_______________________________County RMA Case No. ____________________ Date ____________________

Refugee Medical Assistance (RMA) Application

This application is used to collect the information needed to determine eligibility for Refugee Medical Assistance.

The term "refugee" will refer to all ORR-eligible groups, who are Qualified Aliens, exempted from a five-year band timeframe and potentially eligible for RMA (refer to Chapter I., section III. for definitions, detailed information, and acceptable documentation regarding each ORR-eligible recipient groups). Immigration status for the following include; **Refugee**, admitted under INA § 207; **Asylee**, granted asylum under INA § 208; **Afghan Special Immigrant (SQ or SI) Parole, Afghan Special Immigrant (SI) Conditional Permanent Residence (CPR) and Afghan Humanitarian Parolees (AHP)** individuals granted humanitarian parole by the U.S. Department of Homeland Security, under Operation Allies Refuge/Operation Allies Welcome. **Cuban and Haitian Entrants**, as defined under federal regulations (45 CFR § 401.2); **Amerasian**, individual was fathered by a U.S. citizen under Public Law 100-202 (Act of 12/22/87)**; Victims of Human Trafficking** who have been issued an ORR-certification letter; **Special Immigrant Visa (SIV) Holder** from Afghan or Iraqi nationals granted a**,** by the U.S. Department of Homeland Security for service to the U.S. government. **Ukrainian Humanitarian Parolee, and other Non-Ukrainian individual displaced from Ukraine** as of May 21, 2022, the Additional Ukraine Supplemental Appropriations Act, 2022 (AUSAA).

Does the applicant and/or household member wish to apply for Refugee Cash Assistance? ☐ YES ☐ NO
(If yes, please complete a separate Refugee Cash Assistance application form.)

Does the applicant and/or household member need help completing the application or help during the interview process? ☐ YES ☐ NO
(If yes, please complete form DSS-10001, Language Services Agreement.)

PROGRAM SCREENING (ALL ANSWERS MUST BE YES TO BE POTENTIALLY ELIGIBLE)

Yes	No	Question
☐ Yes	☐ No	Does the applicant and household member's immigration status meet the definition of 'refugee' as identified above?
☐ Yes	☐ No	The applicant and household member were **FIRST** evaluated for all Medicaid program categories including Modified Adjusted Gross Income (MAGI) and determined ineligible prior to being evaluated for RMA.
☐ Yes	☐ No	Currently, the applicant or a household member is **NOT** pregnant? If yes, continue with this application. If applicant or household member **IS PREGNANT**, stop and evaluate the household for all Medicaid program categories
☐ Yes	☐ No	Currently, the applicant and household member, are **BOTH 64 years of age and younger**? If yes, continue with this application. If the applicant and household member are **BOTH** 65 years or older, stop and evaluate both individuals for Medical Assistance to the Aged, Blind and Disable (MAAAB) under the NC Medicaid State Plan. STOP, evaluate the individual age 65 years or older (MAAAB) and the individual is 64 and younger for (RMA).

Primary Applicant Name: ____ Telephone Number: ____________________

Address: ____

Mailing Address (if different from above): ____

NC Refugee Resettlement Agency (if applicable): ____

THE FORMS BELOW MUST BE ATTACHED WITH THIS REFUGEE MEDICAL ASSISTANCE APPLICATION, IF APPLICABLE.

☐ Form DSS-6247 (Notice of Intent to Apply for Benefits) given to the local DSS. Only applicable if the refugee applicant is working with a NC Refugee Resettlement Agency

☐ Form DSS-10001 (Language Services Agreement) provided by the local DSS and signed by the applicant.

☐ Form DSS-6236 (Informed Consent for Release of Information) provided by the local DSS and signed by the applicant. Only applicable if the applicant and/or household member authorized a NC Refugee Resettlement Agency and/or a NC Refugee Service Provider to speak/apply for Refugee Medical Assistance (RMA) on the applicant and/or household member's behalf.

The Department of Health and Human Services complies with Federal and State laws, which restrict the use and disclosure of information concerning applicants and recipients of public assistance and comply with applicable provisions of the Social Security Act concerning confidentiality. The Department of Health and Human Services does not discriminate against any person on the basis of race, color, national origin, sex, religion, age, political beliefs, or disability.

PRIMARY APPLICANT

1	Name (First)	Name (Last)	Name (Middle)	Gender	Date of Birth

Marital Status:

☐ Individual/Single ☐ Couple/Married

County of Origin: ____________________

Immigration Status:
☐ Refugee ☐ Special Immigrant Visa (SIV) Holder from Iraq or Afghanistan ☐ Amerasians
☐ Afghan Special Immigrant Parole SQ/SI ☐ Afghan Humanitarian Parolees
☐ Afghan Humanitarian Parole Afghan Special Immigrant (SI) Conditional Permanent Residence (CPR)
☐ Ukraine Humanitarian Parole or Non-Ukrainian individual displaced from Ukraine
☐ Cuban & Haitian Entrant ☐ Victim of Human Trafficking (certification letter)
☐ Asylee: Asylum Date *(Found on the Granted Asylum letter)* ____________________

Immigration Document(s) Viewed:

☐ I-94 ☐ USCIS Travel Documents ☐ Visa ☐ Passport
☐ Other: ____________________

Alien Number:
(Typically, a 9-digit number not a Social Security, Passport or VISA number)
____

Full-time Student:
(In an Intuition of Higher Learning)
☐ Yes, Where__________
☐ No

SECOND APPLICANT

2	Name (First)	Name (Last)	Name (Middle)	Gender	Date of Birth

Marital Status:

☐ Individual/Single ☐ Couple/Married

County of Origin: ____________________

Immigration Status:
☐ Refugee ☐ Special Immigrant Visa (SIV) Holder from Iraq or Afghanistan ☐ Amerasians
☐ Afghan Special Immigrant Parole SQ/SI ☐ Afghan Humanitarian Parolees
☐ Afghan Humanitarian Parole Afghan Special Immigrant (SI) Conditional Permanent Residence (CPR)
☐ Ukraine Humanitarian Parole or Non-Ukrainian individual displaced from Ukraine
☐ Cuban & Haitian Entrant ☐ Victim of Human Trafficking (certification letter)
☐ Asylee: Asylum Date *(Found on the Granted Asylum letter)* ____________________

Immigration Document(s) Viewed:

☐ I-94 ☐ USCIS Travel Documents ☐ Visa ☐ Passport
☐ Other: ____________________

Alien Number:
(Typically, a 9-digit number not a Social Security, Passport or VISA number)
____

Full-time Student:
(In an Intuition of Higher Learning)
☐ Yes, Where__________
☐ No

EARNED INCOME

(Refer to the SRO Program Manual Chapter II. Section III. Application Process Section. C. Processing Requirements.)

Does applicant and/or household member have income from working? ☐ Yes ☐ No If yes, complete the following:

1. Applicant Name: ____________________ Start Date: __________ Rate of Pay: ____________________

Employer Name: ____________________

Employer Address: ____________________ Telephone Number: ____________________

Supervisor/Manager Name: ____________________ Work Schedule/Hrs. per Week: __________

Pay Received This Month (Month of Application Only)	
Date	Gross Amount

2. Applicant Name: ____________________ Start Date: __________ Rate of Pay: ____________________

Employer Name: ____________________

Employer Address: ____________________ Telephone Number: ____________________

Supervisor/Manager Name: ____________________ Work Schedule/Hrs. per Week: __________

Pay Received This Month (Month of Application Only)	
Date	Gross Amount

ADDITIONAL SERVICES

Check (✓) that each of the following was explained and the applicable notice/form/service provided to applicant.

Service(s) Explained	Referral Yes	Referral No
☐ **Supplemental Security Income (SSI) -** Federal income supplement program designed to help aged, blind, and disabled people, who have little or no income. Referred this recipient to apply for SSI benefits.	☐	☐
☐ **Food and Nutrition Services (FNS) -** Eligibility for the Food Stamp Program is based on certain non-financial and financial requirements. Referred this recipient to be evaluated for expedited services.	☐	☐

Check (✓) that each of the following was explained and the applicable notice/form provided to applicant.

☐ Form NC FAST-20009 (Rights and Responsibilities)

I, ______________________________, understand that by signing this form, I am stating that:
(applicant printed name)

- ✓ I understand the penalties for giving false information, and I have told the truth on this form.
- ✓ I know my rights and what I must do to get assistance.
- ✓ I agree to give information about what I have said.
- ✓ I agree to report changes to the social services agency.
- ✓ I agree to let the social services agency obtain proof of what I have said from any person or another agency.
- ✓ I know the social services agency keeps private anything said about my situation.
- ✓ I know if I do not sign this form, I will not get assistance.

Applicant Signature: ______________________________ **Date:** ______________

Witness Signature: (If signed with an "X") ______________________________ **Date:** ______________

Authorized Agency (Referenced on DSS-6236): ______________________________

Authorized Agency Representative Print Name: ______________________________

Authorized Agency Representative Signature: ______________________________ **Date:** ______________

Interviewer Signature: ______________________________ **Date:** ______________

Interpreter Signature: ______________________________ **Date:** ______________