Print Form

Application for Health Coverage & Help Paying Costs

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 four)

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: 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)***
- Employers 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 Identify
- Proof of NC Residence

Why do we ask for this information

We ask about your 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 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 (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. www.ncdhhs.gov/dss/local/ or call 1-800-662-7030. Filling out this application doesn't mean you have to buy health coverage.

Getting help with this application

- ***Phone: Call your local DSS office***
- In person: Visit your local DSS office. To find the location of your DSS office, visit www.ncdhhs.gov/dss/local/ or call 1-800-662-7030.
- En español: Llame su officina de DSS local. Para obtener mas informacion visite 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 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.

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 of 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)?			
17. If you are NOT registered to vote where you live now, would you like to register to vote here today? □ Yes □ No Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by the agency.			

STEP 2 – Tell us about your family

Who do you need to include in 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 are 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 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.

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 claimed on your federal 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 and Suffix

2. Relationship to you: **SELF**

3. Date of Birth (mm/dd/yyyy): _____

4. Sex ☐ Male ☐ Female

5. Social Security Number (SSN): _____

NOTE: We need this if you want health coverage and have an 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 an 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 question 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 else's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: _____
How are you related to this 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 question on page 4. Leave the rest of this section 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 you, complete Appendix B)
☐ Other: _____

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 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.

12. Are you a resident of North Carolina? ☐ Yes ☐ No

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

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

15. Were you in Foster Care in North Carolina when you turned 18?
☐ Yes ☐ No

16. Are you disabled?
☐ Yes ☐ No

16b. Are you aged 65 or older?
☐ Yes ☐ No

16c. Are you blind?
☐ Yes ☐ No

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

18. Do you want help paying for medical bills in the last 3 months ☐ Yes ☐ No

STEP 2 – Person 1 (Continue with Yourself)

Current Job & Income Information

19. Are you: *(check one)*

☐ ***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) Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a Monthly ☐ Monthly ☐ 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) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a Monthly ☐ Monthly ☐ 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) will you get form this self-employment this month? _____

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).

☐ None $_____ How Often _____
☐ Unemployment $_____ How Often _____
☐ Pensions $_____ How Often _____
☐ Social Security $_____ How Often _____
☐ Retirement Accounts $_____ How Often _____
☐ Alimony Received $_____ How Often _____
☐ Net farming/fishing $_____ How Often _____
☐ Net rental/royalty $_____ How Often _____
☐ Other income $_____ How Often _____
Type: _____

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.

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: _____

32. **YEARLY INCOME:** Complete only if your income changes from month to month. If you don't expect changes to your monthly income, add another person or skip to the next section.

Your total income this year $_____

Your total income next year (if you think it will be different) $ _____

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 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.

STEP 2 – Person 2

Complete Step 2 for PERSON 2, their spouse, their children under age 21 who live with them and anyone they claimed on their federal tax return even if they do not live with PERSON 2. 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 and Suffix

2. Relationship to you:

3. Date of Birth (mm/dd/yyyy): _____

4. Sex ☐ Male ☐ 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? (They can still apply for health insurance even if they don't file a federal income tax return)

☐ **Yes** If yes, please answer question 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 else's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____
Is PERSON 2 related to this tax filer? If so, how? _____

7. Does PERSON 2 need health coverage?
(Even if they 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 question on page 8. Leave the rest of this section 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 their 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 so, complete Appendix B)
☐ Other: _____

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12. Does PERSON 2 live at the same address as you?
If no, list address:
_____

13. Is PERSON 2 a resident of North Carolina?
☐ Yes ☐ No

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

15. Do PERSON 2 lives with at least one child under the age of 18 and are they the main person taking care of that child? ☐ Yes ☐ No

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

17a. Is PERSON 2 disabled?
☐ Yes ☐ No

17b. Is PERSON 2 aged 65 or older?
☐ Yes ☐ No

17c. Is PERSON 2 blind?
☐ Yes ☐ No

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

19. Does PERSON 2 need help paying for medical bills in the last 3 months ☐ Yes ☐ No

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

20. 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: _____

STEP 2 – Person 2

Current Job & Income Information

21. Is Person 2 *(check one)*

☐ ***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 Monthly ☐ 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 Monthly ☐ 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 form 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).

☐ None $_____ How Often _____
☐ Unemployment $_____ How Often _____
☐ Pensions $_____ How Often _____
☐ Social Security $_____ How Often _____
☐ Retirement Accounts $_____ How Often _____
☐ Alimony Received $_____ How Often _____
☐ Net farming/fishing $_____ How Often _____
☐ Net rental/royalty $_____ How Often _____
☐ Other income $_____ How Often _____
Type: _____

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.
Don't include a cost that PERSON 2 already considered in your answer to net self-employment (question 31b)

☐ Alimony Paid $_____How Often _____
☐ Student Loan Interest $_____How Often _____
☐ Other Deductions $_____How Often _____ Type: _____

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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) $ _____

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 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.

STEP 2 – Person 3

Complete Step 2 for PERSON 3, their spouse, their children under age 21 who live with them and anyone they claimed on their federal tax return even if they do not live with PERSON 3. 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 and Suffix

2. Relationship to you:

3. Date of Birth (mm/dd/yyyy): _____

4. Sex ☐ Male ☐ 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? (They can still apply for health insurance even if they don't file a federal income tax return)

☐ **Yes** If yes, please answer question 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 else's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____
Is PERSON 3 related to this tax filer? If so, how? _____

7. Does PERSON 3 need health coverage?
(Even if they 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 question on page 11. Leave the rest of this section 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?

☐ Yes. Fill in their 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? ☐ Yes ☐ 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.

