Application for Health Coverage & Help Paying Costs

THINGS TO KNOW

Use this application to see what coverage choices you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well
- A new tax credit that can immediately help pay your premiums for health coverage
- Free or low-cost insurance from Medicaid or North Carolina Health Choice (NCHC)
- You may qualify for a free or low-cost program even if you earn as much as $94,000 a year (for a family of 4).

Who can use this application?

- Use this application to apply for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- If you're single, you may be able to use a short form. Visit http://www.ncdhhs.gov/dma/medicaid/applications.htm.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete Appendix C.

Apply faster online

- Apply faster online at https://epass.nc.gov.

What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants who need insurance)
- Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family
- Proof of Identity
- Proof of NC Residence

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. We'll keep all the information you provide private and secure, as required by law. To view the Privacy Act Statement, go to http://www.ncdhhs.gov/dma/medicaid/rights.htm

What happens next?

Send your complete, signed application to the Department of Social Services in the county where you live (http://www.ncdhhs.gov/dss/local/) If you don't have all the information we ask for, sign and submit your application anyway. We'll follow-up with you within 1–2 weeks. You'll get instructions on the next steps to complete your applicaiton for health coverage. If you don't hear from us, visit http://www.ncdhhs.gov/dss/local/ or call 1-800-662-7030 Filling out this application doesn't mean you have to buy health coverage.

Get help with this application

- Phone: Call your local DSS office.
- In person: Visit your local DSS office. To find out the location of your DSS office visit http://www.ncdhhs.gov/dss/local/. or call 1-800-662-7030
- En Español: Llame su oficina de DSS local. Para obtener mas informacion visite http://www.ncdhhs.gov/dss/local/ o llame al 1-800-662-7030

NEED HELP WITH YOUR APPLICATION? Contact your county DSS (http://www.ncdhhs.gov/dss/local/) or call us at 1-800-662-7030. Para obtener una copia de este formulario en Español, llame 1-800-662-7030. If you need help in a language other than English, call 1-800-662-7030 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-452-2514.

STEP 1 Tell us about yourself.

1. First name, Middle name, Last name, & Suffix			
2. Home address (Leave blank if you don't have one.)			3. Apartment or suite number
4. City	5. State	6. ZIP code	7. County
8. Mailing address (if different from home address)			9. Apartment or suite number
10. City	11. State	12. ZIP code	13. County
14. Phone number ( ) -		15. Other phone number ( ) -	
16. What is your preferred spoken or written language (if not English)?			

STEP 2 Tell us about your family.

Who do you need to include on this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage).

DO Include:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Anyone you include on your federal tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

You DON'T have to include:

- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

Complete Step 2 for each person in your family. Start with yourself, then add other adults and children. If you have more than 4 people in your family, you'll need to make a copy of the pages and attach them. You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.

NEED HELP WITH YOUR APPLICATION? Contact your county DSS (http://www.ncdhhs.gov/dss/local/) or call us at 1-800-662-7030. Para obtener una copia de este formulario en Español, llame 1-800-662-7030. If you need help in a language other than English, call 1-800-662-7030 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-452-2514.

STEP 2: PERSON 1 (Start with yourself)

Complete Step 2 for yourself, your spouse, your children under age 21 who live with you and anyone you claim on your federal income tax return even if they do not live with you. See page 1 for more information about who to include. If you do not file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix

2. Relationship to you? SELF

3. Date of birth (mm/dd/yyyy)

4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___

We need this if you want health coverage and have a SSN. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting a SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

6. Do you plan to file a federal income tax return NEXT YEAR? *(You can still apply for health insurance even if you don't file a federal income tax return.)*

☐ YES. If yes, please answer questions a–c. ☐ NO. If no, skip to question c.

a. Will you file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

b. Will you claim any dependents on your tax return? ☐ Yes ☐ No

If yes, list name(s) of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____

How are you related to the tax filer? _____

7. Do you need health coverage?
(Even if you have insurance, there might be a program with better coverage or lower costs.)

☐ YES. If yes, answer all the questions below.

☐ NO. If no, SKIP to the income questions on page 4. Leave the rest of this page blank.

