

**NORTH CAROLINA DIVISION OF SERVICES FOR THE BLIND
PROGRAMS AND FACILITIES SECTION
SPECIAL ASSISTANCE FOR THE BLIND PROGRAM**

Section: Appendix C
Title: Forms and Notices
Revision History: Revised 08/02

North Carolina
Department of Health and Human Services
Division of Services for the Blind
309 Ashe Avenue
2601 Mail Service Center
Raleigh, NC 27699-2601

**DETERMINATION OF ELIGIBILITY
FOR
SPECIAL ASSISTANCE FOR THE BLIND**

<input type="checkbox"/> Application	<input type="checkbox"/> Reapplication	<input type="checkbox"/> Domiciliary Care*
<input type="checkbox"/> Review	<input type="checkbox"/> Individual	

NAME: _____ COUNTY: _____

WORKER'S NAME: _____

1. Full name: _____
(First) (Middle/Maiden) (Last)

2. Address: _____
(Street No./PO Box/R. Rt.) (City)

(State) (Zip Code) (County)

(Phone No.) (Authorized Representative's Name)

Mailing Address: _____
(If not the same as above)

3. U.S. Citizen Yes No If not, Alien Status: _____

4. If you moved to North Carolina less than six (6) months ago, where did you move from:

Address City State

Date Moved

Birthdate: _____ Race: _____ Sex: F
(Month) (Day) (Year) M

Marital Status: _____

5. Do you live in a licensed adult care home or specialized community residential center for children? Yes () No () *Please attach a current FL-2 or MR-2 for adult care home. If Yes, give name and address of home: _____

Phone No.: _____ Date Entered Home: _____

Does anyone else in your household receive a public assistance check or other form of financial aid? Yes() No()

If Yes, give name of person, type, and amount of assistance.

2. Are you receiving Rehabilitation Training? Yes() No()

3. Are you employed? Yes() No()

If Yes, give the following information:

Place of employment _____

Name of job _____

What is your salary? _____

4. Is your husband/wife employed? Yes() No()

Is your mother/father employed? Yes() No() **(Complete only if applicant is a minor, under 18 years of age.)**

If Yes, give the following information:

Place of employment _____

Name of job _____

(a) If employed, give amount of pay before deductions. How often paid? Weekly (), Monthly (), or Other (). If Other, explain _____

(b) Show all compulsory deductions.

1. Federal Income Tax deductions

2. State Income Tax deductions

3. Social Security & Medicare deductions . . .

4. List other compulsory deductions and costs:

Applicant/ Recipient	Spouse or Parent
\$	\$
\$	\$

5. Do you, your husband/ wife, or parent(s) receive income from any of the following sources? Check Yes or No by each item. If Yes is checked, show the amount.

A. If you are self-employed, what is your monthly income, less your business expenses.

B. Social Security Yes () No()

Amount of monthly check

Applicant/ Recipient	Spouse or Parent
\$	\$
\$	\$

- C. Supplemental Security Income Yes() No()
Amount of monthly check
- D. Railroad Retirement Yes() No()
Amount of monthly check
- E. Veteran's Pension or Veteran's Pension for
Widows Yes() No()
Amount of monthly check
- F. Workman's Compensation Yes() No()
Amount of monthly check
- G. Pension Yes() No() _____
(Name)
Amount of monthly check
- H. Are you receiving any contributions?
Yes() No()
If Yes, state type _____
Monthly amount
- I. Other income such as (but not limited to) money, checks,
support/alimony payments, income from trusts, interest,
dividends, unemployment, disability insurance, sick pay,
annuities, etc. Yes() No()
If Yes, state sources. _____
How often is income received _____
Amount of income
- J. Farm Income and Expenses
(Show yearly amount by each item.)
 - (1) Soil Bank Yes() No()
 - (2) Crops and/or livestock Yes() No()
Show the total amount received from sale of crops,
and/or livestock for the last crop year. (If you
farm on shares, show only your share.)
 - (3) Rent received
 - (4) How much did it cost to produce the
crops? (Include the cost of seeds,
fertilizer, hired labor, curing (tobacco),
stock feed, and other expenses directly
connected with making the crop or
raising the stock
 - (5) What are the taxes on your farm

Applicant/ Recipient	Spouse or Parent
\$	\$
\$	\$
\$	\$
\$	\$
\$	\$
\$	\$
\$	\$
\$	\$
\$	\$
\$	\$
\$	\$
\$	\$
\$	\$
\$	\$
\$	\$

6. Have you, your husband/ wife, or parent(s) any of the items listed below. Check Yes or No by each item. If Yes is checked, show the amount.

