

NOTICE ON THE USE OF SOCIAL SECURITY NUMBERS

(This is not an application)

If members of your family or household want to receive Food Assistance, Medicaid, Special Assistance or Work First Family Assistance benefits, they must provide Social Security Numbers. Only those who provide or apply for a SSN will receive benefits if otherwise eligible. Applications for Food Stamps and Work First Family Assistance benefits will not be delayed or denied if an individual in your family or household does not provide his or her Social Security Number. These family or household members may be required to answer other questions on the application related to the family's financial circumstances. This notice only applies to social security numbers.

- ¾ Any individual in your household who wants to receive assistance must furnish all social security numbers he has and uses. If he does not have one, he must apply for one. We can help him do this.
- ¾ If an individual refuses to provide his social security number, he is ineligible for assistance for himself.
- ¾ If an individual in your family or household does not wish to receive benefits, he DOES NOT have to give his social security number. If he chooses to provide his social security number, it is strictly voluntary.

HOW WILL MY SOCIAL SECURITY NUMBER BE USED?

Social security numbers are used in matching information with the following agencies:

- Social Security Administration (SSA),
- Internal Revenue Services (IRS),
- Employment Security Commission (ESC),
- Department of Transportation (DOT),
- Out-of-state welfare and ESC agencies, and
- Any other agencies, when applicable.

We will only use social security numbers to verify income and resources.

I have read and understand the statements on this form. By signing this, I agree to allow system matches on the social security numbers I provide.

Applicant's/Representative's Signature: _____ **Date:** _____

Verification Worker's/Caseworker's Signature: _____

Application for Health Coverage & Help Paying Costs

THINGS TO KNOW

Use this application to see what coverage choices you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well
- A new tax credit that can immediately help pay your premiums for health coverage
- Free or low-cost insurance from Medicaid or North Carolina Health Choice (NCHC)
- You may qualify for a free or low-cost program even if you earn as much as \$94,000 a year (for a family of 4).

Who can use this application?

- Use this application to apply for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- If you're single, you may be able to use a short form. Visit <http://www.ncdhhs.gov/dma/medicaid/applications.htm>.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete Appendix C.

Apply faster online

- Apply faster online at <https://epass.nc.gov>.

What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants who need insurance)
- Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family
- Proof of Identity
- Proof of NC Residence

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. We'll keep all the information you provide private and secure, as required by law. To view the Privacy Act Statement, go to <http://www.ncdhhs.gov/dma/medicaid/rights.htm>

What happens next?

Send your complete, signed application to the Department of Social Services in the county where you live (<http://www.ncdhhs.gov/dss/local/>) If you don't have all the information we ask for, sign and submit your application anyway. We'll follow-up with you within 1–2 weeks. You'll get instructions on the next steps to complete your application for health coverage. If you don't hear from us, visit <http://www.ncdhhs.gov/dss/local/> or call 1-800-662-7030 Filling out this application doesn't mean you have to buy health coverage.

Get help with this application

- Phone: Call your local DSS office.
- In person: Visit your local DSS office. To find out the location of your DSS office visit <http://www.ncdhhs.gov/dss/local/>, or call 1-800-662-7030
- En Español: Llame su oficina de DSS local. Para obtener mas informacion visite <http://www.ncdhhs.gov/dss/local/> o llame al 1-800-662-7030



NEED HELP WITH YOUR APPLICATION? Contact your county DSS (<http://www.ncdhhs.gov/dss/local/>) or call us at 1-800-662-7030. Para obtener una copia de este formulario en Español, llame 1-800-662-7030. If you need help in a language other than English, call 1-800-662-7030 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-452-2514. DMA-5200

STEP 1

Tell us about yourself.

1. First name, Middle name, Last name, & Suffix

2. Home address (Leave blank if you don't have one.)

3. Apartment or suite number

4. City

5. State

6. ZIP code

7. County

8. Mailing address (if different from home address)

9. Apartment or suite number

10. City

11. State

12. ZIP code

13. County

14. Phone number () -

15. Other phone number () -

16. What is your preferred spoken or written language (if not English)?

STEP 2

Tell us about your family.

Who do you need to include on this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage).

DO Include:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Anyone you include on your federal tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

You DON'T have to include:

- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

Complete Step 2 for each person in your family. Start with yourself, then add other adults and children. If you have more than 4 people in your family, you'll need to make a copy of the pages and attach them. You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.



NEED HELP WITH YOUR APPLICATION? Contact your county DSS (<http://www.ncdhhs.gov/dss/local/>) or call us at 1-800-662-7030. Para obtener una copia de este formulario en Español, llame 1-800-662-7030. If you need help in a language other than English, call 1-800-662-7030 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-452-2514.

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STEP 2: PERSON 1 (Start with yourself)

Complete Step 2 for yourself, your spouse, your children under age 21 who live with you and anyone you claim on your federal income tax return even if they do not live with you. See page 1 for more information about who to include. If you do not file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix		2. Relationship to you? SELF
3. Date of birth (mm/dd/yyyy)	4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	

5. Social Security number (SSN) _____ - _____ - _____

We need this if you want health coverage and have a SSN. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting a SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

6. Do you plan to file a federal income tax return NEXT YEAR? (You can still apply for health insurance even if you don't file a federal income tax return.)

