Request for Information

To: _____ **County Case No.** _____

Address: _____ **District No.** _____

_____ **Worker's Name:** _____

Date: _____ **Telephone Number** _____

We need additional information to process your Medicaid/Special Assistance application/re-enrollment. Provide this information by to ensure that your application/re-enrollment is processed promptly. If you need more time, contact us.

If you cannot get the items checked below, there are other items we can use. Continue reading about other items we can accept. We were unable to verify your information electronically.

☐ _____ will be required to meet a deductible to receive full Medicaid based on a gross monthly income amount of _____ from _____ If this income is incorrect, you may contact your Medicaid caseworker.

The countable income exceeds the maximum income limit for full Medicaid. To be eligible for full Medicaid, _____must meet a Medicaid deductible. The amount of the deductible for the months of _____ through _____ is $_____.

☐ _____ will be required to meet a deductible to receive full Medicaid in the following retroactive month(s) based on the gross income. If this income amount is incorrect, you may contact your Medicaid caseworker.

The amount of your deductible for the retroactive month(s):

_____ based on gross income of $_____ from _____ is $_____

_____ based on gross income of $_____ from _____ is $_____

_____ based on gross income of $_____ from _____ is $_____

☐ Two- or three-month deductible based on gross monthly income of $_____ from _____. for the months of_____ through _____ is $_____

☐ Provide medical bills for _____ from _____ to present and any old unpaid medical bills or your statement of anticipated medical expenses (eg surgery) expected within the 6-month certification period to meet the deductible amount listed above.

☐ Review, complete, sign, and return the enclosed Medicaid renewal form. If something has changed, mark through and write in correct information. If you need help or want to avoid mailing costs, you can answer these questions by phone by calling your worker within 30 days.

☐ Verification from physician if multiple births are expected.

☐ FL-2 completed by doctor for _____

☐ Proof of income for _____ from the month(s) of _____

☐ Proof of self-employment income and expenses from _____or schedule C from tax return for the year _____

☐ Bank account numbers or statement(s) for _____ showing balance for the months of _____

☐ Bank Consent form/Release of Information forms signed by _____

☐ Life insurance policies or the name of the insurance companies and policy numbers for _____

☐ Copy of the terms of the annuity for _____

☐ Proof that North Carolina Medicaid Program is named as a Remainder Beneficiary for an annuity for _____

☐ Name and contact information for issuer of annuity _____

☐ Social Security Number for _____

☐ Documentation of immigration status for _____

☐ Apply for Unemployment Benefits for _____

☐ Apply for Social Security Disability for _____

☐ DHB-5028, Consent for Release of Information, signed by _____

☐ Health Insurance card or the name of the company and policy number for _____

☐ Proof of Citizenship and Identity for _____

☐ Proof of State Residence for _____

☐ Proof of homesite equity for _____

☐ Documentation to rebut a transfer of assets sanction or to prove a transfer of assets sanction will cause an undue hardship or both.
(See attachment) _____

☐ Resources for _____ exceed the maximum resource limit for _____ Medicaid. Resources counted:

_____ valued at _____>

_____ valued at _____>

_____ valued at _____>

_____ valued at _____>

_____ valued at _____>

☐ See attachment for additional resources and amounts

If this amount is incorrect or you disagree with the value, you may contact your Medicaid worker. You also have the right to rebut the value of your assets or spend them down to the asset level.

☐ Other _____

In addition to the information requested above, **it is very important that you inform us of any changes in your situation since your last review.**

Do you need help or more time to get the information to complete your application/re-enrollment?

Call your Medicaid caseworker _____ at _____ OR
Sign and return this form to DSS.

☐ I need help getting the information to complete my application / re-enrollment.

☐ I need more time to get the information

I know that the information on this application is needed to determine eligibility for help paying for health coverage and/or Medicaid/NCHC and will be checked against electronic databases, Internal Revenue Service (IRS), Social Security, Department of Homeland Security, consumer reporting agencies, financial institutions, and/or other government agencies.

Applicant's Name _____ Telephone Number _____
Address _____

OTHER ITEMS WE CAN ACCEPT TO PROCESS YOUR MEDICAID APPLICATION/RE-ENROLLMENT

If you are unable to get the items checked or the items described below, please contact your caseworker immediately. Your caseworker will help you.

Reporting Changes

Don't forget to report all changes to your county department of social services within 10 calendar days (5 calendar days for Special Assistance). If you don't know whether a change is important, ask your caseworker. If you do not truthfully report information and changes, you **may be guilty of a misdemeanor or felony.**

MEDICAL BILLS

If you do not have all of your medical bills, you can provide:

1. Receipts from medical providers.
2. Statements from medical providers.
3. Cancelled checks to medical providers.
4. Names, addresses, phone numbers of medical providers.
5. Private health insurance receipts, premium books, name of agent.
6. "Explanation of Benefits" letters (EOB) from Medicare and/or private health insurance.
7. To show proof of over-the-counter drugs, provide a dated receipt and box top showing the name and price of the item purchased.
8. To show proof of medical transportation costs, provide a receipt or statement from the person if someone else took you to the doctor, drug store, or other medical facility.

PROOF OF OTHER INCOME

Such as Veteran's benefits, Railroad Retirement, other retirement income, rental income, farm income

1. Copy of check.
2. Award letter or other document from the source of income.
3. A statement from the source of the income or from person in charge of dispensing income(trust funds, etc.).
4. Records of payment received from roomers/boarders.
5. Records from the person paying you room/board.
6. Tax records.
7. Records of farm income.
8. Landlord's records of rental income.
9. Records of self-employment or rental income.
10. A signed statement from your bank, real estate agent, or person renting from you stating how much money you get.

WAGES

If you don't have wage stubs provide one of the following:

1. A statement or form completed by your employer.
2. Personal business records for self-employment.

PROOF OF CHILD CARE OR ADULT CARE

If you are applying for certain Family and Children's Medicaid programs there is a $200 per month limit for childcare for a child under age two and $175 per month limit for care for a child aged two or older and for an adult. You can provide:

1. Statement or receipt from person or the facility providing care. Statement or form indicating whether you are charged a flat fee or an hourly rate.
2. Your record of payment made for child or adult who is your dependent.

PROOF OF OPERATIONAL EXPENSES

If you don't have receipts to prove expenses for rental property or self-employment, provide one of the following:

1. Personal records of expenses such as ledger sheets, check stubs, or tax records.
2. Associations, ASCS Office, and purchase of farm products.
3. Written statements from people who sell you supplies.
4. Written statements from people who provide you with services so that you can earn money.
5. Written statement from real estate agent.

HEALTH INSURANCE

If you don't have your health insurance card, you may provide the name of the insurance company and the policy number.