

MEDICAL ASSISTANCE – REDETERMINATION

FOR AGED, BLIND, AND DISABLED ADULT CATEGORIES AND/OR FAMILY PLANNING WAIVER SERVICES

_____ County Department of Social Services

Date _____

You must complete this form and return any requested information to our agency by _____ or your Medicaid for _____ will stop.

1. Please give a telephone number where you can be reached during the day _____. If you are acting on behalf of the person listed for the Medicaid review, please answer all questions as he/she would and tell us your relationship to him/her: _____
2. Do you speak English? YES NO What language do you prefer to speak? _____
3. Please check the type of income received and tell us the amount.
 Social Security \$ _____ Veterans Benefits \$ _____ Annuities \$ _____
 Other income or check(s) (Amount) \$ _____ Type of Income/Check _____
4. List any other money received since the last review. _____
5. How much cash do you have? (If you are in a nursing home, how much is in your patient account?) \$ _____
6. Do any relatives live with you and depend on you (or your spouse) to provide at least one-half of their financial support?
 YES NO **If yes, who?** _____ **Relationship** _____
7. List the name and age of every person that lives in your home with you and explain how they are related to you.

8. Do you or your spouse have Medicare or a Medicare HMO? YES NO **If Yes, which ones?**
_____ Medicare Claim #(s) _____
9. Are you or your spouse enrolled in a Medicare Prescription Drug Plan? YES NO **If yes, the plan(s) you are enrolled with.** _____
10. Have you bought or dropped any health or medical insurance since the last review or your application? YES No **If yes,**
Company Name & Address: _____ Phone Number _____
Policy Number: _____ Policy Holder's (Owner's) Name: _____ Date of Birth _____
Relationship: _____ Name of Insured: _____
11. Your records show you have the following bank accounts: Checking at _____ Savings at _____
Do you still have the same accounts? YES NO **If no, please tell us what happened to the accounts.** _____

12. Do you have other accounts anywhere? YES NO **If yes, list the name and location of the bank and the account number.** Name of Bank _____ Address _____ Account # _____

(PLEASE SEND YOUR MOST RECENT BANK STATEMENT FOR ALL ACCOUNTS.)

13. Your record shows you have the following motor vehicles: _____
Do you still have all of them? YES NO **If you don't, please tell us what happened.** _____

14. Your record shows that you have the following life insurance policies: _____
Do you still have these life insurance policies? YES NO **If no, what happened to them?** _____

15. Do you have any new life insurance policies? YES NO **If yes, write the company name and policy number.**
Company Name: _____ Address: _____
Phone No.: _____ Policy #: _____
Owner of Policy: _____
Cash Value: \$ _____ Face Value: \$ _____

16. List the address of any land or buildings you own: _____

17. Have you received any sums of money, land, or houses since your last review? YES NO
If yes, explain: _____

18. Have you given away any sums of money, land or houses since your last review? YES NO
If yes, explain: _____

19. Does anyone give you money, or provide you with food or a place to live? YES NO
If yes, explain: _____

Complete Only if the Medicaid Recipient Lives in a Nursing Facility

1. If the Medicaid recipient has a legal spouse at home who is allowed to keep some or all of the Medicaid recipient's monthly income, list any changes in the income of the at home spouse. _____

Medicaid Family Planning Waiver Services

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. If you are found to be ineligible for full Medicaid, but eligible for FPW, the FPW Medicaid is authorized for 12 months. You are "locked in" to this 12 month period. If you later reapply for full Medicaid during this 12 month period, your eligibility will be determined based on this certification period. Medicaid may or may not be authorized based on these requests. 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 #: _____

If you are unable to provide the information we asked for, OR if you do not understand a question OR if you would rather have an office visit for the form to be completed for you, CONTACT ME at _____.

Medicaid Caseworker

Read Each Statement Below and Sign at the Bottom of the Next Page.

What are My Rights?

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, national origin, sex, religion, age or disability in employment or the provision of services

What are My Responsibilities?

- 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 long term medical care, 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 North Carolina must be named remainder beneficiary for annuities purchased after a certain date. Contact the county DSS for more information.
- 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 citizenship status.

SERVICES

Please check the block if you need any of the services listed below or if you would simply like to have additional information.

- MEDICAID TRANSPORTATION:** Assistance with arranging or providing transportation to Medicaid covered services.
- FAMILY PLANNING:** Counseling and birth control for men and women of child-bearing age.
- EPSDT/HEALTH CHECK:** A service to insure that children and teens (birth to age 21) get regular medical checkups and shots they need.
- LIFELINE/LINK-UP ASSISTANCE PROGRAM:** Lifeline Assistance allows a credit each month on a local telephone bill. The Link-up program provides a 50% discount, up to \$30.00 off the price of a telephone hook-up.
- WIC:** Nutrition program for pregnant women and children up to age five.
- 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. I understand a face-to-face interview is required to register to vote or update voter registration. Questions regarding voter registration are answered by the Board of Elections.

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Recipient Certification

I hereby certify that the statements on this review form and any attachments to it are true and correct to the best of my knowledge and belief.

✓ _____
Signature Date Signed

Please sign your name or make your mark and ask someone else to sign their name below as witness to your mark.

Representative or Witness: ✓ _____ Relationship: _____
Signature