North Carolina Division of Social Services
STATE/COUNTY SPECIAL ASSISTANCE FOR ADULTS WORKBOOK
FOR NON-SSI RECIPIENTS ONLY

I.

Date	Case ID	Worker No.	County
Cty Case No.	Dist No.	Aid Program/Category ☐ SAA ☐ SAD	U.S. Citizen ☐ Yes ☐ No
Type of Action ☐ New Application ☐ Review ☐ Reapplication ☐ Change		Race ☐ B ☐ A ☐ H ☐ W ☐ I ☐ O	Sex ☐ F ☐ M

APPLICANT'S/RECIPIENT'S NAME	
Adult Care Home Name	ACH Code
Adult Care Home Mailing Address	
City	State Zip Code
Resident's Phone No. at ACH	

AUTHORIZED REPRESENTATIVE'S NAME	
Mailing Address	No. Street/ PO Box/ R. Rt.
City	State Zip Code
Representative's Phone	Work Phone

Resident's address (if not yet in domiciliary care) _____

Resident's Phone No. _____

II. COMPLETE THIS SECTION AT APPLICATION. ASK RECIPIENT AT EACH REVIEW IF ANY CHANGES HAVE OCCURRED IN SECTION II. IF SO, UPDATE THE SECTION.

A. BIRTH DATE
Month/Day/Year

_____

Verification and date verified:

B. SOCIAL SECURITY NUMBER(S)

_____

_____

Verification of SSN(s):

C. EIS INQUIRY (Check all applicable items)

YES	NO	APPLICANT
		EIS Inquiry
		Receiving MAABD
		Active in CAP
		Receiving MQB only
		Receiving assistance from another state

Where _____ Type _____

Verification and date verified:

D. RESIDENCY

1. State

YES	NO	
		Does the a/r meet NC residence requirement for SA?

Verification of state and county residence:

2. County

_____

E. RESOURCES

1. Does a budget unit member have any of the following resources?

SOURCE	YES	NO	COUNTABLE VALUE	VERIFICATION Include account number, location, etc.
Cash on Hand	☐	☐		
Resident Accounts	☐	☐		
Checking Account	☐	☐		
Savings Account	☐	☐		
IRA, Keough Plan, 401K	☐	☐		
Annuities	☐	☐		
Stocks, Bonds, CD's, etc.	☐	☐		
Lump Sum	☐	☐		
Promissory Note	☐	☐		
Trust Fund	☐	☐		
Life Estate Interest	☐	☐		
Other _____ _____	☐	☐		
		TOTAL	**$0.00**	

E. RESOURCES (continued)

2. LIFE INSURANCE

YES	NO
☐	☐

(a) **Does a budget unit member have life insurance that accrues cash value? (Include term insurance if it can accrue cash value)**

(b) If YES, complete the following information for each policy.

Owner of Policy	Policy Number	Name of Insurance Co.	Face Value	Cash Value	Name of Insured	*
1)						☐ P ☐ NP
2)						☐ P ☐ NP
3)						☐ P ☐ NP
4)						☐ P ☐ NP
5)						☐ P ☐ NP
6)						☐ P ☐ NP
		TOTALS	$0.00	$0.00		

***PARTICIPATING (P)/NONPARTICILPATING (NP)**
A participating policy may earn dividends annually. The dividends can be paid back to the owner or used to reduce the next premium, to increase the face value, or to increase the cash value. Contact the insurance company or ask the applicant/recipient to bring a copy of the annual premium notice.

(c) Verification of cash value if total face value of all policies owned by a budget unit member exceeds $10,000. (If a policy is irrevocably assigned to a funeral home, do not count it towards the $ 10,000 limit.)

List type of verification and date provided.
1)
2)
3)
4)
5)
6)

E. RESOURCES (continued)

3. PERSONAL PROPERTY (Include motor vehicles)

☐ YES ☐ NO	Does the budget unit member have any cars, trucks, boats, boat trailers/motors, campers, mobile homes, motorcycles, farm equipment, or business equipment? ***If YES, please describe.***				
Make	**Model**	**Year**	**Value**	**Amt. Owed**	**Countable Value***
1.					
2.					
3.					
4.					
List type(s) of verification and date provided. DOT checked Date _____ Tax records checked Date _____				**TOTAL**	**$ 0.00**

*Exclude *one* licensed vehicle. Count all other vehicles, including all unlicensed vehicles. If there is *no* licensed vehicle, exclude up to $4,500 tax value of unlicensed vehicles.

Does the budget unit member wish to rebut the value of any of the above personal property? If ***YES***, attach verification of lesser value.	**YES**	**NO**	Rebuttal value, if applicable, must be repeated annually OR the current DMV/tax value is used.	$

3. PREPAID BURIAL PLANS

(a) ☐ **YES** ☐ **NO** Does the budget unit have burial contract(s)?

(b) If ***YES***, complete the following information for each contract.
(Indicate whether Revocable or Irrevocable in Type column).

