North Carolina Department of Health and Human Services

Pat McCrory
Governor

Richard O. Brajer
Secretary

Dave Richard
Deputy Secretary for Medical Assistance

MEMORANDUM

TO: Dave Richard
Deputy Secretary for Medical Assistance

FROM: Teresa Smith
SPA Coordinator

SUBJECT: State Plan Amendment
Title XIX, Social Security Act
Transmittal #2015-0001-MM1 Bucket 1 Amending MAGI-Based Eligibility Groups

DATE: December 14, 2015

Please find attached an amendment for North Carolina's State Plan under Title XIX of the Social Security Act for the Medical Assistance Program.

The purpose of this state plan amendment (SPA) is to allow Medicaid to accept and determine eligibility from an alternative application used to apply for multiple human services programs.

This amendment is effective October 1, 2015.

Your approval of this state plan amendment is requested. If you have any questions or concerns, please contact Teresa Smith or me at 919-855-4116.

Approval for Submission to CMS:

Signature: _____ Date: 12/15/15

DR/tjs

Attachments

www.ncdhhs.gov • www.ncdhhs.gov/dma
Tel 919-855-4100 • Fax 919-733-6608
Location: 1985 Umstead Drive • Dorothea Dix Hospital Campus • Raleigh, NC 27603
Mailing Address: 2501 Mail Service Center • Raleigh, NC 27699-2501
An Equal Opportunity / Affirmative Action Employer

Medicaid Eligibility

State Name: North Carolina

OMB Control Number: 0938-1148

Transmittal Number: NC - 15 - 0001

Expiration date: 10/31/2014

General Eligibility Requirements
Eligibility Process **S94**

42 CFR 435, Subpart J and Subpart M

Eligibility Process

☑ The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard.

☐ The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act

☒ An alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

An attachment is submitted.

☒ An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

Indicate which application the agency uses for individuals applying for coverage who may be eligible on a basis other than the applicable modified adjusted gross income standard:

☒ The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

An attachment is submitted.

☐ An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

An attachment is submitted.

The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person.

The agency also accepts applications by other electronic means:

◉ Yes ○ No

Medicaid Eligibility

Indicate the other electronic means below:

	Name of Method	Description	
+			X

☑ The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

Parents and Other Caretaker Relatives

Pregnant Women

Infants and Children under Age 19

Redetermination Processing

☑ Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 435.916:

■ Once every 12 months

■ Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency

■ If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

■ Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):

☒ Once every 12 months

☐ Once every 6 months

☐ Other, more often than once every 12 months

Coordination of Eligibility and Enrollment

☑ The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.

PRA Disclosure Statement

NC DHHS Economic Benefits Application

You can use this application to apply for the programs listed below. For more information, please visit the North Carolina Department of Health and Human Services website at http://www.ncdhhs.gov. For this application in additional languages, please contact your county DSS or call us at 1-800-662-703 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.

▶ ***You can always apply faster online at ePASS.nc.gov for Nutrition Services, Health Coverage and Help Paying for Health Coverage.***

Use the symbols as a guide for completion based on what program you want to apply for assistance.

Food and Nutrition Services
Food and Nutrition Services help households buy eligible food in authorized retail food stores. This will increase low-income household's food buying power so they can have more nutritious meals. You have the right to receive an application upon request.

Health Coverage & Help Paying Costs
Insurance from Medicaid/North Carolina Health Choice/NCHC that may be free or low cost or private health insurance plans that offer comprehensive coverage to help you stay healthy or tax credit that helps you pay your health coverage premium. **This includes Refugee Medical Assistance.**

Special Assistance
State County Special Assistance (SA) provides a cash supplement to help low-income individuals pay for room and board in licensed residential facilities including adult care homes/assisted living, family care homes and group homes/supervised living. The SA In-Home program provides a cash supplement to the individual(s) who are at risk of entering a residential facility such as the ones listed above, but would like to remain at home. To be eligible, individuals must be 65 or older or disabled.

Subsidized Child Care
Provides eligibility based financial assistance to responsible parties for their child care needs.

If you can't fill out the whole application today, it will be accepted as long as you fill in Section 1 on Page 3. Please submit this section. If you need assistance in completing this form, please let us know so that we can assist you.

For Low Income Home Energy Assistance Program, Crisis Intervention Program, and Work First, please contact your local county Department of Social Services. If you plan on applying for Work First (TANF cash assistance), feel free to complete this application to check eligibility for other programs.

Who can use this application?

Anyone may use this application to:
- Apply for assistance for themselves and/or their household members
- Apply for just one type of assistance or for multiple types of assistance
- Apply for someone else when given permission to apply on their behalf

What you may be asked to provide:

You are not required to submit any documentation with this initial application. However, sending or bringing proof of the items below may help speed up your application process:
- Identity
- Income
- Household expenses
- Resources
- Residency

What happens next?

Drop off your complete, signed application at your local county DSS. The local DSS may give you further instructions for completing your application and/or will assess eligibility. You can also fax or mail your application to the local DSS. The DSS will provide you with instructions for completing your application and for any further information needed to determine eligibility.

A list of county Departments of Social Services can be found at http://www.ncdhhs.gov/dss/local/docs/directory.pdf.

"What if I need help?"

Contact your local county Department of Social Services. Si usted necesita ayuda alsolicitar los beneficios, se le puede otorgar los servicios gratuitos de un intérprete.

APPLICATION FOR ASSISTANCE

If you need a translator, please let us know. Interpretive services are available free of charge.
Si Ud. necesita este formulario en español, comuníquese con su trabajador(a). Intérpretes están disponibles gratuitamente.