YES. If yes, please answer questions a–c. NO. If no, skip to question c.

a. Will you file jointly with a spouse? Yes No

If yes, name of spouse: _____

b. Will you claim any dependents on your tax return? Yes No

If yes, list name(s) of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? Yes No

If yes, please list the name of the tax filer: _____

How are you related to the tax filer? _____

7. Do you need health coverage?

(Even if you have insurance, there might be a program with better coverage or lower costs.)

YES. If yes, answer all the questions below.



NO. If no, SKIP to the income questions on page 4. Leave the rest of this page blank.



8. Are you a U.S. citizen or U.S. National? Yes No

9a. If you are not a U.S. citizen or U.S. national, do you have eligible immigration status?

Yes. Fill in your document type and ID number below.

a. Immigration document type

b. Document ID number

c. Date of entry into the U.S. _____

d. Are you, your spouse or parent a veteran or an active-duty member of the U.S. military? Yes No

9b. If you are not a U.S. citizen or U.S. national, have you had a medical emergency in the past 3 months or do you expect a medical emergency in the next 45/90 days.

Yes No

Date of emergency _____

Name of provider _____

10. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply)

Mexican Mexican American Puerto Rican Cuban Other _____

11. Race (OPTIONAL—check all that apply)

White or Caucasian Black or African American Asian Native Hawaiian Other Pacific Islander

American Indian or Alaska Native If yes, complete Appendix B Other _____

12. Are you a resident of North Carolina with the intent of remaining in North Carolina? Yes No

13. Are you pregnant? Yes No If yes, how many babies are expected during this pregnancy? _____

14. Are you applying for Family Planning Services? Yes No If yes, complete Appendix D.

15. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? Yes No

16. Were you in Foster Care in North Carolina when you turned age 18?

Yes No

17a. Are you disabled? Yes No

17b. Are you age 65 or older? Yes No

17c. Are you blind? Yes No

18. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc), live in a medical facility, nursing home and/or need home and community based services (CAP)? Yes No

19. Do you want help paying for medical bills from the last 3 months? Yes No If yes, complete Appendix E.



NEED HELP WITH YOUR APPLICATION? Contact your county DSS (<http://www.ncdhs.gov/dss/local/>) or call us at 1-800-662-7030. Para obtener una copia de este formulario en Español, llame 1-800-662-7030. If you need help in a language other than English, call 1-800-662-7030 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-452-2514.

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STEP 2: PERSON 1 (Continue with yourself)

Current Job & Income Information

- Employed**
 If you're currently employed, tell us about your income. Start with question 20.
- Self-employed**
 Skip to question 29.
- Not employed**
 Skip to question 30.

CURRENT JOB 1:

20. Employer name and address	21. Employer phone number () -
22. Wages/tips (before taxes) <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly \$ _____	
23. Average hours worked each WEEK	

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

24. Employer name and address	25. Employer phone number () -
26. Wages/tips (before taxes) <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly \$ _____	
27. Average hours worked each WEEK	

28. In the past year, did you: Change jobs Stop working Start working fewer hours None of these

29. If self-employed, answer the following questions:

- a. Type of work _____
- b. How much net income (profits once business expenses are paid) have you received from this self-employment in the past 12 months? _____

30. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.

NOTE: You do not need to tell us about child support, veteran's benefits, or Supplemental Security Income (SSI). If you are requesting Medicaid for the aged, blind, disabled, long term care or in-home services (CAP), complete Appendix F.

- | | | | | | |
|--|----------|--|---|------------|------------|
| <input type="checkbox"/> None | | <input type="checkbox"/> Net farming/fishing | \$ _____ | How often? | |
| <input type="checkbox"/> Unemployment | \$ _____ | How often? | <input type="checkbox"/> Net rental/royalty | \$ _____ | How often? |
| <input type="checkbox"/> Pensions | \$ _____ | How often? | <input type="checkbox"/> Other income | \$ _____ | How often? |
| <input type="checkbox"/> Social Security | \$ _____ | How often? | Type: _____ | | |
| <input type="checkbox"/> Retirement accounts | \$ _____ | How often? | | | |
| <input type="checkbox"/> Alimony received | \$ _____ | How often? | | | |

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.

If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 29b).

- | | | | | | |
|--|----------|------------------|---|----------|------------------|
| <input type="checkbox"/> Alimony paid | \$ _____ | How often? _____ | <input type="checkbox"/> Other deductions | \$ _____ | How often? _____ |
| <input type="checkbox"/> Student loan interest | \$ _____ | How often? _____ | Type: _____ | | |

32. **YEARLY INCOME:** Complete only if your income changes from month to month.

If you do not expect changes to your monthly income, skip to the next person.

Your total income this year \$ _____	Your total income next year (if you think it will be different) \$ _____
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THANKS! This is all we need to know about you.



NEED HELP WITH YOUR APPLICATION? Contact your county DSS (<http://www.ncdhhs.gov/dss/local/>) or call us at 1-800-662-7030. Para obtener una copia de este formulario en Español, llame 1-800-662-7030. If you need help in a language other than English, call 1-800-662-7030 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-452-2514. DMA-5200

STEP 2: PERSON 2

Complete Step 2 for PERSON 2, their spouse, their children under age 21 who live with them and anyone they claim on their federal income tax return even if they do not live with them. See page 1 for more information about who to include. If PERSON 2 does not file a tax return, remember to still add family members who live with them.

