VERIFICATION/ELIGIBILITY DETERMINATION FOR MEDICAL ASSISTANCE APPLICATIONS
ADULT CATEGORIES

Date

Applicant Name	Application Number	Co. Case Number
Applicant Name	Application Number	Co. Case Number

I. RIGHTS OF CLIENT (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, not to exceed 3, participate in the interview for determination of eligibility.
Have any information given to the agency kept in confidence.
Withdraw from the assistance program at any time.
Receive assistance, if found eligible.
Be informed of information needed to determine your eligibility.

Appeal to the county department of social services and to the Division of Social Services for a hearing if:
You were denied the right to apply or reapply for assistance on the same day you or your representative went to the county department of social services.
You were not informed in writing of your right to apply without delay.
You believe you were encouraged to withdraw your application for assistance.
Your application was not acted upon timely.
Your application was denied and you believe the decision is not correct.
You believe your assistance is incorrect based on the county's interpretation of State regulations.
You believe the county failed to act promptly on your request to review your case.

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

RESPONSIBILITIES OF CLIENT (to be read and explained)

☐ I agree to let my income maintenance caseworker know within 10 calendar days following any change in my situation. I will notify my income maintenance 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 income maintenance 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 the State. I understand that the information provided may be stored in a computer Data Bank. I have received, or will receive, a copy of the "Medicaid Notice of Privacy Practices."

☐ 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 homesite, other real property, 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 for long-term medical care, such as in a nursing facility, or for in-home care. I have reported all resource transfers when making this application and will report any new transfers to my worker within 10 calendar days.

☐ I understand I must furnish all social security numbers used by me and/or anyone listed on this application who wants to receive benefits. I understand these social security numbers will be used in matching information with the Social Security Administration (SSA), Internal Revenue Service (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 on 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 I or anyone listed on this application is involved in an accident.

☐ I understand that this assignment of rights continues as long as I or anyone listed on this application receive Medicaid or any cash assistance program and is based on federal regulations (42 CFR 433.147-148).

☐ 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 cash assistance check.

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

☐ 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 making an application are living in North Carolina with the intention of remaining permanently or for an indefinite period.

☐ 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 your income maintenance caseworker who handles your 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:** You may now register to vote or update your voter registration record while applying for benefits, redetermining eligibility, or reporting a change in address.

I have read the statements on this form and agree to them all. Prior to signing this form should you have any questions, please ask the worker conducting this interview.

II. Applicant's/Representative's Signature (First, MI, Last)

Applicant's Signature (First, MI, Last)

III. DOCUMENTATION/WORKSPACE

A. Face sheet completed _____ B. Referral for other services made to_____

NOTE: Face sheet *must* be completed including: Previous work history, parent's names, prior places of residence, Veteran status of immediate family members and financially responsible persons. (FRP)

IV. Referral for Placement/Help with Cost of Care in a Nursing Home/CAP/In-Home Health Services

A. Does the applicant need nursing home placement or is he already residing in a LTC facility? _____

1. If YES, date of admittance _____
2. If needed, date referral made to Adult Services for help with placement _____
3. Complete **D**., to the right.

B. Does the applicant need CAP services? _____

1. Date of Approval for CAP services _____
2. Complete **D**., to the right.
3. ☐ CAP-DA ☐ CAP-MR ☐ CAP-C ☐ CAP-AIDS

C. Does the applicant request In-home Health Services? _____

Date of Physician's Authorization for In-home Health Services _____

D. Date FL-2 requested _____

Date FL-2 received _____

Mental Health Screening done? _____

Date FL-2 sent to EDS _____

Date received from EDS _____

Approved for ☐ SNF ☐ ICF ☐ ICF-MR ☐ Other

☐ Applicant is *not* approved for recommended level of care.

Date Moved To Appropriate Level _____

Dist. No. Co. Case No.

