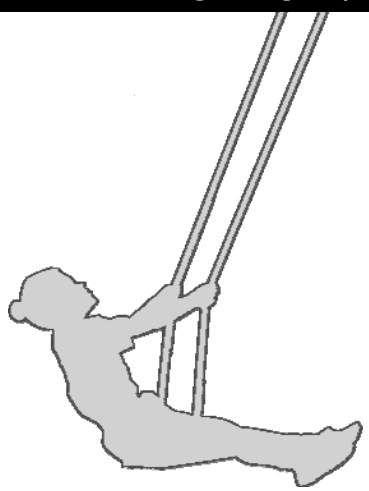
HEALTH CHECK / NC HEALTH CHOICE FOR CHILDREN APPLICATION



Health Check NC Health Choice for children

Better health for you and your children, peace of mind for you.

Free or Low-Cost Health Insurance

(Pregnant women, parents, or other adults may also use this application to apply for Medicaid as a caretaker or for Family Planning Services.)

Si usted desea obtener la forma DMA-5063, solicitud en español para seguro medico para niños, comuníquese con el departamento de servicios sociales de su localidad. También puede llamar a la línea de Recursos de Salud Familiar al 1-800-367-2229. Se le atenderá en español. (You can get a Spanish application at your local department of social services or call 1-800-367-2229.)

WHAT ARE HEALTH CHECK AND NC HEALTH CHOICE FOR CHILDREN?

Health Check (the Medicaid Insurance Program) and Health Choice are two similar health insurance programs. Your family's income, the number of people in your family and the age of the children determine if you or your children qualify. This information will also be used to determine in which program you or the children will be enrolled.

WHAT ARE THE BENEFITS?

- Sick visits
- Checkups
- Hospital care
- Counseling
- Prescriptions
- Dental care
- Eye exams and glasses
- Hearing exams and hearing aids
- And more!

Transportation - If you or your children are enrolled in Health Check, transportation to medical appointments may be provided through your department of social services. If the children are enrolled in Health Choice, you must provide your own transportation.

Children with Special Health Care Needs may be eligible for additional services.

HOW DO I APPLY?

It's easy. Just mail or drop off the completed application at the department of social services in the county where you live. If you would like help filling out the application, call or visit your department of social services. You can find the address and phone number in your phone book under "County Government" or by calling the North Carolina Family Health Resource Line at 1-800-367-2229.

Be careful to answer all the questions completely so we can process your application more quickly. If you need more space, please attach additional pages. It can take 45 days or less to process your application. If we need additional information, we will contact you by mail. The sooner we get the information, the sooner we can let you know if your children qualify.

WHAT ELSE DO I NEED TO KNOW ABOUT HEALTH CHECK AND HEALTH CHOICE?

Will My Children Get Insurance Cards?

YES! Your children will receive insurance cards in the mail. Please keep the card handy so you can show it at medical appointments and when you fill prescriptions.

How Do I Choose a Doctor?

The department of social services will help you choose your doctor.

Will I Need to Re-enroll ?

YES! You will need to re-enroll to continue benefits. For most children this is done once a year. You will be contacted when it is time to re-enroll.

Will I Have to Pay Enrollment Fees and a Co-pay?

Depending on your income, you may have to pay an enrollment fee of $50 to $100 per family per year. In some cases, you also may have a small co-pay for doctor visits and prescriptions. If the fee and/or co-pay apply to you, you will be notified.

Will My Children Be Enrolled Immediately?

Health Check (the Medicaid Insurance Program) has no funding limits, so there is no waiting list. If your children are eligible for Health Choice, they may have to go on a waiting list before being enrolled if federal or state funds are not sufficient to serve more children.

WHAT ARE MY RESPONSIBILITIES?

