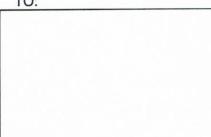
NORTH CAROLINA DIVISION OF SOCIAL SERVICES SERVICES INFORMATION SYSTEM

CLIENT	ORMATION SYSTEM	DATE	
ent Identifying Information CLIENT ENTRY FORM 1 CLIENT ID 1A MD CL 2 CLIENT NAME, LAST		FIRST MI	
3 CLIENT SOCIAL SECURITY NO. 4 DATE OF BIRTH 5	COUNTY 6 COUNTY CASE NO	0 6A FED TRIBE 7 OTHER	
B. Service Plan 8 DECISION 9 SERVICES REQUESTED	10 SERVICE 11 DATE REQUESTE	D 12 DATE TERMINATED 13 REASON 14 SPECIAL USE	
	CODE		
C. Notice of Action Taken	In the second		
☐ You will be able to receive the service which is marked "Yes" I			
After You will not be able to receive			
The policy we followed is	found		
The service which is marked "Change" which you have been rea	ceiving will be		
	ave agreed to contribute to the c		
		rstarting	
	pu		
D. Purchase of Service			
The provider is authorized / no longer authorized to claim reim	bursement for	Beginning	
Provider		Provider ID	
Client Address:		Funding source(s)	
		Client Phone:	
The provider is responsible for collecting the consumer contribut	E. Income Information INCOME TYPE INCOME AMOUNT		
por	starting	PER	
F.	indeal and the second	PER	
Social Worker's Signature	Date		
G. If you disagree with any action checked above or if you think the inform you have the right to ask for a hearing. Instructions on the back of the	nation used to make the decisio form will tell you how to ask for	n was incorrect, COMMENTS: r a hearing.	
By signing below, you are saying that you have given correct and complete		nature	
Signature Witness			
H. Client Information		r	
15 CASE MANAGER NAME, LAST FI MI 10	S CASE MANAGER NO.	17 LOCAL USE 18 STATE USE	
19 SPECIAL AREAS 20 REASON 21 LEGAL STATUS 22	2 LIVING ARR. 23 SEX 24 RACE	EDUCATION 27 LANG 28 SPEC ED 29 RACE DECLINED	
	I		



This form is being sent to notify you of action taken regarding the request/receipt of social services. The action(s) being taken is outlined in Section C of this form.

This form also serves as your record of the information provided by you and used in determining eligibility for services.

Your signature in Section G of the form certifies that you have been made aware of and agree to the rights and responsibilities contained in the following statement. Do not return this letter. Keep it for your records.

Application Statement

I understand that for certain services I am responsible for providing the department of social services with income information necessary to determine the eligibility for the services requested. The information provided by me is reflected on this form and represents a true and complete statement of the facts according to my best knowledge. I understand that it is against the law for me to make false statements or to withhold information affecting eligibility and that I am subject to prosecution If I do. I also understand the information provided by me may be subject to verification and that I may be asked (at this time or at a later date to provide documentation which supports the information I provide. I agree to notify the agency within five days of any changes in address, employment, income, living arrangement or, of family size.

I Understand that the information I provide will be held in strict confidence and will not be revealed to anyone without my written consent except for information necessary to authorize the provisions of service and establish eligibility, and information that may be revealed in the course of agency audits and monitoring. I hereby give consent for release of information by the Social Security Administration needed to determine edibility for services. I understand that certain services may involve a fee based on my gross family income. These services are: Day Care Services for Adults and Children, In-Home Aide Services, Personal and Family Counseling and Preparations and Delivery of Meals.

I also certify that I am not being forced to request or to accept any service against my wishes. I understand that I have a right to request and obtain a fair hearing if the agency does no act upon my request with reasonable promptness (i.e., within 30 days of the date services are requested) and /or if I disagree with agency's action in response to my request. I understand that the agency's decision in no way affects Medicaid, Work First, Food Stamps or any other services, assistance, or income. If eligible, I understand the services will be provided or arranged within 15 days of notification if such services are available.

How to Get a Fair Hearing

If you wish to request a fair hearing, you must contact the county department of social services with sixty (60) days after this letter was mailed. A hearing will be scheduled for you with an official of the county department of social services. If you are dissatisfied with the decision made at that hearing, you may have a hearing with an official from the State Department of Human Resources.

At either of these hearings you may have someone such as a relative or friend represent you. You may have an attorney represent you, but you may need to pay for his/her services yourself, unless free legal services are available in in your community. If you are interested in free legal services, contact your worker.

If your request for services was denied and you wish to request a fair hearing, you must contact the county department of social services within sixty (60) days after this letter was sent. If your services were terminated or modified and you wish to request a fair hearing, you must contact the county department of social services within 60 days after the effective date entered in Section C on the front of this letter.

If your services were terminated or modified for any reason other than lack of public funds to pay for them, you may keep receiving your services until the local hearing decision if you ask for a fair hearing on or before the date entered in Section C on front of the letter. However, if your hearing shows that the decision was correct, you may have to repay the cost of the services you received while waiting for the hearing. If you do not wish to continue to receive the services as before you may ask your worker to stop them. If you have any questions or want further information, please contact your worker as soon as possible.

TO: