NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Health Benefits

NORTH CAROLINA MEDICAID AMBASSADOR

ATTESTATION FORM

The North Carolina Department of Health and Human Services Division of Health Benefits requires that all organizations supporting community partners participation in the Medicaid Ambassador Initiative attest to complying with the following criteria. Each organization that supports one or more persons becoming an ambassador must complete this form. **Only one form is required per organization.**

As an organization serving as a trusted community partner, we attest that our recommended ambassadors:

☐Understand where to find information on Medicaid eligibility, Medicaid expansion, and how to apply.
☐Understand ePASS navigation and have watched the ePASS demo.
☐Will connect the individuals they are serving to a Navigator, or their local Department of Social Services based on need.
☐Will refer all eligibility-related questions to the local Department of Social Services and will not discuss eligibility requirements.
☐Will not collect or ask for Personally Identifiable Information (PII) or Protected Health Information (PHI).
☐May provide navigational/over-the-shoulder support for someone completing a Medicaid application in ePASS but will not complete the application on their behalf.
☐Are bound by state/federally regulated confidentiality laws or have signed a confidentiality agreement with your organization.
☐Understand that NC DHHS will publish the information provided in the [questionnaire name] (e.g., location, contact information, languages spoken) on its website so that interested applicants may reach out for assistance.

By signing below, I attest that I have the authority to act as a representative of my organization, I understand the role of a North Carolina Medicaid Ambassador, I am recommending the listed persons below to become Medicaid Ambassadors supported by my organization, and I attest to all the statements above on behalf of the recommended names and my organization.

Name of Representative:
Role/Title of Representative:
Name of Organization:
List of County/Counties served:
Organization Phone Number:
What languages are supported?:
Organization Address:
Are walk-in services available?:

Signature:

Date:

Name(s) of Recommended Ambassador(s):

Email this completed form to: Medicaid.NCEnagement@dhhs.nc.gov.