

# VERIFICATION/ELIGIBILITY DETERMINATION FOR MEDICAL ASSISTANCE APPLICATIONS ADULT CATEGORIES

\_\_\_\_\_ Date

\_\_\_\_\_ Applicant Name

\_\_\_\_\_ Application Number

\_\_\_\_\_ Co. Case Number

\_\_\_\_\_ Applicant Name

\_\_\_\_\_ Application Number

\_\_\_\_\_ Co. Case Number

**I. 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 determination of eligibility.**  
**Have any information given to the agency kept in confidence.**  
**Withdraw from the assistance program at any time.**  
**Receive assistance, if found eligible.**  
**Be informed of information needed to determine your eligibility.**

**Appeal to the county department of social services and to the Division of Social Services for a hearing if:**  
**You were denied the right to apply or reapply for assistance on the same day you or your representative went to the county department of social services.**  
**You were not informed in writing of your right to apply without delay.**  
**You believe you were encouraged to withdraw your application for assistance.**  
**Your application was not acted upon timely.**  
**Your application was denied and you believe the decision is not correct.**  
**You believe your assistance is incorrect based on the county's interpretation of State regulations.**  
**You believe the county failed to act promptly on your request to review your case.**

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.

**RESPONSIBILITIES OF CLIENT (to be read and explained)**

- I agree to let my income maintenance caseworker know within 10 calendar 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 the information on this form may be checked by a State or Federal reviewer, 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 applicant'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 making this application and will report any new transfers to my worker within 10 calendar days.
- I understand I must furnish all social security numbers used by me and/or anyone listed on this application who wants to receive benefits. 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 an 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 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 that I and all of the persons for whom I am making an application 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 understand that I and all the persons for whom I am requesting assistance, with the exception of assistance with Emergency Medicaid services, must provide proof of identity, U.S. citizenship or eligible immigration status. Persons applying for Emergency Medicaid services only are not required to provide documentation of citizenship, immigration status, or Social Security Number.
- 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?

**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 have read the statements on this form and agree to them all. Prior to signing this form should you have any questions, please ask the worker conducting this interview.

II. Applicant's/Representative's Signature (First, MI, Last)

Applicant's Signature (First, MI, Last)

Witness (If client cannot write) Worker's Signature



Dist. No. Co. Case No.

- MAABD  
 MAABD- Dual Eligibility  Q  B  
 MQB-Q only  MQB-B only  MQB-E

**Medical Assistance To The Aged/Blind  
And Disabled-Verification Document**

County \_\_\_\_\_ Date \_\_\_\_\_

<b>M</b>	Aid/Program Category	*A-Applicant S-Non a/r spouse; P- Non a/r parent FRP-Financially Responsible Person A1/A2 – Couple Case RS – Recipient (SSI, AFDC) Spouse RP – Recipient Parent	Classification
*V.	FIRST NAME	M.I.	LAST NAME
	Applicant		
	Applicant		
	FRP		
	FRP		
Address Of Household:			Phone Number:
Address Of Applicant In LTC:			Mentally Incompetent? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name, Address And Phone No. Of Representative, If Not Applicant: <input type="checkbox"/> Guardian <input type="checkbox"/> POA			Name Of POA/Guard., IF Not Rep:
Directions To Home/Other Information:			Address And Phone Number:
Applicant's/Representative Statement Of What Is Needed:			
Preneed <input type="checkbox"/> Yes <input type="checkbox"/> No		Retro In Months Of: _____	
Ongoing <input type="checkbox"/> Yes <input type="checkbox"/> No		Unpaid Bills In Months Of: _____	
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	

Note: IMC must explain old bills and retro policy when asking if retroactive coverage is needed.

