

M-AF Application – (Supplement 2)

Use for Parent/Caretaker of Child Under 19, Children age 19 or 20, or Children Ineligible for MIC/NC Health Choice.

First	NAME MI	Last	DATE OF BIRTH

RESOURCES (PARENT(S), CHILDREN AGE 19 OR 20, CHILDREN INELIGIBLE FOR MIC)
DO YOU HAVE ANY OF THE FOLLOWING? YES NO

SOURCE	YES	NO	WHOSE / WHERE LOCATED?	VALUE	VERIFICATION
CASH					
CHECKING					
SAVINGS					
CD'S					
STOCKS/BONDS					
FARM/BUSINESS EQUIPMENT					
PERSONAL PROPERTY: (Motorcycles, Boats, Campers, Mobile homes not used as a home, Jetskis, etc.)					
OTHER					

F/C/ BUDGET SHEET

MAF-C / 27.5%

MAF-N, M / MIC

MONTHLY GROSS EARNED INCOME	\$ _____
EITC DEDUCTIONS (-)	\$ _____
TOTAL =	\$ _____
X 27.5% = _____ (-)	\$ _____
 TOTAL NET EARNED	 \$ _____

CHILD/ALIMONY SUPPORT	\$ _____
DISREGARD (-)	\$ _____
COUNTABLE SUPPORT =	\$ _____
ALL OTHER UNEARNED (+)	\$ _____
TOTAL NET UNEARNED =	\$ _____

TOTAL EARNED + UNEARNED =	\$ _____
SUPPORT/ALIMONY PAID BY B.U. MEMBER (-) (COURT ORDERED)	\$ _____
INCOME DEEMED TO WORK FIRST CASE (-)	\$ _____
 TOTAL COUNTABLE INCOME =	 \$ _____

**	
# IN NEEDS UNIT =	_____
MAF - CN INCOME LEVEL =	_____
<p>Note: If ineligible using the 27.5% deduction and the \$90 and child/adult deductions are a higher income deduction, complete a second budget . (See budget for MAF-N, M and MIC in next column.)</p>	

MONTHLY GROSS EARNED INCOME	\$ _____
EITC DEDUCTIONS (-)	\$ _____
TOTAL =	\$ _____
WORK RELATED EXPENSE (-)	\$ <u>90.00</u>
CHILD/ADULT CARE (-)	\$ _____
TOTAL NET EARNED	\$ _____

CHILD/ALIMONY SUPPORT	\$ _____
DISREGARD (-)	\$ _____
COUNTABLE SUPPORT =	\$ _____
ANY OTHER UNEARNED (+)	\$ _____
TOTAL NET UNEARNED =	\$ _____

*	
TOTAL EARNED + UNEARNED =	\$ _____
SUPPORT/ALIMONY PAID BY B.U. MEMBER (-) (COURT ORDERED)	\$ _____
INCOME DEEMED TO WORK FIRST (-)	\$ _____
 TOTAL COUNTABLE INCOME =	 \$ _____

# IN NEEDS UNIT =	_____
MAF/ MIC INCOME LEVEL =	_____
<p>➤ IF OVER FOR MAF-C, (complete separate budget for Children (MIC), and deductible amt. for adults).</p>	
Total Countable Income	\$ _____
MN Income Level (-)	_____
Excess =	\$ _____
X Month(s) _____	
DEDUCTIBLE AMOUNT	\$ _____

	KINSHIP	*LIVING WITH	*This factor does not have to be verified for infant during the post partum period.
A.U. NO	Relationship to Casehead	Does the child live with the Specified Relative? **If yes, Enter Name and Relationship of Specified Relative Below.	Verification - Date and Method
1		<input type="checkbox"/> Yes <input type="checkbox"/> No _____	
2		<input type="checkbox"/> Yes <input type="checkbox"/> No _____	
3		<input type="checkbox"/> Yes <input type="checkbox"/> No _____	
4		<input type="checkbox"/> Yes <input type="checkbox"/> No _____	
5		<input type="checkbox"/> Yes <input type="checkbox"/> No _____	

****SHOW RELATIONSHIP OF SPECIFIED RELATIVE IF NOT PARENT:**

MEDICAL SUPPORT REQUIREMENTS

Name: _____

Relationship:

<p>Does the caretaker who is applying for herself have good cause for non-cooperation? (Review DSS-8104, if appropriate)</p> <p><input type="checkbox"/> YES, give date and verification below</p> <p><input type="checkbox"/> NO, give date and verification below</p> <p>_____</p> <p>_____</p>

NOTE: Refer to IV-D a pregnant woman who is ineligible for MPW and is receiving Medicaid under MAF when she is receiving assistance for children other than the unborn. Do not refer her to IV-D if there are no other children receiving Medicaid.

The information contained above and on the Medicaid/NCHC application is an accurate report of my income and resources.



Applicant

Date

AUTHORIZATION:

NAME	DISPOSITION	CERTIFICATION		DATES AUTHORIZED	
		FROM	THROUGH	FROM	THROUGH
	<input type="checkbox"/> Denied <input type="checkbox"/> Approved <input type="checkbox"/> Withdrawn	-		-	
	<input type="checkbox"/> Denied <input type="checkbox"/> Approved <input type="checkbox"/> Withdrawn	-		-	
	<input type="checkbox"/> Denied <input type="checkbox"/> Approved <input type="checkbox"/> Withdrawn	-		-	
	<input type="checkbox"/> Denied <input type="checkbox"/> Approved <input type="checkbox"/> Withdrawn	-		-	



Worker's Signature

Date

WORKSPACE/DOCUMENTATION: