North Carolina Division of Aging and Adult Services

STATE/COUNTY SPECIAL ASSISTANCE 8190 SSI/NON-SSI APPLICATION WORKBOOK

Please Note: This Application Workbook is an Interviewing/ Application processing guide for the caseworker. Not all policy details are included in this booklet. Current policy must be followed when determining eligibility for Special Assistance, whether or not referred to or noted in this DAAS-8190 workbook.

I. PERSONAL INFORMATION

A. APPLICANT'S NAME			**B. AUTHORIZED REPRESENTATIVE: (POA, Guardian)**	
LAST:		**FIRST**:	**LAST**:	**FIRST:**
Facility Name		Facility License#	Address:	
Address				
			(City) (State) (Zip)	
(City) (State) (Zip)			Phone #:	Relationship
Applicant Home Address (if not in facility/if SA/IH, or intent to return)			Other Representative (if Necessary)	
			Address:	
(City) (State) (Zip)			(City) (State) (Zip)	
Phone #:		Alternate Phone #:	Phone #:	Relationship

C. SA/IN-HOME **Did you Explain the SA/IH Program: ☐YES ☐NO**	**D. SA/IN-HOME** **MEDICAID INFORMATION:**
1. Does the applicant wish to remain at home/live at home? ☐YES ☐NO	1. Is the applicant Medicaid CN? ☐YES ☐NO Note: In the determination of eligibility for Medicaid, a married applicant who lives with a spouse is budgeted differently than in SA. If an applicant is part of a married couple who live in the same household, they must qualify for Medicaid CN as a couple first.
2.If 1 is Yes, is applicant on SA/IH Wait List? ☐YES ☐NO 3. Is applicant approved for the Transitions to Community Living Program (TCLI /DOJ)? ☐YES ☐NO	2. Is the applicant Medicaid Passalong? ☐YES ☐NO If yes, what category? _____ _____ _____

COMPLETE THE FOLLOWING SECTIONS AT APPLICATION:

E. BIRTHDATE (mo/day/year)	Verification source and date verified:
F. SOCIAL SECURITY # / Other Claim (s) #	Verification source and date verified:
/ /	
G. Veteran/Spouse of a Veteran? ☐YES ☐NO	Comments:
VA ID#: Date Verified:	
H. APPLICANT INQUIRY (Check all applicable items)	

YES	NO	APPLICANT	Verification and date verified:
☐	☐	Has an NCFAST inquiry been completed?	
☐	☐	Receiving MAABD?	
☐	☐	Active in CAP? Type of CAP:	
☐	☐	Receiving MQB only? Class:	
☐	☐	Receiving assistance from another state? If yes:	
Where:		**Type:**	

I. RESIDENCY	
1. State:	**Does the applicant meet NC residence requirement for SA? ☐YES ☐NO**
2. County:	Verification of state and county residence:

If Applicant is an SSI recipient, skip Section II. (RESOURCES) and complete the rest of the workbook

II. RESOURCES:

A. LIQUID RESOURCES

Does the applicant have any liquid resources? Enter the 1st moment date:

SOURCE	YES	NO	VALUE	VERIFICATION (Include account number, location and type etc.)
Cash on Hand	☐	☐	$	`
Resident Account	☐	☐	$	
Checking Account	☐	☐	$	
Savings Account	☐	☐	$	
IRA, Keogh Plan, 401K	☐	☐	$	
Stocks, Bonds, CD's, etc.	☐	☐	$	
Lump Sum	☐	☐	$	
Promissory Note	☐	☐	$	
Trust Fund/Type	☐	☐	$	
Date Copy of Trust sent to DMA TPR	☐	☐	$	
Life Estate Interest	☐	☐	$	
Tobacco Buy-Out -If income, see income below.	☐	☐	$	
Annuities	☐	☐	$	
Liquid Assets of a Business	☐	☐	$	
Reverse Mortgage	☐	☐	$	
Net Proceeds from a Discontinued Business or Farm	☐	☐	$	
Other	☐	☐	$	
Other	☐	☐	$	
Other	☐	☐	$	
II.A. TOTAL COUNTABLE LIQUID RESOURCES			$0.00	

II.B. LIFE INSURANCE

Does the applicant have life insurance? (Include term insurance if it can accrue cash value.) ☐**YES** ☐**NO**
(If policy is irrevocably assigned to a burial plan, do not count it towards the applicable Life Insurance FV limit: see burial exclusion).