	Applicant/ Recipient	Spouse or Parent
A. Life Insurance * Yes() No() If <u>Yes</u> , list face value of policy(ies)	\$	\$
B. Irrevocable/Revocable Burial Contract* Yes() No() If <u>Yes</u> , list value	\$	\$
C. Savings Account* Yes() No() If <u>Yes</u> , what is the amount?	\$	\$
D. Cash on Hand* (Checking Account, Patient Fund Account, lump sum payment, etc.) Yes() No() If <u>Yes</u> , give amount	\$	\$
E. Other* , such as money market account, stocks, bonds, 401(k), IRA, trust account, CDs, KEOGH, mutual funds, promissory notes, rights of use (mineral, timber, hunting, fishing, etc.) farm stock, equipment, etc. Yes() No() Briefly describe: _____ Value	\$	\$
F. Personal Property such as boats, boat motors, boat trailers, motor homes or campers (unless primary homesite) Yes() No() If <u>Yes</u> , what is the cash value?	\$	\$
G. Automobile(s)/Motor Vehicles (licensed)* Yes() No() If more than one, give Model _____ Year _____ Give cash value?	\$	\$

***Please attach copy of latest statement from checking account, savings account, IRA, etc. Attach copy of life insurance policy, irrevocable burial, etc. If you own more than one car and there is an automobile loan, please attach a list giving type, account number, current balance, monthly payment, number of remaining payments.**

7. Do you, your husband/ wife, or parent(s) own land or buildings in which you live?:

Yes() No() If Yes, give:

Name of County in which property is located: _____

Current value of property: \$ _____

Name of person in whose name property is listed for taxes: _____

Amount of taxes that are paid on property*: _____

(*Attach copy of latest Property Tax Statement)

Are you receiving rent for your property? Yes() No() If Yes, what is the amount? _____ How often do you receive the rent? _____

8. Do you, your husband/ wife, or parent(s) own land or buildings in which you do not live? Yes() No() If Yes, give:

Name of County in which property is located:

Current value of property: \$ _____

Name of person in whose name property is listed for taxes: _____

Amount of taxes that are paid on property*: _____

(*Attach copy of latest Property Tax Statement)

Are you receiving rent for your property? Yes() No() If Yes, what is the amount? _____ How often do you receive the rent? _____

9. Have you, your husband/ wife, or parent(s) given away, sold, or deeded any property during the past 12 months? Yes() No()

If Yes, give type of property (house, acres of land, etc.)

To whom?

What was the amount received for the property? _____

10. Do you own life estate interest? (A person holds a life estate interest when a former owner deeds or wills property away, but allows the life estate interest holder to live on or use the property for the rest of his life.) Yes() No()

If Yes, give the name of the person who has the lifetime right:

What type of property is involved in the lifetime right?:

Where is the property located?

EXPENSES

(Complete only if applying for individual payment.)

Are you paying shelter and utilities? Yes() No()

If Yes, Rent \$ _____ Utilities \$ _____

Additional Information

I agree if any changes occur in my address, living arrangements, expenses, income and/or resources in my family to notify the County Department of Social Services (who will in turn notify the Division of Services for the Blind), or I will directly notify the Division of Services for the Blind. Yes() No()

You may be contacted by a representative from the Division of Services for the Blind who will review your answers recorded on this form. If additional information is needed, do you agree for the Division to secure the necessary information from other sources for the purpose of determining and/or redetermining eligibility for Special Assistance for the Blind?

Yes() No()

Signature of Applicant or Recipient

Date Signed

YOUR RIGHTS TO APPEAL

If you are dissatisfied with any decision concerning your application or Special Assistance for the Blind payments, you have the right to appeal to the Division of Services for the Blind and request a conference. If you need help in making this request, your County Department of Social Services or Social Worker for the Blind will assist you.

If you are of the opinion that discrimination, on the grounds of race, color, or national origin, has been practiced in connection with your request for assistance or services, you may file a complaint with the County Department of Social Services or with the North Carolina State Division of Services for the Blind. Prompt investigation of your complaint will be made.

Applicant/recipient MUST sign all of the following statements:

My answers to the questions on this form are correct and complete to the best of my knowledge. I understand that if I deliberately give false or incomplete information, I am liable to prosecution under the North Carolina law which deals with fraud.

Signature _____

(Applicant or Recipient)

Date _____

Signature of person who helped complete form: _____

Address _____

Date _____

Information on this form will be treated confidentially as provided by G.S. 111-28. This agency operates under Title VI of the Civil Rights Act of 1964.

G.S. 111-23. Misrepresentation or fraud in obtaining assistance---Any person who shall obtain, or attempt to obtain, by means of a willful, false statement or representation, or impersonation, or other fraudulent devices, assistance to which he is not entitled shall be guilty of a misdemeanor and upon conviction shall be punished by a fine or not more than five hundred dollars (\$500.00), or by imprisonment in the county jail for not more than three months, or by both such fine and imprisonment. The superior court and the recorders' courts shall have concurrent jurisdiction in all prosecutions arising under this Article. (1937, c. 124, s. 12.)

CONSENT STATEMENT

I, the undersigned, do hereby authorize the Social Security Administration to release information on file relating to my entitlement to benefits under Social Security and Supplemental Security Income to the Division of Services for the Blind to aid in the determination of eligibility for Special Assistance for the Blind. This information will include my date of birth, the amount of my benefits, the date I became entitled to benefits, or the reason benefits were denied or terminated.

