DMA-5050
01/01/95

NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE
EMERGENCY CERTIFICATION FOR MEDICAID

TO: _____ (County Department of Social Services)

_____

_____

Fax #_____

FROM: _____ (SSA District Office)

_____

_____

RE: _____ (Name of Client)

_____ (Social Security Number)

_____ (Phone Number)

The above named individual is in need of immediate medical care. Please use the verification provided below to establish Medicaid.

Name of Eligible Individual_____ Race_____

Social Security Number_____ Date of Birth_____ Sex___

Social Security Claim Number (if different)_____

☐ Aged ☐ Blind ☐ Disabled ____ Date of SSI Application

Address_____ County_____

_____

Living Arrangement_____ Medicare Status ☐ A or ☐ B or ☐ BOTH

Current SSI Entitlement Date_____ SSI Amount_____

Date Moved to North Carolina_____ Intent to Remain_____ yes or no

Has this individual Refused to Provide Information Regarding Third Party Resources? ☐ yes or ☐ no

Reason Individual is NOT on SDX_____

_____

Prepared by_____ SSA Office_____
Signature

Title_____ Phone Number_____ Date_____

MAIL OR FAX THIS CERTIFICATION AS SOON AS POSSIBLE.
ATTACHMENT 1