| Finalized English | Finalized Spanish |
| --- | --- |
| MAGI Packet | |
| It's time to see if [v_Individuals_Name], [v_Individuals_Name] still qualify for health coverage.<br><br>Other people in your household who are not listed above may receive different paperwork for their renewal. | |
| 1. Review the information we have on file for your household.<br>- Correct any information that is wrong.<br>- Add any information that is missing.<br>2. Review the "Request for More Information" letter that is included in this packet. It tells you what information is needed for [v_Individuals_Name], [v_Individuals_Name]. We may also need information about other people in your household to complete the renewal for [v_Individuals_Name], [v_Individuals_Name].<br>3. Read and sign the Renewal Signature Page, even if you do not have any new information or changes to report.<br>4. Submit:<br>- The signed signature page, even if nothing has changed.<br>- All of the pages you updated.<br>- All documents we request. | |
| If you need help or can't return the information by the due date, contact [Name County Department of Human Services] at [v_Primary_Worker_Correspondence_Phone] (State Relay: 711). and tell them you are calling about your health coverage renewal. We may be able to give you extra time if you are having trouble getting the information. | |
| You must take action or you or the other people addressed in this letter may lose benefits. | |
| We need to check if [v_Individuals_Name], [v_Individuals_Name], still qualify for Health First Colorado (Colorado's Medicaid program) or Child Health Plan Plus (CHP+). | |
| Sign in to your account at CO.gov/PEAK. You will see a 'To-do list' section on your PEAK dashboard. Select 'Complete now' to begin. | |

| | |
|---|---|
| - Mail or bring the completed signature page and updated renewal form to:<br><br>[Name County Department of Human Services]<br>[v_Primary_Worker_Correspondence_Name<br>[v_Worker_Office_Physical_Address_Line]<br>[v_Worker_Office_Physical_Address_Line]<br>[v_Worker_Office_Physical_Address_Line_3]<br><br>- Fax the completed signature page and updated renewal form to:<br>[v_Primary_Worker_Fax_Number]<br><br>- Call to submit the completed signature page and updated renewal form by phone: [ Name County Department of Human Services] at [v_Primary_Worker_Correspondence_Phone]. State Relay: 711 | |
| If you have questions about the letter or need help completing this form, [Name County Department of Human Services at [v_Primary_Worker_Correspondence_Phone] (State Relay: 711). | |
| If anyone listed below changed their name, please update. | |
| If the relationships listed below changed, please update. | |
| If anyone listed below had a change in marital status, please update. | |
| 5. Is this person a member of a federally recognized American Indian or Alaska Native Tribe? | |
| 6. Was this person in foster care when they turned 18? If Yes, please fill in below. | |
| State where they received foster care | |
| Date they left foster care if known<br>(MM/DD/YYYY) | |
| 7. Is this person currently incarcerated (in jail or prison)? If Yes, please fill in below. | |
| Date entered<br>(MM/DD/YYYY) | |
| Release date, if known.<br>(MM/DD/YYYY) | |
| 8. Does this person currently have Medicare? If Yes, please fill in below. | |

| | |
|---|---|
| Start Date (MM/DD/YYYY) | |
| Part A | |
| Part B | |
| Part C | |
| Part D | |
| 9. Does this person have a medical, physical, mental, or developmental disability or impairment, including blindness, that has lasted or is expected to last more than 12 months? | |
| 10. Does this person need home health care to avoid placement in a nursing or acute care facility, hospital, group home, mental health institution, or long-term care facility within the next 30 days? | |
| 11. Does this person need to move to a nursing or acute care facility, hospital, group home, mental health institution, or long-term care facility within the next 30 days? | |
| If Yes, and this person already has plans to move or has already moved to a facility, please fill in below | |
| Facility name | |
| Date the person entered the facility, or will move to the facility, if known (MM/DD/YYYY) | |
| Is anyone listed below a member of a federally recognized American Indian or Alaska Native tribe? | |
| Individual | |
| Yes or No? | |
| If anyone listed below was in foster care when they turned 18, please update | |
| If anyone listed below is currently incarcerated (in jail or prison), please update | |
| If anyone listed below now has Medicare, please update | |
| Medicare number | |

| | |
|---|---|
| If anyone listed below need home health care to avoid placement in a nursing or acute care facility, hospital, group home, mental health institution, or long-term care facility within the next 30 days? | |
| If anyone listed below need to move to a nursing or acute care facility, hospital, group home, mental health institution, or long-term care facility within the next 30 days? | |