Signature _____
(Applicant or Recipient)

Date _____

If someone else signs your name for you, make an "X" mark by your name and have it witnessed by two persons on the lines below.

Witness _____ (Address) _____ (Date)

Witness _____ (Address) _____ (Date)

You MUST sign that you have read and understand the following statement. You MUST have two witnesses. They may be the same witnesses used earlier in this section.

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 (ESC), out-of-state welfare and ESC agencies, Veterans Administration (VA), U. S. Railroad Retirement Board, 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.

Under the penalty of law, I certify that the above information is correct. If necessary, I authorize an investigation as to the correctness of this information.

Signature _____
(Applicant or Recipient)

Date _____

Witness _____ (Name) _____ (Address) _____ (Date)

Witness _____ (Name) _____ (Address) _____ (Date)

INSTRUCTIONS FOR COMPLETION OF DSB-7204

Check the appropriate box to indicate if the DSB-7204 is being completed for an application, re-application, or review.

Check the appropriate box to indicate if the a/r is in or entering a domiciliary care facility or living in his/her own home (individual). Domiciliary care includes both adult care homes and specialized residential community centers for children.

Enter the name of the a/r, the county of legal residence based on requirements in the section on Residency in Chapter 4, and the name of the Social Worker for the Blind for the Worker's Name.

1. and 2. Enter all current identifying information about the a/r requested in these items.
3. and 4. Enter specific information requested about current residency status. This is necessary to determine eligibility for SAB based on U.S. and N.C. residency requirements. Also provide legal birth date based on SSA data, birth certificate, etc. (see section on Age in Chapter 4), race, sex, and marital status.
5. Enter the requested information about the ACH or specialized community residential center. **It is necessary to attach a current FL-2 or MR-2 form for an application or a review.**
- 6.-10. Enter all requested numbers for a/r and spouse as all sources of possible income must be explored and verified. Medicaid status and veteran status must also be documented. Enter previous status regarding receipt of SAB.
11. If a/r is applying for SAB in his/her own home, then complete information requested in this items. Omit this item if a/r is residing in an ACH or specialized residential community center.

Income and Resources:

- 1.-10. Enter specific information and attach documents necessary to verify information as requested.

Expenses:

Complete this section **only** if a/r is applying for SAB payment while residing in his/her own home.

Additional Information:

Both statements should be read carefully by or to the a/r and he/she must indicate if he/she is willing to respond in the affirmative. If not, the application will be denied.

The a/r should also read or have read to him/her the “Your Rights to Appeal” section.

The additional statements **must** be read by or to the a/r and he/she must sign and date the statements with appropriate witnesses where requested.

It is also necessary for the person who assisted in the completion of the form to sign, date, and provide his/her address in case the SAB Eligibility Specialist should need to make contact to clarify something on the form.

The information about G.S. 111-28 and G.S. 111-23 **must** be read by or to the a/r.

Page 9 serves as a release of information form for various public and private organizations and must be signed and witnessed before the application or review can be processed.

MEDICAL EXPENSE FORM

If you pay for any of the following items not covered by Medicaid or other insurance programs, show the monthly cost.

List prescribed medicines (over-the-counter) that are not covered by Medicaid, how often they are purchased, and the price per unit. (For example, if you list two bottles of aspirin, give price per bottle.)

MEDICINES	NUMBER OF TIMES PURCHASED EACH MONTH	COST PER PURCHASE

Please have above lists verified by your pharmacist.

TO BE COMPLETED BY PHARMACIST

Please review the above section completed by the applicant/recipient. These lists should include **ONLY** medicines and supplies prescribed by a doctor and not covered by Medicaid or other types of medical insurance. They are not to include co-payments.

If the items listed above, frequency of purchase, and costs are correct to the best of your knowledge, please sign below.

Signature of Pharmacist

Name of Pharmacy

MEDICAL EXPENSE FORM—INSTRUCTIONS

Enter the information about medication not covered by Medicaid and then have the list verified by the pharmacist. As indicated, the cost of co-payments is not to be included on this form. The pharmacist must sign and write in the name of the pharmacy at the bottom of the form.

If the a/r has a change in this information after the application or review is approved, another Medical Expense Form can be completed at any time and forwarded to the SAB Eligibility Specialist. Any necessary adjustments will be made in the SAB budget.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
 NORTH CAROLINA DIVISION OF SERVICES FOR THE BLIND
 SPECIAL ASSISTANCE FOR THE BLIND

VERIFICATION OF ELIGIBILITY - BUDGET

APPLICATION: New [] Reinstatement []
 REVISION IN PAYMENT: Redetermination [] Desk Revision []
 COUNTY _____ Date _____
 CONSUMER'S NAME _____ Number in Budget _____
 ADDRESS _____

