

RESOURCES: INTERVIEW, DOCUMENTATION AND CALCULATION

*Indicate each recipient and FRP, R1/R2, RS, S, RP, or P Verified/Rebutted

A. LIQUID ASSETS	*R	*	*	JOINT NAME	ACCOUNT #	BANK/COMPANY	AMOUNT
Cash/Patient Account							
Saving/Checking/Money Market							
Stocks/Bonds/Mutual Funds							
CD's/IRA's/401K Plans							
Trust/Promissory Note							
Lump Sum/Settlement/Other							

TOTAL OF LIQUID ASSETS _____ DATE AND METHOD OF VERIFICATION _____ TOTAL COUNTABLE _____
 Total _____ Months of _____

B. LIFE INSURANCE, PRENEED BURIAL PLANS, OTHER BURIAL FUNDS, ETC.					
Owner R, S, P	NAME OF INSURED	INSURANCE COMPANY	POLICY NUMBER	FACE VALUE	CASH VALUE
Y	IS INSURANCE DESIGNATED FOR BURIAL EXPENSES?				
N	If YES, Complete Burial Exclusion chart on page 3.			TOTALS FOR INSURANCE	

C. PERSONAL PROPERTY (cars, trucks, boats, trailers, boat motors, campers, farm/business equipment, mobile home not used as homesite, motorcycles)									
OWNER R, S, P	NAME OF OWNER	DESCRIPTION	EXCLUDE		VVI VALUE	REBUTTAL			EQUITY
			Yes	No		Yes	No	Value	

Exclude the motor vehicle with the highest equity value.
 Count the equity of all other motor vehicles.
 TOTAL Equity = CMV minus encumbrances.
 EQUITY CMV is VVI value or rebuttal value.

Document encumbrance: _____ TOTAL EQUITY _____

D. REAL PROPERTY INTEREST: Document location(s), total acreage, and tax value for all property interests including those excluded. For countable property interests, also record encumbrances and equity.									
OWNER R, S, P	NAME OF OWNER	DESCRIPTION	EXCLUDE		TAX VALUE	REBUTTAL			EQUITY
			Yes	No		Yes	No	Value	

*If excluded, document basis for exclusion: _____ TOTAL EQUITY _____

E. TRANSFER OF RESOURCES – Evaluate recipients for transfer of resources during the "look back period" at every review. Refer to MA-2240, Transfer of Resources, for definition of the "look back period."

Has any resource been transferred, given away, or sold for less than the CMV? [] YES [] NO
 If YES: Uncompensated Value: _____ Date of Transfer: _____
 Was the transfer allowable? [] YES [] NO
 If No, what is the sanction period? From: _____ through _____
 If YES, describe why it was allowable: _____

PLA BUDGET	MONTH(S)	MONTH(S)	MONTH(S)
1. Total Unearned Income (Minus PASS-ALONG)			
2. \$20.00 General Deduction (Subtract \$0 from VA Pension)	— \$20.00	— \$20.00	— \$20.00
3. Net Unearned Income (Line 1 minus Line 2)			
4. GROSS EARNED (Go to line 12 if no earned income)			
5. Operational expenses for self-employment/business	—	—	—
6. Subtract Remainder of \$20.00 General Deduction, if any not used by unearned income.	—	—	—
7. Subtotal (Line 4 minus Lines 5 and 6)			
8. Subtract \$65.00 Earned Income Deduction	— \$65.00	— \$65.00	— \$65.00
9. Subtotal (Line 7 minus Line 8)			
10. Subtract 1/2 of Line 9	—	—	—
11. NET EARNED INCOME			
12. TOTAL NET INCOME (Line 3 plus Line 11)			
13. INDIVIDUAL INCOME LIMIT (C, N, MQB, MWD, MN)	—	—	—
14. EXCESS			
15. Number of months in period or months budgeted PLA (MN only)	X	X	X
16. EXCESS INCOME FOR THE PERIOD = MEDICAID DEDUCTIBLE			

Evaluate each adult deductible case for MQB coverage. Combined excess income for the certification period, rounded to the nearest dollar, is the amount of the deductible. Attach DMA-5036 for documentation of when the deductible is met.

