



Application for Health Coverage & Help Paying Costs



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?

- Use this application to apply for anyone in your family
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- If you're single, you may be able to use a short form: www.ncdhhs.gov/dma/medicaid/applications.htm
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete Appendix C.



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 everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family
- 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 oficina de DSS local. Para obtener mas informacion visite www.ncdhhs.gov/dss/local/ o llame al 1-88-245-0179.



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. If you are NOT registered to vote where you live now, would you like to register to vote here today? <input type="checkbox"/> Yes <input type="checkbox"/> 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.			

STEP 2 – Tell us about your family

Who do you need to include in this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage).

Do Include

- Yourself
- Your Spouse
- Your children under 21 who live with you
- Anyone you include on your federal tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

You DON'T have to include

- Your parents who live with you, but file their own tax return (if you are over 21)
- Other adult relatives who file their own tax return.

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

Complete Step 2 for each person in your family. Start with yourself, then add other adults and children. If you have more than 4 people in your family, you'll need to make a copy of the pages and attach them. **You don't need to provide immigration status or Social Security Number (SSN) for family members who don't need health coverage.** We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.



NEED HELP WITH YOUR APPLICATION? Contact your county DSS (<http://www.ncdhhs.gov/dss/local/>) or call us at 1-888-245-0179.

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STEP 2 – Person 1 (Start with Yourself)

Complete Step 2 for yourself, your spouse, your children under age 21 who live with you and anyone you claimed on your federal tax return even if they do not live with you. See page 1 for more information about who to include. If you do not file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name and Suffix _____

2. Relationship to you:
SELF

3. Date of Birth (mm/dd/yyyy): _____

4. Sex Male Female

5. 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 who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov; TTY users should call 1-800-325-0778

6. Do you plan to file a federal income tax return NEXT YEAR? (You can still apply for health insurance even if you don't file a federal income tax return)


Yes If yes, please answer question a-c **No** If no, skip to question c.

a. Will you file jointly with a spouse? Yes No If yes, name of spouse: _____

b. Will you claim any dependents on your tax return? Yes No
If yes, list name (s) of dependents: _____

c. Will you be claimed as a dependent on someone else's tax return? Yes No
If yes, please list the name of the tax filer: _____
How are you related to this tax filer? _____

7. Do you need health coverage?
(Even if you have insurance, there might be a program with better coverage or lower costs.)

Yes, If yes, answer all the questions below 

No, If no, SKIP to the income question on page 4. Leave the rest of this section blank 

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

9a. 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

10. If Hispanic/Latino, ethnicity (OPTIONAL – check all that apply)

Mexican Mexican-American Puerto Rican Cuban Other: _____

11. 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: _____

NEED HELP WITH YOUR APPLICATION? Contact your county DSS (<http://www.ncdhs.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.



12. Are you a resident of North Carolina? Yes No

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

14. Do you live with at least one child under the age of 18, and are you the main person taking care of that child?
 Yes No

15. Were you in Foster Care in North Carolina when you turned 18?
 Yes No

16. Are you disabled?
 Yes No

16b. Are you aged 65 or older?
 Yes No

16c. Are you blind?
 Yes No

17. 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

18. Do you want help paying for medical bills in the last 3 months Yes No



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 representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-452-2514.

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STEP 2 – Person 1 (Continue with Yourself)

Current Job & Income Information

19. Are you: (check one)

Employed

If you're currently employed, tell us about your income. Start with question 20.

Self-Employed

Skip to Question 29.

Not employed

Skip to Question 30.

CURRENT JOB 1:

20. Employer name and address

21. Employer phone number:

() -

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

\$ _____

23. Average hours worked each WEEK: _____

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

24. Employer name and address

25. Employer phone number:

() -

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

\$ _____

27. Average hours worked each WEEK: _____

28. In the past year, did you:

Change Jobs Stop Working Start working fewer hours None of these

29. 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 from this self-employment this month? _____

30. **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).