8. Are you a U.S. citizen or U.S. National? ☐ Yes ☐ No

9a. If you are not a U.S. citizen or U.S. national, do you have eligible immigration status?

☐ Yes. Fill in your document type and ID number below.

a. Immigration document type _____

b. Document ID number _____

c. Date of entry into the U.S. _____

d. Are you, your spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

9b. If you are not a U.S. citizen or U.S. national, have you had a medical emergency in the past 3 months or do you expect a medical emergency in the next 45/90 days.

☐ Yes ☐ No

Date of emergency _____

Name of provider _____

10. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply)

☐ Mexican ☐ Mexican American ☐ Puerto Rican ☐ Cuban ☐ Other _____

11. Race (OPTIONAL—check all that apply)

☐ White or Caucasian ☐ Black or African American ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander

☐ American Indian or Alaska Native If yes, complete Appendix B ☐ Other _____

12. Are you a resident of North Carolina with the intent of remaining in North Carolina? ☐ Yes ☐ No

13. Are you pregnant? ☐ Yes ☐ No If yes, how many babies are expected during this pregnancy? _____

14. Are you applying for Family Planning Services? ☐ Yes ☐ No If yes, complete Appendix D.

15. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? ☐ Yes ☐ No

16. Were you in Foster Care in North Carolina when you turned age 18? ☐ Yes ☐ No

17a. Are you disabled? ☐ Yes ☐ No

17b. Are you age 65 or older? ☐ Yes ☐ No

17c. Are you blind? ☐ Yes ☐ No

18. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc), live in a medical facility, nursing home and/or need home and community based services (CAP)? ☐ Yes ☐ No

19. Do you want help paying for medical bills from the last 3 months? ☐ Yes ☐ No If yes, complete Appendix E.

NEED HELP WITH YOUR APPLICATION? Contact your county DSS (http://www.ncdhhs.gov/dss/local/) or call us at 1-800-662-7030. Para obtener una copia de este formulario en Español, llame 1-800-662-7030. If you need help in a language other than English, call 1-800-662-7030 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-452-2514.

STEP 2: PERSON 1 (Continue with yourself)

Current Job & Income Information

☐ Employed
If you're currently employed, tell us about your income. Start with question 20.

☐ Self-employed
Skip to question 29.

☐ Not employed
Skip to question 30.

CURRENT JOB 1:

20. Employer name and address

21. Employer phone number
( ) –

22. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

23. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

24. Employer name and address

25.. Employer phone number
( ) –

26. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

27. Average hours worked each WEEK

28. In the past year, did you: ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

29. If self-employed, answer the following questions:

a. Type of work _____

b. How much net income (profits once business expenses are paid) have you received from this self-employment in the past 12 months? _____

30. OTHER INCOME THIS MONTH: Check all that apply, and give the amount and how often you get it.

NOTE: You do not need to tell us about child support, veteran's benefits, or Supplemental Security Income (SSI). If you are requesting Medicaid for the aged, blind, disabled, long term care or in-home services (CAP), complete Appendix F.

☐ None

☐ Unemployment $ _____ How often? _____

☐ Pensions $ _____ How often? _____

☐ Social Security $ _____ How often? _____

☐ Retirement accounts $ _____ How often? _____

☐ Alimony received $ _____ How often? _____

☐ Net farming/fishing $ _____ How often? _____

☐ Net rental/royalty $ _____ How often? _____

☐ Other income $ _____ How often? _____

Type: _____

31. DEDUCTIONS: Check all that apply, and give the amount and how often you get it.

If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 29b).

☐ Alimony paid $ _____ How often? _____

☐ Student loan interest $ _____ How often? _____

☐ Other deductions $ _____ How often? _____

Type: _____

32. YEARLY INCOME: Complete only if your income changes from month to month.

If you do not expect changes to your monthly income, skip to the next person.

Your total income this year	Your total income next year (if you think it will be different)
$	$

THANKS! This is all we need to know about you.

NEED HELP WITH YOUR APPLICATION? Contact your county DSS (http://www.ncdhhs.gov/dss/local/) or call us at 1-800-662-7030. Para obtener una copia de este formulario en Español, llame 1-800-662-7030. If you need help in a language other than English, call 1-800-662-7030 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-452-2514.