<u>Monthly Requirements</u>	<u>Amount</u>	<u>Monthly Resources</u>	<u>Amount of Resources</u>
I. Personal Allowance	\$ _____	1. (A) Wages of consumer	
1. Individual paying shelter	\$ _____	\$ _____	
2. Individual not paying shelter	\$ _____	(B) Less exempted earned income \$ _____	\$ _____
3. Couple paying shelter	\$ _____	2. Cash contributions regularly available.	
4. Couple not paying shelter	\$ _____	_____	\$ _____
		(Source)	
5. Licensed Adult Care Home	\$ _____	3. Net rentals from real estate	\$ _____
Disenfranchised	\$ _____	4. Pension _____	\$ _____
		(Name)	
II. Medical Care Special	\$ _____	5. Income from savings, insurance, Social Security, SSI, trust funds, V.A., etc.	\$ _____
Total Monthly Requirements	\$ _____	_____	\$ _____
Total Monthly Resources	\$ _____	6. Other (specify) _____	\$ _____
Deficit	\$ _____	Unearned income disregard	\$ _____
RECOMMENDED PAYMENT	\$ _____	TOTAL MONTHLY RESOURCES	\$ _____

Additional Explanation:

DSB-7207 (Rev. 8/02)
 (BA-1-b)

INSTRUCTIONS FOR COMPLETION OF DSB-7207

THIS FORM IS COMPLETED BY THE SAB ELIGIBILITY SPECIALIST.

Check the appropriate box to indicate if the application is new or a reinstatement.

Check the appropriate box to indicate if the revision in payment is the result of a redetermination of eligibility or a desk revision.

County: Enter county of legal residence.

Date: Enter date the form is completed.

Consumer's Name: Enter the complete name.

Number in Budget: This number will always be one (1) if the a/r is residing in an ACH or a specialized residential community center. However, if the a/r is residing in his/her own home and is requesting benefits in that living arrangement, enter the number of persons who are legally in the family unit.

Address: Enter the current mailing address of the a/r.

Monthly Requirements

I. Personal Allowance: Enter \$46 which is the current amount of the allowance but is subject to change by legislative action.

1.-4.: These items apply to an a/r who is requesting assistance in his/her own home. Select the item which describes the a/r's situation and enter the allowance for that living arrangement from page 165.

5.: If the a/r is residing in an ACH or a specialized residential community center, enter the current adult care home rate which is established by the General Assembly. As of 10/1/07, the rate is \$1,173 per month.

If the recipient has been identified as a disenfranchised" recipient, then the rate of \$1,231 should be entered on the corresponding line and item 5 should be left blank. See Appendix A, pages 208 and 209 for detailed information.

II. Medical Care Special:

If the a/r has a one-time need for medical equipment which cannot be totally purchased by another program, then the amount owed by the a/r should be entered in this item. See pages 159-162 and Example 4 which follows page 170 for additional requirements. Any on-going medical expenses which are not covered by Medicaid such as Tylenol, stool softeners, vitamins, etc. and are prescribed by a physician should also be entered on this line. See pages 168-169 for additional requirements.

Total Monthly Requirements:

Add all amounts listed above this item.

Total Monthly Resources:

The total of the resources which have been added in the column on the right side of the DSB-7207 should be entered here.

Monthly Resources**1. (A) Wages of Consumer:**

Enter the gross wages of the a/r.

(B) Less exempted earned income:

Enter the allowed exemptions for earned income that are identified and budgeted in Chapter 6 Income and Chapter 7 Budgeting Principles.

2. Cash Contributions regularly available:

Enter the cash contributions received monthly or at other regular intervals. This could be given directly to the a/r or paid on the cost of care in an ACH or specialized residential community center.

3. Net rentals from real estate:

Enter the net income after all allowable expenses of the property according to regulations in Chapter 6.

4. Pensions:

Enter the name of the pension and the amount of the pension. Refer to Chapter 6 for more information.

5. Income from savings, insurance, Social Security, SSI, trust funds, V.A., etc.:

Enter the source and amount of the unearned income identified above or any other unearned income which should be included as a resource based on the regulations in Chapter 6.

6. Other:

Enter the source and amount of any other monthly resource which should be included in budget computations based on Chapters 6 & 7.

Unearned Income Disregard:

Section: Appendix C
Title: Forms and Notices
Revision History: 08/02

Enter the \$20 disregard which is allowed on unearned income. This allowance is also subject to change by legislative action. Refer to Chapters 6 and 7 to determine when the a/r is eligible for this disregard.

Total Monthly Resources:

Add the amount entered in items 1 through 6. Subtract the unearned income disregard if the a/r is eligible for this. The net is the total monthly resources. This amount should be entered on the corresponding line in the monthly resources column and also in the monthly requirements column.

Deficit:

Subtract the total monthly resources from the total monthly requirements. The remainder is the deficit and should be entered on this line.

Recommended Payment:

Enter the deficit which has been rounded to the nearest whole dollar. The payment can be no less than \$5.

Additional Explanation:

Enter any information which will explain the budget computations such as pro-rating the cost of care for a specific number of days in an ACH or specialized residential community center.

NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SERVICES FOR THE BLIND
309 ASHE AVENUE

SAB AUTHORIZATION

NAME OF APPLICANT		
(First)	(Middle)	(Last)
Substitute Payee or Additional Address		
Street Address		
City or Town	State	Zip Code

ACCOUNTING CLASSIFICATIONS:

County	Co. No.	Case No.	Reg. No.	S. S. No.

S.S. No.	S.S. No.	S.S. No.

AUTHORIZATION FOR:

<input type="checkbox"/> Acceptance	Amount _____	Number in Budget _____
<input type="checkbox"/> Reinstatement	_____	Effective Date: _____
<input type="checkbox"/> Denied Payment		
<input type="checkbox"/> Termination	_____	Reason: _____
<input type="checkbox"/> Change in Payment	Revise From: _____ to _____	Amt. to be Paid _____

IV. Change of Address From: _____ (Effective Date)

To: _____

Change of Name or Payee From: _____ (Effective Date)

To: _____

Change of persons in Assistance Plan:

Delete: _____ (Effective Date)

Add: _____

V. Recommended: _____ (Date)

(Director of Social Services)

Approved: _____ (Date)

(Chairman, Bd. County Comm.)

Approved: _____ (Date)

(Director, Div. of Services for the Blind)

Note: If the Applicant or recipient wishes to exercise his right of a appeal he may secure information and forms for this purpose from the County Department of Social Services.

INSTRUCTIONS FOR DSB-7209 SAB AUTHORIZATION

THIS FORM IS COMPLETED BY THE SAB ELIGIBILITY SPECIALIST.

I. Name of A/R: Enter the identifying information as requested on the form. The mailing address should be entered rather than the residence address.

II. Accounting Classifications:

County: Enter the name of the a/r's county of legal residence.

Co. No.: Enter the two-digit county number

Reg. No.: Enter the Register Number of the a/r.

S.S.: Enter all Social Security numbers know to have been used by the a/r. A separate number should be entered in each block.

III. Authorization for: Check the appropriate block to indicate why the SAB Authorization is being completed.

Amount: Enter the amount of payment being authorized beside either "Acceptance", "Reinstatement", or "Termination".

Revise From: Enter the amount of the previous payment.

To: Enter the amount of the payment being authorized.

Amt. to be Paid: Enter the amount of the present payment.

Number in Budget: Enter the number of persons in the family unit whose needs are being considered in budget computations. See 6 and 7.

Effective Date: Enter the date the authorization will become effective.

Reason: Enter the reason for the action taken.

IV. Check the appropriate block and enter the previous information at "From" and the new information at "To" for Change of Address and/or Change of Name or Payee.

Check the appropriate block if there is a change of persons in the budget. Enter the name of the person(s) being removed on the "Delete" line and/or the name of the person(s) being added to the budget on the "Add" line.

Effective Date: Enter the date the action taken will be effective beside the appropriate option in this section.

V. Obtain the signatures of the persons identified in the positions and the date the person signed the form.

The white and yellow copies of this form must be returned to the SAB Eligibility Specialist at 2601 Mail Service Center (MSC), Raleigh, NC 27699-2601. The pink copy is kept at the

County DSS in the Medicaid case record, the case record kept by the Social Worker for the Blind, or any other record as determined by the County DSS.

The SAB Eligibility Specialist forwards the white original of the SAB Authorization to the Controller's Office with the transmittal and two copies of the Check Register. The yellow copy is sent to the a/r by the SAB Eligibility Specialist and the blue copy is kept by the SAB Eligibility Specialist.

**NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SERVICES FOR THE BLIND**

APPLICATION FOR CONFERENCE

I, _____ residing at _____
Name of Applicant **Address**

City **County** **Telephone Number**

Request a conference with agency staff for the following reason(s):

Date

Signature

DISTRIBUTION:

- White - Chief, Independent Living Services Program in DSB State Office
- Blue - DSB Field Services Manager
- Yellow - Count Department of Social Services
- Pink - Appellant

DSB-7219 (Rev. 8/02)

INSTRUCTIONS FOR DSB-7219 APPLICATION FOR CONFERENCE

The purpose of this form is to notify the Chief, Independent Living Services, Field Services Manager and County DSS of an a/r's dissatisfaction with the service program and to request a conference concerning his/her dissatisfaction.

The Social Worker for the Blind will assist in the preparation of the DSB-7219 if requested.

- Enter a/r's names, mailing address, county, and telephone number on appropriate lines.
- Briefly describe reason(s) for conference request.
- Enter date and obtain signature of a/r.

DISTRIBUTION:

White - Chief, Independent Living Services Program in DSB State Office

Blue - DSB Field Services Manager

Yellow - County Department of Social Services

Pink - Appellant



North Carolina Department of Health and Human Services

Division of Services for the Blind

2601 Mail Service Center • Raleigh, NC 27699-2601

Telephone 919-733-9744 • Fax 919-733-2772 • Courier 56-20-04

Michael F. Easley, Governor
Dempsey Benton, Secretary

Debbie Jackson, Director

*

Dear *:

This is to inform you that your application for Special Assistance for the Blind has been approved and will be effective *. Your * checks should be received on or about *. Your regular monthly check will be in the amount of \$ and will be received during the first week of each month.

