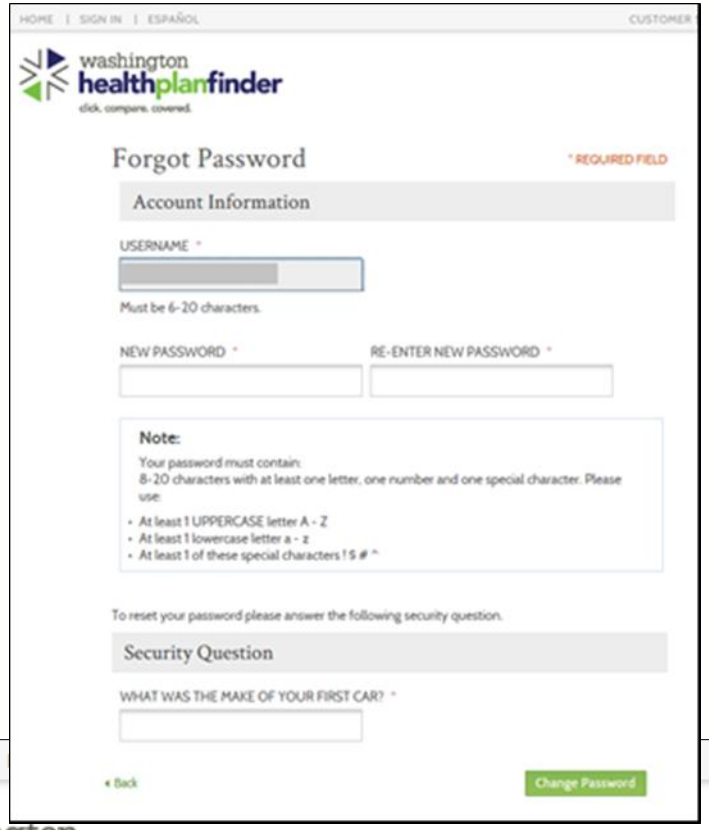


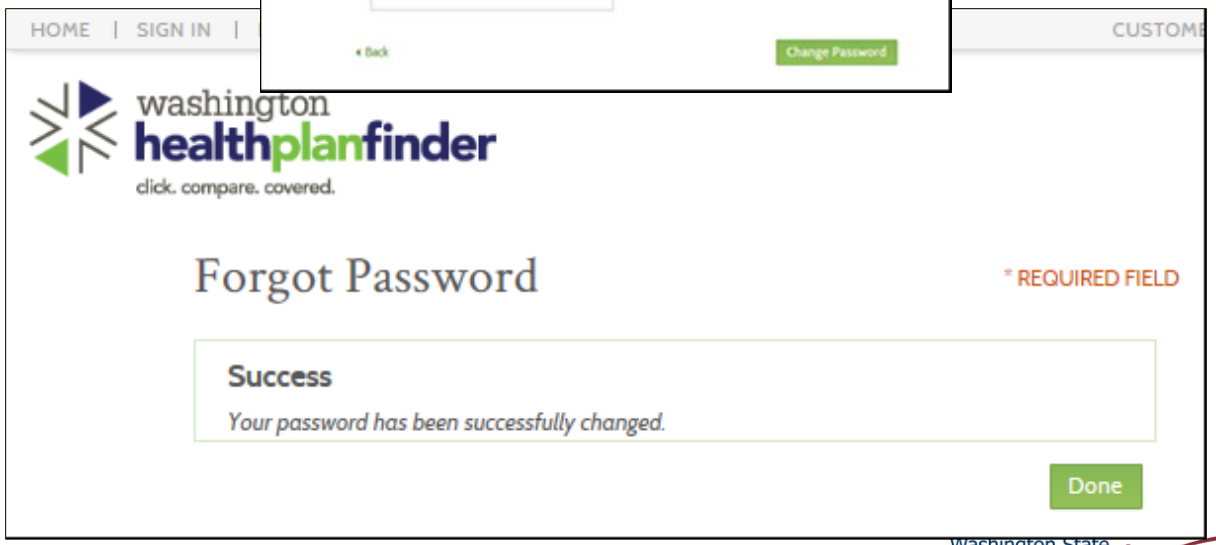
Washington State Health Care Authority

Forgot Password:

4) Type in new password, reenter new password and answer Security Questions.

- If successful, you'll see this response.





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Forgot your Email Address?

Many individuals created an email address specifically for use with Healthplanfinder. One year later they may have forgotten their email address.

- An individual may contact the HPF CSC at 1-855-923-4633 for assistance
- The HPF CSC will verify the individual's account information such as name, date of birth and SSN
- HPF CSC can provide the HPF username and email address and will direct them to the HPF home page to reset their HPF password
- If not successful, the HPF CSC can reset the HPF password for the individual

When other members are active on a QHP

Processing a renewal for Apple Health when others are active on QHP

- When completing renewal and other household members are enrolled in a QHP, it is important to not change the answers to the following questions we will review in the next slides, unless the other member no longer wishes to seek coverage through Healthplanfinder.