- | | | | | | |
|--|---------|-----------------|--|---------|-----------------|
| <input type="checkbox"/> None | \$_____ | How Often _____ | <input type="checkbox"/> Net farming/fishing | \$_____ | How Often _____ |
| <input type="checkbox"/> Unemployment | \$_____ | How Often _____ | <input type="checkbox"/> Net rental/royalty | \$_____ | How Often _____ |
| <input type="checkbox"/> Pensions | \$_____ | How Often _____ | <input type="checkbox"/> Other income | \$_____ | How Often _____ |
| <input type="checkbox"/> Social Security | \$_____ | How Often _____ | Type: _____ | | |
| <input type="checkbox"/> Retirement Accounts | \$_____ | How Often _____ | | | |
| <input type="checkbox"/> Alimony Received | \$_____ | How Often _____ | | | |



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31. **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 29b)

- Alimony Paid \$ _____ How Often _____
- Student Loan Interest \$ _____ How Often _____
- Other Deductions \$ _____ How Often _____ Type: _____

32. **YEARLY INCOME:** Complete only if your income changes from month to month. If you don't expect changes to your monthly income, add another person or skip to the next section. 

Your total income this year \$ _____

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

THANKS! This is all we need to know about YOU





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STEP 2 – Person 2

Complete Step 2 for PERSON 2, their spouse, their children under age 21 who live with them and anyone they claimed on their federal tax return even if they do not live with PERSON 2. See page 1 for more information about who to include. If PERSON 2 does not file a tax return, remember to still add family members who live with them.

1. First name, Middle name, Last name and Suffix		2. Relationship to you:
3. Date of Birth (mm/dd/yyyy): _____	4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
5. Social Security Number (SSN): _____ (Only required if applying for assistance)		
6. Does PERSON 2 plan to file a federal income tax return NEXT YEAR? (They can still apply for health insurance even if they don't file a federal income tax return) <input type="checkbox"/> Yes If yes, please answer question a-c <input type="checkbox"/> No If no, skip to question c.		
a. Will PERSON 2 file jointly with a spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of spouse: _____		
b. Will PERSON 2 claim any dependents on their tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list name (s) of dependents: _____		
c. Will PERSON 2 be claimed as a dependent on someone else's tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list the name of the tax filer: _____ Is PERSON 2 related to this tax filer? If so, how? _____		
7. Does PERSON 2 need health coverage? (Even if they have insurance, there might be a program with better coverage or lower costs.) <input type="checkbox"/> Yes , If yes, answer all the questions below  <input type="checkbox"/> No , If no, SKIP to the income question on page 8. Leave the rest of this section blank 		
8. Is PERSON 2 a U.S. citizen or U.S. National? <input type="checkbox"/> Yes <input type="checkbox"/> No		
9a. If PERSON 2 is not a U.S. citizen or U.S. national, do they have eligible immigration status? <input type="checkbox"/> Yes. Fill in their document type and ID number below: a. Immigration document type: _____ b. Document ID number: _____ c. Date of entry into the U.S.: _____ d. Is PERSON 2, their spouse or parent a veteran or an active-duty member of the U.S. Military? <input type="checkbox"/> Yes <input type="checkbox"/> No		
10. If Hispanic/Latino, ethnicity (OPTIONAL – check all that apply) <input type="checkbox"/> Mexican <input type="checkbox"/> Mexican-American <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Other: _____		
11. Race (OPTIONAL – Check all that apply) <input type="checkbox"/> White or Caucasian <input type="checkbox"/> Black or African-American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> American Indian or Alaska Native (If so, complete Appendix B) <input type="checkbox"/> Other: _____		



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12. Does PERSON 2 live at the same address as you? If no, list address: _____	13. Is PERSON 2 a resident of North Carolina? <input type="checkbox"/> Yes <input type="checkbox"/> No	
14. Is PERSON 2 pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many babies are expected during this pregnancy? _____		
15. Do PERSON 2 lives with at least one child under the age of 18 and are they the main person taking care of that child? <input type="checkbox"/> Yes <input type="checkbox"/> No	16. Was PERSON 2 in Foster Care in North Carolina when they turned 18? <input type="checkbox"/> Yes <input type="checkbox"/> No	
17a. Is PERSON 2 disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	17b. Is PERSON 2 aged 65 or older? <input type="checkbox"/> Yes <input type="checkbox"/> No	17c. Is PERSON 2 blind? <input type="checkbox"/> Yes <input type="checkbox"/> No
18. Does PERSON 2 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)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
19. Does PERSON 2 need help paying for medical bills in the last 3 months <input type="checkbox"/> Yes <input type="checkbox"/> No		

Please answer the following questions if PERSON 2 is age 22 or younger:

20. Did PERSON 2 have insurance through a job and lose it within the past 3 months? Yes No
 a. If yes, end date: _____ b. Reason the insurance ended: _____



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STEP 2 – Person 2

Current Job & Income Information

21. Is Person 2 (check one)

Employed

If you're currently employed, tell us about your income. Start with question 22.