*	Race**	Date Of Birth	Place	How Verified

\*\*Asian=A, Black or African-American=B, American Indian or Alaska Native =I, Native Hawaiian or Pacific Islander=P, Caucasian or White=W

*	Marital Status	How Verified	Language the Person Prefers to Speak	Ethnicity
			English Spanish Other _____	Hispanic/Latino Yes No ***If yes, specify
			English Spanish Other _____	Hispanic/Latino Yes No ***If yes, specify

\*\*\* Hispanic Puerto Rican = P, Hispanic Cuban = C, Hispanic Mexican = M, Hispanic Other = O

**VI. TPR/Medicare**

TPR: Policy Name	Number	Type of Coverage	Date Of Issuance

How Verified: \_\_\_\_\_ DMA-2041 Completed  \_\_\_\_\_ Date \_\_\_\_\_

*	RSDI Claim Number	Med. D	Med. A	Med. B	Household Composition: Relationship to applicant(s)
		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	Name _____ Relationship _____ FRP? <input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	Name _____ Relationship _____ FRP? <input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	Name _____ Relationship _____ FRP? <input type="checkbox"/> Yes <input type="checkbox"/> No

How Verified: (Medicare A enrollment must be verified for MQB-B & E.) \_\_\_\_\_

<p><b>VII. RESIDENCE/CITIZENSHIP</b> (indicate for each <i>applicant</i> using A, A1, A2)</p> <p>Applicant _____ is living in N.C. with the intention of remaining permanently or for an indefinite period.</p> <p>Applicant _____ is incompetent and living in N.C.</p> <p>Applicant _____ is a U.S. citizen.</p> <p>Applicant _____ is a qualified alien, not under or past the 5-year ban, who may be eligible for full coverage.</p> <p>Applicant _____ is a qualified alien, within the 5-year ban who may be eligible for only coverage of emergency services.*</p> <p>Applicant _____ is a non-qualified alien, who may be eligible for only coverage of emergency services.*</p>	<p>How Verified:</p>
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\* Aged, blind or disabled non-qualified and some qualified aliens are restricted to emergency services only. Duration of emergency is established by DMA.

Date medical information requested from hospital \_\_\_\_\_.

Date medical information sent to DMA \_\_\_\_\_.

Emergency approved.

Date decision of emergency services received from DMA \_\_\_\_\_.

Emergency denied.

Date(s) DMA approved for

Emergency medical care \_\_\_\_\_

**VIII. Disability/Blindness**

Does Applicant(s) under 65 receive RSDI disability, or State Aid to the Blind?\*

If already determined disabled, accept SSA's decision. If SAB recipient, verify per SAB register.

<p style="text-align: center;"><u>For Those Not Determined Disabled:</u></p> <ol style="list-style-type: none"> <li>1. Complete DMA-5009 - Social History</li> <li>2. Complete DMA-5028, Authorization to Disclose Information, for each provider listed on DMA-5009.</li> <li>2. Date DMA-4037 sent to DDS: _____.</li> <li>3. Date disability verified: _____.</li> <li>4. DSB-2202 for MAB applicants.</li> </ol>	<p><input type="checkbox"/> Yes, a/r already determined to be disabled/blind.</p> <p>* Document how disability/blindness was verified.</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 70%;">Title II/SSI disability/blindness</td> <td style="width: 30%;">Disability effective _____</td> </tr> <tr> <td>Approved by SSA effective _____</td> <td>Disability effective _____</td> </tr> <tr> <td>Other _____</td> <td>Date of Appeal _____</td> </tr> <tr> <td></td> <td>Reversal _____</td> </tr> </table>	Title II/SSI disability/blindness	Disability effective _____	Approved by SSA effective _____	Disability effective _____	Other _____	Date of Appeal _____		Reversal _____
Title II/SSI disability/blindness	Disability effective _____								
Approved by SSA effective _____	Disability effective _____								
Other _____	Date of Appeal _____								
	Reversal _____								

**IX. Food Stamp Referral**

Is the MA applicant an applicant/recipient for Food Stamps?  Yes  No

If Yes, DSS-8194 sent to FS unit at Application. \_\_\_\_\_  
Date

DSS-8194 or DMA-5002/DSS-8109 sent to FS unit at Disposition. \_\_\_\_\_  
Date

Health Check: Offer each component and document response for each for child under 21.

(A for accepted. D for declined. U for undecided.)