If you are not satisfied with the above action or if you feel your circumstances have not been given proper consideration, you have the right to request a conference with our Area Social Services Supervisor. If you wish to make such a request, please contact your Social Worker for the Blind in the * Co. Dept. of Social Services in *, NC prior to *. They will assist you in filing your request. At the conference, you can:

1. Bring witnesses to help in presenting your case.
2. Present evidence yourself or have someone else present it for you, including a lawyer, if you wish, at your own expense.
3. Ask questions about the agency's recommendation and question any staff member present.
4. Examine and ask questions about papers used during the conference or fair hearing.

Sincerely,

Debra D. Tutor
Eligibility Specialist
Independent Living Services

/ddt

cc: *, SWB, * Co. Dept. of Social Services

DSB-7206 (Rev. 09/08)

Office Address: 309 Ashe Avenue • Fisher Building • Raleigh, NC 27606
An Equal Opportunity / Affirmative Action Employer

INSTRUCTIONS FOR DSB-7206

THIS FORM IS COMPLETED BY THE SAB ELIGIBILITY SPECIALIST.

Enter the date the form is prepared and mailed under the letterhead.

Enter the a/r's name or the name of his/her payee and the mailing address where the asterisks appear on the form.

Enter the a/r's name or the name of his/her payee in the salutation.

Enter the effective date of the SAB payment where the first asterisk is located on the second line of the first paragraph.

Enter the months for which an SAB payment will be received where the second asterisk is located on the second line of the first paragraph.

Enter the date when the a/r can expect to receive the first SAB check where the third asterisk is located on the second line of the first paragraph.

Enter the amount of the regular monthly SAB check where the asterisk is located on the third line of the first paragraph.

Enter the name of the county of legal residence of the a/r where the asterisk is located on the third line of the second paragraph.

Enter the date which is the fifteenth calendar day from the date the DSB-7206 is prepared where the asterisk is located on the fourth line of the second paragraph.

The signature of the SAB Eligibility Specialist should be affixed in the closing.

Enter the name of the Social Worker for the Blind in the county of legal residence of the a/r where the first asterisk is located beside the "cc:".

Enter the county of legal residence of the a/r where the second asterisk is located beside the "cc:".

The original of the letter is mailed to the a/r or his/her representative, a copy is mailed to the Social Worker for the Blind in the county of legal residence, and a copy is kept by the SAB Eligibility Specialist.

North Carolina
Department of Health and Human Services
Division of Services for the Blind
309 Ashe Avenue - Fisher Building
2601 Mail Service Center, Raleigh NC 27699-2601

Michael F. Easley, Governor
Dempsey Benton, Secretary

Debbie Jackson, Director
(919) 733-9822
FAX (919) 733-9769

Operator

Re: _____

Dear Operator:

The above-named resident of your adult care home has been approved for a Special Assistance for the Blind payment to help cover the cost of care in your home. The purpose of this letter is to inform you of our policy regarding continuation of payments during an absence from the adult care home.

If the recipient requires hospitalization or care in a Title XIX facility, Special Assistance for the Blind payments can continue for only sixty (60) days to hold the recipient's space in the facility. Of course, this sixty days would only apply in situations where a physician is reasonably certain the recipient will be able to return to the adult care home. When hospitalization or skilled nursing care is required, you should notify our agency immediately or notify the local Department of Social Services and request they notify our agency.

If questions should arise concerning this policy, please feel free to contact our office.

Sincerely,

Debbie Jackson

DJ/ddt
DSB-7249 (Rev. 04/08)

INSTRUCTIONS FOR DSB-7249 LETTER OF NOTIFICATION TO OPERATOR

THIS FORM IS COMPLETED BY THE SAB ELIGIBILITY SPECIALIST.

Enter the date the form is being mailed to the ACH or specialized residential community center operator where the asterisk is located under the letterhead.

Enter the name of the recipient of SAB on the line provided after "Re:".

The signature of the Director of the Division of Services for the Blind should be affixed in the closing.

The original of the DSB-7249 is mailed to the ACH or specialized residential community center where the SAB recipient resides and a copy is kept by the SAB Eligibility Specialist.

North Carolina
Department of Health and Human Services
Division of Services for the Blind
309 Ashe Avenue - Fisher Building
2601 Mail Service Center, Raleigh NC 27699-2601

Michael F. Easley, Governor
Dempsey Benton, Secretary

Debbie Jackson, Director
(919) 733-9922
FAX (919) 733-9769

Dear:

Recently, you applied for funds to assist with the purchase of a * through the Special Assistance for the Blind Program. Your application was received and has been approved. A check will be mailed in the near future to the * County Department of Social Services. The check will then be forwarded to you by your Social Worker for the Blind. Please remember that the funds from this check must be spent for the medical equipment or supply mentioned above. Failure to spend the funds for their intended purpose will result in your case being referred to the State Attorney General's Office for possible prosecution.

