Request for Premium Contribution Review

MVP Child Health Plus Program

Date

Household Information *(please print)*

Head of Household Name	MVP Member ID Number
Address	Phone Number ( )
City	State / Zip Code
Current Gross Monthly Income $	Number of Persons in the Household

Name and **date of birth** (DOB) of **each member in the household**:

DOB	DOB
DOB	DOB
DOB	DOB
DOB	DOB

I, *(your name)* _____ , request that my health plan, MVP Health Plan, conduct an eligibility review to determine the level of my required family contribution. There has been a change in my income and/or household size since the last time my family's eligibility was reviewed and I believe that change could affect teh amount I am required to pay each month for my child's/children's Child Health Plus premium.

Please give us any additional information that might help us complete your request for review:

You must include documentation of your income with this request. On page two of this form is a list of documents for each type of income that you can provide. If you are not sure if your family's income change is great enough to result in a change in your premium contribution, please call the MVP Customer Care Center at **1-800-852-7826** (TTY: **1-800-662-1220**), or the New York State Child Health Plus Hotline at **1-800-698-4543** (TTY: **1-877-898-5849**).

I certify that all of the above information is true and correct. I understand that this information is to be used to determine the monthly premium for the Child Health Plus program. I also understand that if I intentionally misrepresent my situation, I may have to repay benefits received and may be subjected to prosecution under State law.

Signature Date

You must include documentation of your income with this request. Below is a list of documents for each type of income that you can provide. If you are not sure if your family's income change is great enough to result in a change in premium contribution, please call the MVP Customer Care Center at **1-800-852-7826**, or the New York State Child Health Plus Hotline at **1-800-698-4543**.

One proof for **each type of income** you have is required. Provide the most recent proof of income before taxes and any other deductions. The proof must be dated, include the employee's name, and show gross income for the pay period. The proof must be for the last four weeks, whether you get paid weekly, biweekly, or monthly. **It is important that these be current.**

Wages and Salary
- Paycheck stubs
- Verification of Employment form (available at **mvphealthcare.com**)
- Current signed and dated income tax return and all Schedules
- Business/payroll records

Self-Employment
- Current signed and dated income tax return and all Schedules
- Records of earnings and expenses/ business records

Unemployment Benefits
- Award letter/certificate
- Monthly benefit statement from the New York State Department of Labor
- Printout of recipient's account information from the New York State Department of Labor's website (**labor.ny.gov**)
- Copy of Direct Payment Card with printout
- Correspondence from the New York State Department of Labor

Income from Rent or Room/Board
- Letter from roomer, boarder, or tenant
- Check stub

Social Security
- Award letter/certificate
- Annual benefit statement
- Correspondence from the Social Security Administration

Private Pensions/Annuities
- Statement from pension/annuity

Worker's Compensation
- Award letter or check stub

Veteran's Benefits
- Award letter
- Benefit check stub
- Correspondence from Veterans Affairs

Military Pay
- Award letter or check stub

Support from Other Family Members
- Signed statement or letter from family member

Child Support/Alimony
- Letter from person providing support
- Letter from court
- Child support/alimony check stub
- Copy of New York Epicard with printout
- Copy of child support account information from **childsupport.ny.gov**
- Copy of bank statement showing direct deposit

Interest/Dividends/Royalties
- Recent statement from bank, credit union, or financial institution
- Letter from broker or agent
- 1099 or tax return (if no other documentation is available)

Family Size* ▶	1	2	3	4	5	6	Additional Person
Monthly Contribution Required	**Maximum Monthly Gross Income to Qualify****						
Coverage is Free	**$1,618**	**$2,194**	**$2,770**	**$3,346**	**$3,922**	**$4,498**	**+$576**
$9 per child, per month (Maximum $27 per family)	**$2,246**	**$3,046**	**$3,845**	**$4,644**	**$5,443**	**$6,242**	**+$800**
$15 per child, per month (Maximum $45 per family)	**$2,530**	**$3,430**	**$4,330**	**$5,230**	**$6,130**	**$7,030**	**+$900**
$30 per child, per month (Maximum $90 per family)	**$3,035**	**$4,115**	**$5,195**	**$6,275**	**$7,355**	**$8,435**	**+$1,080**
$45 per child, per month (Maximum $135 per family)	**$3,541**	**$4,801**	**$6,061**	**$7,321**	**$8,581**	**$9,841**	**+$1,260**
$60 per child, per month (Maximum $180 per family)	**$4,047**	**$5,487**	**$6,927**	**$8,367**	**$9,807**	**$11,247**	**+$1,440**
Full premium† per child, per month	**Over $4,047**	**Over $5,487**	**Over $6,927**	**Over $8,367**	**Over $9,807**	**Over $11,247**	**Over +$1,440**

* Pregnant women count as two when determining family size.

** Child Health Plus income levels current as of April 1, 2018. Maximum monthly gross income and full premium amounts subject to change by New York State.

† Full pay premiums as of April 1, 2017 are: **$229.71** for residents of Genesee, Livingston, Monroe, and Ontario counties; **$249.55** for residents of Albany, Columbia, Greene, Rensselaer, Saratoga, Schenectady, Warren, and Washington counties; **$243.36** for residents of Jefferson, Lewis, and Oneida counties; and **$240.48** for residents of Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, and Westchester counties.