Application for Health Coverage & Help Paying Costs (Short Form)

THINGS TO KNOW

Use this application to see what coverage 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

Who can use this application?

Single adults who:

- Aren't offered health coverage from their employer
- Don't have any dependents and can't be claimed as a dependent on someone else's tax return

NOTE: If any of the following apply, you need to fill out a different form to make sure you get the most benefits possible:

- You're married or have dependent children.
- You were in the foster care system, and you're under age 26.
- You have items that can be deducted from your income. If your only deduction is student loan interest, you can use this form.
- You're American Indian or Alaska Native.

Apply faster online

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

What you may need to apply

- Your Social Security number (or document number if you're a legal immigrant)
- Employer and income information (for example, from paystubs, W-2 forms, or wage and tax statements)
- 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. 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)?

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

18. Sex
☐ Male ☐ Female

19. 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 if you're eligible for help with health coverage costs. If you need help getting a SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

20. Are you a U.S. citizen or U.S. national? Yes ☐ No

21(a). 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 a veteran or an active-duty member of the U.S. military?
☐ Yes ☐ No

21(b). If you are not a U.S. citizen or U.S. national, have you had a medical emergency in the last three months or do you expect a medical emergency within the next 45/90 days?
☐ Yes ☐ No
Date of emergency _____
Name of provider _____

22. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)
☐ Mexican ☐ Mexican American ☐ Puerto Rican ☐ Cuban ☐ Other _____

23. 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

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

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

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

27a. Are you disabled? ☐ Yes ☐ No | 27b. Are you age 65 or older? ☐ Yes ☐ No | 27c. Are you blind? ☐ Yes ☐ No

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

29. Do you need help paying medical bills for services received during the last three calendar months? ☐ Yes ☐ No If yes, complete Appendix E.

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STEP 2 Current job & income information

☐ Employed – If you're currently employed, tell us about your income. Start with question 1.

☐ Self-employed – Skip to question 10. ☐ Not Employed – Skip to question 11.

CURRENT JOB 1:

1. Employer name and address	2. Employer phone number	3. Average hours worked each WEEK
	( ) –	

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

$ _____

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

5. Employer name and address	6. Employer phone number	7. Average hours worked each WEEK
	( ) –	

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

$ _____

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

10. 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 then past 12 months? _____

11. 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, veterans 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: _____

12. Do you pay student loan interest (not the amount of the loan) that can be deducted on a federal income tax return?

☐ YES. If yes, how much $ _____ How often? _____ ☐ NO.

13. YEARLY INCOME: Complete only if your income changes from month to month. If you don't expect changes to your monthly income, skip to step 3.

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

STEP 3 Your health coverage

1. Are you enrolled in health coverage now from any of the following?

☐ YES. If yes, check which coverage you have. ☐ NO.

☐ Medicaid
☐ North Carolina Helath Choice
☐ Medicare
☐ TRICARE (don't check if you have Direct Care or Line of Duty)
☐ Peace Corps
☐ VA Healthcare programs
☐ Other

Name of health insurance _____

Policy number _____

Type of coverage _____

2. Have you been in an accident in the past 12 months?

☐ YES. ☐ NO.

? 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 4 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 intentionally provide false or untrue information.
- I know that I must tell the Health Insurance Marketplace or Medicaid/NCHC if anything on this application changes. I can visit (http://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 day 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 Health Insurance Marketplace or Medicaid/NCHC will be protected and kept confidential.
- I confirm that I'm not incarcerated (detained or jailed).
- I confirm that next year I expect to file a federal income tax return, won't claim dependents on that return, and can't be claimed as a dependent on anyone else's federal income tax return.
- I confirm that I'm not offered health coverage from an employer.
- 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 information in our electronic databases, Internal Revenue Service (IRS), Social Security, Department of Homeland Security, consumer reporting agencies, private financial institutions, and/or any 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 or

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

Medicaid/NC Health Choice Eligibililty

- I understand that the date of the Medicaid application 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'm giving the Medicaid/NCHC agency my rights to pursue and get any money from other health insurance, legal settlements, or other third parties.
- I understand that if I am found eligible for full Medicaid benefits, I have the right to assistance with medical transportation.
- I understand that Federal/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 my 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 Marketplace or Medicaid/NCHC has made a mistake, I can appeal its decision. To appeal means to tell someone at the 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 Marketplace or Medicaid/NCHC at 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 5 Completed Application.

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

What happens next?
We'll follow up with you within 1–2 weeks. You'll get instructions on how to take the next steps to get your health coverage. If you don't hear from us within 2 weeks, visit your County DSS (http://www.ncdhhs.gov/dss/local/) or call 1-800-662-7030.

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