Check the assistance program(s) you are applying for (adults not seeking assistance for themselves may apply on behalf of other household members)

Check	Assistance Programs	
☐	**Health Coverage and Help Paying Costs** (If you or your household does not qualify for Medicaid, your application will be automatically forwarded to the Health Insurance Marketplace **where you or your household may be** eligible for other health insurance affordability programs.)	Depending on the income and resources, an individual may qualify for full or partial benefits. The following are types of Medicaid that you may qualify for: • Children up to age 19 • Parent(s)/Caretaker(s) • Pregnant women • Emergency Services for Aliens
		Aged, blind and disabled individuals • Working Disabled Individual • Institutional care • Home and Community Based Services Waiver • Medicare Savings Programs
☐	**Refugee Medical Assistance**	Short-term medical insurance program available to eligible individuals in order to stabilize their health shortly after arrival in the U.S.
☐	**Food and Nutrition Services**	Food and Nutrition Services help households buy eligible food in authorized retail food stores. This will increase low-income household's food buying power so they can have more nutritious meals. The date an application is received is the filing date used to determine eligibility. Immediate filing is encouraged. The filing date is the date of release for an institution if you are in an institution and applying for Food and Nutrition Services and SSI at the same time. If you are only interested in applying for Food and Nutrition Services there is an FNS application only available. Any questions with an asterisk may be completed but are not mandatory for Food and Nutrition Services (*).
☐	**Subsidized Child Care**	Subsidized Child Care helps responsible adults pay for a part of their child care costs while working, going to school, or participating in approved training activities. Eligible families receive a portion of child care costs paid to the provider.
☐	**Special Assistance**	State-County Special Assistance (SA) provides a cash supplement to help low-income individuals pay for room and board in licensed residential facilities including adult care homes/assisted living, family care homes and group homes/supervised living. The SA In-Home program provides a cash supplement to the individuals who are at risk of entering a residential facility such as the ones listed above, but would like to remain at home. To be eligible, individuals must 65 or older or disabled. An application for Special Assistance is also an application for Medicaid/Medical Assistance, if not already receiving.

Food and Nutrition Services | Health Coverage and Help Paying Costs | SA Special Assistance | Subsidized Child Care

1. Tell us about yourself (or another adult in the household who will be the Head of Household for this application)

1. First Name	Middle Name	Last Name	Suffix	2. Date of birth	3. Former Names, if any

4. Physical Address	Apt.#	City	State	Zip Code	County

5. Mailing Address (if different)	Apt.#	City	State	Zip Code	County

6. Daytime Phone	7. Phone type	8. If none, where can we leave a message? Phone:	9. Email*

10. Preferred language spoken (if not English):	11. Preferred language written/read (if not English):

12. Do you want an interpreter if you are interviewed? (Circle 1) No Yes

13. Would you like to name someone as your authorized representative, or are you completing this as an authorized representative? (Circle 1) No Yes - If yes, Complete Medicaid Appendix C | *You may give a trusted friend, partner or third party caseworker permission as an "authorized representative" to talk to the Department, see your information and act on your behalf for all matters relating to your case.*

Expedited Benefits for Food and Nutrition Services

The following information will help us determine whether the applicant and the people in their home maybe eligible for Faster Service for Food and Nutrition Services.

	AMOUNT
What is the household's total countable monthly gross (before taxes) income?	
What is the total household cash/savings?	
What are the total monthly shelter costs (rent or mortgage) that the household pays?	

Is anyone in the home a migrant or seasonal farmworker?	No	Yes	If Yes, complete a – d If no, go to next section
a. Did his/her job end recently?	No	Yes	
b. Did the only income received for the month of application end before today?	No	Yes	
c. Will he/she receive $25 or less from a new employer within 10days?	No	Yes	
d. Will his/her liquid resources such as cash, checking/savings be $100 or less?	No	Yes	

For Food and Nutrition Services only *- If you can't fill out the whole application today, please fill in the bottom of this page with your name, address, date and signature. If you need assistance in completing this form, please let us know so that we can assist you.*

Name Address

Signature Date Witness (if signature is X) Date

2. Tell us who lives in your household.

Who you need to include on this application

- We need information about everyone who lives at the physical address you wrote down in the "Tell Us About Yourself" section above.
- If applying for health coverage for anyone under 65 and not disabled, tell us about everyone included on your federal tax return (if you file taxes), even if they don't live at the same address. You don't have to file taxes unless you are eligible for a premium tax credit and you choose to take it to purchase insurance in the Marketplace.
- Special Assistance applicants need only complete the information in #1.

***** Information that is optional or not required. Most fields in this section are required, but some are optional for certain household members.**
- Social Security Number - optional for people not applying, and for people applying for emergency health coverage or child care assistance. We will not share Social Security Numbers with the Department of Homeland Security. - U.S. citizenship and immigration status - not required for people not applying for assistance. Failure to disclose this information will not affect the potential eligibility of other family members, but it may affect the amount of benefits received. - Race - optional for all types of assistance - Hispanic or Latino - optional for all types of assistance

1. _____
a. Person 1 (First, M.I., Last) b. Social Security Number*** c. Date of Birth (MM/DD/YYYY)

_____
d. Relationship to you e. Sex (M/F) f. Hispanic or Latino?*** (Y/N) g. Race***

h. What program(s) is this person applying for? (Check all that apply)
☐ Food and Nutrition Services ☐ Healthcare ☐ Special Assistance ☐ Special Assistance/In-Home ☐ Subsidized Childcare

Fill out this section only for each person applying for benefits:
i. US Citizen?*** ☐ Yes ☐ No j. Does this person expect to file federal income taxes next year for the current Year?* ☐Yes ☐No

k. Legal Immigrant? ☐ Yes ☐ No l. Will this person be claimed as a tax dependent?* ☐ Yes ☐No If Yes, by whom_____

2. _____
a. Person 2 (First, M.I., Last) b. Social Security Number*** c. Date of Birth (MM/DD/YYYY)

_____
d. Relationship to you e. Sex (M/F) f. Hispanic or Latino?*** (Y/N) g. Race***

h. What program(s) is this person applying for? (Check all that apply)
☐ Food and Nutrition Services ☐ Healthcare ☐ Special Assistance ☐ Special Assistance/In-Home ☐ Subsidized Childcare

