North Carolina
Department of Health and Human Services
Division of Medical Assistance
Recipient Services EIS
1985 Umstead Drive – 2512 Mail Service Center - Raleigh, N.C. 27699-2512
Courier Number 56-20-06

Michael F. Easley, Governor
Carmen Hooker Buell, Secretary

Nina M. Yeager, Director
919-857-4019

January 30, 2002

Re: Revised DMA-5063

Dear County Director of Social Services:

As a part of an ongoing effort to ensure all eligible children in North Carolina are enrolled in Health Check (Medicaid)/NC Health Choice for Children, a work group has been meeting to revise the DMA-5063. The goal of the work group was to create a form that is customer friendly and easy to read and still gathers the information needed to determine eligibility for the programs.

At the same time the work group was meeting, policy changes were implemented that changed the information to be requested on the form. Information regarding the absent parents will no longer be requested of the caretaker in a child only case. Also, enumeration is now a requirement for NC Health Choice applicants. Finally, imposition of a waiting period when a family voluntarily drops health coverage was eliminated from policy. The new form does incorporate these policy changes.

The form expands the race categories and adds ethnicity and language preference questions. These changes are a result of new tracking requirements by the Office of Civil Rights. Enhancements will be made to the Eligibility Information System to capture this information. Until those changes are made, counties are to continue to use existing codes for race. If the individual identifies himself as a member of multiple races, choose an existing code that best describes the individual's response. Once EIS has been updated, counties will be given instructions for collecting race, ethnicity and language preference data.

The DMA-5069, Special Health Care Needs Questionnaire, has been added to the application form. This form will no longer have to be mailed separately to applicants.

Finally, the work group, using grant monies provided by the Robert Wood Johnson Foundation, was able to enlist the help of a professional firm for layout and graphics. Professional input was also received regarding literacy issues. The form was tested by a focus group for clarity and readability. Changes were made based on the results of that testing.

I am pleased to announce that the work group has completed the revision of the English version of the form and the form will be available in February for use by the local agencies. A sample of the form is attached.

A great deal of work has gone into the revision of the form. I would like to thank the following groups and individuals for their numerous hours of work:

Sari Teplin, Covering Kids Foundation
Rebecca Greenleaf-Bailey, Div. of Public Health
Lynda Dixon, Division of Public Health
Carolyn Sexton, Division of Public Health
Dawn Williams, Granville County DSS
Ed Moss, Union County DSS
Julie Collins, Onslow County DSS
Alvinia Parker, Sampson County DSS
Jim Holland, Buncombe County DSS
North Carolina Covering Kids

I would like to give special thanks to the Buncombe County pilot group of NC Covering Kids. This pilot group initially identified the application form as a potential barrier for enrollment and took the lead in developing a more consumer friendly form.

Also, I would like to recognize the Cabarrus County pilot group of NC Covering Kids for their help with the focus testing. This group sought participants, arranged the facility and hosted the focus groups.

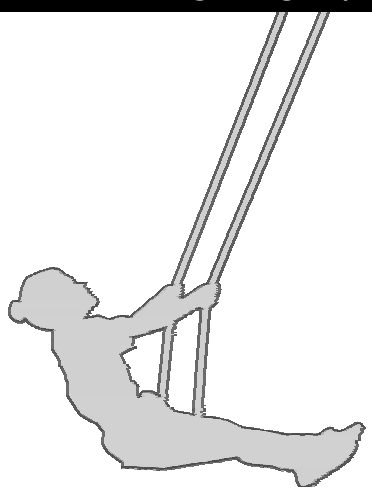
The next phase of this project has already begun. The revised DMA-5063 will be translated into Spanish and made available as soon as possible. Until that time, please continue to use the existing Spanish version of the DMA-5063 which is available on-line at www.dhhs.state.nc.us/dma/. Also, the re-enrollment form will be revised. Again, the goal will be to make the form more consumer friendly and easy to read while still ensuring that information needed to determine eligibility is gathered.

If you have any questions, please contact your Medicaid Program Representative or the Medicaid Eligibility Unit at (919) 857-4019.

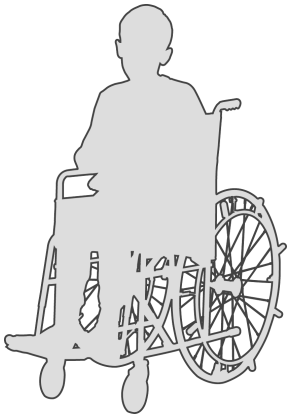
Nina M. Yeager

NMY:rb

HEALTH CHECK / NC HEALTH CHOICE FOR CHILDREN APPLICATION



Health Check NC Health Choice for children



Better health for your children,
peace of mind for you.

Free or Low-Cost Health Insurance for Children and Teens up to 21 Years Old

(Pregnant women, parents or other adult relatives who live with and care for the children may also use this application to apply for Medicaid.)