Policy Number	Insurance Co.	Original Face Value (FV)	Cash Value (CV)	Date Verified	Countable Yes or No	Participating Yes or No
a)		$	$		☐ Y ☐ N	☐ Y ☐ N
b)		$	$		☐ Y ☐ N	☐ Y ☐ N
c)		$	$		☐ Y ☐ N	☐ Y ☐ N
d)		$	$		☐ Y ☐ N	☐ Y ☐ N
e)		$	$		☐ Y ☐ N	☐ Y ☐ N
II.B. TOTAL LIFE INSURANCE VALUE		$0.00	$0.00			

** A participating policy may earn dividends annually. The dividends can be paid back to the owner or used to reduce the next premium, to increase the face value, or to increase the cash value. Contact the insurance company or ask the applicant/recipient to bring a copy of the annual premium notice.*

Obtain verification of cash value if total face value of all cash accruing policies owned by the applicant exceeds $1500 and applicant is not authorized continuously prior to 12/01/2009.

DOCUMENTATION/VERIFICATION

II.C. PREPAID BURIAL CONTRACTS

Does the applicant have burial contract(s)? YES ☐ NO ☐
If **YES**, complete the following information for each contract. (Indicate whether Revocable or Irrevocable.)

Beneficiary	Owner	Revocable or Irrevocable	Burial Plan Company	Date Purchased	Value	Verification
					$	
					$	
					$	

TYPE OF RESOURCE	VALUE	- $1500	BALANCE	EXCESS
Irrevocable Trust (Do Not Count Excess over $1,500)	$		$	$
Face Value of Life Insurance if F.V. is $1,500 or less	$		$	$
Revocable Contract	$		$	$
Cash Value of Designated Life Ins. when F. V. is more than $1,500	$		$	$
Cash Designated for Burial (If in a bank account funds cannot be co-mingled)	$		$	$
II.C. TOTAL COUNTABLE PRE-PAID BURIAL CONTRACTS				$0.00

II.D. PERSONAL PROPERTY

Does the applicant have any vehicles? ☐ **Yes** ☐ **NO (**cars, trucks, boats, boat trailer/motors, campers, mobile homes, motorcycles, farm equipment, or business equipment?)

Make	Model	Year	Value	Amt. Owed	Countable Value or Exclusion Reasons
a.			**$**	**$**	**$**
b.			**$**	**$**	**$**
c.			**$**	**$**	**$**
d.			**$**	**$**	**$**

Exclude <u>one</u> vehicle registered or unregistered, of any value used for transportation of the applicant. Count all other vehicles, including all unlicensed/junked vehicles.

Does the applicant wish to rebut the value of any of the above personal property? ☐YES ☐NO (Attach verif. of lesser value.)	Rebuttal value, if applicable, must be repeated annually OR the current DMV/tax value is used. $
Verification:	
II.D. TOTAL COUNTABLE PERSONAL PROPERTY	$0.00

II.E. REAL PROPERTY **Does the applicant have any real property interest listed below? YES ☐ NO ☐**	CMV: ☐ Tax ☐ Rebuttal	$
Document location(s), total acreage, and Tax Value for all property interest, including those excluded.	Less Encumbrances -	$
☐ Tenancy-in-Common ☐ Life Estate ☐ Single Ownership ☐ Tenancy-by-Entirety ☐ American Indian Tribe Land	Equity Value	$
	Value of Countable Real Property	$
Y ☐ N ☐ Remainder Interest % (from table) Y ☐ N ☐ Negotiable Promissory Note Y ☐ N ☐ Mineral/Timber Rights Y ☐ N ☐ Other ☐ **Intent to Return signed and placed in permanent folder. Date Signed:**	**TOTAL VALUE**	$
Is Real Property Excluded? ☐YES ☐ NO (Indicate reason) ☐ Home site and contiguous property ☐ Applicant Alleged Incompetent (temporary – see policy) ☐ Dependent relative living in the home ☐ Based on usage		
If not excluded, will market value be rebutted? ☐**YES** ☐**NO** Rebuttal of CMV: Rebuttal Value: Date: Rebuttal Value: Date:	New Established Value:	
II.E. TOTAL COUNTABLE VALUE OF REAL PROPERTY		**$**
TAX OFFICE	Date Checked:	
REGISTER OF DEEDS	Date Checked:	

II.F. BURIAL PROPERTY

Does the applicant have any burial property listed below? YES ☐ NO ☐

TYPE		How many?	Designated for Whom? /Relation to applicant	Excluded	Value
Burial Spaces/plots	Y ☐ N ☐			Y ☐ N ☐	$
Crypts/mausoleums	Y ☐ N ☐			Y ☐ N ☐	$
Caskets	Y ☐ N ☐			Y ☐ N ☐	$
Vaults	Y ☐ N ☐			Y ☐ N ☐	$
Urns	Y ☐ N ☐			Y ☐ N ☐	$
			II.F. Total Countable Value of Burial Property		$ 0.00

DOCUMENTATION/VERIFICATION:

II.G. RESOURCE CALCULATIONS: (Enter and add lines from previous resource sections)	
Total Countable Liquid Resources (from II.A.)	$0.00
Total Life Insurance Value (from II.B.)	$0.00
Total Countable Pre-paid Burial Contracts (from II.C.)	$0.00
Total Countable Value of Personal Property (from II.D.)	$0.00
Total Countable Value of Real Property (from II.E.)	$0.00
Total Countable Value of Burial Property (from II.F.)	$0.00
II.G. TOTAL OF ALL ITEMS TO COUNT IN RESOURCES	$0.00

II.H TRANSFER OF ASSETS (TOA)

SA LOOKBACK DATE:

Has the applicant transferred, sold or given away any resources for less than current market value? ☐**YES** ☐**NO**

Title or Property:	Value:	$	Date Tax Office Checked:		Tax Year:	
Date Register of Deeds Checked:		Value:	$	Date Transferred:		
Other Transferred Resources:		Value	$	Date Transferred:		

Allowable Transfer? ☐YES ☐NO Applicant Alleged Incompetent/Defrauded? ☐YES ☐NO
If Yes, Guardian/POA? ☐YES ☐NO
Allowable Transfer Reason:

Sanction Period _____/_____Through _____/_____ Sanction Rebutted/Value $

Revised Sanction Period _____/_____Through _____/_____

DOCUMENTATION/VERIFICATION:

III. INCOME

A. UNEARNED INCOME	**Mo.**		**Yr.**			
DOES THE APPLICANT HAVE ANY UNEARNED INCOME?	YES	NO	Amount	Frequency	Monthly Amount	Verification & Date
1. Alien Sponsor Income	☐	☐	$		$	
2. Alimony & Spousal Support	☐	☐	$		$	
3. Black Lung/Brown Lung Benefits	☐	☐	$		$	
4. Cash Contributions & Monetary Gifts	☐	☐	$		$	
5. Child Support	☐	☐	$		$	
6. Community Spouse/Dependent Income Allowance	☐	☐	$		$	
7. Court-ordered Restitution/Legally Obligated Payments	☐	☐	$		$	
8. Disability Payments	☐	☐	$		$	
9. Dividends, Trust Funds	☐	☐	$		$	
10. Federal Employee's Compensation Act (FECA) Benefits	☐	☐	$		$	
11. Inheritance Payments	☐	☐	$		$	
12. Interest & Dividends	☐	☐	$		$	
13. Insurance Settlements	☐	☐	$		$	
14. Military Allotments	☐	☐	$		$	
15. Native American Gaming Proceeds	☐	☐	$		$	
16. North America Free Trade Agreement (NAFTA) Payments & Trade Readjustment Allowance (TRA) Benefits	☐	☐	$		$	
17. Pensions & Annuities	☐	☐	$		$	
18. Retirement Benefits	☐	☐	$		$	
19. Royalties (Unearned)	☐	☐	$		$	
20. Severance Pay	☐	☐	$		$	
21. Social Security Benefits	☐	☐	$		$	
22. SSI (Supplemental Security Income)	☐	☐	$		$	
23. Strike Benefits	☐	☐	$		$	
24. Tobacco Allotment Settlement (Owner)	☐	☐	$		$	
25. Unemployment Income	☐	☐	$		$	
26. Veteran's Administration Pension & Compensation	☐	☐	$		$	
27. Winnings from gambling, lottery, Bingo, cash prizes	☐	☐	$		$	
28. Work Release Payments	☐	☐	$		$	
29. Workers Compensation	☐	☐	$		$	
30. OTHER	☐	☐	$		$	
TOTAL UNEARNED INCOME (Enter in IV.A.1.)					**$** 0.00	