_____ _____

☐ MAABD

☐ MAABD- Dual Eligibility ☐ Q ☐ B

☐ MQB-Q only ☐ MQB-B only ☐ MQB-E

Medical Assistance To The Aged/Blind And Disabled-Verification Document

County _____ Date _____

Aid/Program Category	*A-Applicant S-Non a/r spouse; P- Non a/r parent FRP-Financially Responsible Person A1/A2 – Couple Case RS – Recipient (SSI, AFDC) Spouse RP – Recipient Parent	Classification
M		

*V.	FIRST NAME	M.I.	LAST NAME	SOCIAL SECURITY NO.
	Applicant			
	Applicant			
	FRP			
	FRP			

Address Of Household:	Phone Number:
Address Of Applicant In LTC:	Mentally Incompetent? ☐ Yes ☐ No
Name, Address And Phone No. Of Representative, If Not Applicant: ☐ Guardian ☐ POA	Name Of POA/Guard., IF Not Rep:
Directions To Home/Other Information:	Address And Phone Number:
Applicant's/Representative Statement Of What Is Needed:	

Preneed ☐ Yes ☐ No Ongoing ☐ Yes ☐ No	Retro In Months Of: _____ _____ _____ ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No	Unpaid Bills In Months Of:

Note: IMC must explain old bills and retro policy when asking if retroactive coverage is needed.

*	Race**	Date Of Birth	Place	How Verified

****Asian=A, Black or African-American=B, American Indian or Alaska Native =I, Native Hawaiian or Pacific Islander=P, Caucasian or White=W**

*	Marital Status	How Verified	Language the Person Prefers to Speak	Ethnicity
			English Spanish Other_____	Hispanic/Latino Yes No ***If yes, specify
			English Spanish Other_____	Hispanic/Latino Yes No ***If yes, specify

***** Hispanic Puerto Rican = P, Hispanic Cuban = C, Hispanic Mexican = M, Hispanic Other = O**

VI. TPR/Medicare

TPR: Policy Name	Number	Type of Coverage	Date Of Issuance

How Verified:

DMA-2041 Completed ☐ _____ Date

*	RSDI Claim Number	Med. D	Med. A	Med. B	Household Composition: Relationship to applicant(s)
		☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	Name Relationship FRP? ☐ Yes ☐ No
		☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	Name Relationship FRP? ☐ Yes ☐ No
		☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	Name Relationship FRP? ☐ Yes ☐ No

How Verified: (Medicare A enrollment *must* be verified for MQB-B & E.)

VII. RESIDENCE/CITIZENSHIP (indicate for each *applicant* using A, A1, A2)	How Verified:
Applicant _____ is living in N.C. with the intention of remaining permanently or for an indefinite period. Applicant _____ is incompetent and living in N.C. Applicant _____ is a U.S. citizen. Applicant _____ is a qualified alien, not under or past the 5-year ban, who may be eligible for full coverage. Applicant _____ is a qualified alien, within the 5-year ban who may be eligible for only coverage of emergency services.* Applicant _____ is a non-qualified alien, who may be eligible for only coverage of emergency services.*	

* Aged, blind or disabled non-qualified and some qualified aliens are restricted to emergency services only. Duration of emergency is established by DMA.

Date medical information requested from hospital _____.

Date medical information sent to DMA _____. ☐ Emergency approved.

Date decision of emergency services received from DMA _____. ☐ Emergency denied.

Date(s) DMA approved for
Emergency medical care _____ _____ _____ _____ _____ _____ _____ _____ _____

VIII. Disability/Blindness

Does Applicant(s) under 65 receive RSDI disability, or State Aid to the Blind?*
If already determined disabled, accept SSA's decision. If SAB recipient, verify per SAB register.

For Those Not Determined Disabled:	☐ Yes, a/r already determined to be disabled/blind.
1. Complete DMA-5009 - Social History	* Document how disability/blindness was verified.
2. Complete DMA-5028, Authorization to Disclose Information, for each provider listed on DMA-5009.	Title II/SSI disability/blindness Approved by SSA effective _____ Disability effective _____
2. Date DMA-4037 sent to DDS: _____.	Other _____ Date of Appeal _____
3. Date disability verified: _____.	Reversal _____
4. DSB-2202 for MAB applicants.	

IX. Food Stamp Referral

Is the MA applicant an applicant/recipient for Food Stamps? ☐ Yes ☐ No

If Yes, DSS-8194 sent to FS unit at Application. _____
Date

DSS-8194 orDMA-5002/DSS-8109 sent to FS unit at Disposition. _____
Date

Health Check: Offer each component and document response for each for child under 21.