Fill out this section only for each person applying for benefits:
i. US Citizen?*** ☐ Yes ☐ No j. Does this person expect to file federal income taxes next year for the current Year?* ☐Yes ☐No

k. Legal Immigrant? ☐ Yes ☐ No l. Will this person be claimed as a tax dependent?* ☐ Yes ☐No If Yes, by whom_____

3. _____
a. Person 3 (First, M.I., Last) b. Social Security Number*** c. Date of Birth (MM/DD/YYYY)

_____
d. Relationship to you e. Sex (M/F) f. Hispanic or Latino?*** (Y/N) g. Race***

h. What program(s) is this person applying for? (Check all that apply)
☐ Food and Nutrition Services ☐ Healthcare ☐ Special Assistance ☐ Special Assistance/In-Home ☐ Subsidized Childcare

Fill out this section only for each person applying for benefits:
i. US Citizen?*** ☐ Yes ☐ No j. Does this person expect to file federal income taxes next year for the current Year?* ☐Yes ☐No

k. Legal Immigrant? ☐ Yes ☐ No l. Will this person be claimed as a tax dependent?* ☐ Yes ☐No If Yes, by whom_____

4. _____
a. Person 4 (First, M.I., Last) b. Social Security Number*** c. Date of Birth (MM/DD/YYYY)

_____
d. Relationship to you e. Sex (M/F) f. Hispanic or Latino?*** (Y/N) g. Race***

h. What program(s) is this person applying for? (Check all that apply)
☐ Food and Nutrition Services ☐ Healthcare ☐ Special Assistance ☐ Special Assistance/In-Home ☐ Subsidized Childcare

Fill out this section only for each person applying for benefits:
i. US Citizen?*** ☐ Yes ☐ No j. Does this person expect to file federal income taxes next year for the current Year?* ☐Yes ☐No

k. Legal Immigrant? ☐ Yes ☐ No l. Will this person be claimed as a tax dependent?* ☐ Yes ☐No If Yes, by whom_____

Attach a piece of paper if you need more space to complete this section. We will determine who will be included in your household for the programs you are applying for.

3. Continue telling us about your household.

Please complete the following questions. Check yes or no when applicable. If you are only applying for Special Assistance, applicants should complete these questions for themselves.

1. Are you or is anyone applying for assistance an American Indian or Alaskan Native?* ☐ Yes ☐ No If yes, completed Medicaid Appendix B with the application.

2. Are you or is anyone applying for applying for or already receiving Foster Care or Adoption Assistance?* ☐ Yes ☐ No

3. Were you or is anyone in your household in foster care when they turned 18?* ☐ Yes ☐ No a. If yes, who?_____b. In what state?_____

4. Is anyone in your home currently receiving assistance from another state? ☐ Yes ☐ No
If yes, provide detail: a. Date_____b. City, State, County_____c. Type of Assistance_____

5. Are you or is anyone who is applying for assistance disabled or blind? ☐ Yes ☐ No a. If yes, who? _____

6. Does anyone who is applying have a pending application for Social Security disability or SSI? ☐ Yes ☐ No a. If yes, who? _____

7. Does anyone who is applying live in a skilled nursing facility? ☐ Yes ☐No
If yes, who_____Name of the facility_____Phone_____

7a. Does anyone live in an adult care home/assisted living facility/group home? ☐ Yes ☐ No

If yes, who_____Name of the facility_____Phone_____

8. Does anyone file taxes jointly? ☐ Yes ☐ No a. If yes who?_____

9. Is anyone listed on this application incarcerated?* ☐ Yes ☐ No a. If yes, who? _____

10. Is anyone listed on this application pregnant? ☐ Yes ☐ No a. If yes, who?_____b. Due Date_____c. How many babies?_____

11. Have you or has anyone in your household been disqualified from public assistance due to an intentional program violation? ☐ Yes ☐ No
a. If yes, who?_____b. When:_____c. State:_____

12. Have you or has anyone in your household been convicted of a felony involving drugs? ☐ Yes ☐ No a. If yes, who?_____b. When: _____

13. Is anyone fleeing to avoid felony prosecution or jail time? ☐ Yes ☐ No a. If yes, who? _____

14. Is anyone currently violating conditions of probation or parole? ☐ Yes ☐ No a. If yes, who?_____

15. Is anyone applying for assistance age 16 to 19 and going to high school?* ☐ Yes ☐No
a. If yes, who?_____b. Name of High School_____c. Expected Graduation Date_____

16. Is anyone applying for assistance age 18 to 49 and going to college?* ☐ Yes ☐No
a. If yes, who?_____b. Name of College:_____c. Expected Graduation Date_____

17. If you have children in your home, do any of them have a parent NOT living with them?* ☐ Yes ☐ No If yes, fill out below:
a. Child name_____ b. Absent parent name_____
c. Absent parent Social Security Number_____ d. Absent parent date of birth_____
a. Additional Child name_____ b. Absent parent name_____
c. Absent parent Social Security Number_____ d. Absent parent date of birth_____

Food and Nutrition Services Household Questions

1. Does everyone in your home buy and cook meals together? ☐ Yes ☐ No If no, who is separate? _____
2. Does anyone in your household have an EBT card? ☐ Yes ☐ No If yes, who?_____What state? __
3. Does anyone get FNS, Food Stamps or SNAP in this or another county or state? ☐ Yes ☐ No If yes, who_____
a. When did the benefits start?_____b. When did they end?_____c. How much did you get?_____
4. Did anyone participate in a Food Distribution Program on an Indian Reservation? ☐ Yes ☐ No
5. Do you have a person who lives in your household not included on this application? ☐ Yes ☐ No If yes, who? _____
6. In your household, is anyone renting a room from you? ☐ Yes ☐ No If yes, who? _____
7. In your household, is anyone paying for food and a place to stay? ☐ Yes ☐ No If yes, who? _____
8. Is anyone going to college or trade/vocational/technical school at least half time? ☐ Yes ☐ No If yes, what school? _____
9. If you are not registered to vote where you live now, would you like to apply to register to vote here today? ☐ Yes ☐ No
10. Have you or any member of your HH been convicted of fraudulently receiving duplicate SNAP benefits in any State after August 22, 1996? ☐ Yes ☐No
11. Please check the type of living situation that defines your household. ☐ Home ☐ Adult Care Home ☐ Alcohol/Drug Treatment Center ☐ Group Home
☐ Halfway House ☐ Hotel ☐ Institution ☐ Residential Treatment Facility ☐ Shelter for Battered Women and Children ☐ Other _____