STEP 2: PERSON 2

Complete Step 2 for PERSON 2, their spouse, their children under age 21 who live with them and anyone they claim on their federal income tax return even if they do not live with them. See page 1 for more information about who to include. If PERSON 2 does not file a tax return, remember to still add family members who live with them.

1. First name, Middle name, Last name, & Suffix | 2. Relationship to you?

3. Date of birth (mm/dd/yyyy) | 4. Sex ☐ Male ☐ Female | 5. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Only required if applying for assistance

6. Does PERSON 2 plan to file a federal income tax return NEXT YEAR? *(You can still apply for health insurance even if you don't file a federal income tax return.)*

☐ YES. If yes, please answer questions a–c. ☐ NO. If no, skip to question c.

a. Will PERSON 2 file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

b. Will PERSON 2 claim any dependents on their tax return? ☐ Yes ☐ No

If yes, list name(s) of dependents: _____

c. Will PERSON 2 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____

How is PERSON 2 related to the tax filer? _____

7. Does PERSON 2 need health coverage?
(Even if you have insurance, there might be a program with better coverage or lower costs.)

☐ YES. If yes, answer all the questions below. ☐ NO. If no, SKIP to the income questions on page 6. Leave the rest of this page blank.

8. Is PERSON 2 a U.S. citizen or U.S. National? ☐ Yes ☐ No

9a. If PERSON 2 is not a U.S. citizen or U.S. national, do they have eligible immigration status?

☐ Yes. Fill in your document type and ID number below.

a. Immigration document type _____
b. Document ID number _____
c. Date of entry into the U.S. _____
d. Is PERSON 2, their spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

9b. If PERSON 2 is not a U.S. citizen or U.S. national, have they had a medical emergency in the past 3 months or do they expect a medical emergency in the next 45/90 days.

☐ Yes ☐ No

Date of emergency _____
Name of provider _____

10. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply)

☐ Mexican ☐ Mexican American ☐ Puerto Rican ☐ Cuban ☐ Other _____

11. Race (OPTIONAL—check all that apply)

☐ White or Caucasian ☐ Black or African American ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander

☐ American Indian or Alaska Native If yes, complete Appendix B ☐ Other _____

12. Does PERSON 2 live at the same address as you? ☐ Yes ☐ No
If no, list address: _____

13. Is PERSON 2 a *resident of North Carolina with the intent of remaining in North Carolina?* ☐ Yes ☐ No

14. Is PERSON 2 pregnant? ☐ Yes ☐ No If yes, how many babies are expected during this pregnancy? _____

15. Is PERSON 2 applying for Family Planning Services? ☐ Yes ☐ No If yes, complete Appendix D.

16. Does PERSON 2 live with at least one child under the age of 19, and are they the main person taking care of this child? ☐ Yes ☐ No

17. Was PERSON 2 in Foster Care in North Carolina when they turned age 18? ☐ Yes ☐ No

18a. Is PERSON 2 disabled? ☐ Yes ☐ No | 18b. Is PERSON 2 age 65 or older? ☐ Yes ☐ No | 18c. Is PERSON 2 blind? ☐ Yes ☐ No

19. Does PERSON 2 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc), live in a medical facility, nursing home and/or need home and community based services (CAP)? ☐ Yes ☐ No

20. Does PERSON 2 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No If yes, complete Appendix E.

Please answer the following questions if PERSON 2 is age 22 or younger:

21. Did PERSON 2 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No

a. If yes, end date: _____ b. Reason the insurance ended: _____

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STEP 2: PERSON 2

Current Job & Income Information

☐ Employed
If you're currently employed, tell us about your income. Start with question 22.

☐ Self-employed
Skip to question 31.

☐ Not employed
Skip to question 32.

CURRENT JOB 1:

22. Employer name and address

23. Employer phone number
( ) –

24. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

25. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

26. Employer name and address

27. Employer phone number
( ) –

28. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

29. Average hours worked each WEEK

30. In the past year, did PERSON 2: ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

31. If self-employed, answer the following questions:

a. Type of work

_____

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

$ _____

32. OTHER INCOME THIS MONTH: Check all that apply, and give the amount and how often you get it.

NOTE: PERSON 2 does not need to tell us about child support, veteran's benefits, or Supplemental Security Income (SSI). If PERSON 2 is requesting Medicaid for the aged, blind, disabled, long term care or in-home services (CAP), complete Appendix F.

