STATE OF NORTH CAROLINA
DIVISION OF SOCIAL SERVICES
STATE ABORTION FUND ELIGIBILITY CERTIFICATION

Date DSS-6847 Signed: ____/____/____ Client Name:_____
Mo Day Yr First MI Last

Social Security #: _____SIS ID#:_____ DOB: ___/___/___ County #: _____

Social Worker: _____County Name:_____

INSTRUCTIONS: Complete Sections I and II for **all** clients. In order to be eligible for the State Abortion Fund, a client must be a resident of North Carolina, be eligible for Health Support Services, have an income below the federal poverty level as revised annually, and **not** be eligible for Medicaid.

I. BASIC ELIGIBILITY CRITERIA: (CHECK ONE)

_____ A. Eligible on the Basis of Income
_____ B. Income Eligible Minor (under 18 years of age)

II. SPECIFIC ELIGIBILITY CRITERIA: (CHECK ONE)

1. _____ Victim of rape or incest as documented in case record
2. _____ Client's life would be endangered if pregnancy continued, based on one physicians's written statement that is filed in case record. Written statement was provided by at least one physician licensed to practice medicine in North Carolina.

WORKER SIGNATURE: _____ DATE: _____