Name	Medical	Dental	Supportive Services
Health Check explained face to face on _____ Date	Health Check pamphlet (DMA-4078) given on _____ Date		

**X. Resource Interview For All Financially Responsible Persons** (check each item owned by a/r or FRP)

Identify FRP: A1/A2, RS, S, RP, or P  1. Real Property 1a. Type of ownership:	*A Y <input type="checkbox"/> N <input type="checkbox"/>	* Y <input type="checkbox"/> N <input type="checkbox"/>	* Y <input type="checkbox"/> N <input type="checkbox"/>	Applicant or representative's statement/worker comments:   [ ] Tenancy in common Property: Excluded from Reserve [ ] Life Estate: Excluded from Reserve unless purchased [ ] Remainder Interest/Negotiable Promissory Note: Will Value be rebutted? [ ] Yes [ ] No [ ] Tenancy by Entirety/Single Owner: Continue to 1b., 1c., 1d. [ ] Mineral/Timber Rights/Tobacco Allotment
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1b. Homesite and all contiguous: Excluded. Intent to return? [ ] Yes [ ] No

1c. Excluded Based on Usage? [ ] Yes [ ] No; continue to 1d.

[ ] Used in a business/trade/farming operation: Excluded  
 [ ] Used to produce goods/services: Exclude up to \$6,000.

Income: \_\_\_\_\_  
 Does it meet 6%? If yes, exclude:  
 up to \$6,000 total equity

[ ] Non-business rental property interest: Is it rented?  
 [ ] Yes \_\_\_\_\_ per \_\_\_\_\_ [ ] No: Will it be rented?

1d. Equity Value: Are there any loans against any property interest? If yes, document source and amount:

1e. Rebuttal of Real Property Value: Does the applicant or FRP hold a promissory note, Remainder Interest, or other property interest with equity value which Results/may result in excess reserve? If yes, discuss rebuttal evidence.

	*A		*		*		
	Y	N	Y	N	Y	N	
2. Bank Accounts/CASH							
2a. Personal C/S							
2b. Patient Account							
2c. CD's/Money Market							
2d. Operating Capital of a business							
2e. Any funds intended for burial?							
3. Stocks/bonds/Mutual Funds US Saving Bonds							
4. IRA/Other Retirement							
5. Trust Fund or Annuity							Date established: _____
6. Receipt of Lump sum							
7. Safe Deposit Box							
8. Personal Property							
8a. Motor Vehicle							
8b. Motor/Mobile Home							(includes camper)
8c. Other							(Includes motorcycles, boats, etc.)

8d. Excluded Based on Usage? [ ] Yes [ ] No

[ ] Used in a business/trade/farming operation: Excluded  
 [ ] Used to produce goods/services: Exclude up to \$6,000 equity

8e. Equity Value: Are there any loans against any property interest? If yes, document source and amount:

8f. Rebuttal: Does the applicant or FRP own personal property with equity value which results/may result in excess reserve? If yes, discuss rebuttal evidence.

	*A		*		*		Explain Burial Exclusion
	Y	N	Y	N	Y	N	
9. Burial Assets							
9a. Life Insurance which accrues CV							Designated for burial? [ ] Y: Date: _____
9b. Term/Burial Ins.							
9c. Burial contract							
Irrevocable?							
Revocable?							
9d. Burial Annuity							
10. Net proceeds from: Discontinued business							
11. Insurance Settlement							(Complete accident report for TPR)

**XI. Resources: Documentation and Calculation**

\*Indicate FRP: A1/A2, RS, S, RP, P

A. Liquid Assets	*A	*	*	Joint/Name	Account No.	Bank/Company	Amount
Cash/Checking							
Savings							
Stocks/Bonds							
CD's/IRA's							
Trust/Promissory Note							
Other							

Totals of Liquid Assets

Date and Method of Verification:

Total \_\_\_\_\_ month of \_\_\_\_\_

Total \_\_\_\_\_ month of \_\_\_\_\_

Total \_\_\_\_\_ month of \_\_\_\_\_

Total \_\_\_\_\_ month of \_\_\_\_\_

Total

**B. Insurance: If Face Value for each FRP does not exceed \$10,000, Cash Value for that FRP is not counted.**

Policy Owner Name/Relationship	Name of Insured	Insurance Company Name, Address and Phone Number	Policy Number	Face Value	Cash Value

