



RE-ENROLLMENT FORM

**It is time to re-enroll**  
**in Health Check Insurance Program or NC Health Choice for Children. Please complete this form and return it to the County Department of Social Services by \_\_\_\_\_ . Print all answers and provide information for everyone in the home.**

**Mail-In Option:**

Please complete all sections, as required, and sign and date the form on page 3. Fold the Re-Enrollment Form (BOTH SHEETS – Front & Back) so that the address of the social services department (see above) shows in the window of the return envelope. Then add a stamp and mail.

**Other Options for Submitting the Form:**

The completed form may be returned to your local department of social services in person. If you would like assistance in completing the form, the local department of social services will be glad to help. No appointment is needed. You may also call Ask to speak to your Health Check or NC Health Choice Representative.

**Help Us Update Our Information About Your Family**

1. **List all the children under age 21 who live in the home.** ▼  
*Fill out this information even for children who will not be applying or re-enrolling in Health Check or NC Health Choice. Social security number, proof of identity and citizenship status are required only for those applying for Health Check.*

Name of Child (first, middle initial, last)	Applying or Re-Enrolling this Child? (Y, N)	Date of Birth (mo/day/yr)	Sex (M,F)	*Race (Use codes below. List all that apply). (Optional)	**Hispanic/Latino (Y, N) If Yes, specify using codes below. (Optional)	Child a U.S. Citizen (Y, N)	Social Security Number (SSN) Not Required if you are not applying for this child.

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

\*\*Ethnicity Codes: Hispanic Cuban = **C** Hispanic Mexican = **M** Hispanic Puerto Rican = **P** Hispanic Other = **H**

2. **Do you and the children live at the address noted at the top of this page?** ►  **Yes**  **No**  
**If no, where do you live now?** ▼

Address:	Mailing Address (if different):
City: State: Zip Code:	City: State: Zip Code:

3. **List the phone numbers where we may contact you.** ▼

Daytime phone: ( )	Home phone: ( )	Cell phone: ( )
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4. **Who are the parents living with the children? If the children do not live with their parents, who are the adults living in the home who care for the children?** ▼

Name of parent or adult caretaker (first, middle initial, last)	Date of Birth (mo/day/yr)	Sex (M,F)	*Race (Use codes listed under #1 above). (Optional)	**Hispanic/Latino (Y, N) (Use codes listed under #1 above). (Optional)	What is this adult's relationship to each of the children listed in Question 1 above? (Example: Mother of John; Stepmother of Mary)

## Tell Us About the Family's Health Insurance

5. Does anyone re-enrolling or applying have a private health insurance plan?  Yes  No

If yes, please give information below:

Name (first, middle initial, last)	Insurance Company Name	Insurance Company Address & Phone Number	Policyholder/Owner Name/Relationship	Group/Policy Number

## Tell Us About the Parent's and Children's Income

6. Who are the parents and children in the home who are working now and what are their wages? If no one is working, write "N/A" or "Not Applicable" on the first line and move on to Question 7.

Name of working person (first, middle initial, last)	Employer's Name and Phone Number	Amount earned before deductions.	Tips Earned.	How often paid? (monthly, weekly, etc.) (Attach documentation. See * below).
		\$	\$	
		\$	\$	
		\$	\$	

\*Attach copies of all of last month's paycheck stubs (or a letter from the employer stating last month's gross wages) for everybody listed. Attaching the stubs now will help us re-enroll your children on time. If this is a new job, provide documentation from the employer of what your gross monthly wages will be.

7. Is there a parent or child in the home who is self-employed?  Yes  No

*For example, does anyone earn money from farming, own his or her own business, or have rental property income?*

If yes, please attach business records showing income and expenses for the last 6 months or the number of months in business if less than 6 months. If the income is annual, please attach business records for the last 12 months.

8. Does the parent or child receive income from any other source?  Yes  No

If yes, please fill in the information below, as appropriate:

Type of Income	Name of the person who receives other income	Amount Received	How often received (monthly, weekly, etc.)
Child Support		\$	
Social Security		\$	
Unemployment		\$	
Other (Please explain)		\$	

## Tell Us About the Parent's and Children's Expenses

Only three types of expenses can be deducted from the income we count:

(1) some of the money paid for childcare (or care of a dependent adult); (2) money paid for court-ordered child support; and a (3) standard deduction for work-related expenses.