- ✓ You agree to tell the department of social services within 10 days if there are any changes in the information you provided on your application.
- ✓ A state or federal reviewer may check the information on this form. You agree to participate in the review and will cooperate with the reviewer.
- ✓ If you knowingly provide false information or if you withhold information and you or your children get health insurance for which they are not eligible, you can be lawfully punished for fraud and may be asked to repay the programs for any medical bills and/or premiums that were paid incorrectly.
- ✓ You agree to tell the department of social services if anyone with Health Check (the Medicaid Insurance Program) is in an accident.
- ✓ If Health Check (the Medicaid Insurance Program)/Health Choice pays for health care for you or your children, you give permission to the state of North Carolina to collect payments from anyone who is supposed to pay for that care. You also agree to share medical information about your children with any insurance company to get the medical bills paid.
- ✓ For a person to be enrolled in Health Check (the Medicaid Insurance Program)/Health Choice, you must provide his/her social security number or apply for a number. Please know that these numbers will be matched by computer with other government agency records (but not the Bureau of Citizenship and Immigration Services) to verify information. If you decide not to give the numbers, the person cannot be enrolled.
- ✓ For Health Check, provide proof of identity and U.S. citizenship or information for the county DSS to obtain the proof for those applying for benefits. For refugees and legally qualified immigrants, provide proof of legal status for those applying.

WHAT ARE MY RIGHTS?

- ✓ Health Check (the Medicaid Insurance Program)/Health Choice cannot discriminate on the basis of race, color, nationality, sex, religion, age, disability in employment or the provision of services.
- ✓ By law, all information that you provide remains private.
- ✓ You can ask for a hearing if you think any decisions are unfair, incorrect or are made too late.

WHO CAN ANSWER MY QUESTIONS?

Contact the department of social services in the county where you live or call the NC Family Health Resource Line at 1-800-367-2229.

Before you return the application, please make sure to do the following:

Read pages 1 and 2. Tear them off and keep for your records.

Complete the questions on pages 3 through 6.

Sign the application on page 5.

Health Check Health Choice for children

APPLICATION

For Office Use Only
County DSS: _____
Date Received: _____
Case #: _____
☐ Mail in ☐ DSS ☐ Health Dept

Please complete. Then send pages 3-6 to your local department of social services. If this application is being completed by or for a pregnant woman who has no other children living with her or you are applying for Family Planning, complete this application as if the pregnant woman or you is already a parent.

Tell Us About the Family

1. Who are *all* the children under age 21 who live in the home?

*Fill out this information **even** for children who will not be applying for Health Check/Health Choice. Social Security number, proof of identity, and citizenship status are required **only** for those applying for Health Check.*

Name of child (first, middle initial, last)	Applying for this child (Y, N)	Date of birth (mo/day/yr)	Sex (M, F)	*Race (Use codes below. List all that apply.)	**Hispanic/Latino (Y, N) If yes, specify using codes below.	Is Child a U.S. citizen? (Y, N)	Social Security Number (SSN)

*Asian= A American Indian or Alaska Native= I Native Hawaiian or other Pacific Islander= P Caucasian or White= W Black or African-American= B
** Hispanic Puerto Rican= P Hispanic Cuban= C Hispanic Mexican= M Hispanic Other= H

2. Where do you & the children live? (If different, please put your address on a separate sheet and return with this application.)

Address:	Mailing address (if different):
City: State: Zip Code:	City: State: Zip Code:

Home phone: ( ) Daytime phone: ( )

3. Who are the parents living with the children? If the children do not live with their parents, who are the adults living in the home who care for the children?

Name of parent or adult (first, middle initial, last)	Date of birth (mo/day/yr)	Sex (M, F)	*Race (Use codes in 1. above. List all that apply.)	**Hispanic/Latino (Y, N) If yes, use codes in 1. above.	Children's names and parent or adult relationship to the children (John – Mother, Mary - Stepmother)

a. Do you want to apply for pregnancy coverage for any of the people listed in #3 above? ☐ Yes ☐ No

If you are applying for pregnancy assistance, you need to provide a statement from the doctor that includes the delivery date and the number of babies expected. However, send in the application form even if you do not have the statement from the doctor yet.