B. EARNED INCOME	Mo.	Yr.				
DOES THE APPLICANT HAVE ANY EARNED INCOME?	YES	NO	Amount	Frequency	Monthly Amount	Verification & Date
1. Wages, tips or salaries	☐	☐	$		$	
2. Armed Forces Pay	☐	☐	$		$	
3. College Work Study or Aid	☐	☐	$		$	
4. Longevity Pay	☐	☐	$		$	
5. On-the-Job Training Benefits/Paid Work Experience	☐	☐	$		$	
6. Rental Income	☐	☐	$		$	
7. Royalties (Earned)See also Royalties (Unearned)	☐	☐	$		$	
8. Self-Employment Income	☐	☐	$		$	
9. Tobacco Settlement (Grower)		☐	$		$	
10. OTHER	☐	☐	$		$	
TOTAL GROSS EARNED INCOME (enter in IV.B.4.)					$0.00	

IV. INCOME CALCULATION

A.	**UNEARNED INCOME:**	/ **Mo. / Yr.**	/ **Mo./ Yr.**
1.	Enter applicant's Total GROSS Unearned Income	$	$
2.	Subtract $20 General Deduction (Subtract $0 from VA Pension and payment to parent of Veteran)	- $	- $
3.	**Net Unearned Income (Line 1 minus Line 2)**	**$**	**$**
B.	**EARNED INCOME**	/ **Mo. / Yr.**	/ **Mo./ Yr.**
4.	Enter applicant's Total GROSS earned Income (This is the amt. after operational expenses)	$	$
5.	Subtract remainder of $20 General Deduction if any not used by Unearned Income	- $	- $
6.	Subtotal (Line 4 minus Line 5)	$	$
7.	Subtract $65 Earned Income Exclusion	- 65.00	- 65.00
8.	Subtotal (Line 6 minus Line 7)		
9.	Subtract Impairment Related Work Expenses (IRWE)	- $	- $
10.	Subtotal (Line 8 minus Line 9)		
11.	½ of Line 10	- $25.00	- $25.00
12.	**Net Earned Income (Line 10 minus Line 11)**	**$**	**$**

DOCUMENTATION/VERIFICATION:

V. HEALTH INSURANCE/MEDICARE (Not applicable to SCD)

A. Medicare A	☐ Yes ☐ No	Effective Date:	Verification and Date:
B. Medicare B	☐ Yes ☐ No	Effective Date:	
C. Medicare D	☐ Yes ☐ No	Effective Date:	
D. Health Insurance	☐ Yes ☐ No	Effective Date:	
E. Long Term Care Insurance	☐ Yes ☐ No	Copy of policy in record? ☐ Yes ☐ No	
F. TPR Insurance Keyed	☐ Yes ☐ No		
G. CCNC Explained	☐ Yes ☐ No	Medical Home / Exempt ☐ Yes ☐ No	
H. LIS Application Completed	Date:		

Insurance Company	Policy No.	Type of Coverage	Effective Date

VI. MISCELLANEOUS

	Explained	Pamphlet Given		Explained	Pamphlet Given
1. FRAUD			4. SERVICES		
2. MEDICAID			5. DAAS-3003 (TOA)		
3. APPEALS			6. VOTER REGISTRATION		

VII. PAYMENT CALCULATION

Valid FL-2 dated:	
SA RATE	
■ Basic	☐ Special Care Unit
☐ SA In-Home	

ONGOING SA or SA/IH PAYMENT	___/___ Mo. Yr.	___/___ Mo. Yr.
A. Rate	$	$
B. Personal Needs Allowance	+ $ personal needs allowance	+ $
C. Maintenance Amount (A+B)	$ maintenance amount	$
D. Total Countable Income	- $ total countable income	- $
E. Equals SA Payment or Maximum allowable SA/IH payment	$ equals SA Payment or Max	$
Payment (rounded to nearest dollar)	**$** Payment	**$**

Partial SA Payment (SAA/SAD): Use this budget when the applicant enters the ACH and meets the eligibility criteria *after* the first day of the month.		___/___ **Mo. / Yr.**
A.	Number of days in month of entry (28,29, 30, 31)	
B.	Date of Entry Enter the DAY of entry (Between 2 and 31)	-
C.	Number of eligible SA days (A. – B.) + 1	= +1 = days
D.	SA Rate	$
E.	Number from Line A.	÷
F.	Per Diem Rate (D. ÷ E.)	$
G.	Actual Number of Days of Eligibility (C.)	X
H.	Room and Board for eligible days (F. x G.)	$
I.	Personal Needs Allowance	+
J.	Total SA Partial Payment (H. + I.) (Not rounded)	=
K.	**Partial SA Payment (Round amount on Line J. to the nearest dollar.)**	$

