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 and return in the enclosed envelope or take the form to your county department of social services.
3. Include any other information requested below with the review form.
4. Put a stamp on the envelope.

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 Street Address:		N.C.	
	City	State	Zip

Phone Number or number where you (applicant) can be reached:

Do you (applicant) live with a spouse? ☐Yes ☐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 own application.

Income- Do you or your spouse have any of the following income?

Type of Income	**Gross Amount**	**How often received**	**Who receives benefit. Applicant or Spouse. (Write Names)**
Social Security			
Any Retirement or Pension. For example: Railroad, State, Federal, etc.			
Income from Rental Property **or** Income from roomer/boarder.			

Income Continued			
Type of Income (cont.)	**Gross Amount**	**How often received**	**Who receives benefit. Applicant or Spouse. (Write Names)**
Disability Insurance			
Veteran's Benefit			
Dividends/Interest from Stocks, Bonds or Income from Trust Account			
Alimony			
Contributions: Amount anyone pays for your food, clothing or shelter.			
List any other income here. Including income received from a **job(s) or self-employment.**			

- ✓ **Include a copy of most recent award letters, pay stubs, or other verification of income with this form if available. Attach a copy of business or tax records for the last year if you are self-employed. 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	1. Amount	2.Name of Bank, Broker, or Financial Institution	3. Account Number	4. Cash Value or Tax value
Cash on hand (List amount in 1st column.)				**N/A**
Checking Account(s) (Complete columns number 1,2 and 3.)				**N/A**
Savings, CD's, Money Market, IRA's, or 401-K Accounts (Complete columns 1, 2, and 3.)				**N/A**
Real Property- Do you own any land, homes, buildings other than the home you live in? ☐Yes ☐No List **tax value** of property in Column 4				

Assets continued:

Type of Asset	1. Amount	2. Name of Bank, Broker, or Financial Institution	3. Account Numbers	4. Cash Value or Tax Value
Vehicles-Do you own any cars, trucks, motorcycles, mobile homes, etc? ☐Yes ☐No List amount still owed on each vehicle in column 4 along with Year and Make.				**Amount owed on car.**
Life Insurance and or Burial Contracts- ☐Yes ☐No List name of life insurance company, and/or funeral home in column 2. List policy number in column 3. List cash and face value of policy or burial contract in column 4.				**List cash value and face value.**
Do you have any other assets? ☐Yes ☐No If yes, list type, amount, accounts, and 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 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 on the back of this form.

____

Applicant's Signature or Person Completing Form Date

____

Witness Signature if Applicant signs with an "X" Date

RIGHTS AND RESPONSILBILITES 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.