

Notice of Incomplete Application

Dear _____:

Recently you sent an application for health care coverage to _____ County Department of Social Services. We are not able to accept your application for the reasons shown below. Please complete these items before sending the application back in the enclosed envelope.

It is important that you return your application as soon as possible.

If you are found eligible for **Medicaid**, your benefits cannot begin earlier than three calendar months before the month we receive a complete application.

If you are found eligible for **NC Health Choice**, your benefits cannot begin until the month we receive a complete application.

If you have questions, please feel free to contact us at the telephone number shown below. Thank you.

Your application cannot be accepted because:

- _____ You did not sign the application form.
- _____ We need the full name/date of birth/sex of person (s) applying
- _____ We need the full name/date of birth/sex of child(ren) under age 19 for whom health care assistance is requested
- _____ We need your complete mailing address
- _____ We cannot read your application. Please come to our office for assistance or ask the health department or a friend to help you complete the enclosed application form.

We will also need the following to process your application:

Sincerely,

Caseworker Signature & Date Signed

Telephone Number