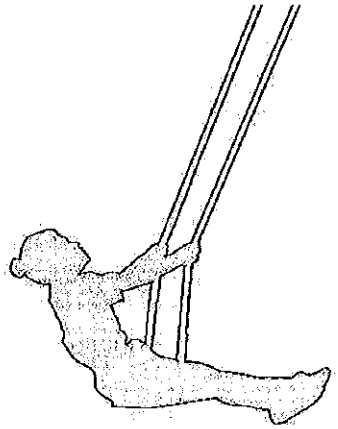
HEALTH CHECK (MEDICAID)
NC HEALTH CHOICE FOR CHILDREN APPLICATION
Free or Low-Cost Health Coverage

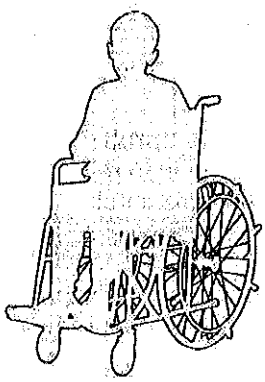
This application may also be used by parents, caretakers, pregnant women & other adults to apply for Medicaid.

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 al Centro de Atención al Cliente del Departamento de Salud y Servicios Humanos (DHHS, por sus siglas en inglés) al 1-800-662-7030. Se le atenderá en español. (You can get a Spanish application at your local department of social services or call 1-800-662-7030.)



Health Check NC Health Choice for children

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



WHAT ARE HEALTH CHECK (MEDICAID) & NC HEALTH CHOICE FOR CHILDREN?

Health Check (Medicaid) and Health Choice are two similar health coverage programs. Your family's income, the number of people in your family and the age of the children determine if you or 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 - Medical transportation may be available to individuals authorized and receiving Health Check (Medicaid). If you need assistance with transportation to receive medical care, contact your local department of social services after you receive a letter approving Health Check (Medicaid). If the children are enrolled in Health Choice, you must provide your own transportation.

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 DHHS Customer Service Center at 1-800-662-7030.

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 you or your children qualify.

WHO CAN ANSWER MY QUESTIONS?

Contact the department of social services in the county where you live or call the DHHS Customer Service Center at 1-800-662-7030.

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

Will I Be Enrolled Immediately?
Health Check (Medicaid) 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.

Will I Get Identification Cards?
YES! You will receive identification 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.

Will I Have to Pay Enrollment Fees and Co-pays?
Depending on your income, you may have to pay an enrollment fee of $50 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 I Need to Re-enroll?
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.

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 you or your children get health coverage 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.
- ✓ If Health Check (Medicaid)/Health Choice pays for health care for you or 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.
- ✓ You agree to tell the department of social services if anyone with Health Check (Medicaid) is in an accident.
- ✓ For a person to be enrolled in Health Check (Medicaid)/Health Choice, you must provide his/her social security number or apply for a number. These numbers will be matched by computer with other government agency records (but not the Bureau of Citizenship and Immigration Services) to verify information. If you decide not to give the numbers, the person cannot be enrolled.
- ✓ For a person to be enrolled in Health Check (Medicaid)/Health Choice, you must provide proof of identity and U.S. citizenship or information for the county DSS to obtain the proof for those applying for benefits. For refugees and legally qualified immigrants, provide proof of legal status for those applying.

WHAT ARE MY RIGHTS?

- ✓ Health Check (Medicaid)/Health Choice cannot discriminate on the basis of race, color, nationality, sex, religion, age, or disability in employment or the provision of services.
- ✓ 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. You have the right to have an attorney or other legal representative represent you at the hearing. Free legal aid may be available. Call 1-866-219-5262 for more information.

REPORTING FRAUD/ABUSE

To report fraud, waste or program abuse, please contact the DHHS Customer Service Center at 1-800-662-7030.

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 6.

Health Check for children Health Choice

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

APPLICATION

Please complete. Then send pages 3-6 to your local department of social services. If you are an adult who has no children living with you and you are applying for Medicaid, Medicaid for Pregnant Women or Family Planning Services, begin with Question #2.

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 (Medicaid)/Health Choice. Social Security number, proof of identity, and citizenship status are required **only** for those applying.*

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.)	**Hispanic/Latino (Y, N) If yes, specify using codes below.	Is Child a U.S. citizen? (Y, N)	Social Security Number (SSN)

*Asian= A American Indian or Alaska Native= I Native Hawaiian or other Pacific Islander= P Caucasian or White= W Black or African-American= B
** Hispanic Puerto Rican= P Hispanic Cuban= C Hispanic Mexican= M Hispanic Other= H

2. Where do you & the children live? ▼ **(If different, please put your address on a separate sheet and return with this application.)**

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 (Use codes in #1. List all that apply.)	**Hispanic/ Latino (Y, N) If yes, specify using codes in #1.	Children's names and parent or adult relationship to the children (John – Mother, Mary - Stepmother)

Anyone who applies for Medicaid, Medicaid for Pregnant Women, or Family Planning Services must provide their Social Security numbers and may have to give information to the child support office.

a. Do you want to apply for pregnancy coverage for any of the people listed in #3 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? _____ Relationship to child(ren): _____ SSN _____

b. Do you want to apply for Medicaid for any of the people listed in #3 above? If you want to apply, you will be contacted for information about bank accounts, personal property, stocks, bonds, etc. The total of these must be less than $3,000. Also, if eligible, the person may be responsible for some medical bills. ▸ ☐ **Yes** ☐ **No**

If yes, for whom? _____ Relationship to child(ren): _____ SSN _____

c. Do you want to apply for family planning services for any people ages 19 and older listed above? ☐ **Yes** ☐ **No**

If yes, for whom? _____ Relationship to child(ren): _____ 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)	Relationship to child(ren)	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, what is that parent's name? (optional) _____

Is that parent required by an agreement to pay for health insurance? ▸ ☐ Yes ☐ No

6. Does anyone applying have other health plan/coverage? ▸ ☐ Yes ☐ No

If yes, please give information below: ▾

Name of Insured (first, middle initial, last)	Owner of Policy	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 12 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 anyone 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 anyone 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. If the parent or child receives income from any other source please complete the blocks below.

Type of income	Name of the person who receives other income	Amount received	How often received (monthly, weekly, etc.)
Child Support:		$	
Social Security:		$	
Unemployment:		$	
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 (Medicaid)/Health Choice.

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

If yes, please fill in the information: ▾

Name, address & phone number of sitter or care 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 & to whom	For whom is the support paid	Is it court ordered? (Y, N)	Amount paid **Please Attach Verification**	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 medical and financial 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 financial or medical 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.**

Voter Registration

ARE YOU REGISTERED TO VOTE IN NORTH CAROLINA? ☐ **Yes** ☐ **No**

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 would like to register to vote in North Carolina, ask your caseworker for a voter registration form, and if you need help, to assist you in completing the form.

What Language Does the Family Prefer to Speak? (optional)

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(s)/other adult(s)** living in the home. (NOTE: You may still apply for Health Check (Medicaid)/Health Choice even if you don't answer the questions below.)

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

By signing this application, you are stating that you understand the following.

- ✓ 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 coverage 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.
- ✓ I have received or understand that I will receive a copy of the "Medicaid Notice of Privacy Practices."
- ✓ I understand that if Medicaid pays for nursing facility care, in-home care services, or services provided under the Community Alternatives Program (CAP), Medicaid may become a creditor of my estate and my estate may be subject to recovery to repay Medicaid.

Signature (parent or other adult): _____

Date: _____