9. Does a working parent living in the home pay for childcare, a babysitter or care for a dependent adult?  Yes  No

If yes, please fill in the information:

Name, address & phone number of sitter or childcare provider	Name of person cared for	Name of person paying for care	Amount Paid* (*Attach Documentation)	How often Paid (monthly, weekly, etc.)
			\$	
			\$	

\*Attach cancelled checks, receipts or a statement from the provider to show how much you paid last month.

10. Does a parent living in the home pay child support for a child who is not living in the home?  Yes  No

If yes, please fill in the information:

Who pays the support	For whom is the support paid	Is it court ordered (Y, N)	Amount Paid	How often Paid (monthly, weekly, etc.)
			\$	
			\$	

## Tell Us About Your Child's Medical Home

A medical home (primary care provider) is the **one place** you take your child for **all** their health care needs - regular check-ups, immunizations (shots), sick visits, minor accidents, or if they need to be referred to a specialist. A medical home can be a doctor's office or community clinic where the staff knows you, your child and your child's health history.

**Carolina Community Care of North Carolina/Carolina ACCESS (CCNC/CA)** – CCNC/CA is a Medicaid program which lets you choose your own doctor. Your doctor's name and phone number will be either on your Medicaid card or sent to you in a letter. Carry your card with you at all times. You must call your doctor before seeing any other doctor or you may be responsible for the bill. If you have not seen the doctor listed on your card, call for an appointment now. Your doctor will help you and your child stay healthy with regular check-ups and will care for you when you are sick or hurt. Call your doctor as soon as you or your child begins to have earaches, toothaches, colds, fever, diarrhea, vomiting, or other symptoms. If you have any questions about CCNC/CA, call your caseworker. **Please check the appropriate box below:**

I am currently enrolled in Carolina ACCESS     I am currently enrolled in Carolina ACCESS and would like to change my doctor  
*(If you checked this box, please list the name and address of the new doctor below or contact your caseworker.)*

**11. List each child who is applying or re-enrolling and note the name of his or her doctor or clinic. ▼**

Name of Child Who is Applying or Re-enrolling	Name of Doctor or Clinic (Medical Home) Where You Plan to Take this Child

## What Language Does the Family Prefer to Speak?

The federal government requires the State to provide information about the languages that the family speak? Please help us by providing this information for the parent or other adult caretaker living in the home.

Name of parent or adult caretaker (first, middle initial, last)	Language person prefers to speak (circle one)
1.	English    Spanish    Other (Specify _____ )
2.	English    Spanish    Other (Specify _____ )

- ✓ I attest that all statements recorded on this document are true and correct to the best of my knowledge.
- ✓ I have either read or had read to me all attachments to this application, and I understand my rights and responsibilities as an applicant/recipient.
- ✓ I authorize the release of any information necessary to establish my family's eligibility. I understand that this information may include medical information about the individuals applying for health insurance and/or non-medical information about individuals applying and others. This might include information from doctors, hospitals, employers, insurance companies and other financial institutions.
- ✓ I have received or understand that I will receive a copy of the "Medicaid Notice of Privacy Practices."
- ✓ I understand that if Medicaid pays for nursing facility care in-home health services, or services provided under the Community Alternatives Program (CA), Medicaid may become a creditor of my estate and my estate may be subject to recovery to pay Medicaid.
- ✓ Estate Recovery Notice: I understand that Federal and State laws require the Division of Medical Assistance (DMA) to file a claim against the estate of certain individuals to recover the amount paid by the Medicaid program during the time the individual received assistance with certain medical services. Ask your Medicaid case worker for specific information regarding which services are applicable to estate recovery.

**Signature of parent or other adult:** \_\_\_\_\_ **Date** \_\_\_\_\_

**Before You Return the Re-Enrollment Form...Review This Checklist:**

- Did you keep the Information Sheet for your records?
- Have you completed every question on the Re-Enrollment Form? (See next page for Optional Questions).
- Did you include copies of last month's paycheck stubs for each parent or child in the home who works?
- Did you include a daytime phone number (see Question #3)?
- Have you signed and dated the form?**
- Fold the completed Re-Enrollment Form so that the address of the social services department at the top of page 1 shows through the window of the return envelope provided. **If you do not return both sheets of the Re-Enrollment Form, your child's receipt of benefits may be delayed.**
- Add a stamp and it is ready to mail!