I am glad or agency has been able to assist you in this matter. If additional needs arise, please contact your Social Worker for the Blind.

Sincerely,

Debbie Jackson

DJ/ddt

cc: * Co. Department of Social Services
with check

INSTRUCTIONS FOR APPROVAL FOR MEDICAL CARE SPECIAL ONE-TIME NOTICE

THIS FORM IS COMPLETED BY THE SAB ELIGIBILITY SPECIALIST.

Enter the date the notice is prepared and mailed under the letterhead.

Enter the name and mailing address or the a/r or his/her payee where the asterisk is located above the salutation.

Enter the name of the a/r or his/her payee in the salutation.

Enter the name of the device for which the a/r requested financial assistance where the asterisk is located on one line, paragraph one.

Enter the county of legal residence of the a/r on line three, paragraph one.

The signature of the Director of the Division of Services for the Blind should be affixed in the closing.

Enter the county of legal residence of the a/r where the asterisk is located beside the "cc:".

The original is mailed to the a/r, a copy mailed to the county of legal residence and a copy is kept by the SAB Eligibility Specialist.

North Carolina
Department of Health and Human Services
Division of Services for the Blind
309 Ashe Avenue - Fisher Building
2601 Mail Service Center, Raleigh NC 27699-2601

Michael F. Easley, Governor
Dempsey Benton, Secretary

Debbie Jackson, Director
(919) 733-9822
FAX (919) 733-9769

Re: _____

Dear

On *, 200 , I received an application for Special Assistance for the Blind to assist with the purchase of * for *. This was an application for a medical one-time payment. The request was approved effective *. As a request has been made to this office that we document satisfactory delivery of the above stated item to the customer, I am requesting that you send me a statement verifying that * received *. As the Controller's Office is also requesting we obtain a copy of the invoice, I am asking that you send a copy of the invoice as well.

Thank you for your assistance in this matter. If you have any questions, please call me at (919) 733-9744.

Sincerely,

Debra D. Tutor
Eligibility Specialist
Independent Living Services

/ddt

cc: Ms. Debbie Jackson

INSTRUCTIONS FOR VERIFICATION OF RECEIPT OF MEDICAL CARE SPECIAL ONE-TIME NOTICE

THIS FORM IS COMPLETED BY THE SAB ELIGIBILITY SPECIALIST.

Enter the date the form is completed and mailed under the letterhead.

Enter the name and mailing address of the a/r or his/her payee where the asterisk is located above the salutation.

Enter the name of the recipient of the medical care special one-time payment after "Re:" on the line provided.

Enter the name of the Social Worker for the Blind in the county of legal residence of the a/r.

Enter the date the SAB application was received by the SAB Eligibility Specialist in the area where the first asterisk is located on line one of paragraph one.

Enter the name of the device for the purchase of which the a/r received financial assistance where the first asterisk is located on the second line of paragraph one.

Enter the a/r's name where the second asterisk is located on the second line of paragraph one.

Enter the effective date of the approval of the SAB application at the location of the asterisk on line three of paragraph one.

Enter the name of the recipient of the SAB medical care special one-time payment on line five of paragraph one where the first asterisk is located.

Enter the name of the device that was purchased at the location of the second asterisk on line five, paragraph one.

The signature of the SAB Eligibility Specialist should be affixed in the closing.

The original is mailed to the Social Worker for the Blind with copies going to the Chief of Independent Living and Medical Services, the Deputy Director of DSB, the Controller's Office and one is kept by the SAB Eligibility Specialist.



North Carolina Department of Health and Human Services

Division of Services for the Blind

2601 Mail Service Center • Raleigh, NC 27699-2601
Telephone 919-733-9744 • Fax 919-733-2772 • Courier 56-20-04

Michael F. Easley, Governor
Dempsey Benton, Secretary

Debbie Jackson, Director

*

*

Dear *:

This letter is to inform you that after careful review of your circumstances, the following change regarding your Special Assistance for the Blind is required:

- () Payment increased from \$_____ to \$_____ effective _____, 20__.
- () Payment decreased from \$_____ to \$_____ effective _____, 20__.
- () Payment terminated. Your last check will be the one for _____, 20__.

The reason for the above action is _____

If you are not satisfied with the above action or if you feel your circumstances have not been given proper consideration, you have the right to request a conference with our Area Social Services Supervisor. If you wish to make such a request, please advise the Social Worker for the Blind in the office of the * in *, NC prior to *, 2008.

They will assist you in filing your request. At the conference, you can:

1. Bring witnesses to help in presenting your case.
2. Present evidence yourself or have someone else present it for you, including a lawyer, if you wish at your own expense.

Office Address: 309 Ashe Avenue • Fisher Building • Raleigh, NC 27606
An Equal Opportunity / Affirmative Action Employer

3. Ask questions about the agency's recommendation and question any staff member present.
4. Examine and ask questions about papers and records used during the conference.