Beneficiary	**Owner**	**Type**	**Funeral Home**	**Date Purchased**	**Value**	**Date**	**Verification**
				***TOTAL**	**$ $0.00**		

***Show in TOTAL only the value of Revocable Burial Plans.**

E. RESOURCES (continued)

5. HOMESITE (Include all contiguous property)

REAL PROPERTY INTEREST: Document location(s), total acreage, and Tax Value for all property interests, including those excluded.

a. Excluded Real Property
☐ Tenancy In Common ☐ Life Estate

b. Will market value be rebutted?

YES	NO	
☐	☐	Remainder Interest _____% (from table)
☐	☐	Negotiable Promissory Note
☐	☐	Mineral/Timber Rights
☐	☐	Other _____

c. ☐ Single Ownership ☐ Tenancy by Entirety

Excluded as:
☐ Homesite ☐ Based on Usage

☐ Intent to Return

☐ Rebuttal of CMV: Value established: _____

Document method of sale/rebuttal

CMV: ☐ Tax ☐ Rebuttal		
Less Encumbrances		
Equity		
Homesite Exclusion		
Excluded Based on Usage		
Value of countable REAL PROPERTY		
TOTAL VALUE		

6. TAX RECORDS

Grantee/Grantor Records
Findings:

Date Checked: _____
Date Checked: _____

_____

_____

List type of verification and date provided.

GROSS TOTAL OF ALL ITEMS TO COUNT IN RESORCES

Add totals from E.l., 2., 3., 4., and 5. (if countable) _____ $

Note: If the budget unit exceeds the resource limit, liquid assets up to $1,500 may be excluded. See Burial Exclusion Computation Chart on page 6.

E. RESOURCES (continued)

7. TRANSFER OF ASSETS

Title or Property: Value: $_____ Tax Office Checked: _____ Tax Year: _____

Register of Deeds Checked _____ Value $_____

Other Transferred Resources: _____ Value $_____

8. BURIAL EXCLUSION: $1,500

TYPE OF ASSET	VALUE	$10,000	BALANCE	EXCESS	
Irrevocable Trust					
Face Value of Life Insurance If F.V. is less than $10,000.					
Revocable Contract					
Cash Value of Designated Life Ins. When F.V. is more than $10,000.					
Cash Designated for Burial					

III. VERIFICATION BY USING SOLQ

SOLQ Date _____
File a copy of the SOLQ in record. If payment CANNOT be calculated, proceed as follows.

IV. INCOME DOCUMENTATION AND VERIFICATION

TYPE	___/___ Mo. Yr.		___/___ Mo. Yr.	
Source: Earned	YES	NO	AMOUNT	VERIFICATION
Wages, Salaries, Commissions, Tips				
Self-Employment/Business ****				
Farm Income ****				
ADAP				
Sick Pay (1st 6 months)				
Other				

TOTAL GROSS EARNED	TOTAL COUNTABLE	TOTAL EXPENSES

IV. INCOME DOCUMENTATION AND VERIFICATION (cont.)

Source: Unearned	YES	NO	AMOUNT	VERIFICATION
Social Security				
SSI				
Retirement Railroad				
VA Benefit**				
Unemployment				
Disability Insurance				
Worker's Comp.				
Sick Pay (after 6 months)				
Pensions-Retirement				
Support/Alimony				
Work Release				
Military Allotment				
Contributions				
Educational Loans				
Grants/Scholarships***				
Income from Trusts				
Dividends/Interest				
Rentals****				
Other				

** Do not count VA aid and attendance and housebound or lump sum clothing allowance.
*** Count any portion used or designated for maintenance
**** Deduct actual paid operational expenses directly related to producing the income for the corresponding base period.

TOTAL UNEARNED

$0.00

V. HEALTH INSURANCE/MEDICARE

A. Medicare A ☐ Yes ☐ No Effective: _____
B. Medicare B ☐ Yes ☐ No Effective: _____
C. Health Insurance? ☐ Yes ☐ No
Carolina Access Recipient: _____

Verification and date:

Insurance Company	Policy No.	Type of Coverage	Effective Date

D. DMA-2041 completed? ☐ Yes ☐ No

VI. INCOME CALCULATION

A. UNEARNED INCOME:	___/___ Mo. Yr.	___/___ Mo. Yr.
1. Enter a/r's total GROSS Unearned Income	$	$
2. Subtract $20 General Deduction (Subtract $0 from VA Pension and payment to parent of Veteran)	-	-
3. Net Unearned Income (Line 1 - Line 2)	$	$

B. EARNED INCOME:	___/___ Mo. Yr.	___/___ Mo. Yr.
4. Enter a/r's Total GROSS Earned Income. (This is the amt. after operational expenses	$	$
5. Subtract the remainder of $20 General Deduction if any not used by Unearned Income.	-	-
6. Subtotal (Line 4 - Line 5)		
7. Subtract $65 Earned Income Exclusion	-65.00	-65.00
8. Subtotal (Line 6 - Line 7)		
9. Subtract Impairment Related Work Expenses (IRWE)	-	-
10. Subtotal (Line 8 - Line 9)		
11. 1/2 of Line 10 (Line 10/2)	-	-
12. Net Earned Income (Line 10 - Line 11)	$	$