Self-Employed

Skip to Question 31.

Not employed

Skip to Question 32.

CURRENT JOB 1:

22. Employer name and address

23. Employer phone number:

() -

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

\$ _____

25. Average hours worked each WEEK: _____

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

26. Employer Name and Address

27. Employer phone number:

() -

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

\$ _____

29. Average hours worked each WEEK: _____

30. In the past year, did PERSON 2:

Change Jobs Stop Working Start working fewer hours None of these

31. 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 from this self-employment this month? _____

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

NOTE: PERSON 2 does not need to tell us about child support, veteran's benefits, or Supplemental Security Income (SSI).

None \$_____ How Often _____

Net farming/fishing \$_____ How Often _____

Unemployment \$_____ How Often _____

Net rental/royalty \$_____ How Often _____

Pensions \$_____ How Often _____

Other income \$_____ How Often _____

Social Security \$_____ How Often _____

Type: _____

Retirement Accounts \$_____ How Often _____

Alimony Received \$_____ How Often _____



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

If PERSON 2 pays 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.

Don't include a cost that PERSON 2 already considered in your answer to net self-employment (question 31b)

- Alimony Paid \$ _____ How Often _____
 - Student Loan Interest \$ _____ How Often _____
 - Other Deductions \$ _____ How Often _____ Type: _____
-

34. **YEARLY INCOME:** Complete only if PERSON 2's income changes from month to month. If you don't expect changes to PERSON 2's monthly income, add another person or skip to the next section. 

PERSON 2's total income this year \$ _____

PERSON 2's total income next year (if you think it will be different) \$ _____

THANKS! This is all we need to know about PERSON 2





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STEP 2 – Person 3

Complete Step 2 for PERSON 3, their spouse, their children under age 21 who live with them and anyone they claimed on their federal tax return even if they do not live with PERSON 3. See page 1 for more information about who to include. If PERSON 3 does not file a tax return, remember to still add family members who live with them.

1. First name, Middle name, Last name and Suffix		2. Relationship to you:	
3. Date of Birth (mm/dd/yyyy): _____		4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
5. Social Security Number (SSN): _____ (Only required if applying for assistance)			
6. Does PERSON 3 plan to file a federal income tax return NEXT YEAR? (They can still apply for health insurance even if they don't file a federal income tax return)			
<input type="checkbox"/> Yes If yes, please answer question a-c <input type="checkbox"/> No If no, skip to question c.			
a. Will PERSON 3 file jointly with a spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of spouse: _____			
b. Will PERSON 3 claim any dependents on their tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list name (s) of dependents: _____			
c. Will PERSON 3 be claimed as a dependent on someone else's tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list the name of the tax filer: _____ Is PERSON 3 related to this tax filer? If so, how? _____			
7. Does PERSON 3 need health coverage? (Even if they have insurance, there might be a program with better coverage or lower costs.)			
<input type="checkbox"/> Yes , If yes, answer all the questions below 			
<input type="checkbox"/> No , If no, SKIP to the income question on page 11. Leave the rest of this section blank 			
8. Is PERSON 3 a U.S. citizen or U.S. National? <input type="checkbox"/> Yes <input type="checkbox"/> No			
9a. If PERSON 3 is not a U.S. citizen or U.S. national, do they have eligible immigration status?			
<input type="checkbox"/> Yes. Fill in their document type and ID number below:			
a. Immigration document type: _____			
b. Document ID number: _____			
c. Date of entry into the U.S.: _____			
d. Is PERSON 3, their spouse or parent a veteran or an active-duty member of the U.S. Military? <input type="checkbox"/> Yes <input type="checkbox"/> No			
10. If Hispanic/Latino, ethnicity (OPTIONAL – check all that apply)			
<input type="checkbox"/> Mexican <input type="checkbox"/> Mexican-American <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Other: _____			
11. Race (OPTIONAL – Check all that apply)			
<input type="checkbox"/> White or Caucasian <input type="checkbox"/> Black or African-American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian			
<input type="checkbox"/> Other Pacific Islander			
<input type="checkbox"/> American Indian or Alaska Native (If so, complete Appendix B)			
<input type="checkbox"/> Other: _____			