1. First name, Middle name, Last name, & Suffix		2. Relationship to you?
3. Date of birth (mm/dd/yyyy)	4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	5. Social Security number (SSN) _____ - _____ - _____ Only required if applying for assistance

6. Does PERSON 2 plan to file a federal income tax return NEXT YEAR? (You can still apply for health insurance even if you don't file a federal income tax return.)
 YES. If yes, please answer questions a–c. NO. If no, skip to question c.

a. Will PERSON 2 file jointly with a spouse? Yes No

If yes, name of spouse: _____

b. Will PERSON 2 claim any dependents on their tax return? Yes No


If yes, list name(s) of dependents: _____


c. Will PERSON 2 be claimed as a dependent on someone's tax return? Yes No

If yes, please list the name of the tax filer: _____

How is PERSON 2 related to the tax filer? _____

7. Does PERSON 2 need health coverage?
(Even if you have insurance, there might be a program with better coverage or lower costs.)

YES. If yes, answer all the questions below. 

NO. If no, SKIP to the income questions on page 6. 
Leave the rest of this page blank.

8. Is PERSON 2 a U.S. citizen or U.S. National? Yes No

9a. If PERSON 2 is not a U.S. citizen or U.S. national, do they have eligible immigration status?

Yes. Fill in your document type and ID number below.

a. Immigration document type

b. Document ID number

c. Date of entry into the U.S.

d. Is PERSON 2, their spouse or parent a veteran or an active-duty member of the U.S. military? Yes No

9b. If PERSON 2 is not a U.S. citizen or U.S. national, have they had a medical emergency in the past 3 months or do they expect a medical emergency in the next 45/90 days.

Yes No

Date of emergency _____

Name of provider _____

10. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply)

Mexican Mexican American Puerto Rican Cuban Other _____

11. Race (OPTIONAL—check all that apply)

White or Caucasian Black or African American Asian Native Hawaiian Other Pacific Islander

American Indian or Alaska Native If yes, complete Appendix B Other _____

12. Does PERSON 2 live at the same address as you? Yes No

If no, list address: _____

13. Is PERSON 2 a resident of North Carolina with the intent of remaining in North Carolina? Yes No

14. Is PERSON 2 pregnant? Yes No If yes, how many babies are expected during this pregnancy? _____

15. Is PERSON 2 applying for Family Planning Services? Yes No If yes, complete Appendix D.

16. Does PERSON 2 live with at least one child under the age of 19, and are they the main person taking care of this child? Yes No

17. Was PERSON 2 in Foster Care in North Carolina when they turned age 18? Yes No

18a. Is PERSON 2 disabled? Yes No 18b. Is PERSON 2 age 65 or older? Yes No 18c. Is PERSON 2 blind? Yes No

19. Does PERSON 2 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc), live in a medical facility, nursing home and/or need home and community based services (CAP)? Yes No

20. Does PERSON 2 want help paying for medical bills from the last 3 months? Yes No If yes, complete Appendix E.

Please answer the following questions if PERSON 2 is age 22 or younger:

21. Did PERSON 2 have insurance through a job and lose it within the past 3 months? Yes No

a. If yes, end date: _____ b. Reason the insurance ended: _____



NEED HELP WITH YOUR APPLICATION? Contact your county DSS (<http://www.ncdhs.gov/dss/local/>) or call us at 1-800-662-7030. Para obtener una copia de este formulario en Español, llame 1-800-662-7030. If you need help in a language other than English, call 1-800-662-7030 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-452-2514. DMA-5200

STEP 2: PERSON 2

Current Job & Income Information

- Employed**
 If you're currently employed, tell us about your income. Start with question 22.
- Self-employed**
 Skip to question 31.
- Not employed**
 Skip to question 32.

CURRENT JOB 1:

22. Employer name and address _____ 23. Employer phone number
 () -

24. Wages/tips (before taxes) Hourly Weekly Every 2 weeks Twice a month Monthly Yearly
 \$ _____

25. Average hours worked each WEEK _____

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

26. Employer name and address _____ 27. Employer phone number
 () -

28. Wages/tips (before taxes) Hourly Weekly Every 2 weeks Twice a month Monthly Yearly
 \$ _____

29. Average hours worked each WEEK _____

30. In the past year, did PERSON 2: Change jobs Stop working Start working fewer hours None of these

31. If self-employed, answer the following questions:

a. Type of work

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

\$ _____

32. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.

NOTE: PERSON 2 does not need to tell us about child support, veteran's benefits, or Supplemental Security Income (SSI). If PERSON 2 is requesting Medicaid for the aged, blind, disabled, long term care or in-home services (CAP), complete Appendix F.

- | | | | | | |
|--|----------|--|---|------------|------------|
| <input type="checkbox"/> None | | <input type="checkbox"/> Net farming/fishing | \$ _____ | How often? | |
| <input type="checkbox"/> Unemployment | \$ _____ | How often? | <input type="checkbox"/> Net rental/royalty | \$ _____ | How often? |
| <input type="checkbox"/> Pensions | \$ _____ | How often? | <input type="checkbox"/> Other income | \$ _____ | How often? |
| <input type="checkbox"/> Social Security | \$ _____ | How often? | Type: _____ | | |
| <input type="checkbox"/> Retirement accounts | \$ _____ | How often? | | | |
| <input type="checkbox"/> Alimony received | \$ _____ | How often? _____ | | | |

33. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.

If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 29b).


- | | | | | | |
|--|----------|------------------|---|----------|------------------|
| <input type="checkbox"/> Alimony paid | \$ _____ | How often? _____ | <input type="checkbox"/> Other deductions | \$ _____ | How often? _____ |
| <input type="checkbox"/> Student loan interest | \$ _____ | How often? _____ | Type: _____ | | |

34. **YEARLY INCOME:** Complete only if PERSON 2's income changes from month to month.

