NC Medicaid

North Carolina Department of Health and Human Services

Verification Checklist for Adult Mail-in Application

Case Name: ______________________________ Case Number: ____________________ Date: _________________

Aid Program: ☐ **MAD** ☐ **MAA** ☐ **MQB** ☐ **LTC** ☐ **CAP** ☐ **MAF**

Phone Number: _________________________

Date Application Received____________________________

Application Complete ☐ Y ☐ N

District / Worker Number: __________/___________

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 ☐ Y ☐ N ANTICIPATED $______________________ OLD BILLS $_________________________ CURRENT BILLS $____________________	

B. Disability

Source	
SSA	RSDI ☐ Disability Onset Date ___________________________ SSI ☐ Disabled as of _________________________________ Passalong evaluation completed ☐ Y ☐ N Appeal Status of RSDI / SSI: Appeal Level __________________ Request Date __________________
DDS	5009 completed ☐ Y ☐ N 5028's mailed/returned for signature________________________________ 4037 mailed ____ DDS Finding: ☐ "Disabled" ☐ "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	$

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

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	$

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