☐ None

☐ Unemployment $ _____ How often? _____

☐ Pensions $ _____ How often? _____

☐ Social Security $ _____ How often? _____

☐ Retirement accounts $ _____ How often? _____

☐ Alimony received $ _____ How often? _____

☐ Net farming/fishing $ _____ How often? _____

☐ Net rental/royalty $ _____ How often? _____

☐ Other income $ _____ How often? _____

Type: _____

33. DEDUCTIONS: Check all that apply, and give the amount and how often you get it.

If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 29b).

☐ Alimony paid $ _____ How often? _____

☐ Student loan interest $ _____ How often? _____

☐ Other deductions $ _____ How often? _____

Type: _____

34. YEARLY INCOME: Complete only if PERSON 2's income changes from month to month.

If you don't expect changes to PERSON 2's monthly income, add another person or skip to the next section.

PERSON 2's total income this year	PERSON 2's total income next year (if you think it will be different)
$	$

THANKS! This is all we need to know about PERSON 2.

NEED HELP WITH YOUR APPLICATION? Contact your county DSS (http://www.ncdhhs.gov/dss/local/) or call us at 1-800-662-7030. Para obtener una copia de este formulario en Español, llame 1-800-662-7030. If you need help in a language other than English, call 1-800-662-7030 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-452-2514.

STEP 2: PERSON 3

Complete Step 2 for PERSON 3, their spouse, their children under age 21 who live with them and anyone they claim on their federal income tax return even if they do not live with them. See page 1 for more information about who to include. If PERSON 3 does not file a tax return, remember to still add family members who live with them.

1. First name, Middle name, Last name, & Suffix | 2. Relationship to you?

3. Date of birth (mm/dd/yyyy) | 4. Sex ☐ Male ☐ Female | 5. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Only required if applying for assistance

6. Does PERSON 3 plan to file a federal income tax return NEXT YEAR? *(You can still apply for health insurance even if you don't file a federal income tax return.)*

☐ YES. If yes, please answer questions a–c. ☐ NO. If no, skip to question c.

a. Will PERSON 3 file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

b. Will PERSON 3 claim any dependents on their tax return? ☐ Yes ☐ No

If yes, list name(s) of dependents: _____

c. Will PERSON 3 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____

How is PERSON 3 related to the tax filer? _____

7. Does PERSON 3 need health coverage?
(Even if you have insurance, there might be a program with better coverage or lower costs.)

☐ YES. If yes, answer all the questions below. ☐ NO. If no, SKIP to the income questions on page 8. Leave the rest of this page blank.

8. Is PERSON 3 a U.S. citizen or U.S. National? ☐ Yes ☐ No

9a. If PERSON 3 is not a U.S. citizen or U.S. national, do they have eligible immigration status?

☐ Yes. Fill in your document type and ID number below.

a. Immigration document type _____

b. Document ID number _____

c. Date of entry into the U.S. _____

d. Is PERSON 3, their spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

9b. If PERSON 3 is not a U.S. citizen or U.S. national, have they had a medical emergency in the past 3 months or do they expect a medical emergency in the next 45/90 days.

☐ Yes ☐ No

Date of emergency _____

Name of provider _____

10. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply)

☐ Mexican ☐ Mexican American ☐ Puerto Rican ☐ Cuban ☐ Other _____

11. Race (OPTIONAL—check all that apply)

☐ White or Caucasian ☐ Black or African American ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander

☐ American Indian or Alaska Native If yes, complete Appendix B ☐ Other _____

12. Does PERSON 3 live at the same address as you? ☐ Yes ☐ No
If no, list address: _____

13. Is PERSON 3 *a resident of North Carolina with the intent of remaining in North Carolina?* ☐ Yes ☐ No

14. Is PERSON 3 pregnant? ☐ Yes ☐ No If yes, how many babies are expected during this pregnancy? _____

15. Is PERSON 3 applying for Family Planning Services? ☐ Yes ☐ No If yes, complete Appendix D.

16. Does PERSON 3 live with at least one child under the age of 19, and are they the main person taking care of this child? ☐ Yes ☐ No

