Additional Information Needed for Mail-In Application

Date _____

_____

_____

_____

Dear _____:

Recently you sent an application for health care coverage to _____ County Department of Social Services. We are not able to accept your application for the reasons shown below. Please complete these items before sending the application back in the enclosed envelope.

It is important that you return your application as soon as possible. If you are found eligible for NC Health Choice, your benefits cannot begin until the month we receive a complete application. If you have questions, please feel free to contact us at the telephone number shown below. Thank you.

Your application cannot be accepted because:

☐ You did not sign the form.

☐ We need the full name/date of birth/race/sex of person applying

☐ We need the full name/date of birth/race/sex of Child(ren) Under Age 19 (for whom assistance is requested)

☐ We need a complete mailing address

☐ We cannot read your application. Please come to our office for assistance or ask the health department or a friend to help you complete the enclosed form.

We will also need the following to process your application:

_____

_____

Sincerely,

_____

Phone: _____