Partial SA-IH Payment (SAA/SAD): Use this budget when the applicant applies for SA-IH and meets eligibility requirements after the first day of the month.		___/___ **Mo. / Yr.**
A	Number of days in month of application (28, 29, 30, 31)	
B	Date of SA/IH eligibility	-
C	Number of days eligible for payment	= +1 = days
D	SA Rate	$
E	Number from Line A.	÷
F	Per Diem Rate (D. ÷ E.)	$
G	Actual Number of Days of Eligibility (C.)	X
H	Total Per Diem for month	I
I.	Personal Needs Allowance	+
J.	Maximum Allowable SA/IH Payment (not rounded)	=
K	**Maximum Allowable SA/IH Partial Payment (Round line J. to nearest dollar)**	$

Open/Shut SA Payment (SAA/SAD): Use this budget for an Open/Shut application when the applicant entered the ACH *after* the first day of the month, and left *before* the end of the month.		____/____ **Mo. / Yr.**
A.	Date of Discharge. Enter the DAY of discharge	
B.	Date of Entry. Enter the DAY of entry (between 2 and 31)	-
C.	Number of days for which payment is needed (A. – B. +1)	=
D.	SA Rate	$
E.	Number of days in the month of entry (28, 29,30, or 31)	÷
F.	Per Diem Rate (D. ÷ E.)	$
G.	Actual Number of Days of Care (C.)	X
H.	Cost of Care (F. x G.)	$
I.	Personal Needs Allowance	+
J.	Open/Shut Payment (not rounded) (H. +I.)	$
K.	**Actual SA Open/Shut Payment (Round line J. to nearest dollar)**	**$**

Open/Shut SA Payment (SAA/SAD): Use this budget for an Open/Shut application when the applicant entered the ACH *on* the first day of the month, and left *before* the end of the month.		____/____ **Mo. / Yr.**
A.	SA Rate	$
B.	Total Countable Income (VI.A. 3 + VI. B.12)	-
C.	SA Portion of Cost of Care (Personal Needs not included)	$
D.	Number of days in the month (28,29,30, or 31)	÷
E.	Per Diem Amount (C. ÷ D.)	$
F.	Date of Discharge	X
G.	SA Portion of Cost of Care (E. x F.)	X
H.	Personal Needs Allowance	+
I.	SA Open/Shut Payment (not-rounded) (G. ÷ H.)	$
J.	Actual SA Open/Shut Payment (Rounded)	$

VIII. CERTIFICATIONS

Certification Period	
From:	To:
Date Received: 12/14/1919	Income Support Number:
Date Completed:	Product Delivery Case Number:
Effective Date of Payment:	Date Notice Sent:

IX. RIGHTS AND RESPONSIBILITIES

A. RIGHTS OF THE APPLICANT (to be read and explained)

You have the right to:

- Apply for assistance, and, if found not eligible, reapply at any time.
- Have any person participate in the application interview or in the Re-determination of eligibility.
- Have any information given to the agency kept in confidence.
- Receive assistance, if found eligible.
- Be informed of information needed to determine continuing Special Assistance/Medicaid eligibility.
- Withdraw your application at any time.
- Withdraw from the assistance program at any time.
- Be protected against discrimination on the grounds of race, color, or national origin by Title VI of the Civil Rights Act of 1965.
- Choose a substitute payee if applicant is unwilling or unable to manage the SA payment.

You have a right to appeal to the county DSS for a hearing if:

- You were not informed in writing of your right to apply or reapply for assistance on the same day you or your representative went to the county DSS.
- Your application was not acted on timely.
- Your application was denied and you believe the decision was incorrect.
- Your assistance was terminated and you believe the decision is not correct.
- You believe your assistance is incorrect based on the county's interpretation of State regulations.
- Your request for a review of your circumstances was delayed beyond 30 days or rejected.

The NC Department of Health and Human Services does not discriminate on the basis of race, color, natural origin, sex, religion, age, or disability in employment or the provision of services.

B. RESPONSIBILITIES OF THE APPLICANT (to be read and explained)

☐ I agree to let my caseworker know of any change within 5 days following the change in my situation. I will notify my caseworker concerning any change in address, employment, property, resources, expenses or needs, living arrangements or number in the family or at any other time when I am in doubt whether a particular change in circumstances should be reported. In addition, I will notify my caseworker immediately when the amount of my assistance is greater than the amount to which I am entitled.