(**A** for accepted. **D** for declined. **U** for undecided.)

Name	Medical	Dental	Supportive Services
_____	_____	_____	_____

Health Check explained face to face on _____
Date

Health Check pamphlet (DMA-4078) given on _____
Date

_____
_____

X. Resource Interview For All Financially Responsible Persons (check each item owned by a/r or FRP)

Identify FRP: A1/A2, RS, S, RP, or P	*A	*	*	Applicant or representative's statement/worker comments:
1. Real Property 1a. Type of ownership:	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	

[ ] Tenancy in common Property: Excluded from Reserve
[ ] Life Estate: Excluded from Reserve unless purchased
[ ] Remainder Interest/Negotiable Promissory Note:
Will Value be rebutted? [ ] Yes [ ] No
[ ] Tenancy by Entirety/Single Owner: Continue to 1b., 1c., 1d.
[ ] Mineral/Timber Rights/Tobacco Allotment

1b. Homesite and all contiguous: Excluded. Intent to return? [ ] Yes [ ] No

1c. Excluded Based on Usage? [ ] Yes [ ] No; continue to 1d.

[ ] Used in a business/trade/farming operation: Excluded
[ ] Used to produce goods/services: Exclude up to $6,000.

Income: _____
Does it meet 6%? If yes, exclude: up to $6,000 total equity

[ ] Non-business rental property interest: Is it rented?
[ ] Yes _____ per _____ [ ] No: Will it be rented?

1d. Equity Value: Are there any loans against any property interest? If yes, document source and amount:

1e. Rebuttal of Real Property Value: Does the applicant or FRP hold a promissory note, Remainder Interest, or other property interest with equity value which Results/may result in excess reserve? If yes, discuss rebuttal evidence.

	*A		*		*		
	Y	N	Y	N	Y	N	
2. Bank Accounts/CASH 2a. Personal C/S							
2b. Patient Account							
2c. CD's/Money Market							
2d. Operating Capital of a business							
2e. Any funds intended for burial?							
3. Stocks/bonds/Mutual Funds US Saving Bonds							
4. IRA/Other Retirement							
5. Trust Fund or Annuity							Date established:
6. Receipt of Lump sum							
7. Safe Deposit Box							
8. Personal Property 8a. Motor Vehicle							
8b. Motor/Mobile Home							(includes camper)
8c. Other							(Includes motorcycles, boats, etc.)

8d. Excluded Based on Usage? [ ] Yes [ ] No

[ ] Used in a business/trade/farming operation: Excluded
[ ] Used to produce goods/services: Exclude up to $6,000 equity

8e. Equity Value: Are there any loans against any property interest? If yes, document source and amount:

8f. Rebuttal: Does the applicant or FRP own personal property with equity value which results/may result in excess reserve? If yes, discuss rebuttal evidence.

	*A		*		*		
	Y	N	Y	N	Y	N	
9. Burial Assets							Explain Burial Exclusion
9a. Life Insurance which accrues CV							Designated for burial? [ ] Y: Date: _____
9b. Term/Burial Ins.							
9c. Burial contract							
Irrevocable?							
Revocable?							
9d. Burial Annuity							
10. Net proceeds from: Discontinued business							
11. Insurance Settlement							(Complete accident report for TPR)

XI. Resources: Documentation and Calculation *Indicate FRP: A1/A2, RS, S, RP, P

A. Liquid Assets	*A	*	*	Joint/Name	Account No.	Bank/Company	Amount
Cash/Checking							
Savings							
Stocks/Bonds							
CD's/IRA's							
Trust/Promissory Note							
Other							

Totals of Liquid Assets

Date and Method of Verification:

Total _____ month of _____

Total _____ month of _____

Total _____ month of _____

Total _____ month of _____

Total

B. Insurance: If Face Value for each FRP does not exceed $10,000, Cash Value for that FRP is not counted.

Policy Owner Name/Relationship	Name of Insured	Insurance Company Name, Address and Phone Number	Policy Number	Face Value	Cash Value

Y ☐ Cash Value Applied To Burial Exclusion?