Si usted desea obtener la forma DMA-5063, solicitud en español para seguro medico para niños, comuníquese con el departamento de servicios sociales de su localidad. También puede llamar a la línea de Recursos de Salud Familiar al 1-800-367-2229. Se le atenderá en español. (You can get a Spanish application at your local department of social services or call 1-800-367-2229.)

WHAT ARE HEALTH CHECK AND NC HEALTH CHOICE FOR CHILDREN?

Health Check (Children's Medicaid Insurance) and Health Choice are two similar health insurance programs for children. Your family's income, the number of people in your family and the age of the children determine if your children qualify. This information will also be used to determine in which program the children will be enrolled.

WHAT ARE THE BENEFITS?

- **Sick visits**
- **Checkups**
- **Hospital care**
- **Counseling**
- **Prescriptions**
- **Dental care**
- **Eye exams and glasses**
- **Hearing exams and hearing aids**
- **And more!**

Transportation - If your children are enrolled in Health Check, transportation to medical appointments may be provided through your department of social services. If the children are enrolled in Health Choice, you must provide your own transportation.

Children with Special Health Care Needs may be eligible for additional services.

HOW DO I APPLY?

It's easy. Just mail or drop off the completed application at the department of social services in the county where you live. If you would like help filling out the application, call or visit your department of social services. You can find the address and phone number in your phone book under "County Government" or by calling the North Carolina Family Health Resource Line at 1-800-367-2229.

Be careful to answer all the questions completely so we can process your application more quickly. If you need more space, please attach additional pages. It can take 45 days or less to process your application. If we need additional information, we will contact you by mail. The sooner we get the information, the sooner we can let you know if your children qualify.

WHAT ELSE DO I NEED TO KNOW ABOUT HEALTH CHECK AND HEALTH CHOICE?

Will My Children Get Insurance Cards?

YES! Your children will receive insurance cards in the mail. Please keep the card handy so you can show it at medical appointments and when you fill prescriptions.

How Do I Choose a Doctor?

The department of social services will help you choose your doctor if your children are enrolled in Health Check (Children's Medicaid Insurance). If your children are enrolled in Health Choice, you may contact the doctor of your choice.

Will I Need to Re-enroll My Children?

YES! You will need to re-enroll to continue benefits. For most children this is done once a year. You will be contacted when it is time to re-enroll.

Will I Have to Pay Enrollment Fees and a Co-pay?

Depending on your income, you may have to pay an enrollment fee of $0 to $100 per family per year. In some cases, you also may have a small co-pay for doctor visits and prescriptions. If the fee and/or co-pay apply to you, you will be notified.

Will My Children Be Enrolled Immediately?

Health Check (Children's Medicaid Insurance) has no funding limits, so there is no waiting list. If your children are eligible for Health Choice, they may have to go on a waiting list before being enrolled if federal or state funds are not sufficient to serve more children.

WHAT ARE MY RESPONSIBILITIES?

- ✓ You agree to tell the department of social services within 10 days if there are <u>any</u> changes in the information you provided on your application.
- ✓ A state or federal reviewer may check the information on this form. You agree to participate in the review and will cooperate with the reviewer.
- ✓ If you knowingly provide false information or if you withhold information and your children get health insurance for which they are not eligible, you can be lawfully punished for fraud and may be asked to repay the programs for any medical bills and/or premiums that were paid incorrectly.
- ✓ You agree to tell the department of social services if anyone with Health Check (Children's Medicaid Insurance) is in an accident.
- ✓ If Health Check (Children's Medicaid Insurance)/Health Choice pays for health care for your children, you give permission to the state of North Carolina to collect payments from anyone who is supposed to pay for that care. You also agree to share medical information about your children with any insurance company to get the medical bills paid.
- ✓ For a person to be enrolled in Health Check (Children's Medicaid Insurance)/Health Choice, you must provide his/her social security number or apply for a number. Please know that these numbers will be matched by computer with other government agency records (but not Immigration and Naturalization Services) to verify information. If you decide not to give the numbers, the person cannot be enrolled.

WHAT ARE MY RIGHTS?

- ✓ Health Check (Children's Medicaid Insurance)/Health Choice cannot discriminate because of race, color, nationality, sex, religion, age, disability or political belief.
- ✓ By law, all information that you provide remains private.
- ✓ You can ask for a hearing if you think any decisions are unfair, incorrect or are made too late.

WHO CAN ANSWER MY QUESTIONS?

Contact the department of social services in the county where you live or call the NC Family Health Resource Line at 1-800-367-2229.

Before you return the application, please make sure to do the following:

Read pages 1 and 2. Tear them off and keep for your records.

Complete the questions on pages 3 through 6.

Sign the application on page 5.