4. Tell us about your household income (required for all types of assistance).

Tell us about all income your household receives. We want to know about the last full month, as well as any money received quarterly or annually. Income is money earned (wages or salary) from a job or self-employment, or unearned from sources such as Social Security, child support, unemployment benefits, gifts, rental income, retirement income, etc.

~~Temporary Work, Work Study for College, and Working for Tips.~~

1. Do you or does anyone in your household work? ☐ Yes ☐ No

Name (Who Works)	Employer (Name, address, phone number)	Start Date	Gross Pay (Pay Before Taxes)	How Often Is Pay Received?	Last date pay received?	Day of Week Pay received?	Hours per week?	# of Days Worked per Week?

2. Are you or is anyone in your household self-employed? ☐ Yes ☐ No If yes, complete below.

Examples are babysitting, selling Avon or other products, farming, doing hair, renting houses, doing yard work for other people or odd jobs.

Name (Who is Self Employed)	Start Date	Business Name	Type of Business	Gross Monthly Income	Monthly Expenses

3. Have you or has anyone stopped working in the past 30 days or past month? ☐ Yes ☐ No If yes, please complete below.

Name (Who has stopped working)	Employer	End Date	Date Last Pay Received or will be Received?	Gross Amount of Last Pay	Reason Stopped Working

4. Are you or is anyone on strike? ☐ Yes ☐ No If yes, please provide detail:
Who?_____Last date worked?_____Place worked & phone number? _____

5. What Money Do You or People in Your Household Receive?

We need to know the money or checks you get other than from work. Please check off all of the following ways you get money.

__ Adoption, Foster Care, or Guardianship Payments
__ Alimony
__ Child Support from parent or Child Support from the Court
__ Educational Scholarships
__ Military Allotment
__ Money from friends or relatives that is not a loan and you don't have to pay back
__ Payments for the sale of an asset (such as a car, boat, mobile home or house)
__ Private Disability
__ Social Security
__ Annuities, Pensions, or Retirement
__ Special Assistance (SA)
__ Supplemental Security Income (SSI)
_Unemployment Benefits
__ Veterans Benefits
__ Work First/TANF
_Interest and Dividends
_Workers Compensation
__ Other _____
__ My Household does not get any other money

Type of Money	Who Receives the Money?	Who Gives the Money	Phone, Address, Phone Number of person/ organization who gives the money	How Much?	How Often?	Date Last Received

Is any of the income listed above child support? ☐ Yes ☐ No

If yes, is the child support court ordered? ☐ Yes ☐ No

If yes, what is the Court Order Number_____Date Established_____Obligated Amount _____

Do you expect any income to end? ☐Yes ☐ No If yes, when_____

5. Please tell us about your resources.

Please complete this section for all the resources your household owns.

If you're are 65 or older or disabled, please complete this section for all the resources your household owns.

Tell us about any real property you own such as land, buildings, time shares, life estates, jointly held real estate, or real estate you own alone, etc. including where you live.

Owner/Owners	Type of Property	Address Location

Tell us about your life insurance.

Owner	Company Name/Address	Policy Number	Original Face Value	Cash Value

Tell us about your liquid assets.

Type of Account Do you have any of the following?:	Yes or No	Bank/ Company	Account Number	Value (In Dollars)
Cash				
Savings				
Checking				
Money Market*				
Prepaid Debit*				
Certificate of Deposit				
Mutual Funds				
Trust Account				
Patient Account*				
Stocks				
Bonds				
Promissory Note*				
Other Type_____				

Tell us about more of your assets.

Burial Contract*				
401K*				
Safety Deposit Box*				
Annuity*				

Have you or has anyone in your household transferred assets in the last 3 months in order to receive Food and Nutrition Services? This may not apply to all households.

What did you or anyone in your household give away?	Value	Given to Who?	Their Relationship to You?	When?	How much did you receive?

Assets are valuable items that you own such as cash or bank accounts. We will determine if verification is needed and if it is accessible to you. Please check all the assets you own, or someone else in your household owns, or jointly own with non-household member.

Tell us about your personal property.

Type Do you have any of the following?:	Yes or No	Owner	Year	Make	Model (In US $)	Licensed Yes or No
Car/Truck						
Car/Truck						
Car/Truck						
Mobile Home						
Motorcycle						
Boat/Boat						
Campers						
Utility Trailers						
Tractors						
Other Type_____						

Have you transferred/given away any property or assets in the past 3 years?

What was it?	Value	Given to whom?	Relationship to you?	When?	How much did you receive?

Have you transferred/given away any property or assets in the past 5 years?

What was it?	Value	Given to whom?	Relationship to you?	When?	How much did you receive?

Please Tell Us About Your Household Bills

Please complete this section for all expenses your household is responsible for paying.

Expense Type	Name, Address and Phone to whom you pay the bill	Amount Billed	How often paid?	Who Pays the Bill?
Rent or Mortgage				
Lot Rent				
Property Taxes (If not included in mortgage)				
Homeowners Insurance (If not included in mortgage)				
Homeowner's Dues				

Check the utility cost(s) your household is responsible for paying.

