Print Form

Application for Health Coverage & Help Paying Costs (Short Form)

Use this application to see what coverage choices you qualify for

- ***Affordable private health insurance plans that offer comprehensive coverage to help you stay well***
- A new tax credit that can immediately help pay your premiums for health coverage
- Free or low-cost insurance from Medicaid or North Carolina Health Choice (NCHC)
- You may qualify for a free or low-cost program even if you earn as much as $94,000 a year (for a family of four)

Who can use this application?

Single adults who:

- Aren't offered health coverage from their employer
- Don't have any dependents and can't be claimed as a dependent on someone else's tax return

NOTE: If any of the following apply, you need to fill out a different form to make sure you get the most benefits possible:

- You're married or have dependent children
- You were in the foster care system, and you're under age 26
- You have items that can be deducted from your income. If your only deduction is student loan interest, you can use this form.
- You're American Indian or Alaska Native

Apply faster online

- ***Apply faster online at https://epass.nc.gov***

What you may need to apply

- ***Social Security Numbers (or document numbers for any legal immigrants who need insurance)***
- Employers and income information (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Proof of Identify
- Proof of NC Residence

Why do we ask for this information

We ask about your income and other information to let you know what coverage you qualify for, and if you can get any help paying for it. We'll keep all the information you provide private and secure, as required by law. To view the Privacy Act Statement, go to www.ncdhhs.gov/dma/medicaid/rights.htm

What happens next?

Send your complete, signed application to the Department of Social Services in the county where you live (www.ncdhhs.gov/dss/local). If you don't have all the information we ask for, sign and submit your application anyway. We'll follow-up with you within 1-2 weeks. You'll get instructions on the next steps to complete your application for health coverage. If you don't hear from us, visit. www.ncdhhs.gov/dss/local/ or call 1-888-245-0179. Filling out this application doesn't mean you have to buy health coverage.

Getting help with this application

- ***Phone: Call your local DSS office***
- In person: Visit your local DSS office. To find the location of your DSS office, visit www.ncdhhs.gov/dss/local/ or call 1-888-245-0179.
- En español: Llame su officina de DSS local. Para obtener mas informacion visite www.ncdhhs.gov/dss/local/ o llame al 1-888-245-0179.

NEED HELP WITH YOUR APPLICATION? Contact your county DSS (http://www.ncdhhs.gov/dss/local/) or call us at 1-888-245-0179. Para obtener una copia de este formulario en Español, llame 1-888-245-0179. If you need help in a language other than English, tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-452-2514.

STEP 1 – Tell us about yourself

1. First name, Middle name, Last name & Suffix

2. Home address (Leave blank if you don't have one)			3. Apartment or Suite Number
4. City	5. State	6. Zip Code	7. County
8. Mailing Address (if different from home address)			9. Apartment of Suite Number
10. City	11. State	12. Zip Code	13. County
14. Phone Number		15. Other Phone Number	

16. What is your preferred spoken or written language (if not English)?

17. Date of birth (mm/dd/yyyy): _____	18. Sex ☐ Male ☐ Female

19. Social Security Number (SSN):_____-_____- _____

NOTE: We need this if you want health coverage and have an SSN. We use SSNs to check income and other information to see if you're eligible for help with health coverage costs. If you need help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov; TTY users should call 1-800-325-0778.

20. If you are NOT registered to vote where you live now, would you like to register to vote here today?
☐ Yes ☐ No
Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by the agency.

21. Are you a U.S. citizen or U.S. National? ☐ Yes ☐ No

22. If you are not a U.S. citizen or U.S. national, do you have eligible immigration status?

☐ Yes. Fill in your document type and ID number below:

a. Immigration document type: _____
b. Document ID number: _____
c. Date of entry into the U.S.: _____
d. Are you, your spouse or parent a veteran or an active-duty member of the U.S. Military?
☐ Yes ☐ No

23. If Hispanic/Latino, ethnicity (OPTIONAL – check all that apply)
☐ Mexican ☐ Mexican-American ☐ Puerto Rican ☐ Cuban ☐ Other: _____

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24. Race (OPTIONAL – Check all that apply)

☐ White or Caucasian ☐ Black or African-American ☐ Asian ☐ Native Hawaiian
☐ Other Pacific Islander
☐ American Indian or Alaska Native (If you, complete Appendix B)
☐ Other: _____

25. Are you a resident of North Carolina? ☐ Yes ☐ No

26. Are you pregnant? ☐ Yes ☐ No If yes, how many babies are expected during this pregnancy? _____

27. Are you disabled?	27a. Are you aged 65 or older?	27b. Are you blind?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

28. Do you have a physical, mental or emotional health condition that causes limitations in activities of daily living (such as bathing, dressing, daily chores, etc.), live in a medical facility, nursing home and/or need home and community based services (CAP)? ☐ Yes ☐ No

29. Do you want help paying for medical bills in the last 3 months ☐ Yes ☐ No If yes, complete Appendix E

STEP 2 – Current Job & Income Information

1. Are you: (check one)

☐ Employed - if you're currently employed, tell us about your income. Start with question 2
☐ Self-Employed - Skip to question 11 ☐ Not employed - Skip to question 12

CURRENT JOB 1:

2. Employer name and address	3. Employer phone number:

4. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a Monthly ☐ Monthly ☐ Yearly

$ _____

5. Average hours worked each WEEK:

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper)

6. Employer name and address	7. Employer phone number:

8. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a Monthly ☐ Monthly ☐ Yearly

$_____

9. Average hours worked each WEEK:

10. In the past did you ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of These

11. If self-employed, answer the following questions: a. Type of work:	b. How much net income (profits once business expenses are paid) will you get form this self-employment this month?