VII. PAYMENT CALCULATION

FL-2/MR-2 dated _____

_____ semi-ambulatory _____ ambulatory

Regular SA Payment	____ /___ Mo. Yr.	____/____ Mo. Yr.
A. Rate	$	$
B. Personal Needs Allowance	$	$
C. Maintenance Amount (A + B)	$	$
D. Total Countable Income (VI. A. 3 +VI. B. 12.)	-	-
E. Difference C. - D.	$	$
SA PAYMENT (E. rounded to nearest dollar)	$	$

Payment Review Period:

From: _____

To _____

Effective Date of Payment: _____

System Updated?
___Yes ____No

Date Keyed: _____

Form Number: _____

Action Code: _____

Notice override
___Yes ____No

Partial SA Payment (SAA/SAD) Use this budget when the A/R enters the ACH and meets the eligibility criteria *after* the first day of the month.	___/___ Mo. Yr.
A. Number of days in month of entry (28, 29, 30, 31)	
B. Date of Entry Enter the **DAY** of entry (Between 2 and 31)	-
C. Number of days for which a payment is needed (A. – B.) + 1	=
D. Monthly cost of care	$
E. Number from Line A.	÷
F. Per Diem Rate (D. ÷ E.)	$
G. Actual Number of Days of Care (C.)	x
H. Cost of Care (F. x G.)	=
I. Personal Needs Allowance	+
J. Total Needs (H. + I.)	=
K. **Partial Payment** (Round amount on Line J. to the nearest dollar)	$

Open/Shut SA Payment (SAA/SAD) Use this budget for an Open/Shut application when the A/R entered the ACH *after* the first day of the month, and left *before* the end of the month.	___/___ Mo. Yr.
A. Date of Discharge. Enter the DAY of discharge	
B. Date of Entry Enter the **DAY** of entry (between 2 and 31)	-
C. Number of days for which payment is needed (A. – B. + 1)	=
D. SA Rate	$
E. Number of days in the month of entry (28, 30, or 31)	+
F. Cost of Care Per Diem Rate (D. ÷ E.)	$
G. Actual Number of Days of Care (C.)	x
H. Cost of Care (F. x G.)	$
I. Personal Needs Allowance	+
J. Open/Shut Payment (not-rounded) (H. + I.)	**$**
K. **Actual SA Open/Shut Payment** (Rounded)	**$**

Open/Shut SA Payment (SAA/SAD) Use this budget for an Open/Shut application when the A/R entered the ACH *on* the first day of the month and left *before* the end of the month.	___/___ Mo. Yr.
A. SA Rate	$
B. Total Countable Income (VI. A. 3 + VI. B. 12)	-
C. SA Portion of Cost of Care (Personal Needs not included)	$
D. Number of days in the month (28, 30, or 31)	+
E. SA Portion of Cost of Care Per Diem Amount (C. ÷ D.)	$
F. Date of Discharge	x
G. SA Portion of Cost of Care (E. x F.)	x
H. Personal Needs Allowance	+
I. Open/Shut Payment (not-rounded) (G. + H.)	**$**
J. **Actual SA Open/Shut Payment** (Rounded)	**$**

VIII. MISCELLANEOUS

	Explained	*Pamphlet Given
FRAUD		
MEDICAID		

	Explained	*Pamphlet Given
APPEALS		
SERVICES		

WORK SPACE

Use this space to record changes in situation and any other documentation or calculation needed for the case

RIGHTS (to be read and explained)

You have the right to:

- Apply for assistance, and, if found not eligible, reapply at any time.
- Have any person participate in the interview for redetermination 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.

You have a right to a hearing if:

- Your assistance was terminated and you believe the decision is not correct.
- You believe you 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 of rejected.

The N.C. 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.

RESPONSIBILITIES

☒ I agree to let my caseworker know of any change within 5 days following the change in my situation. I will notify my caseworker concerning any change in address, employment, property, resources, expenses or needs, living arrangements or number in the family or at any other time when I am in doubt whether a particular change in circumstances should be reported. In addition, I will notify my caseworker immediately when the amount of my assistance is greater than the amount to which I am entitled.

☒ I 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 that if any resources (including the homesite, 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 Service (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 accompany 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 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.

☐ Yes ☐ No In addition to the Income Maintenance Worker who handles your Medicaid, the Department of Social Services has social workers to help with other needs you might have. Would you like to talk with a social worker?

VOTER REGISTRATION You may now register to vote or update your voter registration record while applying for benefits, redetermining eligibility or reporting a change in situation.

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/REPRESENTATIVE'S SIGNATURE (First, MI, Last)	**DATE**
RECIPIENT'S SIGNATURE (First, MI, Last)	
WITNESS: (if client cannot write)	**IMC SIGNATURE**