

Case Name: _____ Case Number: _____ Date: _____

Aid Program: MAD MAA MQB LTC CAP MAF

Phone Number: _____

Date Application Received _____

District / Worker Number: _____ / _____

Application Complete Y N

If No, Date Letter Mailed _____

Date of Telephone Call: _____ Person Contacted: _____

A. Requirements Verification

Item	Source	Date
Age/DOB		
Enumeration		
Residence		
Soc. Sec # *Not Required for Non-applicants		
Citizenship Qualified Immigrant Status *Not Required for Non-applicants		
Medical Needs	RETRO <input type="checkbox"/> Y <input type="checkbox"/> N ANTICIPATED \$ _____ OLD BILLS \$ _____ CURRENT BILLS \$ _____	

B. Disability

Source	
SSA	RSDI <input type="checkbox"/> Disability Onset Date _____ SSI <input type="checkbox"/> Disabled as of _____ Passalong evaluation completed <input type="checkbox"/> Y <input type="checkbox"/> N Appeal Status of RSDI / SSI: Appeal Level _____ Request Date _____
DDS	5009 completed <input type="checkbox"/> Y <input type="checkbox"/> N 5028's mailed/returned for signature _____ 4037 mailed _____ DDS Finding: <input type="checkbox"/> "Disabled" <input type="checkbox"/> "Not Disabled"

C. Unearned Income

Budget Unit Member	Source/Verification	Monthly Amt.
		\$
		\$
		\$
Deduct Operational Expenses for Rental Income		
Item		Monthly Amt.
		\$
		\$
		\$
Total Unearned		\$

D. Earned Income

Budget Unit Member	Employer	Monthly Gross	Standard WR Expense
		\$	
		\$	
		\$	
		\$	
Deduct Operational Expenses for Self-Employment			
Item	Paid To	Monthly Amount	Verification
		\$	
		\$	
		\$	
		\$	
Total Earned			\$

To calculate total countable income, add total values from listed sections.

Total Countable Income	\$
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E. Resources

1. Bank Accounts

Type of Account	Name of Bank or Institution	Account Name/Account Number	Verification (check one)		Amount
			Bank Statement	DSS-3431 Form	
					\$
					\$
					\$
					\$
Total Values					\$

2. Life Insurance / Burial / Burial Pre-pays / Burial Exclusions/ Remainder Beneficiary/ Life Estate

Owner	Company Name	Policy No.	Insured	Cash Value	Participating Yes / No	Dividend Amount	Verification
						\$	
						\$	
						\$	
						\$	
Total Values							\$

3. Transfer of Assets

Item Transferred and Owner's Name	Sanction		Value	Date Transferred	Sanction Period
	Yes	No			
			\$		
			\$		
			\$		
			\$		
			\$		
Total Values			\$		

4. Undue Hardship

Undue Hardship (Y/N)	Verification/Documentation

Verification Checklist for Adult Mail-in Application
Page 3

5. Motor Vehicles / Personal Property

Owner	Year	Make	Model	Amount Owed	Rebuttal Amt.	Countable Value	Verification	Date
				\$	\$	\$		
				\$	\$	\$		
				\$	\$	\$		
				\$	\$	\$		
Total Values						\$		

6. Liquid Assets

Type of Account	Name on Account	Account. Number	Bank/Company	Amount	Verification	Date
Money Market				\$		
Burial Contract				\$		
Safety Deposit Box				\$		
Certif. of Deposit				\$		
Stocks				\$		
Trusts				\$		
Bonds				\$		
Mutual Funds				\$		
Annuities/Verification of Remainder Beneficiary				\$		
401 K, Keough				\$		
Retirement Accounts				\$		
Promissory Notes				\$		
Other Account				\$		
Total Values				\$		

7. Real Property

Owner/Owner's or Buyer's Name:	Address	Value	Amt. Owed	Countable Value	Verification	Date
		\$	\$	\$		
		\$	\$	\$		
		\$	\$	\$		
		\$	\$	\$		
Total Values						

To calculate total countable resources, add total values from listed sections.

Total Countable Resources	\$
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F. Dependents

Name	Age/DOB	Sex

G. Certification / Authorization

Program/Class	Certification Period		Authorization Period		Deductible Period		Deductible Amount
		to		to		to	\$

G. Referrals

Services	Referral Sent Yes / No	Date
Health Check (EPSDT)		
Food Stamps		
Family Planning		
Medical Transportation		
LIS		
Lifeline/Linkup		
Women, Infants and Children Program (WIC)		
National Voter Registration Act (NVRA)		
Health Insurance Premium Payment (HIPP)		
Carolina Access or Community Care of NC		
Other		

H. Family & Children's Medicaid Evaluated. Y N

DOCUMENTATION/WORKSPACE:

I have verified the information listed on this form.



Worker Signature

Date