North Carolina Division of Aging and Adult Services
STATE/COUNTY SPECIAL ASSISTANCE FOR ADULTS WORKBOOK
FOR 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?

2. County

_____

Verification of state and county residence:

III. INCOME

TYPE	____/____ Mo. Yr.	____/____ Mo. Yr.
A. SSI	$	$
B. Earned	$	$
C. Unearned	$	$
D. TOTAL (A+B+C)	$ 0.00	$ 0.00
E. For General $20 Exclusion, see Verification Block*	-	-
F. TOTAL COUNTABLE (D. - E.)	$ 0.00	$ 0.00

Verification

☐ SOLQ Date checked _____
(File a copy of SOLQ in record).

*Apply the General $20 Exclusion for A/R's who receive SSI *only* and A/R's who receive VA Compensation Payments paid to a Veteran's spouse, child, or widow(er).

IV. REGULAR SA PAYMENT CALCULATION

FL-2/MR-2 dated _____

_____semi-ambulatory_____ ambulatory

	____/____ Mo. Yr.	____/____ Mo. Yr.
A. Rate	$	$
B. Personal Needs Allowance	$	$
C. Maintenance Amount (A + B)	$	$
D. Total Countable Income (III.F.)	- 0.00	- 0.00
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

V. PARTIAL SA PAYMENT

Use this budget when the A/R enters the ACH and meets the eligibility criteria *after* the first day of the month and stays the entire 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 A. above	÷
F. Per Diem rate (D. ÷ E.)	=
G. Number on C. above	X
H. Cost of care (F. x G.)	=
I. Personal needs allowance	+
J. Total needs (H. + I.)	= 0.00
K. **Partial Payment** (Round amount on J. to the nearest dollar)	$

VI. OPEN/SHUT SA PAYMENT

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.

A. Date of Discharge	
B. Date of Entry	-
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.xG.)	$
I. Personal Needs Allowance	+
J. Open/Shut Payment (not-rounded) (H.+I.)	$ 0.00
K. **Actual SA Open/Shut Payment** (Rounded)	**$**

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.

A. SA Rate	$
B. Total Countable Income	-
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.)	$
H. Personal Needs Allowance	$
I. Open/Shut Payment (not-rounded) (G. + H.)	$ 0.00
J. **Actual SA Open/Shut Payment** (Rounded)	$

VII. HEALTH INSURANCE/MEDICARE

A. Medicare A? ☐ Yes ☐ No Effective: _____

B. Medicare B? ☐ Yes ☐ No Effective: _____

C. Health Insurance? ☐ Yes ☐ No

Verification and date:

Insurance Company	Policy No.	Type of Coverage	Effective Date

D. DMA-2041 completed? ☐ Yes Date:_____ ☐ N/A

VIII. MISCELLANEOUS

	Explained	*Pamphlet Given
FRAUD		
MEDICAID		

	Explained	*Pamphlet Given
APPEALS		
SERVICES		

WORKSPACE and REMARKS:
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 the right to a hearing if:

- Your assistance was terminated and you believe the decision is not correct.
- You believe your assistance is incorrect based on the county's interpretation of State regulations.
- You request for a review of your circumstances was delayed beyond 30 days or 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 (SEC), 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 your income maintenance caseworker 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 address.

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**