☐ Electricity LP/Natural Gas ☐ Water/Sewage Garbage/Trash ☐ Utility Excess (Public Housing) ☐ Telephone/Cell Phone
Name of phone company? _____

Are you responsible for paying for heating or cooling your home? ☐ Yes ☐ No

How do you heat your home? (Check One)
☐ Electricity ☐ LP Gas ☐ Natural Gas ☐ Coal ☐ Kerosene ☐ Oil ☐ Wood ☐ Other _____

Were you a member of a household that received a Low Income Energy Assistance Program (LIEAP) check at your current address within the past 12 months?
☐ Yes ☐ No

Do you receive Section 8 or HUD Assistance? ☐ Yes ☐ No

Help Paying Bills

Does any agency, organization, or person (Including Section 8) outside your household help pay any of your rent or utilities? ☐ Yes ☐ No

If yes, complete questions below.

Was the money given to you? ☐ Yes ☐ No If yes, was it a loan? ☐ Yes ☐ No

Which bill is paid?	Name, Address, Phone Number of the person that pays the bill?	Was the money given to you?	Amount paid	How often paid	Date of last payment

6. Please tell us about your other bills.

Who gets care?	Who pays for care?	Name, address and phone number of care provider/babysitter	Amount Paid	How often?	Start Date	Why needed?	Date of last payment

Does any agency, organization or person (Including Social Services) outside your household help pay any of your childcare? ☐ Yes ☐ No
If yes, complete questions below.

Which bill is paid?	Name, address and phone number of person that pays the bill?	Amount paid?	How often paid?	Date of last payment

Court Ordered Child Support

☐ Yes ☐ No If yes, complete questions below.

Who pays child support?	Name of child	Name, address and phone number of person that pays the child support?	Amount paid?	Start Date?	How often paid?	Date of last payment

Medical Bills

Disability, or Medicaid for disabled persons.)

When did the disability begin?_____Who made the disability determination? _____

If yes, we need to know the medical bills you have or are responsible for paying. Medical bills include, but are not limited to:

- Health and hospital insurance premiums or co-payments
- Prescription and over-the-counter medications and medical supplies such as aspirin, diabetic supplies and eye glasses
- Food and/or veterinary care for a trained service animal
- Rental and purchase of medical equipment and supplies
- Transportation and lodging to get medical treatment
- Prescribed eye glasses and contact lenses
- Medicare Premiums
- Dentures, hearing aids, and prostheses
- Doctor and hospital bills
- Payments for aides, attendants, and nurses
- Medical and dental care

Type of expense	When did the expense start?	Name, Address, Phone number of medical provider?	Amount due?	How often due?	Date of last payment?

Does any agency, organization or person (Including Social Services) outside your household help pay any of your medical bills? Yes No If yes, complete below.

Who Pays the Bill?_____Which Bill Is Paid?_____Amount during certification period?_____

Who Pays the Bill?_____Which Bill Is Paid?_____Amount during certification period?_____

7. Tell us about your health coverage situation.

1. Does anyone who is applying for health coverage want help paying for medical costs from the last 3 months?

☐ Yes – Complete questions a. and b. ☐ No – Skip to #2.

a. If yes, tell us who_____

b. If yes, tell us your gross household income (income before taxes) received by your family in each of the last three months:
Last month_____Two months ago_____Three months ago _____

2. Is anyone on this application insured by any of the following?

Program	Yes or No	Who?
Medicaid		
North Carolina Health Choice		
TRICARE		
Veterans Affairs Health Care		
Peace Corps		
Medicare		

Is anyone covered by employer insurance? ☐ Yes ☐No

Name of insurance:_____Policy number: _____

Is this COBRA coverage? ☐ Yes ☐ No Is this a retiree health plan? ☐ Yes ☐ No

What services are covered? Check all that apply.
☐ Inpatient/outpatient hospital services ☐ Lab services ☐ Physicians medical/surgical services ☐ X-ray services

Other Insurance

Name of insurance:_____Policy number: _____

Is this COBRA coverage? ☐ Yes ☐ No Is this a retiree health plan? ☐ Yes ☐ No

What services are covered? Check all that apply.
☐ Inpatient/outpatient hospital services ☐ Lab services ☐ Physicians medical/surgical services ☐ X-ray services

3. If not currently receiving coverage, does anyone have access to health insurance from a job? *Check "yes" even if the coverage is from someone else's job such as a parent or a spouse.* ☐ Yes ☐ No ***Complete Medicaid Appendix A***

Additional Questions

Does anyone who is applying need medical services provided in the home? ☐ Yes ☐No a. If yes, who? _____

Do you or does anyone in your household have access to employer sponsored health insurance coverage? ☐ Yes ☐No
a. If yes, who?_____What employer? _____

FOOD AND NUTRITION SERVICES INFORMATION FACT SHEE

Please Read This Information

Changes You Must Report and How to Report Them

Your caseworker will give you a Change Report Form for your household's situation and explain it to you.
This form will tell you all the changes you must report to us and when to report them.
When you have a change, fill out the form and mail it to us. You may also call your caseworker or come in to our office to report changes.
Your caseworker will contact you about the change.

Information About Social Security Numbers

You can choose to give us the Social Security Number (SSN) used by each person in your household. If you need help getting a SSN, ask your caseworker for help. We will only give Food and Nutrition Services to the eligible people who give us their SSN. We will use the SSN's you give us to do computer matches and check what you told us with State and Federal Agencies. The legislative authority for requesting SSNs is the Food and Nutrition Act of 2008.

We will only use the SSNs you give us to do computer matches to check what you told with State and Federal Agencies Income and Eligibility Verification System (IEVS), other computer matching systems, program reviews and audits. This information may be verified through other sources when discrepancies are found and may affect your household's eligibility and benefit level.

Information About U.S. Citizenship and Immigration Status

You must be a United States (U.S.) citizen or an eligible alien to get Food and Nutrition Services. You must also meet other Food and Nutrition Services rules. You can choose to give us the US Citizenship and Immigration Service (USCIS) documents used by each person in your household. We will only give Food and Nutrition Services to the eligible people who give us their legal USCIS documents. We will only contact USCIS to check the immigration status of the people who give us their immigrant documents.