Y  Cash Value Applied To Burial Exclusion?  
 N

Totals For Insurance

Date And Method Of Verification:

**\*C. Burial Exclusion: \$1,500.00 for each FRP**

Type Of Asset	Value	\$1,500	Balance Remaining In B.E.	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 Burial				

\*Explain Retro Burial Exclusion Policy.  
 Date statement of intent signed \_\_\_\_\_

Page Subtotal

D. Personal Property (Cars, etc.) Type		Indicate FRP	Exclude		Current Market Value	Rebuttal			Equity
Owner			Yes	No		Yes	No	Value	

Total Countable Equity

Document basis of exemption:

E. REAL PROPERTY INTEREST: Document locations(s), total acreage, and tax value for all property interests including those excluded. For countable property interests, also record encumbrances and equity.									
OWNER A, S, P	NAME OF OWNER	DESCRIPTION	EXCLUDE		TAX VALUE	REBUTTAL			EQUITY
			YES*	NO		YES	NO	VALUE	

TOTAL EQUITY OF COUNTABLE  
REAL PROPERTY


TOTAL RESERVE (ONGOING)

TOTAL RESERVE (RETRO MONTHS)  
 Month 1 \_\_\_\_\_ Date reserve met \_\_\_\_\_  
 Month 2 \_\_\_\_\_ Date reserve met \_\_\_\_\_  
 Month 3 \_\_\_\_\_ Date reserve met \_\_\_\_\_

DATE RESERVE MET \_\_\_\_\_

**XIII. TRANSFER OF RESOURCES**

Evaluate applicants and recipients for transfer of resources during the "look back period." 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:

**XII. Documentation Of Required Matches**

On-Line	*A	*	Date Checked	No Hit	Hit	Print-Out Attached	
						Yes	No
ESC/UI							
Bendex							
SDX							
DOT (See pg. 7)							
MCI							
TPQY/SOLQ							

Tax Office Checked \_\_\_\_\_ Tax Year \_\_\_\_\_

Register of Deeds Checked \_\_\_\_\_ through \_\_\_\_\_

ESC/UI Quarterly Match: \_\_\_\_\_

\_\_\_\_\_ Date

SDX/Bendex Sheets: \_\_\_\_\_

Beer: \_\_\_\_\_

FRR: \_\_\_\_\_

**XIV. INCOME INTERVIEW AND DOCUMENTATION FOR APPLICANT (S) & FRP \*DESIGNATE A1/A2, RS, S, RP, OR P.**

A. Source: Unearned	Yes (X)	No (X)	Amt. For Each FRP			Date And Method Of Verification
			*A	*	*	
Social Security						Claim# _____
SSI/Work First for RS, RP						
Retirement: Railroad/ State/Other						Retirement Acct # _____
VA Benefit/ A&A and UME (excluded for PLA)						VA File# _____
Civil Service Annuity/Other Retirement/Pensions						CSA# _____
Unemployment/ Disability Insurance						
Worker's comp./ Sick Pay (unearned after 6 mos.)						
Support/Alimony						
Work Release/ Military Allotment						
Contributions Cash/Inkind						
Educational Loans Grants/Scholarships						
Income From Trusts						
Dividends/Interest						
Roomers and Boarders						Operational Costs: _____ Net: _____
Rentals						Operational Costs: _____ Net: _____
Other _____						

Total Unearned:

Separate couple month of entry to LTC:  
Total  
Countable For \_\_\_\_\_ \$ \_\_\_\_\_ Effective Date \_\_\_\_\_

\*Designate A1/A2, RS, S, RP, or P.

Total  
Countable For \_\_\_\_\_ \$ \_\_\_\_\_ Effective Date \_\_\_\_\_

**XIV. Income Interview and Documentation (Cont.)**

B. Source: Earned	Yes (X)	No (X)	Amt. For Each FRP			Date And Method Of Verification
			*A	*	*	
Wages/Salaries (Attach computation)						(Sick Pay Is Earned For First 6 Mos.)
Net Self-Employment/ Business (after operational)						
Farm Income/ Seasonal Employment						
Earned Income Credit						
ADAP/Workshop						<b>Total Gross Earned:</b> <span style="border: 1px solid black; display: inline-block; width: 100px; height: 20px; vertical-align: middle;"></span>

For Married Applicant, Attach Sup. A

**XV. Deductible Computation For Single Applicant Only** - For Child, Attach Supp. E

**Evaluate For 1/3 Reduction:** If the A/R lives in the household of a person who is not financially responsible for the A/R: does the A/R pay an equal share of all the household expenses?