## Does Your Child Have Special Health Care Needs?

Please help us improve services for children with special health care needs and meet federal reporting requirements by answering the following questions. The answers will not affect your child's eligibility for Health Check (Children's Medicaid) or NC Health Choice.

1. Do any of your children currently need medicine prescribed by a doctor other than vitamins?  Yes  No  
If yes, does this child (or children) need this medicine because of *any* medical, behavioral or other health condition that has lasted or is expected to last *at least* 12 months?  Yes  No  
If yes, list the name of the child (or children): \_\_\_\_\_
2. Do any of your children need more medical care, mental health or education services than usual or routine for most children of the same age?  Yes  No  
If yes, does this child (or children) need these services because of *any* medical, behavioral or health condition that has lasted or is expected to last *at least* 12 months?  Yes  No  
If yes, list the name of the child (or children): \_\_\_\_\_
3. Are any of your children limited or prevented in **any way** in their ability to do the things most children their age can do?  Yes  No  
If yes, is this limitation because of *any* medical, behavioral or health condition that has lasted or is expected to last *at least* 12 months?  Yes  No  
If yes, list the name of the child (or children): \_\_\_\_\_
4. Do any of your children need special therapy, such as physical, occupational, or speech therapy?  Yes  No  
If yes, does this child (or children) need this therapy because of *any* medical, behavioral or other health condition that has lasted or is expected to last *at least* 12 months?  Yes  No  
If yes, list the name of the child (or children): \_\_\_\_\_
5. Do any of your children currently have any kind of emotional, developmental or behavioral difficulty for which they need treatment or counseling?  Yes  No  
If yes, does this child (or children) need this treatment or counseling because of *any* medical, behavioral or other health condition that has lasted or is expected to last *at least* 12 months?  Yes  No  
If yes, list the name of the child (or children): \_\_\_\_\_

## Tell Us If You Would Like Help With Child Support

The Child Support Agency can help get financial and medical help for the child from the child's absent parent. If you seek assistance from the Child Support Agency, the courts can establish paternity and establish and enforce medical support obligations.

There are other benefits to working with the Child Support Agency. For example, your child may be eligible for other financial benefits, including Social Security, pension benefits, veteran's benefits and possible inheritance. Also, your child may benefit by having a bond between parent and child. Finally, your child may benefit by getting important medical history information.

If you want the Child Support Agency's help in establishing paternity or obtaining a medical support order through the court, check the "Yes" box. If you check the box, someone will contact you.  **Yes, I would like help from the Child Support Agency.**

## Optional Benefits for Other Members of Your Family

- A. Do you want to apply for pregnancy coverage for any of the people listed in this application?  Yes  No  
*If you are applying for pregnancy assistance, you need to provide a statement from the doctor that includes the delivery date and the number of babies expected. However, send in the application form even if you do not have the statement from the doctor yet.*  
If yes, for whom? \_\_\_\_\_ Relationship \_\_\_\_\_ SSN# \_\_\_\_\_
- B. The Medicaid program provides coverage of family planning waiver services for women ages 19-55 or men ages 19-60 if they have not had a medical procedure to prevent them from having a baby or fathering a baby. Services include, but are not limited to: an annual physical examination, birth control methods, pregnancy tests, pap tests, screening for sexually transmitted diseases and voluntary sterilizations for women and men.  
If you meet these requirements, do you want to apply for or continue coverage of these services through Medicaid's Family Planning Waiver Program?  Yes  No  
If yes, for whom? \_\_\_\_\_ Relationship \_\_\_\_\_ SSN# \_\_\_\_\_
- C. Do you want to apply for Medicaid for any parent or adult relative listed in this application? The adult must be related to the child to be eligible and meet a different monthly income limit. If you want to apply, you will be contacted for information about income, bank accounts, real and personal property, cash value of life insurance, stocks, bonds, etc. Total resources must be less than \$3,000. Also, if you are eligible, you may be responsible for some of your medical bills. Parents/other adults applying must provide their Social Security numbers.  
*Meanwhile, we will continue to process this application for your children.*  
Do you still wish to apply for Medicaid for a parent or other adult relative of the child living in the home?  Yes  No  
If yes, for whom? \_\_\_\_\_ Relationship \_\_\_\_\_ SSN# \_\_\_\_\_