If you don't expect changes to PERSON 2's monthly income, add another person or skip to the next section. 

PERSON 2's total income this year \$ _____	PERSON 2's total income next year (if you think it will be different) \$ _____
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THANKS! This is all we need to know about PERSON 2.

 **NEED HELP WITH YOUR APPLICATION?** Contact your county DSS (<http://www.ncdhhs.gov/dss/local/>) or call us at 1-800-662-7030. Para obtener una copia de este formulario en Español, llame 1-800-662-7030. If you need help in a language other than English, call 1-800-662-7030 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-452-2514. DMA-5200

Complete Step 2 for PERSON 3, their spouse, their children under age 21 who live with them and anyone they claim on their federal income tax return even if they do not live with them. See page 1 for more information about who to include. If PERSON 3 does not file a tax return, remember to still add family members who live with them.

1. First name, Middle name, Last name, & Suffix		2. Relationship to you?
3. Date of birth (mm/dd/yyyy)	4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	5. Social Security number (SSN) _____ - _____ - _____ Only required if applying for assistance

6. Does PERSON 3 plan to file a federal income tax return NEXT YEAR? (You can still apply for health insurance even if you don't file a federal income tax return.)



YES. If yes, please answer questions a–c. NO. If no, skip to question c.

a. Will PERSON 3 file jointly with a spouse? Yes No
If yes, name of spouse: _____

b. Will PERSON 3 claim any dependents on their tax return? Yes No
If yes, list name(s) of dependents: _____

c. Will PERSON 3 be claimed as a dependent on someone's tax return? Yes No
If yes, please list the name of the tax filer: _____
How is PERSON 3 related to the tax filer? _____

7. Does PERSON 3 need health coverage?
(Even if you have insurance, there might be a program with better coverage or lower costs.)

YES. If yes, answer all the questions below.  NO. If no, SKIP to the income questions on page 8. Leave the rest of this page blank. 

8. Is PERSON 3 a U.S. citizen or U.S. National? Yes No

9a. If PERSON 3 is not a U.S. citizen or U.S. national, do they have eligible immigration status? <input type="checkbox"/> Yes. Fill in your document type and ID number below. a. Immigration document type b. Document ID number c. Date of entry into the U.S. d. Is PERSON 3, their spouse or parent a veteran or an active-duty member of the U.S. military? <input type="checkbox"/> Yes <input type="checkbox"/> No	9b. If PERSON 3 is not a U.S. citizen or U.S. national, have they had a medical emergency in the past 3 months or do they expect a medical emergency in the next 45/90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No Date of emergency _____ Name of provider _____
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10. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply)

Mexican Mexican American Puerto Rican Cuban Other _____

11. Race (OPTIONAL—check all that apply)

White or Caucasian Black or African American Asian Native Hawaiian Other Pacific Islander

American Indian or Alaska Native If yes, complete Appendix B Other _____

12. Does PERSON 3 live at the same address as you? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, list address: _____	13. Is PERSON 3 a resident of North Carolina with the intent of remaining in North Carolina? <input type="checkbox"/> Yes <input type="checkbox"/> No
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14. Is PERSON 3 pregnant? Yes No If yes, how many babies are expected during this pregnancy? _____

15. Is PERSON 3 applying for Family Planning Services? Yes No If yes, complete Appendix D.

16. Does PERSON 3 live with at least one child under the age of 19, and are they the main person taking care of this child? <input type="checkbox"/> Yes <input type="checkbox"/> No	17. Was PERSON 3 in Foster Care in North Carolina when they turned age 18? <input type="checkbox"/> Yes <input type="checkbox"/> No
--	---

18a. Is PERSON 3 disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	18b. Is PERSON 3 age 65 or older? <input type="checkbox"/> Yes <input type="checkbox"/> No	18c. Is PERSON 3 blind? <input type="checkbox"/> Yes <input type="checkbox"/> No
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19. Does PERSON 3 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc), live in a medical facility, nursing home and/or need home and community based services (CAP)? Yes No

20. Does PERSON 3 want help paying for medical bills from the last 3 months? Yes No If yes, complete Appendix E.

Please answer the following questions if PERSON 3 is age 22 or younger:

21. Did PERSON 3 have insurance through a job and lose it within the past 3 months? Yes No

a. If yes, end date: _____ b. Reason the insurance ended: _____

 **NEED HELP WITH YOUR APPLICATION?** Contact your county DSS (<http://www.ncdhs.gov/dss/local/>) or call us at 1-800-662-7030. Para obtener una copia de este formulario en Español, llame 1-800-662-7030. If you need help in a language other than English, call 1-800-662-7030 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-452-2514. DMA-5200

Current Job & Income Information

Employed

If you're currently employed, tell us about your income. Start with question 22.

Self-employed

Skip to question 31.

Not employed

Skip to question 32.

CURRENT JOB 1:

22. Employer name and address

23. Employer phone number

() -

24. Wages/tips (before taxes) Hourly Weekly Every 2 weeks Twice a month Monthly Yearly

\$ _____

25. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

26. Employer name and address

27. Employer phone number

() -

28. Wages/tips (before taxes) Hourly Weekly Every 2 weeks Twice a month Monthly Yearly

\$ _____

29. Average hours worked each WEEK

30. In the past year, did PERSON 3: Change jobs Stop working Start working fewer hours None of these

31. If self-employed, answer the following questions:

a. Type of work

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

\$ _____

32. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.

