

**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**

**DATE:** \_\_\_\_\_

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

C. SA IN-HOME	D. SA IN-HOME TCL/DOJ INFORMATION:
1. Did you Explain the SAIH Program: <input type="checkbox"/> YES <input type="checkbox"/> NO 2. Does the applicant wish to remain at home/live at home? <input type="checkbox"/> YES <input type="checkbox"/> NO	1. Is the applicant approved for the Transitions to Community Living Program (TCL/DOJ)? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, who is the LME/MCO? _____  2. Date applicant confirmed to be on Transitions to Community Living housing list: _____

**COMPLETE THE FOLLOWING SECTIONS AT APPLICATION:**

<b>E. BIRTHDATE (mo/day/year)</b>			Verification source and date verified:			
/ /						
<b>F. SOCIAL SECURITY # / Other Claim (s) #</b>			Verification source and date verified:			
/ /						
<b>G. Veteran/Spouse of a Veteran? <input type="checkbox"/> YES <input type="checkbox"/> NO</b>			Comments:			
<b>VA ID#:</b>		<b>Date Verified:</b>				
<b>H. APPLICANT INQUIRY (Check all applicable items)</b>						
<b>YES</b>	<b>NO</b>	<b>APPLICANT</b>	Verification and date verified:			
<input type="checkbox"/>	<input type="checkbox"/>	Has an NCFAST inquiry been completed?				
<input type="checkbox"/>	<input type="checkbox"/>	Receiving MAABD?				
<input type="checkbox"/>	<input type="checkbox"/>	Active in CAP? Type of CAP:				
<input type="checkbox"/>	<input type="checkbox"/>	Receiving MQB only? Class:				
<input type="checkbox"/>	<input type="checkbox"/>	Receiving assistance from another state? If yes:				
<b>Where:</b>		<b>Type:</b>				
<b>I. RESIDENCY</b>						
<b>1. State:</b>		<b>Does the applicant meet NC residence requirement for SA? <input type="checkbox"/> YES <input type="checkbox"/> NO</b>				
<b>2. County:</b>		Verification of state and county residence:				

**If Applicant is an SSI recipient, skip Section II. (RESOURCES) and complete 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	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Resident Personal Funds Account	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Checking Account	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Savings Account	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Individual Retirement Account, Keogh Plan, 401K	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Stocks, Bonds, Certificate of Deposit, etc.	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Mutual Funds/Securities	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Money Market Account	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Lump Sum	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Promissory Note	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Trust Fund/Type	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Date Copy of Trust sent to DMA TPR	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Life Estate Interest	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Tobacco Buy-Out -If income, see income below.	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Annuities	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Liquid Assets of a Business	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Reverse Mortgage	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Net Proceeds from a Discontinued Business or Farm	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Other	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Other	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Other	<input type="checkbox"/>	<input type="checkbox"/>	\$	
<b>II.A. TOTAL COUNTABLE LIQUID RESOURCES</b>			\$	

**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)		\$	\$		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
b)		\$	\$		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
c)		\$	\$		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
d)		\$	\$		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
e)		\$	\$		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

**II.B. TOTAL LIFE INSURANCE VALUE**

\$

\* 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)	\$		\$	\$
<b>II.C. TOTAL COUNTABLE PRE-PAID BURIAL CONTRACTS</b>				\$

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

Does applicant wish to rebut the value of any of the above personal property?  YES  NO (Attach verification 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**

\$

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

<b>II.F. BURIAL PROPERTY</b>					
Does the applicant have any burial property listed below? YES <input type="checkbox"/> NO <input type="checkbox"/>					
TYPE		How many?	Designated for Whom? /Relation to applicant	Excluded	Value
Burial Spaces/plots	Y <input type="checkbox"/> N <input type="checkbox"/>			Y <input type="checkbox"/> N <input type="checkbox"/>	\$
Crypts/mausoleums	Y <input type="checkbox"/> N <input type="checkbox"/>			Y <input type="checkbox"/> N <input type="checkbox"/>	\$
Caskets	Y <input type="checkbox"/> N <input type="checkbox"/>			Y <input type="checkbox"/> N <input type="checkbox"/>	\$
Vaults	Y <input type="checkbox"/> N <input type="checkbox"/>			Y <input type="checkbox"/> N <input type="checkbox"/>	\$
Urns	Y <input type="checkbox"/> N <input type="checkbox"/>			Y <input type="checkbox"/> N <input type="checkbox"/>	\$
<b>II.F. Total Countable Value of Burial Property</b>					\$
<b>DOCUMENTATION/VERIFICATION:</b>					

