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DSS Name and Address

SPECIAL ASSISTANCE
RE-ENROLLMENT INFORMATION NOTICE

Case Name: _____ **Mail Date:** _____

Address _____ **NCF Case ID**_____

City, State ZIP _____ **WORKER**_____

Every 12 months we must review your eligibility for the State/ County Special Assistance (SA) program or the SA- In Home program. SA is a state supplement that pays cash benefits to eligible recipients who reside in licensed facilities authorized to receive SA payments or who receive SA payments to enable them to remain at home.

It is time for a review for: (*Name*) _____

This form must be returned by: (*1st of the following month.*)

Please complete this form and return to (DSS name and Address)

IMPORTANT REMINDER: If you would like to change the way you receive your Special Assistance benefit, either as a direct deposit into a bank account or on an Electronic Benefit Transfer (EBT) card, you must contact the county department of social services.

Recipient	Facility (if applicable)	Authorized Representative
Name:	Name:	Name:
Address:	Address:	Address:
contact #:	contact #:	contact #:

****Your case worker may contact you if additional information is needed**

1. You must report any income, both earned and unearned you receive.

Please complete the following chart, indicating what kind of income you receive and the amount you receive. (You may be asked to provide verification of this income.)

Type of Income	Yes √	No √	$ Amount	How Often?	Type of Income	Yes √	No √	$ Amount	How Often
Social Security (RSDI)					Wages (from a job)				
Supplemental Security Income (SSI)					Wages (from self-employment)				
Veteran's Benefits(VA)					Dividends/Interest				
Vocational Rehabilitation					Farm Income				
Military Allotment					Sick Pay				
Unemployment Benefits					Rental Income				
Workman's Compensation					Tobacco Buyout				
Disability Insurance					Other income: (list type)				
Railroad Retirement					1.				
Alimony/Support					2.				

2. You must report any Assets (things you own).

Please complete the following indicating if you have any of these assets. (If you receive SSI, you do not need to answer information in this section. Please proceed to #3.)

(You may be asked to provide verification of these assets.)

Type Of Asset	Yes √	No √	With What Company?	Account Number	Value/Balance
Cash					
Resident Personal Funds Accounts					
Checking Accounts					
Savings Accounts					
Certificate of Deposit					
Money Market Account					
Individual Retirement Account (IRA), 401K, Keogh Plan					
Annuities					
Trust Fund					
Stocks and/or Bonds,					
Mutual Funds/Securities					
Life Insurance					
Prepaid Burial Contracts					
Motor vehicles					
Mobile Home					
Real Property					
Burial Spaces					
Other					

If you own a home, is it your plan to someday return to that home? ☐ **Yes** ☐ **No**

Have you transferred, sold or given away any asset in the past year? ☐ **Yes** ☐ **No**

If yes, what was transferred, sold or given away and when? _____

3.Do you have any Health Insurance? ☐Yes ☐No

(If yes, please indicate what kind. You may be asked to provide verification of this insurance.)

☐Medicare A ☐Medicare B ☐Medicaid D

☐Private Health Insurance**:** Name: _____ Policy Number: _____

☐ Long Term Care Insurance: Name: _____ Policy number: _____

☐ Other: Name: _____ Policy number: _____

Community Care of North Carolina/Carolina ACCESS (CCNC/CA): CCNC/CA is a Medicaid program which lets you chose your own doctor (medical home). Your doctor's name and phone number will be either on your Medicaid card or sent to you in a letter. If you have any questions about CCNC/CA, call your Medicaid caseworker at the local county Department of Social Services.

☐I am currently enrolled in Carolina ACCESS and would like to change my doctor.

(If you checked this box, please list the name and address of the new doctor or contact your caseworker.)

_____ _____

New Medical Provider Address Phone Number

All Applicants and Recipients 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 Medical eligibility.
- Withdraw your application at any time.
- Withdraw from the assistance program at any time.
- If you want to register to vote, you can complete a voter registration form at http://www.ncsbe.gov/. 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 filling out the voter registration application form, we will help you. The decision either to see or accept help is yours. You may fill out the application form in private. If you believe that someone has interfered with your right 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 Board of Elections.

All Applicants and Recipients 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.
- You 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.**

All Applicants and Recipients have RESPONSIBILITES listed below:

- **I agree to let my caseworker know of any change within 5 days following a change in my situation**. In addition, I will notify my caseworker immediately when the amount of my assistance is greater than the amount to which I am entitled.

- You 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 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 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 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).

- 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 if I need an explanation of family planning services, health screening for adults, and other services available through the department of social services (DSS), I can contact my local DSS.

- 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.

- I understand that I may be eligible for Transportation services. If I have a need for these services, I will contact the local DSS.

❖ Your Special Assistance Review is not complete without your signature.

Please be sure to sign below

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.

Recipient's Signature (First, Mi, Last)			**Date:**
Representative's Signature (First, Mi, Last)		**Relationship to Recipient**	**Date:**
WITNESS: (If A/R Cannot Write)	**Date**	**IMC SIGNATURE**	**Date**