NOTE: PERSON 3 does not need to tell us about child support, veteran's benefits, or Supplemental Security Income (SSI). If PERSON 3 is requesting Medicaid for the aged, blind, disabled, long term care or in-home services (CAP), complete Appendix F.

None

Net farming/fishing

\$ _____ How often?

Unemployment

\$ _____ How often?

Net rental/royalty

\$ _____ How often?

Pensions

\$ _____ How often?

Other income

\$ _____ How often?

Social Security

\$ _____ How often?

Type: _____

Retirement accounts

\$ _____ How often?

Alimony received

\$ _____ How often? _____

33. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.

If PERSON 3 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 29b).

Alimony paid

\$ _____ How often? _____

Other deductions

\$ _____ How often? _____

Student loan interest

\$ _____ How often? _____

Type: _____

34. **YEARLY INCOME:** Complete only if PERSON 3's income changes from month to month.

If you don't expect changes to PERSON 3's monthly income, add another person or skip to the next section.



THANKS! This is all we need to know about PERSON 3.



NEED HELP WITH YOUR APPLICATION? Contact your county DSS (<http://www.ncdhhs.gov/dss/local/>) or call us at 1-800-662-7030. Para obtener una copia de este formulario en Español, llame 1-800-662-7030. If you need help in a language other than English, call 1-800-662-7030 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-452-2514.

DMA-5200

STEP 2: PERSON 4

Complete Step 2 for PERSON 4, their spouse, their children under age 21 who live with them and anyone they claim on their federal income tax return even if they do not live with them. See page 1 for more information about who to include. If PERSON 4 does not file a tax return, remember to still add family members who live with them.

1. First name, Middle name, Last name, & Suffix _____	2. Relationship to you? _____
---	-------------------------------

3. Date of birth (mm/dd/yyyy) _____	4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	5. Social Security number (SSN) _____ - _____ - _____ Only required if applying for assistance
-------------------------------------	--	---

6. Does PERSON 4 plan to file a federal income tax return NEXT YEAR? (You can still apply for health insurance even if you don't file a federal income tax return.)

YES. If yes, please answer questions a–c. NO. If no, skip to question c.

a. Will PERSON 4 file jointly with a spouse? Yes No
If yes, name of spouse: _____

b. Will PERSON 4 claim any dependents on their tax return? Yes No
If yes, list name(s) of dependents: _____

c. Will PERSON 4 be claimed as a dependent on someone's tax return? Yes No
If yes, please list the name of the tax filer: _____
How is PERSON 4 related to the tax filer? _____

7. Does PERSON 4 need health coverage?
(Even if you have insurance, there might be a program with better coverage or lower costs.)

YES. If yes, answer all the questions below.

NO. If no, SKIP to the income questions on page 10. Leave the rest of this page blank.

8. Is PERSON 4 a U.S. citizen or U.S. National? Yes No

<p>9a. If PERSON 4 is not a U.S. citizen or U.S. national, do they have eligible immigration status?</p> <p><input type="checkbox"/> Yes. Fill in your document type and ID number below.</p> <p>a. Immigration document type _____</p> <p>b. Document ID number _____</p> <p>c. Date of entry into the U.S. _____</p> <p>d. Is PERSON 4, their spouse or parent a veteran or an active-duty member of the U.S. military? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>9b. If PERSON 4 is not a U.S. citizen or U.S. national, have they had a medical emergency in the past 3 months or do they expect a medical emergency in the next 45/90 days.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Date of emergency _____</p> <p>Name of provider _____</p>
--	--

10. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply)

Mexican Mexican American Puerto Rican Cuban Other _____

11. Race (OPTIONAL—check all that apply)

White or Caucasian Black or African American Asian Native Hawaiian Other Pacific Islander

American Indian or Alaska Native If yes, complete Appendix B Other _____

<p>12. Does PERSON 4 live at the same address as you? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, list address: _____</p>	<p>13. Is PERSON 4 a resident of North Carolina with the intent of remaining in North Carolina? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
---	--

14. Is PERSON 4 pregnant? Yes No If yes, how many babies are expected during this pregnancy? _____

15. Is PERSON 4 applying for Family Planning Services? Yes No If yes, complete Appendix D.

<p>16. Does PERSON 4 live with at least one child under the age of 19, and are they the main person taking care of this child? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>17. Was PERSON 4 in Foster Care in North Carolina when they turned age 18? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
---	--

18a. Is PERSON 4 disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	18b. Is PERSON 4 age 65 or older? <input type="checkbox"/> Yes <input type="checkbox"/> No	18c. Is PERSON 4 blind? <input type="checkbox"/> Yes <input type="checkbox"/> No
---	--	--

19. Does PERSON 4 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc), live in a medical facility, nursing home and/or need home and community based services (CAP)? Yes No

20. Does PERSON 4 want help paying for medical bills from the last 3 months? Yes No If yes, complete Appendix E.

Please answer the following questions if PERSON 4 is age 22 or younger:

21. Did PERSON 4 have insurance through a job and lose it within the past 3 months? Yes No

a. If yes, end date: _____ b. Reason the insurance ended: _____



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STEP 2: PERSON 4

Current Job & Income Information

Employed

If you're currently employed, tell us about your income. Start with question 22.

Self-employed

Skip to question 31.

Not employed

Skip to question 32.