☐ 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 so, complete Appendix B)
☐ Other: _____

12. Does PERSON 3 live at the same address as you?

If no, list address:

_____

13. Is PERSON 3 a resident of North Carolina?

☐ Yes ☐ No

14. Is PERSON 3 pregnant? ☐ Yes ☐ No If yes, how many babies are expected during this pregnancy? _____

15. Does PERSON 3 live with at least one child under the age of 18 and are they the main person taking care of that child? ☐ Yes ☐ No

16. Was PERSON 3 in Foster Care in North Carolina when they turned 18?

☐ Yes ☐ No

17a. Is PERSON 3 disabled?

☐ Yes ☐ No

17b. Is PERSON 3 aged 65 or older?

☐ Yes ☐ No

17c. Is PERSON 3 blind?

☐ Yes ☐ No

18. Does PERSON 3 have a physical, mental or emotional health condition that causes limitations in activities of daily living (such as bathing, dressing, daily chores, etc.), live in a medical facility, nursing home and/or need home and community based services (CAP)? ☐ Yes ☐ No

19. Does PERSON 3 need help paying for medical bills in the last 3 months ☐ Yes ☐ No

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

20. 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: _____

STEP 2 – Person 3

Current Job & Income Information

21. Is Person 3 *(check one)*

☐ ***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 Monthly ☐ 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 Monthly ☐ 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 form 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).

☐ None $_____ How Often _____
☐ Unemployment $_____ How Often _____
☐ Pensions $_____ How Often _____
☐ Social Security $_____ How Often _____
☐ Retirement Accounts $_____ How Often _____
☐ Alimony Received $_____ How Often _____
☐ Net farming/fishing $_____ How Often _____
☐ Net rental/royalty $_____ How Often _____
☐ Other income $_____ How Often _____
Type: _____

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.
Don't include a cost that PERSON 3 already considered in your answer to net self-employment (question 31b)

☐ Alimony Paid $_____How Often _____
☐ Student Loan Interest $_____How Often _____
☐ Other Deductions $_____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.

PERSON 3's total income this year $_____
PERSON 3's total income next year (if you think it will be different) $ _____

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 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.

STEP 2 – Person 4

Complete Step 2 for PERSON 4, their spouse, their children under age 21 who live with them and anyone they claimed on their federal tax return even if they do not live with PERSON 3. 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 and Suffix

2. Relationship to you:

3. Date of Birth (mm/dd/yyyy): _____

4. Sex ☐ Male ☐ 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? (They can still apply for health insurance even if they don't file a federal income tax return)

☐ **Yes** If yes, please answer question 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 else's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: _____
Is PERSON 4 related to this tax filer? If so, how? _____

7. Does PERSON 4 need health coverage?
(Even if they 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 question on page 14. Leave the rest of this section blank

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

9a. If PERSON 4 is not a U.S. citizen or U.S. national, do they have eligible immigration status?

☐ Yes. Fill in their 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 4, their spouse or parent a veteran or an active-duty member of the U.S. Military? ☐ Yes ☐ No

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.

☐ 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 so, complete Appendix B)
☐ Other: _____

12. Does PERSON 4 live at the same address as you?

If no, list address:

_____

13. Is PERSON 4 a resident of North Carolina?

☐ Yes ☐ No

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

15. Does PERSON 4 live with at least one child under the age of 18 and are they the main person taking care of that child? ☐ Yes ☐ No

16. Was PERSON 4 in Foster Care in North Carolina when they turned 18?

☐ Yes ☐ No

17a. Is PERSON 4 disabled?

☐ Yes ☐ No

17b. Is PERSON 4 aged 65 or older?

☐ Yes ☐ No

17c. Is PERSON 4 blind?

☐ Yes ☐ No

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

19. Does PERSON 4 need help paying for medical bills in the last 3 months Yes No

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

20. 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: _____

STEP 2 – Person 4

Current Job & Income Information

21. Is Person 4 *(check one)*

☐ ***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 Monthly ☐ 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 Monthly ☐ 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 form 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).

☐ None $_____ How Often _____
☐ Unemployment $_____ How Often _____
☐ Pensions $_____ How Often _____
☐ Social Security $_____ How Often _____
☐ Retirement Accounts $_____ How Often _____
☐ Alimony Received $_____ How Often _____
☐ Net farming/fishing $_____ How Often _____
☐ Net rental/royalty $_____ How Often _____
☐ Other income $_____ How Often _____
Type: _____

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.
Don't include a cost that PERSON 3 already considered in your answer to net self-employment (question 31b)

☐ 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.

PERSON 4's total income this year $_____
PERSON 4's total income next year (if you think it will be different) $ _____

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

If you have more people to include, make a copy of STEP 3 PERSON (page 6 thru 9) and compete for each additional person

STEP 3

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

1. Are you or 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 insurance

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: _____
☐ N.C. Health Choice (NCHC) _____
☐ Medicare: _____
☐ TRICARE (Don't check if you have Direct Care or Line of Duty)
☐ VA health care programs: _____
☐ Peace Corps: _____

☐ Other: _____

Name of Health Insurance: ____
Policy Number: _____
Type of Coverage: _____

2. Is anyone listed on this application offered health insurance 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
   ☐ **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

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 year □ 1 year
□ Do not 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 I 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 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 in 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 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)

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 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.

Step 6 Completed Application

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

If you are NOT registered to vote where you live now, would you like to register to vote here today?
□ *Yes* □ *No*

If you want to register to vote, you can complete a voter registration form at www.ncsbe.gov/. Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency. If you would like help filling out the voter registration application form, we will help you. The decision either to see or accept help is yours. You may fill out the application form in private. If you believe that someone has interfered with your right register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Board of Elections.

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 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.