

ELIGIBILITY INFORMATION SYSTEM

APPLICATION FOR WORK FIRST FAMILY ASSISTANCE, MA, REFUGEE, AND SA

APPLICATION TYPE	
(X ONE)	
1 <input type="checkbox"/> NEW APPLICATION 2 <input type="checkbox"/> REAPPLICATION 3 <input type="checkbox"/> ADMINISTRATIVE ADD INDIVIDUAL(S) TO CASE	4 <input type="checkbox"/> NEW MA APPLICATION WITH RETROACTIVE BENEFITS 5 <input type="checkbox"/> MA REAPPLICATION WITH RETROACTIVE BENEFITS 6 <input type="checkbox"/> ADD AN INDIVIDUAL 7 <input type="checkbox"/> AUTOMATIC NEWBORN

FORM I.D.	WORKER

CO.NO.	CO.CASE NUMBER	DIST.NO.

_____ COUNTY

ADDRESS LINE 1

ADDRESS LINE 2

CITY _____ STATE _____ ZIP CODE _____

Food Stamps:			
I would like to apply for Food Stamps.	<input type="checkbox"/> Yes	I currently receive Food Stamps.	<input type="checkbox"/> Yes
	<input type="checkbox"/> No		<input type="checkbox"/> No
Food Stamp No.: _____			

AID Pro-Cat	BD (Y/N)	Trans. (Y/N)	DIS/DET y/n	ong	retro	CASE I.D.			
<input type="checkbox"/>									
<input type="checkbox"/>	Health Choice (Y/N)	C/H Inclu (Y/N)	HOW APP. RECEIVED	Total # on this App.					

LINE NO.	FIRST	MI	CASE INDIVIDUALS LAST	SUFFIX	DATE OF BIRTH MONTH DAY YEAR	RACE	SEX	SOCIAL SECURITY NO. required for applicants only
01	To be included in case? (Answer for Types 1, 2, 4, 5 and 7) <input type="checkbox"/> YES <input type="checkbox"/> NO				Is this the Casehead/Payee? (Answer for Types 3 and 6) <input type="checkbox"/> YES <input type="checkbox"/> NO			
	INDIVIDUAL I.D.			CD				
02								
	INDIVIDUAL I.D.			CD				
03								
	INDIVIDUAL I.D.			CD				
04								
	INDIVIDUAL I.D.			CD				
05								
	INDIVIDUAL I.D.			CD				
06								
	INDIVIDUAL I.D.			CD	APPLICATION DATE Month Day Year	I have read the statements on the back of this form and understand and agree to them all. APPLICANT'S/REPRESENTATIVE'S SIGNATURE		

DISPOSITION				DISPOSITION				JOBS/WORK REQ. SAVINGS REASON
PROSP. DISPO.	TYPE	DISPOSITION DATE	REASON	RETRO. DISPO.	TYPE	DISPOSITION DATE	REASON	
	D <input type="checkbox"/> Denial W <input type="checkbox"/> Withdrawal	Month Day Year			D <input type="checkbox"/> Denial W <input type="checkbox"/> Withdrawal	Month Day Year		<input type="checkbox"/>

WITNESS'S SIGNATURE	CASEWORKER'S SIGNATURE:(WITNESS)	COUNTY DIRECTOR'S SIGNATURE & DATE	White Copy - Data Entry. Canary Copy - Files. Goldenrod Copy- Food Stamp Office DSS 8124 (REV.02/08)
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What are my Rights?

You have the right to:

- Apply for help and if denied, reapply at any time.
- Get help if you are eligible.
- Have any person, not to exceed three, participate in the interview for determination of eligibility.
- Have any information given to the agency kept in confidence.
- Withdraw from any assistance you get at any time.
- Apply to have another person added to your case.
- Get a written notice of any information we need to complete your application.
- Be protected by federal law against discrimination on the basis of race, color, national origin, sex, religion, age, disability, or political beliefs.
- Get a written notice telling you why your application is denied.
- Apply for retroactive Medicaid for up to 3 months prior to your date of application.
- To have your Medicaid considered under all categories
- Not have a permanent address as long as you plan to stay in North Carolina.
- Ask for a hearing from the department of social services and the Division of Social Services if:
 - You are denied the right to apply or reapply for assistance on the same day you or your representative went to the county department of social services.
 - You were not informed, verbally or in writing, of your right to apply without delay.
 - Your application was not acted upon timely
 - Your application was denied, and you think the decision was wrong.
 - You believe your assistance is wrong based on the county's interpretation of State regulations.
 - Your assistance is changed or stopped.
 - Your request for a review of your circumstances was delayed longer than 30 days or rejected.
- As a Family Assistance applicant, you have the right to:
 - Use your check however you want, as long as it is in the best interest of your family. If you do not use your check correctly, another person may be appointed to get your check and use it for you and your family.

What are my Responsibilities?

You must:

- Provide the county department of social services, as well as state and federal officials, upon request, the information necessary to determine eligibility.
- Report to the county department of social services any change in your situation within 10 calendar days of knowing of the change (5 calendar days for Special Assistance).
- Cooperate with state and federal Quality Control staff if your case is investigated.
- Report to the county department of social services the receipt of assistance which you know is incorrect.

Certify by signing this application that all information that you have provided, concerning your situation and/or that of all the persons for whom you are making an application, is a true and complete statement of facts according to your best knowledge and belief.

If you receive cash assistance, you must report immediately to the county department the receipt of a check you know is erroneous, such as the wrong amount.

To 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.

RESIDENCE

I hereby certify that I and all of the persons for whom I am making an application are living in North Carolina with the intention of remaining.

MEDICAL RECORDS

I understand that my medical and financial records must be made available to the agency and the state by any provider for whom I have received **Medical Assistance Program** services. I hereby agree to the release of those records by those providers when requested by the agency and the state.

ASSIGNMENT OF RIGHTS

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 on this application from any insurance company 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 I or anyone listed on this application is involved in any accident.

If I receive Family Assistance cash assistance, all financial support (money) paid or owed due to court order for me or anyone listed on this application must be sent to the North Carolina Department of Health and Human Services to repay current and past Family Assistance payments we receive.

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 cash assistance check.

I understand that this assignment of rights continues as long as I or anyone listed on this application receives Medicaid or any cash assistance program and is based on 42 CFR 433.147-148.

SOCIAL SECURITY NUMBERS

I understand that I must furnish all social security numbers used by all individuals applying for assistance to determine eligibility for assistance. (Non-applicant household members are not required to provide a social security number, immigrant or citizenship status). I also understand these social security numbers will be used in matching information with the Social Security Administration (SSA), Internal Revenue Service (IRS), Employment Security Commission (ESC), Department of Transportation (DOT), out of state welfare and ESC agencies and any other agency when applicable. If I do not want these social security numbers used in the matches, I understand that I have the right to withdraw my application or have my assistance terminated.