Food and Nutrition Services Rules

The following rules apply for getting and using Food and Nutrition Services:

- Don't hide or give wrong information on purpose to get Food and Nutrition Services benefits.
- Don't use Food and Nutrition Services to buy non-food items like alcohol or tobacco.
- Don't trade or sell your Food and Nutrition Services.
- Don't use someone else's Food and Nutrition Services for yourself.
- Don't use your Food and Nutrition Services for someone else.
- Don't use your Food and Nutrition Services to pay on any kind of credit account even if it is for eligible Food and Nutrition Services items.
- DO cooperate with state and federal personnel in a Quality Control review

Penalties for Breaking the Rules of the Food and Nutrition Services Program

- If you intentionally break any of the rules above you may not be able to get any more Food and Nutrition Services from one year to permanently, and may be fined up to $250,000 and/or jailed up to twenty years.
- Giving wrong information may also mean we will reduce your benefits, or you may be required to repay benefits.
- If a court finds you guilty of buying, selling, trading or trafficking more than $500 in Food and Nutrition Services, after August 22, 1996, you may lose Food and Nutrition Services forever. Trafficking is defined as buying or selling EBT cards or FNS benefits for cash or consideration other than eligible food or the attempt to buy or sell FNS benefits online and/or in public.
- If a court finds you guilty of trading Food and Nutrition Services for firearms, ammunition, or explosives after August 22, 1996, you will lose Food and Nutrition Services forever.
- If a court finds you guilty of trading Food and Nutrition Services for controlled substances, after August 22, 1996, you will lose Food and Nutrition Services for two years the first time and forever the second time.
- S/he may also be barred from the SNAP for an additional 18 months if court ordered.
- You will not get Food and Nutrition Services for 10 years if you are found guilty of getting or trying to get Food and Nutrition Services in more than one household at a time. This penalty happens if you give wrong information about who you are or where you live.

Information About Hearings

- If you do not agree with our decision about your Food and Nutrition Services, you or the person helping you may ask for a hearing. You may call or write us to ask for the hearing. You have up to 90 days from the date of the decision to ask for the hearing.
- A friend, relative, or lawyer may speak for you at your hearing.

Information About Work and Training Rules

Some people have to work or attend training to get Food and Nutrition Services. If this is true for you or for other people in your household, we will tell you. You will have to follow the rules about work and training to get Food and Nutrition Services.

We Check What You TELUS

- The information you give us may be checked by federal, state, and local officials to make sure it is true. If any information you give us is not correct, we may deny Food and Nutrition Services.
- All eligibility procedures are strictly supported by the Food and Nutrition Services policies. The other programs time limits or requirements do not affect your Food and Nutrition Services benefits. Your household may not be denied food assistance because your household has been denied benefits from other programs.
- I am aware of the information I give may be disclosed to other Federal and State agencies for official examination, and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law.
- If you have a Food and Nutrition Services claim arise against you overpayment we will give your answers and Social Security Numbers to federal and state agencies, as well as private claims collection agencies, to collect the overpayment.

We Must Obtain Data

We are required to obtain racial and ethnic data on participating households. The information is voluntary; neither your eligibility nor Food and Nutrition Services amount will be affected if you choose not to provide it.

Additional Program Violations:

- If you use your food assistance benefits to buy nonfood items, such as alcohol or cigarettes, or to pay on credit accounts you will lose your benefits.
- Giving wrong information knowingly may also mean we may reduce your benefits, or you may have to repay benefits, or maybe subject to criminal prosecution or not able to get benefits for twenty-four months.
- If a court finds you guilty of trading Food and Nutrition Services for controlled substances, you will lose Food and Nutrition Services for two years the first time.
- If a court finds you guilty of buying, selling, or trading benefits $500 more than, trading benefits for firearms, drug trafficking, ammunition, or explosives after August 22, 1996 you may lose Food and Nutrition Services forever.
- You will not get Food and Nutrition Services for 10 years if you are found guilty of getting or trying to get Food and Nutrition Services in more than one household at a time. This penalty happens if you give wrong information about who you are or where you live.
- If a court finds you guilty of trading Food and Nutrition Services for controlled substances, you will lose Food and Nutrition Services for forever the second time.
- If you intentionally break any of the rules above you may not be able to get any more Food and Nutrition Services permanently, and may be fined up to $250,000 and/or jailed up to 20 years. You may also be ineligible for Food and Nutrition Services for an additional 18 months if court ordered.

Getting Help With Your Telephone Bill

- If you receive SSI, Food and Nutrition Services, Medicaid, Sec. 8 Housing Assistance, Energy Assistance (LIHEAP) or Work First Family Assistance benefits you may be eligible for a local telephone service discount.
- The Lifeline Program allows recipients to receive a credit on their monthly telephone bill.
- The Link-Up Program allows recipients who are Native Americans residing on federally recognized tribal lands a discount toward the cost of hooking up local telephone service.
- Households interested in these services must contact their telephone company to apply for these programs.

Are You Registered to Vote in North Carolina?

Registering to vote is easy in North Carolina. State law requires voters to register 25 days before an election. DSS can help you with registration paperwork. 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.

Non Discrimination Statement

The U.S. Department of Agriculture (USDA) prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form (PDF), found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339 or (800) 845-6136 (in Spanish).

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers, found online at http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

USDA is an equal opportunity provider and employer.

By signing this application I am saying that:

- I have told the truth on this form.
- I know Food and Nutrition Services rules and what I must do to get Food and Nutrition Services.
- I agree to give information about what I have said so that my application can be processed.
- I give permission to social services to get proof of what I have said from any person, agency, or business. Other persons, agencies, or businesses include, but are not limited to: employers, banks, savings and loans, landlords, etc.
- I have given correct information on the citizenship/immigration status of all individuals applied for.
- I understand my expenses may be used to figure my Food and Nutrition Services amount. If I do not tell you about some of my expenses and/or verify them, they may not be used in the budget to calculate the amount of my benefits.
- I have read, understand, and received the Program Information and Rights and Responsibilities form.