17. Was PERSON 3 in Foster Care in North Carolina when they turned age 18? ☐ Yes ☐ No

18a. Is PERSON 3 disabled? ☐ Yes ☐ No | 18b. Is PERSON 3 age 65 or older? ☐ Yes ☐ No | 18c. Is PERSON 3 blind? ☐ Yes ☐ No

19. Does PERSON 3 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc), live in a medical facility, nursing home and/or need home and community based services (CAP) ? ☐ Yes ☐ No

20. Does PERSON 3 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No If yes, complete Appendix E.

Please answer the following questions if PERSON 3 is age 22 or younger:

21. Did PERSON 3 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No

a. If yes, end date: _____ b. Reason the insurance ended: _____

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STEP 2: PERSON 3

Current Job & Income Information

☐ Employed
If you're currently employed, tell us about your income. Start with question 22.

☐ Self-employed
Skip to question 31.

☐ Not employed
Skip to question 32.

CURRENT JOB 1:

22. Employer name and address

23. Employer phone number
( ) –

24. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

25. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

26. Employer name and address

27. Employer phone number
( ) –

28. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

29. Average hours worked each WEEK

30. In the past year, did PERSON 3: ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

31. If self-employed, answer the following questions:

a. Type of work

_____

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

$ _____

32. OTHER INCOME THIS MONTH: Check all that apply, and give the amount and how often you get it.

NOTE: PERSON 3 does not need to tell us about child support, veteran's benefits, or Supplemental Security Income (SSI). If PERSON 3 is requesting Medicaid for the aged, blind, disabled, long term care or in-home services (CAP), complete Appendix F.

☐ None

☐ Unemployment $ _____ How often? _____

☐ Pensions $ _____ How often? _____

☐ Social Security $ _____ How often? _____

☐ Retirement accounts $ _____ How often? _____

☐ Alimony received $ _____ How often? _____

☐ Net farming/fishing $ _____ How often? _____

☐ Net rental/royalty $ _____ How often? _____

☐ Other income $ _____ How often? _____

Type: _____

33. DEDUCTIONS: Check all that apply, and give the amount and how often you get it.

If PERSON 3 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 29b).

☐ Alimony paid $ _____ How often? _____

☐ Student loan interest $ _____ How often? _____

☐ Other deductions $ _____ How often? _____

Type: _____

34. YEARLY INCOME: Complete only if PERSON 3's income changes from month to month.

If you don't expect changes to PERSON 3's monthly income, add another person or skip to the next section.

THANKS! This is all we need to know about PERSON 3.

NEED HELP WITH YOUR APPLICATION? Contact your county DSS (http://www.ncdhhs.gov/dss/local/) or call us at 1-800-662-7030. Para obtener una copia de este formulario en Español, llame 1-800-662-7030. If you need help in a language other than English, call 1-800-662-7030 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-452-2514.

STEP 2: PERSON 4

Complete Step 2 for PERSON 4, their spouse, their children under age 21 who live with them and anyone they claim on their federal income tax return even if they do not live with them. See page 1 for more information about who to include. If PERSON 4 does not file a tax return, remember to still add family members who live with them.

1. First name, Middle name, Last name, & Suffix

2. Relationship to you?

3. Date of birth (mm/dd/yyyy)

4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Only required if applying for assistance

6. Does PERSON 4 plan to file a federal income tax return NEXT YEAR? *(You can still apply for health insurance even if you don't file a federal income tax return.)*

☐ YES. If yes, please answer questions a–c. ☐ NO. If no, skip to question c.

a. Will PERSON 4 file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

b. Will PERSON 4 claim any dependents on their tax return? ☐ Yes ☐ No

If yes, list name(s) of dependents: _____

c. Will PERSON 4 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____

How is PERSON 4 related to the tax filer? _____

7. Does PERSON 4 need health coverage?
(Even if you have insurance, there might be a program with better coverage or lower costs.)

☐ YES. If yes, answer all the questions below.