Note: HIPTC/QHP applicants are required to "create an account" in Healthplanfinder.

About You:

1) If everyone who has coverage still wants coverage (whether WAH or QHP), do <u>not</u> change the response for these two questions.

FIRST NAME *

M.I

LAST NAME *

SUFFIX

Notice:

Please provide your official name such as the name on your social security card.

SOCIAL SECURITY NUMBER

DATE OF BIRTH *

SOCIAL SECURITY DISCLOSURE

SEX *

- MALE
- FEMALE

WHO ARE YOU APPLYING FOR? *

Myself and Others

DO YOU WANT TO APPLY FOR HEALTH INSURANCE PREMIUM TAX CREDIT, COST-SHARING REDUCTIONS OR WASHINGTON APPLE HEALTH? *

- YES
- NO

Other Household Members or Tax Dependents:

2) If everyone who has coverage still wants coverage (whether WAH or QHP), do <u>not</u> change the response from “yes” to “no” for the household member on QHP.

Do you have other household members or tax dependents?

Note: All household and tax dependents must be listed, even if they do not need health care coverage

Name	Sex	Social Security Number	Date of Birth (MM/DD/YYYY)	Applying for Coverage	Living in Same Home as [redacted]	Edit	Remove
[redacted]	Male	XXX-XX-[redacted]	[redacted]	Yes	N/A		
[redacted]	Female	XXX-XX-[redacted]	[redacted]	Yes	Yes		
[redacted]	Female	XXX-XX-[redacted]	[redacted]	Yes	Yes		
[redacted]	Female	XXX-XX-[redacted]	[redacted]	Yes	Yes		
[redacted]	Male	XXX-XX-[redacted]	[redacted]	Yes	Yes		
[redacted]	Male	XXX-XX-[redacted]	[redacted]	Yes	Yes		

Add Member

Back

Save and Exit

Next

Missed Your Renewal?

90 days after coverage ends

- If found eligible for Apple Health within 90 days of coverage terminating, due to no renewal, coverage goes back to date of termination.
- No loss of coverage.

Renewals and Age Requirements

Age Reminders

- System sends update reminders 60 days prior to individual's birthday

Individuals Turning 19

- No longer eligible for Apple Health for Kids under parents
- If income eligible for Apple Health, individual must apply for coverage on their own application

Note: If an individual qualifies only for HIPTC/QHP, they may remain on their parents QHP coverage up to age 26.

Resource & Contact Info

Cross Agency Desk Aid

Department of Social and Health Services			Health Benefit Exchange		Health Care Authority	
Community Services Division Customer Service Contact Center	**Home & Community Services Long Term Care (LTC)**	**Long-Term Care Specialty Unit**	**Washington Healthplanfinder Customer Support Center**	**Lead Organizations In-Person Assisters/ Navigators**	**Medical Assistance Customer Service Center (MACSC)**	**Medical Eligibility Determination Services (MEDS)**
1-877-501-2233 1-877-980-9220 (Answer Phone) www.washingtonconnection.org 1-888-336-7410 (FAX)	**No call center at HCS.** Contact your local office by checking at http://fortwebb.dshs.wa.gov/hcs/maps.htm www.washingtonconnection.org	1-855-873-0642 www.washingtonconnection.org 1-855-845-6306 (FAX)	1-855-923-4633 www.wahealthplanfinder.org customersupport@healthbenefitexchange.org 1-855-889-2590 (FAX)	Lead Organization Contact Information available at: http://healthbenefitexchange.org/find-your-person-assister/	1-800-562-3022 https://fortress.wa.gov/hca/portal/	1-855-625-0357 https://fortress.wa.gov/hca/magi-contact/
• **Apply for, report changes or renew Food, Cash and Child Care programs (SNAP, EBT, ABD, TANF, HEN, WorkFirst)** • Apply for **Classic Medicaid** programs, **SSI, 65+, and disabled** • Request an appeal of Classic Medicaid, Food, Cash and Childcare programs • Answer Phone: Automated system where clients can check their DSHS benefits • For additional application assistance refer to the Public Access Directory for **community partners**: http://www.washingtonconnection.org/home/publicaccessdirectory.jsp	• Long-term care **nursing facility services** • In home care • **Assisted living** or adult family home • Medicaid personal care • Request an appeal for LTC programs • **WASHCAP** (Food for households whose **only income** is SSI/SSA)	• Medicaid coverage for **clients with developmental disabilities** • Hospice • Healthcare for Workers with Disabilities (HWD) program (SSI) • Children's institutional (KIN) • **Residential mental health** eligibility questions	• **Apply for or renew** health care coverage **(families, children, pregnant women and single adults)** • Health Insurance Premium Tax Credit (HPTC) questions • Qualified Health Plans (QHP) questions • Small Business Health Options (SHOP) questions- 1-855-256-2598 • Locate an HBE **In-person Assister / Navigator or Broker** http://healthbenefitexchange.org/files/2014/04/3/3784HBE_CatAssist_061414_InPersonAsstNavigator.pdf • Request an **appeal** for denial of HPTC/QHP, Special Enrollment: www.wahbexchange.org/appeals or call for information: 1-855-889-2612	• For system functionality visit Healthplanfinder Status Center: http://wahbexchange.org/news-resources/healthplanfinder-status-updates/ • If an IPA needs to submit a **Zendesk** ticket • Questions about becoming a certified assister • To **request outreach** materials and presentations • **HPF password reset** or lockout: 1-855-256-2598	• **ProviderOne** Client Services Card • Provider **billing** and claims questions • Apple Health **Managed Care enrollment**, and questions • ProviderOne benefit **coverage** questions	• Apple Health Modified Adjusted Gross Income **(MAGI)** Medicaid eligibility questions **(families, children, pregnant women and single adults)** • **Post-Eligibility** Case Review **questions or report changes** • Apple Health for Kids **premium payment questions (CHIP)** • Request an appeal for Apple Health Programs