PATIENT MONTHLY LIABILITY FOR RECIPIENT IN LTC

- () A/R's Gross Monthly income is less than minimum rate from table in manual.
- () Supplement B attached.

Deductible Periods

Gross Income		
Operational expenses/Guardian Fees, etc.	-	-
Mandatory Deduction	-	-
Personal Needs		
Spouse/Dependent Allowance	-	-
Unmet Medical Needs		
Effective PML:	\$	\$

\$	
FROM	THROUGH
\$	
FROM	THROUGH

DOCUMENTATION

BURIAL EXCLUSION: \$1,500.00 for each B.U. Member

TYPE OF ASSET	VALUE	\$1,500	BALANCE	EXCESS
Irrevocable Trust				
Face Value of Life Insurance If F.V. is less than \$10,000.				
Revocable Contract				
Cash Value of Designated Life Ins. when F.V. is more than \$10,000.				
Cash Designated for Burials				

RIGHTS OF CLIENT (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, not to exceed 3, 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.
- Your 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 OF CLIENT (to be read and explained)

- I agree to let my income maintenance caseworker know within 10 days following any change in my situation. I will notify my income maintenance 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 income maintenance 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 a State or Federal reviewer may check the information on this form, 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 the State. I understand that the information provided may be stored in a computer Data Bank. I have received, or will receive, a copy of the "Medicaid Notice of Privacy Practices."
- 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, other real property, cash, bank accounts, and other investments) are transferred out of the recipient's name without receiving fair market value for the resources, it could result in a period of ineligibility for institutional services, such as in a nursing facility, or for in-home care. I have reported all resource transfers when completing this review of my eligibility and will report any new transfers to my worker within 10 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 (ESC), 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 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.
- I understand that this assignment of rights continues as long as I or anyone listed on this application receive Medicaid or any cash assistance program 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 cash assistance check.
- I understand that if Medicaid pays for certain medical services, Medicaid may become a creditor of my estate and my estate may be subject to recovery to repay Medicaid. Ask your Medicaid case worker for specific information regarding which services are applicable to estate recovery.
- I hereby certify, under penalty of perjury, that I and all of the persons for whom I am requesting assistance are living in North Carolina with the intention of remaining permanently or for an indefinite period.
- I have received an explanation of family planning services, health screening for adults, and other services available through the department of social services.
- I certify that I and all of the persons for whom I am requesting assistance, with the exception of assistance with Emergency Medicaid services, are U.S. citizens or have eligible immigration status. Persons applying for Emergency Medicaid services only are not required to provide documentation of immigration status.
- I understand that North Carolina must be named remainder beneficiary for annuities purchased after a certain date. Contact the county DSS for more information.

- Transportation services have been explained and offered. 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? Yes No
- To be eligible for Medicaid Family Planning Waiver services, you must be a woman age 19 through 55 or a man age 19 through 60 and have not had a medical procedure that would prevent you from having a baby or fathering a baby. Medicare recipients are ineligible for Medicaid Family Planning Waiver Services. Do you wish to apply for Medicaid Family Planning Waiver? Yes No

If yes, for whom _____ Social Security # _____

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. Individuals interested in voter registration assistance must visit the department of social services for a face-to-face interview.

Prior to signing this form, should you have any questions, please ask the worker conducting the interview.

I have read the statements on this form and agree to them all.																	
RECIPIENT'S SIGNATURE: ✓	DATE:																
REPRESENTATIVE'S SIGNATURE: ✓	DATE:																
WITNESS: (if client cannot write) ✓	WORKER SIGNATURE: ✓																
CERTIFICATION/AUTHORIZATION																	
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Attach DMA-5036 for documentation of met deductible.