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

<b>II.H. TRANSFER OF ASSETS (TOA)</b>					
<b>SA LOOKBACK DATE:</b>					
Has the applicant transferred, sold or given away any resources for less than current market value? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO	Applicant Alleged Incompetent/Defrauded? <input type="checkbox"/> YES <input type="checkbox"/> NO
Allowable Transfer reason:	If Yes, Guardian/POA? <input type="checkbox"/> YES <input type="checkbox"/> NO
Sanction Period _____ / _____ Through _____ / _____	Sanction Rebutted/Value \$ _____
Revised Sanction Period _____ / _____ Through _____ / _____	
<b>DOCUMENTATION/VERIFICATION:</b>	

**III. HEALTH INSURANCE/MEDICARE (Not applicable to SCD)**

A. Medicare A	<input type="checkbox"/> Yes <input type="checkbox"/> No	Effective Date:	Verification and Date:
B. Medicare B	<input type="checkbox"/> Yes <input type="checkbox"/> No	Effective Date:	
C. Medicare D	<input type="checkbox"/> Yes <input type="checkbox"/> No	Effective Date:	
D. Health Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	Effective Date:	
E. Long Term Care Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	Copy of policy in record? <input type="checkbox"/> Yes <input type="checkbox"/> No	
F. TPR Insurance Keyed	<input type="checkbox"/> Yes <input type="checkbox"/> No		
G. CCNC Explained	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medical Home	Exempt <input type="checkbox"/> Yes <input type="checkbox"/> No
H. LIS Application Completed	Date:		
<b>Insurance Company</b>	<b>Policy No.</b>	<b>Type of Coverage</b>	<b>Effective Date</b>

**IV. MISCELLANEOUS**

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

**V. INCOME**

A. UNEARNED INCOME	Mo.		Yr.		Monthly Amount	Verification & Date
DOES APPLICANT HAVE ANY UNEARNED INCOME?	YES	NO	Amount	Frequency		
1. Alien Sponsor Income	<input type="checkbox"/>	<input type="checkbox"/>	\$		\$	
2. Alimony & Spousal Support	<input type="checkbox"/>	<input type="checkbox"/>	\$		\$	
3. Black Lung/Brown Lung Benefits	<input type="checkbox"/>	<input type="checkbox"/>	\$		\$	
4. Cash Contributions & Monetary Gifts	<input type="checkbox"/>	<input type="checkbox"/>	\$		\$	
5. Child Support	<input type="checkbox"/>	<input type="checkbox"/>	\$		\$	
6. Community Spouse/Dependent Income Allowance	<input type="checkbox"/>	<input type="checkbox"/>	\$		\$	
7. Court-ordered Restitution/Legally Obligated Payments	<input type="checkbox"/>	<input type="checkbox"/>	\$		\$	
8. Disability Payments	<input type="checkbox"/>	<input type="checkbox"/>	\$		\$	
9. Dividends, Trust Funds	<input type="checkbox"/>	<input type="checkbox"/>	\$		\$	
10. Federal Employee's Compensation Act (FECA) Benefits	<input type="checkbox"/>	<input type="checkbox"/>	\$		\$	
11. Inheritance Payments	<input type="checkbox"/>	<input type="checkbox"/>	\$		\$	
12. Interest & Dividends	<input type="checkbox"/>	<input type="checkbox"/>	\$		\$	
13. Farm Income	<input type="checkbox"/>	<input type="checkbox"/>	\$		\$	
14. Sick Pay	<input type="checkbox"/>	<input type="checkbox"/>	\$		\$	
15. Insurance Settlements	<input type="checkbox"/>	<input type="checkbox"/>	\$		\$	
16. Military Allotments	<input type="checkbox"/>	<input type="checkbox"/>	\$		\$	
17. Native American Gaming Proceeds	<input type="checkbox"/>	<input type="checkbox"/>	\$		\$	
18. North America Free Trade Agreement (NAFTA) Payments & Trade Readjustment Allowance (TRA) Benefits	<input type="checkbox"/>	<input type="checkbox"/>	\$		\$	
19. Pensions & Annuities	<input type="checkbox"/>	<input type="checkbox"/>	\$		\$	
20. Retirement Benefits	<input type="checkbox"/>	<input type="checkbox"/>	\$		\$	
21. Royalties (Unearned)	<input type="checkbox"/>	<input type="checkbox"/>	\$		\$	