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12. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.

NOTE: You do not need to tell us about child support, veteran's benefits, or Supplemental Security Income (SSI). If you are requesting Medicaid for the aged, blind, disabled, long-term care or in-home services (CAP) complete Appendix F.

- ☐ None
- ☐ Unemployment $_____How Often _____
- ☐ Pensions $_____How Often _____
- ☐ Social Security $_____How Often _____
- ☐ Retirement Accounts $_____How Often _____
- ☐ Alimony Received $_____How Often _____
- ☐ Net farming/fishing $_____How Often _____
- ☐ Net rental/royalty $_____How Often _____
- ☐ Other income $_____How Often _____
  Type: _____

13. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.

If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.
You shouldn't include a cost that you already considered in your answer to net self-employment (question 11b)

- ☐ Alimony Paid $_____How Often _____
- ☐ Student Loan Interest $_____How Often _____
- ☐ Other Deductions $_____How Often_____ Type: _____

14. **YEARLY INCOME:** Complete only if your income changes from month to month. If you don't expect changes to your monthly income, skip to step 3.

Your total income this year $_____

Your total income next year (if you think it will be different) $ _____

STEP 3 – Your Health Coverage

1. Are you enrolled in health coverage now from the following?

☐ Yes ☐ No

If yes, check which coverage you have

- ☐ Medicaid
- ☐ N.C. Health Choice (NCHC)
- ☐ Medicare
- ☐ TRICARE (Don't check if you have Direct Care or Line of Duty)
- ☐ VA Healthcare Programs
- ☐ Peace Corps:
- ☐ Other
  Name of Health Insurance _____
  Policy Number _____
  Type of coverage _____

2. Have you been in an accident in the past 12 months ☒ Yes ☒ No

THANKS! This is all we need to know about YOU

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STEP 4– Read & Sign this application

- *I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and/or untrue information.*
- I know that I must tell the Marketplace and Medicaid/NCHC if anything on this application changes. I can visit www.ncdhhs.gov/dss/local/ or call 1-800-662-7030 to report any changes. I understand that a change in my information must be reported within 10 calendar days and could affect my eligibility.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting http://www.ncdhhs.gov/dma/epsdt/DueProcessRights050311.pdf.
- I know that any information given to the Marketplace or Medicaid/NCHC will be protected and kept confidential.
- I know that the information on this application is needed to determine eligibility for help paying for health coverage and/or Medicaid/ NCHC and will be checked against electronic databases, Internal Revenue (IRS), Social Security, Department of Homeland Security, consumer reporting agencies, financial institutions and/or other government agencies.

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Marketplace to use income data, including information from tax returns. The Marketplace will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next:

☐ 5 years (the maximum number of years allowed ☐ 4 years ☐ 3 years ☐ 2 year ☐ 1 year

☐ Do not use information from tax returns to renew my coverage.

Medicaid/NCHC Eligibility

- I understand that the date of the Medicaid/NCHC application is the date that it is received by the County Department of Social Services.
- I understand that Medicaid coverage can be requested for any medical bills incurred up to three months prior to the month of application.
- I understand that if I enroll in Medicaid /NCHC , I am giving the Medicaid/NCHC agency rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medicaid/NCHC agency rights to pursue and get medical support from a spouse or parent.
- I understand that I may be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.
- I understand that if found eligible for full Medicaid benefits, I have the right to assistance with medical transportation.
- 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.
- I understand that any resources that are transferred out of the name of anyone requesting Medicaid assistance without receiving fair market value could result in ineligibility for assistance with nursing home cost of care and/or in-home care.
- I understand that North Carolina must be named beneficiary for annuities purchased after November 1, 2007.

My right to appeal

If I think the Health Insurance Marketplace or Medicaid/NCHC has made a mistake, I can appeal its decision. To appeal means to tell someone at the Health Insurance Marketplace or Medicaid/NCHC that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting the Department of Social Services or by calling 1-800-662-7030. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here, as long as you have provided the information required in Appendix C.

Signature	Date (mm/dd/yyyy)

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Step 5 Completed Application

Take or mail your application to your local County Department of Social Services (www.ncdhhs.gov/dss/local/).

If you are NOT registered to vote where you live now, would you like to register to vote here today?
☐ *Yes* ☐ *No*

If you want to register to vote, you can complete a voter registration form at www.ncsbe.gov/. Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency. If you would like help filling out the voter registration application form, we will help you. The decision either to see or accept help is yours. You may fill out the application form in private. If you believe that someone has interfered with your right register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Board of Elections.

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