CURRENT JOB 1:

22. Employer name and address

23. Employer phone number

() -

24. Wages/tips (before taxes) Hourly Weekly Every 2 weeks Twice a month Monthly Yearly

\$ _____

25. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

26. Employer name and address

27. Employer phone number

() -

28. Wages/tips (before taxes) Hourly Weekly Every 2 weeks Twice a month Monthly Yearly

\$ _____

29. Average hours worked each WEEK

30. In the past year, did PERSON 4: Change jobs Stop working Start working fewer hours None of these

31. If self-employed, answer the following questions:

a. Type of work

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

\$ _____

32. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.

NOTE: PERSON 4 does not need to tell us about child support, veteran's benefits, or Supplemental Security Income (SSI). If PERSON 4 is requesting Medicaid for the aged, blind, disabled, long term care or in-home services (CAP), complete Appendix F.

None

Unemployment

Pensions

Social Security

Retirement accounts

Alimony received

\$ _____ How often? _____

\$ _____ How often? _____

\$ _____ How often? _____

\$ _____ How often? _____

\$ _____ How often? _____

Net farming/fishing

Net rental/royalty

Other income

Type: _____

\$ _____ How often? _____

\$ _____ How often? _____

\$ _____ How often? _____

33. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.

If PERSON 4 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 29b).

Alimony paid \$ _____ How often? _____

Student loan interest \$ _____ How often? _____

Other deductions \$ _____ How often? _____

Type: _____

34. **YEARLY INCOME:** Complete only if PERSON 4's income changes from month to month.

If you don't expect changes to PERSON 4's monthly income, add another person or skip to the next section.



THANKS! This is all we need to know about PERSON 4.

If you have more people to include, make a copy of Step 2: PERSON 2 (pages 5 and 6) and complete for each additional person.



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DMA-5200

STEP 3

American Indian or Alaska Native (AI/AN) family member(s)

1. Are you or is anyone you are requesting assistance for an American Indian or Alaska Native?

If yes, complete Appendix B.

If no, complete Step 4.

STEP 4

Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1. Is anyone enrolled in health coverage now from the following?

YES. NO.

If yes, check the type of coverage and write the person(s)' name(s) next to the coverage they have.

Medicaid _____

North Carolina Health Choice /NCHC

Medicare _____

TRICARE (Don't check if you have direct care or Line of Duty)

VA health care programs _____

Peace Corps _____

Employer insurance _____

Name of health insurance: _____

Policy number: _____

Type of coverage: _____

Is this COBRA coverage? Yes No

Is this a retiree health plan? Yes No

Other

Name of health insurance: _____

Policy number: _____

Type of coverage: _____

2. Is anyone listed on this application offered health coverage from a job? Check yes even if the coverage is from someone else's job, such as a parent or spouse.

YES. If yes, you'll need to complete and include Appendix A.

Is this a state employee benefit plan? Yes No

NO. If no, continue to Step 5.

3. Have you or anyone requesting assistance been in an accident in the past 12 months? YES. NO.

4. Does any child on this application have a parent living outside the home? YES. NO.



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STEP 5

Read & sign this application.

- I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and or untrue information.
- I know that I must tell the Marketplace and Medicaid/NCHC if anything on this application changes. I can visit www.ncdhhs.gov/dss/local/ or call 1-800-662-7030 to report any changes. I understand that a change in my information must be reported within 10 calendar days and could affect my eligibility.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting <http://www.ncdhhs.gov/dma/epsdt/DueProcessRights050311.pdf>.
- I know that any information given to the Marketplace or Medicaid/NCHC will be protected and kept confidential.
- I know that the information on this application is needed to determine eligibility for help paying for health coverage and/or Medicaid/NCHC and will be checked against electronic databases, Internal Revenue (IRS), Social Security, Department of Homeland Security, consumer reporting agencies, financial institutions and/or other government agencies.

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Marketplace to use income data, including information from tax returns. The Marketplace will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next:

- 5 years (the maximum number of years allowed), 4 years 3 years 2 years 1 year
 Don't use information from tax returns to renew my coverage.

Medicaid/NCHC Eligibility

- I understand that the date of the Medicaid/NCHC application is the date that it is received by the County Department of Social Services.
- I understand that Medicaid coverage can be requested for any medical bills incurred up to three months prior to the month of application.
- I understand that if I enroll in Medicaid /NCHC, I am giving the Medicaid/NCHC agency rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medicaid/NCHC agency rights to pursue and get medical support from a spouse or parent.
- I understand that may be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.
- I understand that if I found eligible for full Medicaid benefits, I have the right to assistance with medical transportation.
- I understand that Federal and State laws require the Division of Medical Assistance (DMA) to file a claim against the estate of certain individuals to recover the amount paid by the Medicaid program during the time the individual received assistance with certain medical services.
- I understand that any resources that are transferred out of the name of anyone requesting Medicaid assistance without receiving fair market value could result ineligibility for assistance with nursing home cost of care and/or in-home care.
- I understand that North Carolina must be named beneficiary for annuities purchased after November 1, 2007.

My right to appeal

If I think the Health Insurance Marketplace or Medicaid/NCHC has made a mistake, I can appeal its decision. To appeal means to tell someone at the Health Insurance Marketplace or Medicaid/NCHC that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting the the Department of Social Services or by calling 1-800-662-7030. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here, as long as you have provided the information required in Appendix C.

Signature

Date (mm/dd/yyyy)

STEP 6

Completed application.

Take or mail your signed application to your local County Department of Social Services (<http://www.ncdhhs.gov/dss/local/>).



If you want to register to vote, you can complete a voter registration form at <http://www.ncsbe.gov/>.