☐ NO. If no, SKIP to the income questions on page 10. Leave the rest of this page blank.

8. Is PERSON 4 a U.S. citizen or U.S. National? ☐ Yes ☐ No

9a. If PERSON 4 is not a U.S. citizen or U.S. national, do they have eligible immigration status?

☐ Yes. Fill in your document type and ID number below.

a. Immigration document type _____

b. Document ID number _____

c. Date of entry into the U.S. _____

d. Is PERSON 4, their spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

9b. If PERSON 4 is not a U.S. citizen or U.S. national, have they had a medical emergency in the past 3 months or do they expect a medical emergency in the next 45/90 days.

☐ Yes ☐ No

Date of emergency _____

Name of provider _____

10. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply)

☐ Mexican ☐ Mexican American ☐ Puerto Rican ☐ Cuban ☐ Other _____

11. Race (OPTIONAL—check all that apply)

☐ White or Caucasian ☐ Black or African American ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander

☐ American Indian or Alaska Native If yes, complete Appendix B ☐ Other _____

12. Does PERSON 4 live at the same address as you? ☐ Yes ☐ No
If no, list address: _____

13. Is PERSON 4 *a resident of North Carolina with the intent of remaining in North Carolina?* ☐ Yes ☐ No

14. Is PERSON 4 pregnant? ☐ Yes ☐ No If yes, how many babies are expected during this pregnancy? _____

15. Is PERSON 4 applying for Family Planning Services? ☐ Yes ☐ No If yes, complete Appendix D.

16. Does PERSON 4 live with at least one child under the age of 19, and are they the main person taking care of this child? ☐ Yes ☐ No

17. Was PERSON 4 in Foster Care in North Carolina when they turned age 18? ☐ Yes ☐ No

18a. Is PERSON 4 disabled? ☐ Yes ☐ No

18b. Is PERSON 4 age 65 or older? ☐ Yes ☐ No

18c. Is PERSON 4 blind? ☐ Yes ☐ No

19. Does PERSON 4 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc), live in a medical facility, nursing home and/or need home and community based services (CAP) ? ☐ Yes ☐ No

20. Does PERSON 4 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No If yes, complete Appendix E.

Please answer the following questions if PERSON 4 is age 22 or younger:

21. Did PERSON 4 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No

a. If yes, end date: _____ b. Reason the insurance ended: _____

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STEP 2: PERSON 4

Current Job & Income Information

☐ Employed
If you're currently employed, tell us about your income. Start with question 22.

☐ Self-employed
Skip to question 31.

☐ Not employed
Skip to question 32.

CURRENT JOB 1:

22. Employer name and address

23. Employer phone number
( ) –

24. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

25. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

26. Employer name and address

27. Employer phone number
( ) –

28. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

29. Average hours worked each WEEK

30. In the past year, did PERSON 4: ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

31. If self-employed, answer the following questions:

a. Type of work

_____

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

$ _____

32. OTHER INCOME THIS MONTH: Check all that apply, and give the amount and how often you get it.

NOTE: PERSON 4 does not need to tell us about child support, veteran's benefits, or Supplemental Security Income (SSI). If PERSON 4 is requesting Medicaid for the aged, blind, disabled, long term care or in-home services (CAP), complete Appendix F.

☐ None

☐ Unemployment $ _____ How often? _____

☐ Pensions $ _____ How often? _____

☐ Social Security $ _____ How often? _____

☐ Retirement accounts $ _____ How often? _____

☐ Alimony received $ _____ How often? _____

☐ Net farming/fishing $ _____ How often? _____

☐ Net rental/royalty $ _____ How often? _____

☐ Other income $ _____ How often? _____

Type: _____

33. DEDUCTIONS: Check all that apply, and give the amount and how often you get it.

If PERSON 4 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 29b).

☐ Alimony paid $ _____ How often? _____

☐ Student loan interest $ _____ How often? _____

☐ Other deductions $ _____ How often? _____

Type: _____

34. YEARLY INCOME: Complete only if PERSON 4's income changes from month to month.

If you don't expect changes to PERSON 4's monthly income, add another person or skip to the next section.

THANKS! This is all we need to know about PERSON 4.