Suggested Script for General Lead-in: *This is an issue that (agency) can help you with. You can do this online at (agency website). The phone number is (xxx-xxx-xxxx) and the information you will need to have available is (insert agency specific information). If you prefer to call then, the hours of operation are (from 0:00 am to 0:00 pm) and again that phone number is (xxx-xxx-xxxx).*

Hours of operation: 8:00 am – 5:00 pm, Monday – Friday (except state holidays). Please have your Client ID or Social Security Number available.	Hours of operation: 8:00 am – 5:00 pm, Monday – Friday (except state holidays). Please have your Client ID or Social Security Number available.	Hours of operation: 8:00 am – 5:00 pm, Monday – Friday (except state holidays). Please have your Client ID or Social Security Number available.	Hours of operation: 7:30 am – 8:00 pm, Monday – Friday (except state holidays). Please have your HPF application ID or Social Security Number available.	Hours of operation are generally 8:00 am – 5:00 pm, Monday – Friday (except holidays). For application issues, please have the HPF application ID available.	Hours of operation: 7:30 am – 5:00 pm, Monday – Friday (except state holidays). Please have your Application ID, Client ID, Provider One Client ID or Social Security Number available.	Hours of operation: 7:30 am – 7:00 pm Monday – Friday (except State holidays). Please have your Application ID, Client ID or Social Security Number available.

JP Morgan/Chase
1-888-328-9271 (24hrs)
www.ucard.chase.com
- **EBT Card** Replacement and Balance Information
- **Change PIN number**
- Client will need their EBT card number and Social Security Number

Office of Financial Recovery
1-800-562-6114
- DSHS **Overpayments**
- Premium Payments
- Estate Recovery

Office of the Insurance Commissioner
1-800-562-6900
- Complaints against insurance agents, brokers and producers, or **fraud**
- Insurance regulations

Last Updated 08/12/2014

Referral Communications Committee

Washington State Health Care Authority

HCA Community-Based Specialists

HCA has placed a community-based eligibility worker in most counties across the state.

These specialists can assist with answering questions about MAGI Medicaid eligibility.

If a renewal application gets stuck in the system, these HCA staff are available to assist with error code resolution.

You may find an updated list of these HCA staff at the following link on the HCA Training & Education web page:

www.hca.wa.gov/hcr/me/Documents/Community_Based_Staff_Contact.pdf

HCA Area Representatives

Area	Counties	Representative
East	Asotin Ferry Garfield Lincoln Pend Oreille Spokane Stevens Whitman	Mark Westenhaver mark.westenhaver@hca.wa.gov 360-725-1324
North Central	Adams Chelan Douglas Grant Okanogan	Dody McAlpine dody.mcalpine@hca.wa.gov 360-725-9964
South Central	Benton Columbia Franklin Kittitas Klickitat Walla Walla Yakima	Karin Kramer karin.kramer@hca.wa.gov 360-725-0754
North West	Island San Juan Skagit Snohomish Whatcom	Maggie Clay margaret.clay@hca.wa.gov 360-725-0934

HCA Area Representatives

Area	Counties	Representative
King	King	Rebecca Janeczko rebecca.janeczko@hca.wa.gov 360-725-0752 Mick Pettersen mick.pettersen@hca.wa.gov 360-725-0913
Central West	Clallam Jefferson Kitsap Mason Pierce	Melissa Rivera melissa.rivera@hca.wa.gov 360-725-1713
South West	Clark Cowlitz Grays Harbor Lewis Pacific Thurston Skamania Wahkiakum	Colleen Clifford colleen.clifford@hca.wa.gov 360-725-1321

Washington State Health Care Authority

Additional Medicaid Resources

- **HCA Training & Education Resources**
  www.hca.wa.gov/hcr/me/Pages/training_education.aspx

- **Cross-agency Desk Aid**
  http://www.hca.wa.gov/hcr/me/Documents/customer_support_center_referrals.pdf

- **HCA Community-Based Specialists**
  http://www.hca.wa.gov/hcr/me/Documents/Community_Based_Staff_Contact.pdf

- **Questions? Contact Us**
  medicaidexpansion2014@hca.wa.gov