Health Check Health Choice for children

APPLICATION

For Office Use Only
County DSS: _____
Date Received: _____
Case #: _____
☐ Mail in ☐ DSS ☐ Health Dept

Please complete. Then send pages 3-6 to your local department of social services. If this application is being completed by or for a pregnant woman who has no other children living with her, complete this application as if the pregnant women is already a parent.

Tell Us About the Family

1. Who are *all* the children under age 21 who live in the home?

*Fill out this information **even** for children who will not be applying for Health Check/Health Choice. Social Security number and citizenship status are required **only** for those applying for health insurance.*

Name of child (first, middle initial, last)	Applying for this child (Y, N)	Date of birth (mo/day/yr)	Sex (M, F)	*Race (Use codes below. List all that apply.) (Optional)	Hispanic/ Latino (Optional) (Y, N)	Child a U.S. citizen (Y, N)	Social Security Number (SSN)

***Asian=A** **American Indian or Alaska Native= I** **Native Hawaiian or Pacific Islander=P** **Black or African-American=B** **Caucasian or White=W**

2. Where do the children live?

Address:	Mailing address (if different):
City: State: Zip Code:	City: State: Zip Code:
Home phone: ( )	Daytime phone: ( )

3. Who are the parents living with the children? If the children do not live with their parents, who are the adults living in the home who care for the children?

Name of parent or adult (first, middle initial, last)	Date of birth (mo/day/yr)	Sex (M, F)	*Race (Optional)	Hispanic/Latino (Optional) (Y, N)	Children's names and parent or adult relationship to the children (John – Mother, Mary - Stepmother)

a. Do you want to apply for pregnancy coverage for any of the people listed above? ☐ **Yes** ☐ **No**

If you are applying for pregnancy assistance, you need to provide a statement from the doctor that includes the delivery date and the number of babies expected. However, send in the application form even if you do not have the statement from the doctor yet.

If yes, for whom? _____ SSN# _____

b. Do you want to apply for Medicaid for any of the people listed above? The adult must be related to the child to be eligible. If you want to apply, you will be contacted for information about bank accounts, real and personal property, cash value of life insurance, stocks, bonds, etc. The total of these must be less than $3,000. Also, if you are eligible, you may be responsible for some of your medical bills.

Do you still wish to apply for Medicaid for a parent or other adult in the home? ☐ **Yes** ☐ **No**

Parents/other adults applying must provide their Social Security numbers and may have to give information to the child support office.

If yes, for whom: _____ SSN# _____

4. Is there a family member living away from the home for less than 12 months (Example: military service, attending school)? ☐ **Yes** ☐ **No**

If yes, please give information below:

Full name (first, middle initial, last)	Reason for absence	Expected date of return

Tell Us About the Family's Health Insurance and Medical Needs

5. Is there currently a parent **not** living in the home? ☐ **Yes** ☐ **No**

If yes, is that parent required by an agreement to pay for health insurance? ☐ **Yes** ☐ **No**

6. Does anyone applying have another health insurance plan? ☐ **Yes** ☐ **No**

If yes, please give information below:

Name (first, middle initial, last)	Insurance company name	Insurance company address	Insurance company phone number	Group/policy number

7. Does anyone applying need help paying medical bills from the past three months? ☐ **Yes** ☐ **No**

If yes, please give the information below: *We may be able to help pay those bills.*

Name of person(s) with bill (first, middle initial, last)	Name of doctor, clinic and/or hospital where person was treated	Date of medical treatment

8. Has anyone applying been in an accident in the past three months? ☐ **Yes** ☐ **No**

Did he/she receive medical care because of the accident? ☐ **Yes** ☐ **No**

If yes, please tell us who. _____ When was the accident? _____/_____/_____

Tell Us About the Parent's and Children's Income

9. Who are the parents and children in the home who work, and what are their wages?

Name of working person (first, middle initial, last)	Employer's name and phone number	Amount earned before deductions	Tips earned	How often paid (monthly, weekly, etc.)
		$	$	
		$	$	
		$	$	

Please provide copies of all of last month's paycheck stubs for everybody listed. Send in the application even if you do not have your stubs.

10. Is there a parent or child in the home who is self-employed? ☐ **Yes** ☐ **No**

For example, does anyone earn money from farming, own his or her own business, or have rental property income?

If yes, please attach business records showing income and expenses for the last 6 months or the number of months in business if less than 6 months. If the income is annual, please attach business records for the last 12 months.

11. Has a parent or child in the home lost a job in the past three months? ☐ **Yes** ☐ **No**

If yes, please complete the following:

Name of person(s) who lost a job	Date job lost	Former employer's name	Former employer's address & phone number

12. What other income does the parent or child receive?

Check the types of income parent or child receives	Name of the person who receives other income	Amount received	How often received (monthly, weekly, etc.)
Child Support ☐Yes ☐No		$	
Social Security ☐Yes ☐No		$	
Unemployment ☐Yes ☐No		$	
Other (Please explain)		$	

Tell Us About the Parent's and Children's Expenses

Some of these expenses may be used to reduce the income that we count to determine enrollment in Health Check/Health Choice.