22. Severance Pay	<input type="checkbox"/>	<input type="checkbox"/>	\$		\$	
23. Social Security Benefits	<input type="checkbox"/>	<input type="checkbox"/>	\$		\$	
24. SSI (Supplemental Security Income)	<input type="checkbox"/>	<input type="checkbox"/>	\$		\$	
25. Strike Benefits	<input type="checkbox"/>	<input type="checkbox"/>	\$		\$	
26. Tobacco Allotment Settlement (Owner)	<input type="checkbox"/>	<input type="checkbox"/>	\$		\$	
27. Unemployment Income	<input type="checkbox"/>	<input type="checkbox"/>	\$		\$	
28. Veteran's Administration Pension & Compensation	<input type="checkbox"/>	<input type="checkbox"/>	\$		\$	
29. Winnings from gambling, lottery, Bingo, cash prizes	<input type="checkbox"/>	<input type="checkbox"/>	\$		\$	
30. Work Release Payments	<input type="checkbox"/>	<input type="checkbox"/>	\$		\$	
31. Workers Compensation	<input type="checkbox"/>	<input type="checkbox"/>	\$		\$	
32. Vocational Rehabilitation	<input type="checkbox"/>	<input type="checkbox"/>	\$		\$	
33. OTHER	<input type="checkbox"/>	<input type="checkbox"/>	\$		\$	
<b>TOTAL GROSS UNEARNED INCOME (Enter in VI.A.1.)</b>					<b>\$</b>	

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

## VI. INCOME CALCULATION

<b>A. UNEARNED INCOME:</b>		/	/
		<b>Mo. / Yr.</b>	<b>Mo./ Yr.</b>
1.	Enter applicant's Total GROSS Unearned Income	\$	\$
2.	Subtract \$20 General Deduction (Subtract \$0 from VA Pension and payment to parent of Veteran)	- \$	- \$
<b>3.</b>	<b>Net Unearned Income (Line 1 minus Line 2)</b>	<b>\$</b>	<b>\$</b>
<b>B. EARNED INCOME</b>		/	/
		<b>Mo. / Yr.</b>	<b>Mo./ Yr.</b>
4.	Enter applicant's Total GROSS earned Income (This is the amount after self-employment 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	- \$	- \$
<b>12.</b>	<b>Net Earned Income (Line 10 minus Line 11)</b>	<b>\$</b>	<b>\$</b>
<b>C. TOTAL COUNTABLE INCOME:</b>		/	/
		<b>Mo. / Yr.</b>	<b>Mo./ Yr.</b>
1.	Enter applicant's Net Unearned Income from VI.A.3.	\$	\$
2.	Add applicant's Net Earned Income from VI.B.12.	+ \$	+ \$
<b>3.</b>	<b>Total Countable Income (Line 1 plus Line 2)</b>	<b>\$</b>	<b>\$</b>
<b>INCOME DOCUMENTATION/VERIFICATION:</b>			

**VII. PAYMENT CALCULATION**

**STEP 1:**

<b>Valid FL-2 dated:</b>	
<b>Special Assistance Level of Care TYPE:</b>	
<input type="checkbox"/> SA Facility - Basic	<input type="checkbox"/> SA Facility Special Care Unit - Enhanced
<input type="checkbox"/> SA In-Home - Basic	<input type="checkbox"/> SA In-Home - Enhanced
<input type="checkbox"/> SA In-Home TCL(DOJ) - Basic	<input type="checkbox"/> SA In-Home TCL(DOJ) - Enhanced