If you have more people to include, make a copy of Step 2: PERSON 2 (pages 5 and 6) and complete for each additional person.

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STEP 3 American Indian or Alaska Native (AI/AN) family member(s)

1. Are you or is anyone you are requesting assistance for an American Indian or Alaska Native?

☐ If yes, complete Appendix B.

☐ If no, complete Step 4.

STEP 4 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1. Is anyone enrolled in health coverage now from the following?
   ☐ YES. ☐ NO.

   If yes, check the type of coverage and write the person(s)' name(s) next to the coverage they have.

☐ Medicaid _____

☐ North Carolina Health Choice /NCHC
_____

☐ Medicare _____

☐ TRICARE (Don't check if you have direct care or Line of Duty)
_____

☐ VA health care programs _____

☐ Peace Corps _____

☐ Employer insurance _____
Name of health insurance: _____
Policy number: _____
Type of coverage: _____
Is this COBRA coverage? ☐ Yes ☐ No
Is this a retiree health plan? ☐ Yes ☐ No

☐ Other
Name of health insurance: _____
Policy number: _____
Type of coverage: _____

2. Is anyone listed on this application offered health coverage from a job? Check yes even if the coverage is from someone else's job, such as a parent or spouse.
   ☐ YES. If yes, you'll need to complete and include Appendix A.
   Is this a state employee benefit plan? ☐ Yes ☐ No
   ☐ NO. If no, continue to Step 5.

3. Have you or anyone requesting assistance been in an accident in the past 12 months? ☐ YES. ☐ NO.

4. Does any child on this application have a parent living outside the home? ☐ YES. ☐ NO.

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STEP 5 Read & sign this application.

- I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and or untrue information.
- I know that I must tell the Marketplace and Medicaid/NCHC if anything on this application changes. I can visit www.ncdhhs.gov/dss/local/ or call 1-800-662-7030 to report any changes. I understand that a change in my information must be reported within 10 calendar days and could affect my eligibility.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting http://www.ncdhhs.gov/dma/epsdt/DueProcessRights050311.pdf.
- I know that any information given to the Marketplace or Medicaid/NCHC will be protected and kept confidential.
- I know that the information on this application is needed to determine eligibility for help paying for health coverage and/or Medicaid/NCHC and will be checked against electronic databases, Internal Revenue (IRS), Social Security, Department of Homeland Security, consumer reporting agencies, financial institutions and/or other government agencies.

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Marketplace to use income data, including information from tax returns. The Marketplace will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next:

☐ 5 years (the maximum number of years allowed), ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year

☐ Don't use information from tax returns to renew my coverage.

Medicaid/NCHC Eligibility

- I understand that the date of the Medicaid/NCHC applicatioin is the date that it is received by the County Department of Social Services.
- I understand that Medicaid coverage can be requested for any medical bills incurred up to three months prior to the month of application.
- I understand that if I enroll in Medicaid /NCHC , I am giving the Medicaid/NCHC agency rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medicaid/NCHC agency rights to pursue and get medical support from a spouse or parent.
- I understand that may be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.
- I understand that if I found eligible for full Medicaid benefits, I have the right to assistnce with medical transportation.
- I understand that Federal and State laws require the Division of Medial Assistance (DMA) to file a claim against the estate of certain individuals to recover the amount paid by the Medicaid program during the time the indidvidual received assistance with certain medical services.
- I understand that any resources that are transferred out of the name of anyone requesting Medicaid assistance without receiving fair market value could result ineligibility for assistance with nursing home cost of care and/or in-home care.
- I understand that North Carolina must be named beneficiary for annunities purchased after November 1, 2007.

My right to appeal

If I think the Health Insurance Marketplace or Medicaid/NCHC has made a mistake, I can appeal its decision. To appeal means to tell someone at the Health Insurance Marketplace or Medicaid/NCHC that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting the the Department of Social Services or by calling 1-800-662-7030. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here, as long as you have provided the information required in Appendix C.

Signature	Date (mm/dd/yyyy)

STEP 6 Completed application.

Take or mail your signed application to your local County Department of Social Services (http://www.ncdhhs.gov/dss/local/).

If you want to register to vote, you can complete a voter registration form at http://www.ncsbe.gov/.

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