13. Does a working parent living in the home pay for childcare, a babysitter or care for dependent adult? ☐ **Yes** ☐ **No**

If yes, please fill in the information:

Name, address & phone number of sitter or childcare provider	Name of person cared for	Name of person paying for care	Amount paid	How often paid (monthly, weekly, etc.)
			$	
			$	

14. Does a parent living in the home pay child support for a child who is not living in the home? ☐ **Yes** ☐ **No**

If yes, please fill in the information.

Who pays the support	Who is the support paid to	Is it court ordered (Y, N)	Amount paid	How often paid (monthly, weekly, etc.)
			$	
			$	

Tell Us If You Would Like Help With Child Support

The Child Support Agency can help get financial and medical help for the child from the child's absent parent. If you seek assistance from the Child Support Agency, the courts can establish paternity and establish and enforce child support obligations.

There are other benefits to working with the Child Support Agency. For example, your child may be eligible for other financial benefits, including Social Security, pension benefits, veteran's benefits and possible inheritance. Also, your child may benefit by having a bond between parent and child. Finally, your child may benefit by getting important medical history information.

If you want the Child Support Agency's help in establishing paternity or in getting a support order through the court, check the "Yes" box. If you check the box, someone will contact you. ☐ **Yes, I would like help from the Child Support Agency.**

- ✓ I attest that all statements recorded on this document are true and correct to the best of my knowledge.
- ✓ I have either read or had read to me all attachments to this application, and I understand my rights and responsibilities as an applicant/recipient.
- ✓ I authorize the release of any information necessary to establish my family's eligibility. I understand that this information may include medical information about the individuals applying for health insurance and/or nonmedical information about individuals applying and others. This might include information from doctors, hospitals, employers and insurance companies.
- ✓ I authorize the copying of this release form to verify information. It shall remain valid and in force until revoked by me in writing.

Signature of parent or other adult: _____

Date: _____/_____/_____

Health Check Health Choice for children

Language Preference and Special Needs (Optional)

You may still apply for Health Check/Health Choice even if you don't answer the questions on this page.

What Language Does the Family Prefer to Speak?

The federal government requires the State to provide information about the languages the family speaks. Please help us by providing the information for the parent/other adult and those applying for health insurance.

Name of person (first, middle initial, last)	Language person prefers to speak (circle one)
1.	English Spanish Other (Specify_____)
2.	English Spanish Other (Specify_____)
3.	English Spanish Other (Specify_____)

Does Your Child Have Special Health Care Needs?

Please help us improve services for children with special health care needs and meet federal reporting requirements by answering these questions.

1. Does your child (or children) currently need medicine prescribed by a doctor other than vitamins? ▸ ☐**Yes** ☐**No**
   Does your child (or children) need this medicine because of *any* medical, behavioral or other health condition that has lasted or is expected to last *at least* 12 months? ▸ ▸ ☐ **Yes** ☐**No**
   If yes, please list the child (or children):_____

2. Does your child (or children) need more medical care, mental health or education services than usual or routine for most children of the same age? ▸ ▸ ☐**Yes** ☐**No**
   Does your child (or children) need these services because of *any* medical, behavioral or health condition that has lasted or is expected to last *at least* 12 months? ▸ ▸ ☐**Yes** ☐ **No**
   If yes, please list the child (or children): _____

3. Is your child (or children) limited or prevented in **any way** in his or her ability to do the things most children the same age can do? ▸ ▸ ☐ **Yes** ☐ **No**
   Is this limitation because of *any* medical, behavioral or health condition that has lasted or is expected to last *at least* 12 months? ▸ ▸ ☐ **Yes** ☐ **No**
   If yes, please list the child (or children): _____

4. Does your child (or children) need special therapy, such as physical, occupational, or speech therapy? ▸ ☐ **Yes** ☐ **No**
   Does your child (or children) need this therapy because of *any* medical, behavioral or other health condition that has lasted or is expected to last *at least* 12 months? ▸ ▸ ☐ **Yes** ☐ **No**
   If yes, please list the child (or children):_____

5. Does your child (or children) currently have any kind of emotional, developmental or behavioral difficulty for which they need treatment or counseling? ▸ ▸ ☐ **Yes** ☐ **No**
   Does your child (or children) need this treatment or counseling because of *any* medical, behavioral or other health condition that has lasted or is expected to last *at least* 12 months? ▸ ☐ **Yes** ☐ **No**
   If yes, please list the child (or children):_____

DID YOU SIGN THE APPLICATION ON PAGE 5?