

Mail-In Review for Help with Medicare Costs

Dear Recipient,

If you want to continue to receive reimbursement for your Medicare Part B premium, and/or assistance in paying deductibles, and coinsurance you must complete this review form and return it to your county department of social services. To assure continuing benefits, please return by _____.

If you have any questions or need help completing this form, call your county department of social services.

Read these instructions first. Fill out this form completely.

1. Read the Rights and Responsibilities thoroughly.
2. Sign your name on the third page of the review form.
3. Put the review form in the envelope and include any other information requested below.
4. Put a stamp on the envelope and mail it or take the form to your county department of social services.

A county staff member will contact you if additional information is needed.

If you are acting on behalf of the person listed above, please answer all the following questions for that person and tell us your relationship to them: _____

Please complete all blocks that apply to you.

Current address: _____			
Street address	City	State	Zip
Phone number or number where you (recipient) can be reached: _____			
Do you (applicant) live with a spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, spouse's name: _____			
Spouse's Social Security Number (if spouse is receiving Medicaid): _____			
If spouse wants to apply for Medicaid or Medicare-Aid, he/she must complete his/her own application.			
Income -Do you or your spouse have any of the following income? (Mark Yes or No for each type of income.)			
Type of Income	Gross Amount:	How often received:	Who receives benefit? (Applicant or spouse) (Write names.)
Social Security <input type="checkbox"/> Yes <input type="checkbox"/> No			
Any Retirement or Pension. (Railroad, State, Federal, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No			

Income continued:

Type of Income	Gross Amount:	How often received:	Who receives benefit? (Applicant or spouse) (Write names.)
Income from Rental Property or Income from roomer/boarder. <input type="checkbox"/> Yes <input type="checkbox"/> No			
Disability Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No			
Veteran's Benefit <input type="checkbox"/> Yes <input type="checkbox"/> No			
Dividends/Interest from Stocks, Bonds or Income from Trust Account <input type="checkbox"/> Yes <input type="checkbox"/> No			
Alimony <input type="checkbox"/> Yes <input type="checkbox"/> No			
Contributions: Amount anyone pays for your food, clothing or shelter. <input type="checkbox"/> Yes <input type="checkbox"/> No			
List any other income here, including income received from a job(s) or self-employment. <input type="checkbox"/> Yes <input type="checkbox"/> No			

✓ **Include a copy of most recent award letters, pay stubs, or other verification of income with this form if available. If you are self-employed, attach a copy of business or tax records for the last 6 months, unless you receive income annually. If you receive income annually, provide business records for the last 12 months. Provide copies of receipts for proof of operational expenses.**

Assets- Do you (applicant) or your spouse have any of the following assets?

Type of Asset	Amount	Name of Bank, Broker, or Financial Institution	Account Number
Cash on hand <input type="checkbox"/> Yes <input type="checkbox"/> No		N/A	N/A
Checking Account(s) <input type="checkbox"/> Yes <input type="checkbox"/> No			
Savings, CD's, Money Market, IRA's, or 401-K Accounts <input type="checkbox"/> Yes <input type="checkbox"/> No			
Real Property- Do you own any land, homes, buildings other than the home you live in? <input type="checkbox"/> Yes <input type="checkbox"/> No	Address of property		Tax value of property
Vehicles-Do you own any cars, trucks, motorcycles, mobile homes, etc? <input type="checkbox"/> Yes <input type="checkbox"/> No	Year, Make, Model		Amount owed on vehicle.
Life Insurance and/ or Burial Contracts- <input type="checkbox"/> Yes <input type="checkbox"/> No	List name of life insurance company and/or funeral home.	Policy number(s).	Cash and face value of policy or burial contract.
Do you have any other assets? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of asset	Account Number(s)	Amount/Value

✓ **Attach copy of most recent bank/financial statements with this form.**

- If you have a medical or health supplemental insurance policy to Medicare, write the name of the company and account/policy number: _____

READ, SIGN AND DATE HERE

I authorize the release of any information necessary to establish Medicaid eligibility. I understand this information may include medical or non-medical information, including such collateral sources as banks, employers, and insurance companies. This authorization may be reproduced.

I certify I have read the Rights and Responsibilities for Medicaid Individuals.

Applicant's Signature or Person Completing Form

Date

Witness Signature if Applicant signs with an "X"

Date

RIGHTS AND RESPONSIBILITIES FOR MEDICAID INDIVIDUALS

RIGHTS

You have the right to:

Apply for assistance, and, if found ineligible, reapply at any time. Have any person participate in the interview for determination of eligibility. Be protected against discrimination on the grounds of race, creed, or national origin by Title VI of the Civil Rights Act of 1964. Have any information given to the agency kept in confidence. Be informed of information needed to determine Family Assistance/Medicaid eligibility. Withdraw from the assistance program at any time. Receive assistance, if found eligible.

RESPONSIBILITIES

You must:

Provide the county department of social services, as well as state and federal officials, upon request, the information necessary to determine eligibility. Report to the county department of social services any change in your situation within 10 calendar days of knowing the change (5 calendar days for Special Assistance). Report to the county department of social services the receipt of assistance that you know is incorrect. Certify by signing this form that all information that you have provided is a true and complete statement of facts according to your best knowledge and belief.

RESIDENCE

I hereby certify that I and all the persons for whom I am making an application are living in North Carolina with the intention of remaining.

MEDICAL RECORDS

I understand that my medical and financial records must be made available to the agency and the state by any provider from whom I have received **Medical Assistance Program** services. I hereby agree to the release of those records by those providers when requested by the agency and the state. The privacy of this information is protected by law. I have received a copy of the "Medicaid Notice of Privacy Practices."

ASSIGNMENT OF RIGHTS

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.

SOCIAL SECURITY NUMBERS

I understand that I must furnish all social security numbers used by me and/or anyone receiving assistance with me to determine my eligibility for assistance. I also 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), Department of Transportation (DOT), 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 that I have the right to have my assistance terminated.