N ☐

Totals For Insurance

Date And Method Of Verification:

*C. Burial Exclusion: $1,500.00 for each FRP

Type Of Asset	Value		$1,500		Balance Remaining In B.E.		Excess	
Irrevocable Trust								
Face Value Of Life Insurance If F.V. is Less Than $10,000								
Revocable Contract								
Cash Value Of Designated Life Ins. When F.V. is more than $10,000								
Cash Designated for Burial								

*Explain Retro Burial Exclusion Policy.

Date statement of intent signed _____

Page Subtotal

D. Personal Property (Cars, etc.) Type	Owner	Indicate FRP	Exclude Yes	No	Current Market Value	Rebuttal Yes	No	Value	Equity

Total Countable Equity

Document basis of exemption:

E. REAL PROPERTY INTEREST: Document locations(s), total acreage, and tax value for all property interests including those excluded. For countable property interests, also record encumbrances and equity.

OWNER A, S, P	NAME OF OWNER	DESCRIPTION	EXCLUDE YES*	NO	TAX VALUE	REBUTTAL YES	NO	VALUE	EQUITY

TOTAL EQUITY OF COUNTABLE REAL PROPERTY

TOTAL RESERVE (RETRO MONTHS)
Month 1_____ Date reserve met _____

Month 2_____ Date reserve met _____

Month 3_____ Date reserve met _____

TOTAL RESERVE (ONGOING)

DATE RESERVE MET _____

XIII. TRANSFER OF RESOURCES

Evaluate applicants and recipients for transfer of resources during the "look back period." Refer to MA-2240, Transfer of Resources, for definition of the "look back period."

Has any resource been transferred, given away, or sold for less than the CMV? [ ] Yes [ ] No

If Yes: Uncompensated Value: _____ Date of Transfer _____

Was the transfer allowable? [ ] Yes [ ] No

If No, what is the sanction period? From: _____ through _____

If Yes, describe why it was allowable:

XII. Documentation Of Required Matches

On-Line	*A__	*	Date Checked	No Hit	Hit	Print-Out Attached	
						Yes	No
ESC/UI							
Bendex							
SDX							
DOT (See pg. 7)							
MCI							
TPQY/SOLQ							

Tax Office Checked _____ Tax Year _____

Register of
Deeds Checked _____ through _____

ESC/UI Quarterly Match:

_____
Date

SDX/Bendex Sheets: _____

Beer: _____

FRR: _____

XIV. INCOME INTERVIEW AND DOCUMENTATION FOR APPLICANT (S) & FRP *DESIGNATE A1/A2, RS, S, RP, OR P.

A. Source: Unearned	Yes (X)	No (X)	Amt. For Each FRP *A_____	*	*	Date And Method Of Verification	
Social Security						Claim# _____	
SSI/Work First for RS, RP							
Retirement: Railroad/ State/Other						Retirement Acct # _____	
VA Benefit/ A&A and UME (excluded for PLA)						VA File# _____	
Civil Service Annuity/Other Retirement/Pensions						CSA# _____	
Unemployment/ Disability Insurance							
Worker's comp./ Sick Pay (unearned after 6 mos.)							
Support/Alimony							
Work Release/ Military Allotment							
Contributions Cash/Inkind							
Educational Loans Grants/Scholarships							
Income From Trusts							
Dividends/Interest							
Roomers and Boarders						Operational Costs:	Net:
Rentals						Operational Costs:	Net:
Other _____							

Total Unearned: [ ]

Separate couple month of entry to LTC:

Total
Countable For _____ $ _____ _____.
Effective Date

*Designate A1/A2, RS, S, RP, or P.

Total
Countable For _____ $ _____ _____.
Effective Date

XIV. Income Interview and Documentation (Cont.)

B. Source: Earned	Yes (X)	No (X)	Amt. For Each FRP *A____ * *			Date And Method Of Verification	
Wages/Salaries (Attach computation)						**(Sick Pay Is Earned For First 6 Mos.)**	
Net Self-Employment/ Business (after operational)							
Farm Income/ Seasonal Employment							
Earned Income Credit							
ADAP/Workshop						**Total Gross Earned:**	

XV. Deductible Computation For Single Applicant Only - For Married Applicant, Attach Sup. A
For Child, Attach Supp. E

Evaluate For 1/3 Reduction: If the A/R lives in the household of a person who is not financially responsible for the A/R: does the A/R pay an equal share of all the household expenses?

