

**CHILDREN'S HEALTH INSURANCE PROGRAM
(County Letterhead)**

DATE _____

CASE HEAD _____

ADDRESS _____

APPLICATION NUMBER _____

We have determined that the child(ren) for whom you filed an application for medical care is eligible for NC Health Choice. Your family income is above 150% of the federal poverty level, therefore State law requires payment of an annual enrollment fee to obtain NC Health Choice Coverage. The enrollment fee is \$ _____ and must be paid by _____, or the application will be denied. If we must deny the application because of failure to pay the enrollment fee, you will have to file a new application to obtain health care coverage.

Mail or bring this letter with your enrollment fee to _____
_____.

Your payment must be paid in full by: _____ cash, _____ money order, _____ certified check, or _____ personal check. Partial payments will not be accepted.

Income Maintenance Caseworker

Telephone Number _____

Official Use Only

Date of Payment _____

Amount Paid _____

Signature of Collector

Copy to: Applicant
County File
Collector