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APPENDIX A

Health Coverage from Jobs

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the **job that offers coverage**.

Take the **Employer Coverage Tool** on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the **Employer Coverage Tool**

EMPLOYEE Information

1. Employee name (First, Middle, Last)	2. Employee Social Security number ____-____-_____
--	---

EMPLOYER Information

3. Employer name	4. Employer Identification Number (EIN) ____-____-_____	
5. Employer address	6. Employer phone number () - _____	
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above) () - _____	12. Email address	

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

Yes (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____ (mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name: _____ Name: _____ Name: _____

No (Stop here and go to Step 5 in the application)

Tell us about the **health plan** offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? <input type="checkbox"/> Yes <input type="checkbox"/> No
15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs. a. How much would the employee have to pay in premiums for this plan? \$ _____ b. How often? <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Once a month <input type="checkbox"/> Quarterly <input type="checkbox"/> Yearly
16. What change will the employer make for the new plan year (if known)? <input type="checkbox"/> Employer won't offer health coverage <input type="checkbox"/> Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.) a. How much will the employee have to pay in premiums for that plan? \$ _____ b. How often? <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Once a month <input type="checkbox"/> Quarterly <input type="checkbox"/> Yearly Date of change (mm/dd/yyyy): _____

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

NEED HELP WITH YOUR APPLICATION? Contact your County DSS (<http://www.ncdhhs.gov/dss/local/>) or call us at 1-800-662-7030. Para obtener una copia de este formulario en Español, llame 1-800-662-7030. If you need help in a language other than English, call 1-800-662-7030 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-452-2514.

DMA-5202-A

EMPLOYER COVERAGE TOOL

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below match the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage.



EMPLOYEE Information

The **employee** needs to fill out this section.

1. Employee name (First, Middle, Last)	2. Social Security Number ____-____-_____
--	--



EMPLOYER Information

Ask the **employer** for this information.

3. Employer name	4. Employer Identification Number (EIN) ____-____-____	
5. Employer address (the Marketplace will send notices to this address)	6. Employer phone number () -	
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above) () -	12. Email address	

13. Is the **employee** currently eligible for coverage offered by this employer, or will the **employee** be eligible in the next 3 months?

Yes (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____(mm/dd/yyyy) (Continue)

No (STOP and return this form to employee)

Tell us about the **health plan** offered by this **employer**.

Does the employer offer a health plan that covers an employee's spouse or dependent?

Yes. Which people? Spouse Dependent(s)

No

(Go to question 14)

14. Does the employer offer a health plan that meets the minimum value standard*?

Yes (Go to question 15) No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? Weekly Every 2 weeks Twice a month Once a month Quarterly Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

Employer won't offer health coverage

Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? \$ _____

b. How often? Weekly Every 2 weeks Twice a month Once a month Quarterly Yearly

Date of change (mm/dd/yyyy): _____

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)



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DMA-5202-A

APPENDIX B

American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or family members are American Indian or Alaska Native. Submit this with your Application for Health Coverage & Help Paying Costs.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1		AI/AN PERSON 2	
1. Name (First name, Middle name, Last name)	First	Middle	First	Middle
	Last		Last	
2. Member of a federally recognized tribe?	Yes If yes, tribe name		Yes If yes, tribe name	
	No		No	
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	Yes		Yes	
	No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? Yes No		No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? Yes No	
4. Certain money received may not be counted for Medicaid/NCHC. List any income (amount and how often) reported on your application that includes money from these sources: <ul style="list-style-type: none"> Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) Money from selling things that have cultural significance 	\$ _____		\$ _____	
	How often?		How often? _____	



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APPENDIX C

Designation of Authorized Representative

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an “authorized representative.” If you ever need to change your authorized representative, contact the Marketplace or the Department of Social Services in the County where you live (<http://www.ncdhhs.gov/dss/local/>). If you’re a legally appointed representative for someone on this application, submit proof with the application.

1. Name of Applicant/Beneficiary			
2. Name of Authorized Representative			
3. Address		Apt/Suite #	
4. City	5. State	6. Zip code	
7. Phone Number () -	Language Preference		

- I understand that by signing this authorization, I am allowing the above named individual to sign my application, complete my re-enrollment/redetermination, get official information about my case status, and act for me on all future matters with this agency.
- I understand that by signing this authorization, my authorized representative may view and discuss any information contained in my case file or pertaining to my case other than information from another source specifically designated as “Confidential” or “Do Not Release”.
- I understand that my authorized representative and I are responsible for any incorrect or incomplete information provided.
- I understand that I may revoke this designation of Authorized Representative at any time.

Applicant/Beneficiary Signature	Date
Authorized Representative Signature	Date



NEED HELP WITH YOUR APPLICATION? Contact your County DSS (<http://www.ncdhhs.gov/dss/local/>) or call us at 1-800-662-7030. Para obtener una Copia de este formulario en Español, llame 1-800-662-7030. If you need help in a language other than English, call 1-800-662-7030 and tell the customer service representative the language you need. We’ll get you help at no cost to you. TTY users should call 1-800-452-2514.

APPENDIX D

MEDICAID FAMILY PLANNING

In order to evaluate for all Medicaid programs, including the Medicaid Family Planning Program, you must answer the questions below.

The Medicaid Family Planning Program provides coverage of family planning services for women and men if they have not had a medical procedure to prevent them from having a baby or fathering a baby. Services include, but are not limited to: an annual physical examination, birth control methods, pregnancy tests, pap tests, screening for sexually transmitted infections (STIs) and voluntary sterilizations for women and men.