	Month(s)	Month(s)	Month(s)
1. TOTAL UNEARNED INCOME (Minus Pass-Along)			
2. $20.00 General Exclusion (Subtract $0, from VA pension)	- $20.00	- $20.00	- $20.00
3. NET UNEARNED INCOME (Line 1 minus Line 2)			
4. GROSS EARNED (Go to line 12 if no earned)			
5. Operational expenses for self-employment/business	-	-	-
6. Subtract remainder of $20 General Exclusion	-	-	-
7. Subtotal (Line 4 minus lines 5 and 6)			
8. Subtract $65 Earned Income Deduction	- $65.00	- $65.00	- $65.00
9. Subtotal (Line 7 minus line 8)			
10. Subtract ½ of line 9	-	-	-
11. NET EARNED INCOME			
12. TOTAL NET INCOME (Line 3 plus line 11)			
13. INDIVIDUAL INCOME LIMIT (CN/MN/MQB/MWD)	-	-	-
14. If excess ineligible for CN/MQB/MWD. If excess for MN, use to determine deductible amount.			
15. Number of Months in period or months budgeted PLA	X	X	X
16. **EXCESS INCOME FOR THE PERIOD = MEDICAID DEDUCTIBLE Excess is rounded to the nearest whole dollar.**			

Evaluate each adult deductible case for MQB coverage. Combined excess income for the certification period, rounded to the nearest dollar, is the amount of the deductible. Attach DMA-5036 for documentation of when the deductible is met.

Maintenance Allowance Adjustment

☐ Full Medicaid/Deductible met.

☐ MQB (Q, B, or E)

☐ Case Change from MAABD to MQB Deductible not met.

Deductible – Combine excess income for the certification period and round to the nearest dollar.

$

For the period

_____ through _____

$

For the period

_____ through _____

For LTC Applicant, Attach Supp. B

XVI. Lifeline/Linkup Assistance Program

The **Lifeline/Link-up Assistance Program** is for individuals who have low-income. **Lifeline** can help pay a portion of your local telephone bill. If you are eligible, Lifeline will give you a credit each month on your local telephone bill.

Link-UP is a program that can help pay to connect your telephone service. This program is for low-income individuals. The program serves recipients of the Food Assistance, Work First Family Assistance, Medicaid and Low Income Home Energy Assistance Programs, which includes the Low Income Energy Assistance Program, Crisis Intervention Program and Weatherization.

Do you or your spouse have telephone service in your name? ☐ Yes ☐ No

If yes, in **whose name(s)** is the telephone bill? _____

What company provides your local telephone service? _____

XVII. MEDICAID FAMILY PLANNING WAIVER SERVICES

To be eligible for Medicaid Family Planning Waiver services, you must be a woman age 19 through 55 or a man age 19 through 60 and have not had a medical procedure that would prevent you from having a baby or fathering a baby.

Do you wish to apply for Medicaid Family Planning Waiver? ☐ Yes ☐ No

IF YES, FOR WHOM_____SOCIAL SECURITY #_____

☐ Carolina Access Recipient _____
(Primary Care Provider)

XVIII. All Statements recorded in this document are correct and represent my best knowledge and belief about the circumstances of all persons listed on this application.

_____ _____
Signature of Applicant/Representative Date

_____ _____
Signature of Witness Date

Disposition Of Application	Reason
Date ☐ Denied/Withdrawn: Retro ☐ Denied/Withdrawn: Ongoing	
6 mos. Date ☐ Pended	
☐ Approved: Retro ☐ Approved: Ongoing	Date

MQB only:

☐ Eligible MQB-Q
☐ Eligible MQB -B
☐ Eligible MQB-E
☐ Ineligible MQB

MAABD:

☐ Dual Eligible
☐ Eligible, deductible pending MAABD
☐ Eligible, MQB, MAABD
☐ Ineligible MAABD

MWD only:

☐ Eligible MWD
☐ Ineligible MWD

IMC _____

Date _____