	Month(s)	Month(s)	Month(s)
1. TOTAL UNEARNED INCOME (Minus Pass-Along)			
2. \$20.00 General Exclusion (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)			
5. Operational expenses for self-employment/business	-	-	-
6. Subtract remainder of \$20 General Exclusion	-	-	-
7. Subtotal (Line 4 minus lines 5 and 6)			
8. Subtract \$65 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 (CN/MN/MQB/MWD)	-	-	-
14. If excess ineligible for CN/MQB/MWD. If excess for MN, use to determine deductible amount.			
15. Number of Months in period or months budgeted PLA	X	X	X
16. <b>EXCESS INCOME FOR THE PERIOD = MEDICAID DEDUCTIBLE</b> <b>Excess is rounded to the nearest whole dollar.</b>			

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.

<p style="text-align: center;"><u>Maintenance Allowance Adjustment</u></p>          <input type="checkbox"/> Full Medicaid/Deductible met. <input type="checkbox"/> MQB (Q, B, or E) <input type="checkbox"/> Case Change from MAABD to MQB Deductible not met.	<p>Deductible – Combine excess income for the certification period and round to the nearest dollar.</p> <div style="border: 1px solid black; width: 100px; height: 40px; margin: 10px auto; display: flex; align-items: center; justify-content: center;"> <span style="font-size: 24px;">\$</span> </div> <p style="text-align: center;">For the period</p> <p style="text-align: center;">_____ through _____</p>          <div style="border: 1px solid black; width: 100px; height: 40px; margin: 10px auto; display: flex; align-items: center; justify-content: center;"> <span style="font-size: 24px;">\$</span> </div> <p style="text-align: center;">For the period</p> <p style="text-align: center;">_____ through _____</p>
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For LTC Applicant, Attach Supp. B

**XVI. Lifeline/Linkup Assistance Program**

The **Lifeline/Link-up Assistance Program** is for individuals who have low-income. **Lifeline** can help pay a portion of your local telephone bill. If you are eligible, Lifeline will give you a credit each month on your local telephone bill.

**Link-UP** is a program that can help pay to connect your telephone service. This program is for low-income individuals. The program serves recipients of the Food Assistance, Work First Family Assistance, Medicaid and Low Income Home Energy Assistance Programs, which includes the Low Income Energy Assistance Program, Crisis Intervention Program and Weatherization.

Do you or your spouse have telephone service in your name?  Yes  No

If yes, in **whose name(s)** is the telephone bill? \_\_\_\_\_

What company provides your local telephone service? \_\_\_\_\_

**XVII. 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.

Do you wish to apply for Medicaid Family Planning Waiver?  Yes  No

IF YES, FOR WHOM \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

Carolina Access Recipient \_\_\_\_\_  
(Primary Care Provider)

**XVIII. All Statements recorded in this document are correct and represent my best knowledge and belief about the circumstances of all persons**

\_\_\_\_\_  
Signature of Applicant/Representative Date

\_\_\_\_\_  
Signature of Witness Date

Disposition Of Application	Reason
<input type="checkbox"/> Denied/Withdrawn: Retro <input type="checkbox"/> Denied/Withdrawn: Ongoing Date	
<input type="checkbox"/> Pended 6 mos. Date	
<input type="checkbox"/> Approved: Retro <input type="checkbox"/> Approved: Ongoing Date	

MQB only:

MAABD:

MWD only:

- Eligible MQB-Q
- Eligible MQB -B
- Eligible MQB-E
- Ineligible MQB

- Dual Eligible
- Eligible, deductible pending MAABD
- Eligible, MQB, MAABD
- Ineligible MAABD

- Eligible MWD
- Ineligible MWD

IMC \_\_\_\_\_

Date \_\_\_\_\_