If yes, for whom? _____ Relationship: _____ SSN _____

b. Do you want to apply for Medicaid for any of the people listed in #3 above? If you want to apply, you will be contacted for information about bank accounts, real and personal property, cash value of life insurance, stocks, bonds, etc. The total of these must be less than $3,000. Also, if you are eligible, you may be responsible for some of your medical bills. ☐ Yes ☐ No

Applicants must provide their Social Security numbers and may have to give information to the child support office.

If yes, for whom: _____ Relationship: _____ SSN _____

c. Do you want to apply for family planning services for any people ages 19 and older listed above? ☐ Yes ☐ No

Applicants must provide their Social Security numbers.

If yes, for whom: _____ Relationship: _____ SSN _____

4. Is there a family member living away from the home for less than 12 months (Example: military service, attending school)? ☐ Yes ☐ No

If yes, please give information below:

Full name (first, middle initial, last)	Relationship	Reason for absence	Expected date of return

Tell Us About the Family's Health Insurance and Medical Needs

5. Is there currently a parent **not** living in the home? ☐ Yes ☐ No

If yes, what is that parent's name? (optional) _____

Is that parent required by an agreement to pay for health insurance? ☐ Yes ☐ No

6. Does anyone applying have another health insurance plan? ☐ Yes ☐ No

If yes, please give information below:

Name of Insured (first, middle initial, last)	Owner of Policy	Insurance Company Name	Insurance Company Address	Insurance Company Phone Number	Group/Policy Number

7. Does anyone applying need help paying medical bills from the past three months? ☐ Yes ☐ No

If yes, please give the information below: *We may be able to help pay those bills.*

Name of person(s) with bill (first, middle initial, last)	Name of doctor, clinic and/or hospital where person was treated	Date of medical treatment

8. Has anyone applying been in an accident in the past 12 months? ☐ Yes ☐ No

Did he/she receive medical care because of the accident? ☐ Yes ☐ No

If yes, please tell us who. _____ When was the accident? _____/_____/_____

Tell Us About the Parent's and Children's Income

9. Who are the parents and children in the home who work, and what are their wages?

Name of working person (first, middle initial, last)	Employer's name and phone number	Amount earned before deductions	Tips earned	How often paid (monthly, weekly, etc.)
		$	$	
		$	$	
		$	$	

Please provide copies of all of last month's paycheck stubs for everybody listed. Send in the application even if you do not have your stubs.

10. Is there a parent or child in the home who is self-employed? ☐ Yes ☐ No

For example, does anyone earn money from farming, own his or her own business, or have rental property income?

If yes, please attach business records showing income and expenses for the last 6 months or the number of months in business if less than 6 months. If the income is annual, please attach business records for the last 12 months.

11. Has a parent or child in the home lost a job in the past three months? ☐ Yes ☐ No

If yes, please complete the following:

Name of person(s) who lost a job	Date job lost	Former employer's name	Former employer's address & phone number

12. If the parent or child receives income from any other source please complete the blocks below.

Type of income	Name of the person who receives other income	Amount received	How often received (monthly, weekly, etc.)
Child Support:		$	
Social Security:		$	
Unemployment:		$	
Other (Please explain):		$	

Tell Us About the Parent's and Children's Expenses

Some of these expenses may be used to reduce the income that we count to determine enrollment in Health Check/Health Choice.

13. Does a working parent living in the home pay for childcare, a babysitter or care for dependent adult? ☐ Yes ☐ No

If yes, please fill in the information:

Name, address & phone number of sitter or childcare provider	Name of person cared for	Name of person paying for care	Amount paid	How often paid (monthly, weekly, etc.)
			$	
			$	

14. Does a parent living in the home pay child support for a child who is not living in the home? ☐ Yes ☐ No

If yes, please fill in the information.

Who pays the support & to whom	For whom is the support paid	Is it court ordered (Y, N)	Amount paid Please Attach Verification	How often paid (monthly, weekly, etc.)
			$	
			$	

Tell Us If You Would Like Help With Child Support

The Child Support Agency can help get financial and medical help for the child from the child's absent parent. If you seek assistance from the Child Support Agency, the courts can establish paternity and establish and enforce medical support obligations.