Sincerely,

Debra D. Tutor
Eligibility Specialist
Independent Living Services

/ddt

Attachment

cc: *, SWB, * Co. Dept. of Social Services

INSTRUCTIONS FOR CHANGE AND ACTION NOTICE

THIS FORM IS COMPLETED BY THE SAB ELIGIBILITY SPECIALIST.

Enter the date the notice is prepared and mailed under the letterhead.

Enter the name and mailing address of the a/r or his/her payee at the location of the asterisk above the salutation.

Enter the name of the a/r or his/her payee in the salutation.

Check the block which describes the action being taken in the SAB payment.

After "from", enter the old amount of the SAB payment.

After "to", enter the new amount of the SAB payment.

After "effective", enter the date the change will take effect.

If the payment is being terminated, enter the month and year that represents the last payment for the a/r.

Explain the reason, giving Manual Chapter if a reduction or termination, that details why the action is being taken in the SAB payment.

Enter the name of the legal county of residence of the a/r where the asterisk is located on line three of paragraph three.

Enter the date which is fifteen calendar days after the date of the notice on line four, paragraph three.

The signature of the SAB Eligibility Specialist should be affixed in the closing.

Enter the name of the Social Worker for the Blind in the a/r's county of legal residence in the area where the first asterisk is located after "cc:".

Enter the county of legal residence where the second asterisk is located after the "cc:".

The original notice is mailed to the SAB recipient, the Social Worker for the Blind receives a copy and the SAB Eligibility Specialist keeps a copy.

North Carolina
Department of Health and Human Services
Division of Services for the Blind
309 Ashe Avenue - Fisher Building
2601 Mail Service Center, Raleigh NC 27699-2601

Michael F. Easley, Governor
Dempsey Benton, Secretary

Debbie Jackson, Director
(919) 733-9822
FAX (919) 733-9769

Dear

This is to notify you that your Special Assistance for the Blind review form for the period of * was received.

The review has been completed, and we find there are no changes to be made. You will continue to receive Special Assistance for the Blind in the amount of \$ per month. A copy of your budget is attached.

If you are not satisfied with the above action or you feel your circumstances have not been given proper consideration, please notify your Social Worker for the Blind prior to *.

Sincerely,

Debra D. Tutor
Eligibility Specialist
Independent Living Services

/ddt

Attachment

cc: *, Social Worker for the Blind

INSTRUCTIONS FOR THE NO CHANGE AFTER REVIEW NOTICE

THIS FORM IS COMPLETED BY THE SAB ELIGIBILITY SPECIALIST.

Enter the date the notice is prepared and mailed at the asterisk under the letterhead.

Enter the name and mailing address of the a/r or his/her payee at the location of the asterisk above the salutation.

Enter the month and year the review of SAB eligibility was due where the asterisk is located in line one of paragraph one.

Enter the amount of the SAB payment on line two of paragraph two after the "\$".

Enter the date which is fifteen calendar days after the date of the notice at the asterisk on line two of paragraph three.

The signature of the SAB Eligibility Specialist should be affixed in the closing.

Enter the name of the Social Worker for the Blind in the a/r's county of legal residence after the "cc:".

The original notice is mailed to the a/r, a copy is sent to the Social Worker for the Blind, and a copy of the notice is kept by the SAB Eligibility Specialist.

North Carolina
Department of Health and Human Services
Division of Services for the Blind
309 Ashe Avenue - Fisher Building
2601 Mail Service Center, Raleigh NC 27699-2601
(919) 733-9744 Fax (919) 733-9744

Michael F. Easley, Governor
Dempsey Benton, Secretary

Debbie Jackson, Director
(919) 733-9822
FAX (919) 733-9767

Dear

This letter is to inform you that we have been notified of your change of address for your Special Assistance for the Blind checks. Our records show your new address is:

The change will be effective with your * Special Assistance for the Blind check.

If you are not satisfied with the above action or if you feel your circumstances have not been given proper consideration, please notify us by *.

Sincerely,

Debra D. Tutor
Eligibility Specialist
Independent Living Services

/ddt

cc: *, County Department of Social Services

INSTRUCTIONS FOR CHANGE OF ADDRESS NOTICE

THIS FORM IS COMPLETED BY THE SAB ELIGIBILITY SPECIALIST.

Enter the date the notice is prepared and mailed at the asterisk below the letterhead.

Enter the name and mailing address of the a/r or his/her payee at the asterisk above the salutation.

Enter the name of the a/r or his/her payee at the asterisk in the salutation.

Enter the new address of the a/r or his/her payee at the asterisk in the paragraph one.

Enter the month at the asterisk in paragraph two to indicate when the change of address will be effective on the SAB check.

Enter the date which is fifteen calendar days following the date of the notice at the location of the asterisk on line two of paragraph three.

The signature of the SAB Eligibility Specialist should be affixed in the closing.

The county of legal residence should be entered after the "cc:".