Section 5: Acknowledgment of Rights and Responsibilities

I understand my rights and responsibilities as explained in the previous sections.

Applicant Signature:_____ Date:_____

Representative:_____ Date:_____

Caseworker:_____ Date:_____

NORTH CAROLINA | PUBLIC ASSISTANCE RIGHTS AND RESPONSIBILITIES

If you are applying or receiving for one of the following public assistance programs: Medicaid, Special Assistance, and/or Child Care in North Carolina, you have the following Rights and Responsibilities.

Your Rights:

- Apply for and receive assistance. If your application is denied or stops, reapply at any time.
- Have all information you provide to the agency kept in confidence and remain private unless required by law or policy. Be advised that information provided to this agency may be stored in a computer database.
- Have an interpreter or translator services at no cost to you when communicating with the agency.
- Apply for assistance for new or additional household members at any time.
- Withdraw from applying for or receiving benefits at any time.
- Get written notices of information needed to determine your eligibility or to complete your application.
- Get written notices if your assistance is approved, denied, changed or stopped.
- Receive your monthly benefit until notice of termination or until it is withheld by appropriate action.
- Be advised that racial and ethnic data is obtained on participating household members. This information is voluntary. Neither your eligibility nor benefit amount will be affected if you choose not to provide it.
- Be protected by federal law against discrimination based on race, color, national origin, sex, age, disabilities or political beliefs. This agency follows the standards set by Title VI of the Civil Rights Act.
- You do not need a permanent address as long as you plan to stay in North Carolina.
- Ask questions regarding program rules and requirements. You can contact your worker or the agency if you have questions about your case.
- Ask for a hearing from the county department of social services and the state Division of Social Services. Hearing requirements may be different for each Program. Refer to Hearing Rights.
- 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. Authorize a representative to act on your behalf if you are unable to act on your own behalf.
- View information contained in your case file, except third party information. Third party information includes any reports written by outside agencies or persons regarding you or your case.
- Have anyone with you to help you complete forms and be with you at your interview. Have agency staff help you fill out forms and let us know if you need help getting information we need.
- Be told about other programs we have that might help you or your family.

Medical Assistance (Medicaid) Additional Rights

The time standard for completing and processing a Medicaid application is 45 calendar days from the date of application. Exceptions to this 45-day time standard may apply; your caseworker will explain if applicable.

Your Rights:

- Apply for retroactive Medicaid for up to 3 months prior to the date of your application.
- Request Medicaid transportation to your primary care physician or other medical appointments if receiving certain Medicaid coverage.
- Apply for a deceased individual.

Special Assistance Additional Rights

The time standard for completing and processing a Special Assistance application is 45 calendar days from the date of application. Exceptions to this 45-day time standard may apply; your caseworker will explain if applicable.

Your Rights:

- If approved for Special Assistance, you have the right to spend the Special Assistance payment as needed when it is considered to be in your best interest of your health and safety. A substitute payee may be appointed for those individuals who cannot manage the payment. If you are receiving payment because you reside in an adult care home "best interest" means paying for your adult care home. If you receive Special Assistance In-Home 'best-interest" means spending your money as agreed upon in your service plan.

Your Responsibilities:

- Provide all information requested and certify that all information provided concerning your situation and all persons for whom you are applying or receiving benefits for is true and complete. If you fail to provide true and complete information you may face penalties ranging from being denied services, paying funds back to the agency, being banned from services, fined and being charged with a crime.
- Report timely to the county department of social services if you receive incorrect Medical, Special Assistance, or Special Assistance In-Home . If you get too much in benefits you may have to repay money for the benefits.
- Report timely to the county department of social services any change in your situation. If you are unsure if you need to report something or not, call your caseworker. Report any changes concerning you or your family (such as changes to where you live, who is living in your home, getting or losing a job, money your household receives, etc.) as soon as possible after the change occurs. If you are not sure whether to report a change, please call your worker to be sure. If you don't report a change you may be asked to pay back the agency for your benefits.
- Provide the county department of social services, state and federal officials, upon request, information needed to determine eligibility by the date it is due. You may have your application denied or have your benefits stopped if you fail to provide information by the due date.
- Cooperate with state and federal personnel in Quality Control reviews.

- Understand that any Medical ID card or Electronic Benefits Transfer (EBT) card received is to be used only for the person(s) listed on the card. It is against the law to give your Medical ID or EBT card to someone else and you could be prosecuted for fraud. If you do not use your benefits as intended, you may face penalties ranging from paying funds back to the agency, being banned from services, fined, have someone appointed to handle your benefits, and being charged with a crime. It is illegal to buy, sell or trade your benefits.
- Understand that you may be required to apply for all benefits to which you may be entitled (such as Unemployment Benefits, Social Security benefits, Veteran's benefits, etc.) including receiving the maximum benefit for which you are eligible.
- Report any child or spousal support paid directly to you. This information must be reported and will be counted as income in determining your eligibility and understand that you may be asked to cooperate with the agency that collects medical support from an absent parent. If you think that cooperating to collect medical support will harm me or my children, you can tell Medicaid and I may not have to cooperate.
- North Carolina must be named remainder beneficiary for annuities purchased after a certain date.
- Follow program rules and requirements unless you have good cause. Good cause is determined on a case by case basis depending on the rules or requirements of the program.
- Tell us if the people that you are applying for you are a U.S. citizen, a qualified immigrant or not a U. S. citizen. Proof of citizenship is not required for persons who are not asking for help.

