North Carolina_____ _____County Department of Social Services

YOUR APPLICATION FOR MEDICAID IS PENDING

Date _____

_____
Name

_____
Address

_____

Your application for Medicaid cannot be completed because we do not have all the needed information.

Case Number: _____

District Number: _____

Dear_____:

Your application for Medicaid cannot be completed because we do not have the following information:

☐ Disability Determination Services (DDS) has not determined if your medical condition meets the definition of disability for Medicaid. Your application will be held until DDS makes a decision. As soon as DDS makes the decision, we will notify you.

☐ We have asked for medical records needed to determine if you had a medical emergency. We asked for those records from the following medical providers:_____

_____

The records have not been provided. Your application will be denied on _____if we do not get the records.

☐ We need a completed FL-2 or CAP Plan of Care to prove you need long term care services. The form has not been provided. Your application will be denied on _____if we do not get the form.

☐ Documentation to demonstrate that a sanction for transfer of assets will cause an undue hardship.

☐ We need your North Carolina Health Choice Fee payment of $_____. Your application will be denied if payment is not received by _____.

☐ Other_____.

If you have any questions, please contact your caseworker immediately. Copies of original documents may be mailed to your worker.

_____
Caseworker

_____
Address

_____
Phone Number

DHB-5098
Revised 06/2020