**STEP 2:**

<b>ONGOING SA or SAIH PAYMENT</b>	<u>        /        </u> Mo. Yr.	<u>        /        </u> Mo. Yr.
A. Rate	\$	\$
B. Personal Needs Allowance	+ \$	+ \$
C. Maintenance Amount (A+B)	\$	\$
D. Total Countable Income (from VI.C.3.)	- \$	- \$
E. Equals SA Payment or SAIH payment	\$	\$
<b>Payment (rounded to nearest dollar)</b>	<b>\$</b>	<b>\$</b>

<b>Partial SA Payment (SAA/SAD): Use this budget when the applicant enters the ACH and meets the eligibility criteria <u>after</u> the first day of the month.</b>		<u>        /        </u> 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.	<b>Partial SA Payment (Round amount on Line J. to the nearest dollar.)</b>	<b>\$</b>

<b>Partial SAIH Payment (SAA/SAD): Use this budget when the applicant applies for SAIH and meets eligibility requirements after the first day of the month.</b>		<u>        /        </u> Mo. / Yr.
A	Number of days in month of application (28, 29, 30, 31)	
B	Date of SAIH 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	SAIH Payment (not rounded)	=
K	<b>SAIH Partial Payment (Round line J. to nearest dollar)</b>	<b>\$</b>

<b>Open/Shut SA Payment (SAA/SAD): Use this budget for an Open/Shut application when the applicant entered the ACH <u>after</u> the first day of the month and left <u>before</u> the end of the month.</b>		<u>        /        </u> 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.	<b>Actual SA Open/Shut Payment (Round line J. to nearest dollar)</b>	\$

<b>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</b>		<u>        </u> <b>Mo. / Yr.</b>
A.	SA Rate	\$
B.	Total Countable Income (VI.C.3.)	-
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.)	\$
H.	Personal Needs Allowance	+
I.	SA Open/Shut Payment (not rounded) (G. + H.)	\$
J.	<b>Actual SA Open/Shut Payment (Rounded)</b>	\$

### VIII. CERTIFICATIONS

<b>Certification Period</b>	
From:	To:
Date Received:	Income Support Number:
Date Completed:	Product Delivery Case Number:
Effective Date of Payment:	Date Notice Sent:

### IX. RIGHTS AND RESPONSIBILITIES

<b>A. RIGHTS OF THE APPLICANT (to be read and explained)</b>	
<p><b>You have the right to:</b></p> <ul style="list-style-type: none"> <li>Apply for assistance and, if found not eligible, reapply at any time.</li> <li>Have any person participate in the application interview or in the Re-determination of eligibility.</li> <li>Have any information given to the agency kept in confidence.</li> <li>Receive assistance, if found eligible.</li> <li>Be informed of information needed to determine continuing Special Assistance/Medicaid eligibility.</li> <li>Withdraw your application at any time.</li> <li>Withdraw from the assistance program at any time.</li> <li>Be protected against discrimination on the grounds of race, color, or national origin by Title VI of the Civil Rights Act of 1965.</li> <li>Choose a substitute payee if applicant is unwilling or unable to manage the SA payment.</li> </ul>	<p><b>You have a right to appeal to the county DSS for a hearing if:</b></p> <ul style="list-style-type: none"> <li>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.</li> <li>Your application was not acted on timely.</li> <li>Your application was denied, and you believe the decision was incorrect.</li> <li>Your assistance was terminated, and you believe the decision is not correct.</li> <li>You believe your assistance is incorrect based on the county's interpretation of State regulations.</li> <li>Your request for a review of your circumstances was delayed beyond 30 days or rejected.</li> </ul>

*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>B. RESPONSIBILITIES OF THE APPLICANT (to be read and explained)</b>	
<input type="checkbox"/>	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.
<input type="checkbox"/>	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.
<input type="checkbox"/>	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 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, except for 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

**IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.**

If you want to register to vote or to update your registration, you can complete a voter registration form at [www.ncsbe.gov/nvra/01](http://www.ncsbe.gov/nvra/01). Ask your caseworker or contact your local DSS for a voter registration form. **Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.** If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the North Carolina State Board of Elections, PO Box 27255, Raleigh NC 27611-7255 or you may call the toll free number, 1-866-522-4723.

**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.**

<b>Applicant/Representative's Signature: (First, Middle, Last)</b>		<b>Date:</b>	
<b>Witness:</b> (If applicant cannot write)	<b>Date:</b>	<b>IMC Signature:</b>	<b>Date:</b>