There are other benefits to working with the Child Support Agency. For example, your child may be eligible for other financial benefits, including Social Security, pension benefits, veteran's benefits and possible inheritance. Also, your child may benefit by having a bond between parent and child. Finally, your child may benefit by getting important medical history information.

If you want the Child Support Agency's help in establishing paternity or in getting a medical support order through the court, check the "Yes" box.
If you check the box, someone will contact you. ☐ Yes, I would like help from the Child Support Agency.

- ✓ I attest that all statements recorded on this document are true and correct to the best of my knowledge.
- ✓ I have either read or had read to me all attachments to this application, and I understand my rights and responsibilities as an applicant/recipient.
- ✓ I authorize the release of any information necessary to establish my family's eligibility. I understand that this information may include medical information about the individuals applying for health insurance and/or nonmedical information about individuals applying and others. This might include information from doctors, hospitals, employers and insurance companies.
- ✓ I have received or understand that I will receive a copy of the "Medicaid Notice of Privacy Practices."
- ✓ I authorize the copying of this release form to verify information. It shall remain valid and in force until revoked by me in writing.
- ✓ I understand that if Medicaid pays for nursing facility care, in-home health services, or services provided under the Community Alternatives Program (CAP), Medicaid may become a creditor of my estate and my estate may be subject to recovery to repay Medicaid.

Signature of parent or other adult: ✓_____

Date: _____

Health Check Health Choice for children

Language Preference and Special Needs (Optional)

You may still apply for Health Check/Health Choice even if you don't answer the questions on this page.

What Language Does the Family Prefer to Speak?

The federal government requires the State to provide information about the languages the family speaks. Please help us by providing the information for the parent/other adult living in the home.

Name of person (first, middle initial, last)	Language person prefers to speak (circle one)
1.	English Spanish Other (Specify_____)
2.	English Spanish Other (Specify_____)
3.	English Spanish Other (Specify_____)
4.	English Spanish Other (Specify_____)
5.	English Spanish Other (Specify_____)
6.	English Spanish Other (Specify_____)

Does Your Child Have Special Health Care Needs?

Please help us improve services for children with special health care needs and meet federal reporting requirements by answering these questions. The answers will not affect your child's eligibility for Health Check or NC Health Choice.

1. Do any of your children currently need medicine prescribed by a doctor other than vitamins? ☐Yes ☐No
   If yes, does your child (or children) need this medicine because of *any* medical, behavioral or other health condition that has lasted or is expected to last *at least* 12 months? ☐ Yes ☐No
   If yes, please list the name of the child (or children):_____

2. Do any of your children need more medical care, mental health or education services than usual or routine for most children of the same age? ☐Yes ☐No
   If yes, does your child (or children) need these services because of *any* medical, behavioral or health condition that has lasted or is expected to last *at least* 12 months? ☐Yes ☐ No
   If yes, please list the name of the child (or children):
   _____

3. Are any of your children limited or prevented in any way in their ability to do the things most children their age can do? ☐ Yes ☐ No
   If yes, is this limitation because of *any* medical, behavioral or health condition that has lasted or is expected to last *at least* 12 months? ☐ Yes ☐ No
   If yes, please list the name of the child (or children): _____

4. Do any of your children need special therapy, such as physical, occupational, or speech therapy? ☐ Yes ☐ No
   If yes, does your child (or children) need this therapy because of *any* medical, behavioral or other health condition that has lasted or is expected to last *at least* 12 months? ☐ Yes ☐ No
   If yes, please list the name of the child (or children):_____

5. Do any of your children currently have any kind of emotional, developmental or behavioral difficulty for which they need treatment or counseling? ☐ Yes ☐ No
   If yes, does your child (or children) need this treatment or counseling because of *any* medical, behavioral or other health condition that has lasted or is expected to last *at least* 12 months? ☐ Yes ☐ No
   If yes, please list the name of your child (or children):_____

DID YOU SIGN THE APPLICATION ON PAGE 5?