Medical Assistance (Medicaid) Additional Responsibilities

- Report changes in your situation within 10 calendar days from the date of the change.
- Report if you or a household member receiving Medicaid or NC Health Choice is in an accident.
- Provide third-party insurance information if applicable. 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.
- Understand that any medical or financial records must be made available to the agency and the state by any provider from whom you and/or your children have received medical care services. You agree to the release of those records by those providers when requested by the agency and the state. The privacy of this information is protected by law.
- Understand you are giving the State of North Carolina permission to collect payments and share information with insurance companies or anyone else who is supposed to pay for your medical bills.
- Request medical transportation as far in advance of your appointments as possible.
- Understand that Federal and State laws require the Division of Medial 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.
- Understand that North Carolina must be named beneficiary for annuities purchased after November 1, 2007.

Special Assistance Additional Responsibilities

SA

- Report changes to your caseworker within 5 calendar days following the change in situation.
- Report changes that would affect an SSI payment amount to the Social Security Administration within 10 calendar days.

Additional Responsibilities and Information You Need To Know:

- Under North Carolina law, persons must provide all information needed to decide if they can receive public assistance.
- If you knowingly provide false information or withhold information, you can be lawfully punished for fraud.
- You may be asked to repay the benefits that were paid incorrectly.

Identity/Citizenship

- You must tell us about and provide documents for the citizenship and immigration status of all persons in your household applying for benefits or receiving benefits to determine eligibility. Non-applicant household members are not required to provide immigrant or citizenship status. This means if you are not applying for someone in your home you are not required to give us their immigrant or citizenship status.
- You must be a United States Citizen or qualified immigrant/eligible alien to receive public assistance. Exceptions may apply to Medical Assistance in emergency situations.
- Information given to use in verifying your immigration status will be used in matching information with a web-based service called the Systematic Alien Verification for Entitlements (SAVE). If additional information is required we may check with the United States Citizenship and Immigration Services (USCIS).

Child Support/Assignment of Rights

- As a condition of eligibility for Medical Assistance programs (not including Special Assistance) the law requires a caretaker of a child receiving public assistance to cooperate with the Social Services and Child Support Enforcement agencies to establish a support case.
- The medical or child support paid to Child Support Enforcement is used to repay the Work First Family Assistance or Medicaid benefits you receive for your child(ren).
- You may claim good cause for not cooperating. Please notify your caseworker if you think you have good cause.
- Understand this assignment of rights continues for as long as you or anyone you am applying for receives Work First or Medicaid.

Social Security Numbers

- Non-applicant household members are not required to provide a social security number. You must tell the county department of social services all the social security numbers used by all applicants.
- The social security numbers will be matched with the Social Security Administration, Internal Revenue Service, the Division of Employment Security, out-of- state welfare agencies and any other necessary agency. You have the right to withdraw your application if you do not want this done. Social Security numbers will be used

to verify information; information obtained by computer matching will be used to determine eligibility.

Reviews

A review of eligibility may be completed twice a year or once a year depending on the benefit you are receiving.

- If you get a notice of review or a report, you must fill out, sign and return all forms and requested verifications to the county department of social services by the deadline date printed on the form. Benefits could terminate or be delayed if review or report is not completed.
- If you are required to have an interview and fail to do so it will result in a delay or denial of benefits. You are responsible for rescheduling a missed interview and for providing required verification information.

Hearing and Appeal Rights

Your Rights to a Hearing:

- You have the right to a hearing if you were denied or discouraged from applying for benefits.
- You have the right to request a hearing if your application is denied or your case is terminated, your benefit is changed or your case is not acted upon timely. Program requirements are listed in Program Rights and Responsibilities.
- For Medical and Special Assistance, the standard time to request a hearing is 60 days from the date of your notice.
- You can request a hearing in person, by telephone or in writing. Contact your caseworker to ask for a hearing. A local hearing will be held within 5 days of your request unless you ask for it to be postponed. The hearing can be postponed, for good reasons, for as much as 10 calendar days. If you think the decision from the local hearing is wrong, call or write your caseworker WITHIN 15 DAYS to ask for a second hearing. The second hearing is before a state hearing official.
- If you are requesting a hearing about disability, there is no local hearing. A state hearing officer holds the disability hearing.
- You may have someone speak for you at your hearing, such as a relative or a paralegal or attorney obtained at your expense. Free legal services may be available in your community. Contact your nearest Legal Aid or Legal Services office or call 1-866-219-5262 toll free.
- You (or the person speaking for you) can view your record at any time, except for third-party information. If you ask, you may also see additional information to be used at the hearing.
- If you have additional questions or concerns, contact your caseworker for information, or call DHHS Customer Service Center toll free at 1-800-662-7030. TDD/ Voice for the hearing impaired is also available through the DHHS Customer Service Center number. The DHHS Customer Service Center is available Monday through Friday 8 a.m. to 5 p.m. except for state holidays. A bilingual information and referral specialist is available to translate for persons with limited English proficiency.

Your Right to a Appeal

If you think the Health Insurance Marketplace or Medicaid/NCHC has made a mistake, you 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. You know that you can find out how to appeal by contacting the Department of Social Services or by calling 1-800-662-7030. You know that you can be represented in the process by someone other than you. Your eligibility and other important information will be explained to you.

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 Medicaid/NCHC and the Marketplace 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 understand that the date of the Medicaid/NCHC and Special Assistance application is the date that it is received by the County Department of Social Services.
- I know that any information given to the Marketplace or Medicaid/NCHC and/or other benefits programs for which I am applying 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, Medicaid/ NCHC, and/or other benefits programs for which I am applying 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.
- I know that I must verify the information on this application with an interview.

Medical Assistance (Medicaid)

- 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 for Medicaid/ NCHC and could affect my eligibility.
- **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.

If you are an authorized representative, you may sign here as long as you have provided the information required.

I understand my rights and responsibilities as explained in the previous sections.

Applicant Signature:_____ Date:_____

Representative:_____ Date:_____

Caseworker:_____ Date:_____