QUESTIONS FOR WOMEN:

Name _____

1. Have you had your tubes tied, cut or burnt? Yes No
2. Have you been sterilized by having any other medical procedure that would prevent you from having a baby? Yes No

QUESTIONS FOR MEN:

Name _____

1. Have you had a vasectomy? Yes No
2. Have you been sterilized by having any other medical procedure that would prevent you from fathering a baby? Yes No

If you are not eligible for full Medicaid, but are eligible for the Medicaid Family Planning Program, the program is authorized for 12 months. If you later want full Medicaid during this 12 month period, you can not apply for retro Medicaid. Eligibility will be determined based on this 12 month certification period.

After reading the information above, do you wish to be evaluated for the Medicaid Family Planning Program?

Yes No

Signature _____

Date _____



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APPENDIX E


Medical Bills

Do you, your spouse or children under the age of 21 need help paying medical bills for services received during the last three calendar months? Yes No

If yes, please provide a copy of the medical bills from the last 3 calendar months.

If you do not have copies of your medical bills, please fill out the chart below.

◆ Tell us about your medical bills.		
Who owes the bill(s) Please give us the Patient's name	List the name of the doctor, clinic, hospital, telephone number and city where treated	Date of medical treatment

 **NEED HELP WITH YOUR APPLICATION?** Contact your County DSS (<http://www.ncdhhs.gov/dss/local/>) or call us at 1-800-662-7030. Para obtener una copia de este formulario en Español, llame 1-800-662-7030. If you need help in a language other than English, call 1-800-662-7030 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-452-2514.

APPENDIX F INCOME/RESOURCES

Note: You only need to complete this form if you are requesting Medicaid for the aged, blind, disabled, long term care or in-home services (CAP).

Complete for yourself, your spouse and your children in the home under age 21 who receives any of the income or own any of the resources listed below. Check all that apply, give the amount, value and account number when applicable.

◆ Tell us about your other income.				
Type of Income		Who Gets It	Amount Received	How Often Received (monthly, weekly, etc)
Supplemental Security Income (SSI)	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$	
Veterans Benefits	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$	
Child Support	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$	
Dividend/Interest Income from Trust	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$	
Annuities	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$	
Income from Promissory Notes	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$	
Workman's Compensation	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$	
Contributions	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$	
Other Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$	

◆ Tell us about any real property you own such as land, buildings, time shares, life estates, jointly held real estate, etc., including where you live.	
Owner/Owners	Address Location



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◆ Tell us about your life insurance.

Owner	Company Name/ Address	Policy Number	Face Value	Cash Value
			\$	\$
			\$	\$
			\$	\$
			\$	\$

◆ Tell us about your liquid assets.

Type of Account		Owner	Bank/Company	Account Number	Value
Cash	<input type="checkbox"/> Yes <input type="checkbox"/> No				\$
Checking	<input type="checkbox"/> Yes <input type="checkbox"/> No				\$
Savings	<input type="checkbox"/> Yes <input type="checkbox"/> No				\$
Pre-Paid Debit	<input type="checkbox"/> Yes <input type="checkbox"/> No				\$
Money Market	<input type="checkbox"/> Yes <input type="checkbox"/> No				\$
Certificate of Deposit	<input type="checkbox"/> Yes <input type="checkbox"/> No				\$
Mutual Funds	<input type="checkbox"/> Yes <input type="checkbox"/> No				\$
Trust /Patient Account	<input type="checkbox"/> Yes <input type="checkbox"/> No				\$
Burial Contract	<input type="checkbox"/> Yes <input type="checkbox"/> No				\$
401-K/IRA	<input type="checkbox"/> Yes <input type="checkbox"/> No				\$
Annuity	<input type="checkbox"/> Yes <input type="checkbox"/> No				\$
Stocks/Bonds	<input type="checkbox"/> Yes <input type="checkbox"/> No				\$
Promissory Note	<input type="checkbox"/> Yes <input type="checkbox"/> No				\$
Safety Deposit Box	<input type="checkbox"/> Yes <input type="checkbox"/> No				\$
Other Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No				\$

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◆ Tell us about your personal property.

TYPE		OWNER	YEAR	MAKE	MODEL	VALUE
Car/Truck	<input type="checkbox"/> Yes <input type="checkbox"/> No					\$
Car/Truck	<input type="checkbox"/> Yes <input type="checkbox"/> No					\$
Car/Truck	<input type="checkbox"/> Yes <input type="checkbox"/> No					\$
Mobile Home	<input type="checkbox"/> Yes <input type="checkbox"/> No					\$
Motorcycle	<input type="checkbox"/> Yes <input type="checkbox"/> No					\$
Boat/Boat Motor	<input type="checkbox"/> Yes <input type="checkbox"/> No					\$
Campers	<input type="checkbox"/> Yes <input type="checkbox"/> No					\$
Utility Trailer	<input type="checkbox"/> Yes <input type="checkbox"/> No					\$
Tractors	<input type="checkbox"/> Yes <input type="checkbox"/> No					\$
Other Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No					\$

◆ Tell us about any assets such as cash, streams of income, houses, land, mobile homes, cars, trucks, boats, tractors, etc. that you or your spouse have transferred, sold, or given away in the last 5 years.

What did you or your spouse give away?	Value	Given to Whom?	Their relationship to you?	When?	How much did you receive?
	\$				\$
	\$				\$
	\$				\$
	\$				\$

Signature

Date (mm/dd/yyyy)