☐ I understand that it is against the law to willfully withhold information or make false statements and that I am subject to prosecution if I do. I certify that the information I have provided (concerning my situation or that of the person(s) for whom I am making application) is a true and complete statement of facts according to my best knowledge and belief. I understand that all statements will be thoroughly investigated by the county department of social services. I understand that the information on this form may be checked by a State or Federal reviewer, and I agree to this investigation and understand that I must cooperate with the reviewer. I understand I must provide the county department of social services as well as State and Federal officials, upon request, the information necessary to determine eligibility. I further agree that my medical and financial records may be made available to the agency and State. I understand that the information provided may be stored in a computer data bank.

☐ I understand that any Medicaid ID card I receive is to be used only for the persons listed on the ID card. I understand that it is against the law to give my ID card to someone whose name is not listed on it and that I may be prosecuted for fraud if I let someone else use my ID card.

☐ I understand that if any resources (including the home site, real property interest, cash, bank accounts, and other investments) are transferred out of the applicant's name without receiving fair market value for the resources, it could result in a period of ineligibility in the event the applicant requires long term medical care, such as in a residential or nursing facility. I have reported all resource transfers when making this application and will report any new transfers to my worker within 5 days.

☐ I understand I must furnish all social security numbers used by me and/or anyone listed on this application to determine my/our eligibility for assistance. I understand these social security numbers will be used in matching information with the Social Security Administration (SSA), Internal Revenue Services (IRS), Employment Security Commission (ESC), out-of-state welfare and ESC agencies, and any other agencies, when applicable. If I do not want these social security numbers used in the matches, I understand I have the right to withdraw my application or have my assistance terminated.

☐ I understand that by accepting Medical Assistance under any aid/program category, I agree to give back to the State any and all money that is received by me or anyone listed in this application from any insurance company for payment of medical and/or hospital bills for which the Medical Assistance program has or will make payment. In addition, I agree that all medical payments or medical support paid or owed due to a court order for me or anyone listed on this application must be sent to the State to repay past or current medical expenses paid by the State. This includes insurance settlements resulting from an accident. I further agree to notify the county department of social services if anyone listed on this application is involved in any accident.

☐ I understand that this assignment of rights continues as long as anyone listed in this application receives Medicaid and is based on Federal regulations (42 CFR 433.147-148).

☐ I understand North Carolina must be named remainder beneficiary for annuities purchased after a certain date. Contact the county DSS for more information

☐ Any child or spousal support (money) which is paid directly to me must be reported to the county department of social services and will be counted as income when determining eligibility for Medicaid benefits and/or the amount of any assistance check.

☐ I understand that if Medicaid pays for certain medical services, Medicaid may become a creditor of my estate and my estate may be subject to recovery to repay Medicaid. Ask your Medicaid case worker for specific information regarding which services are applicable to estate recovery.

☐ I hereby certify that I, and all of the persons for whom I am requesting assistance, are living in North Carolina with the intention of remaining.

☐ I understand that I can have an authorized representative act on my behalf.

☐ I understand that I can ask for an interpreter or translator services at no cost to me when communicating with the agency.

☐ I understand that I may view information contained in my case file, except third party information. Third party information includes reports written by outside agencies or persons regarding my case.

☐ I have received an explanation of family planning services, health screening for adults, and other services available through the department of social services.

☐ I understand that I and all the persons for whom I am requesting assistance, with the exception of assistance with Emergency Medicaid services, must provide proof of identity, U.S. citizenship, or eligible immigration status. Persons applying for Emergency Medicaid services only are not required to provide documentation of citizenship, immigration status, or Social Security Number.

☐ Transportation services have been explained and offered.

☐ **Yes** ☐ **No** In addition to the Income Maintenance Worker who handles your Special Assistance/Medicaid, the Department of Social Services has social workers to help with other needs you might have. Would you like to talk with a social worker?

VOTER REGISTRATION: If you are not registered to vote where you live now, would you like to apply to register to vote here today ____ yes ____ no?
Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

I certify that the information I have provided is true and complete to the best of my knowledge. I declare under penalty of perjury (and being subject to prosecution under the N.C. General Statutes) that the information is true and correct. I have read the statements on this form and agree to them all.

Applicant /Representative's Signature: (First, Mi, Last)		**Date:**	
WITNESS: (If applicant cannot write)	**Date:**	**IMC SIGNATURE:**	**Date:**