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12. Does PERSON 3 live at the same address as you? If no, list address: _____		13. Is PERSON 3 a resident of North Carolina? <input type="checkbox"/> Yes <input type="checkbox"/> No	
14. Is PERSON 3 pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many babies are expected during this pregnancy? _____			
15. Does PERSON 3 live with at least one child under the age of 18 and are they the main person taking care of that child? <input type="checkbox"/> Yes <input type="checkbox"/> No		16. Was PERSON 3 in Foster Care in North Carolina when they turned 18? <input type="checkbox"/> Yes <input type="checkbox"/> No	
17a. Is PERSON 3 disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	17b. Is PERSON 3 aged 65 or older? <input type="checkbox"/> Yes <input type="checkbox"/> No	17c. Is PERSON 3 blind? <input type="checkbox"/> Yes <input type="checkbox"/> No	
18. Does PERSON 3 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)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
19. Does PERSON 3 need help paying for medical bills in the last 3 months <input type="checkbox"/> Yes <input type="checkbox"/> No			

Please answer the following questions if PERSON 3 is age 22 or younger:

20. Did PERSON 3 have insurance through a job and lose it within the past 3 months? Yes No
a. If yes, end date: _____ b. Reason the insurance ended: _____



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STEP 2 – Person 3

Current Job & Income Information

21. Is Person 3 (*check one*)

Employed

If you're currently employed, tell us about your income. Start with question 22.

Self-Employed

Skip to Question 31.

Not employed

Skip to Question 32.

CURRENT JOB 1:

22. Employer name and address

23. Employer phone number:
() -

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

\$ _____

25. Average hours worked each WEEK: _____

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

26. Employer name and address

27. Employer phone number:
() -

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

\$ _____

29. Average hours worked each WEEK: _____

30. In the past year, did PERSON 3:

Change Jobs Stop Working Start working fewer hours None of these

31. 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 from this self-employment this month? _____

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

NOTE: PERSON 3 does not need to tell us about child support, veteran's benefits, or Supplemental Security Income (SSI).

- | | | | | | |
|--|----------|-----------------|--|----------|-----------------|
| <input type="checkbox"/> None | \$ _____ | How Often _____ | <input type="checkbox"/> Net farming/fishing | \$ _____ | How Often _____ |
| <input type="checkbox"/> Unemployment | \$ _____ | How Often _____ | <input type="checkbox"/> Net rental/royalty | \$ _____ | How Often _____ |
| <input type="checkbox"/> Pensions | \$ _____ | How Often _____ | <input type="checkbox"/> Other income | \$ _____ | How Often _____ |
| <input type="checkbox"/> Social Security | \$ _____ | How Often _____ | Type: _____ | | |
| <input type="checkbox"/> Retirement Accounts | \$ _____ | How Often _____ | | | |
| <input type="checkbox"/> Alimony Received | \$ _____ | How Often _____ | | | |



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

If PERSON 3 pays 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.

Don't include a cost that PERSON 3 already considered in your answer to net self-employment (question 31b)

- Alimony Paid \$_____ How Often _____
- Student Loan Interest \$_____ How Often _____
- Other Deductions \$_____ How Often _____ Type: _____

34. **YEARLY INCOME:** Complete only if PERSON 3's income changes from month to month. If you don't expect changes to PERSON 3's monthly income, add another person or skip to the next section. 

PERSON 3's total income this year \$_____

PERSON 3's total income next year (if you think it will be different) \$ _____

THANKS! This is all we need to know about PERSON 3





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STEP 2 – Person 4

Complete Step 2 for PERSON 4, their spouse, their children under age 21 who live with them and anyone they claimed on their federal tax return even if they do not live with PERSON 3. See page 1 for more information about who to include. If PERSON 4 does not file a tax return, remember to still add family members who live with them.

1. First name, Middle name, Last name and Suffix		2. Relationship to you:	
3. Date of Birth (mm/dd/yyyy): _____		4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
5. Social Security Number (SSN): _____ (Only required if applying for assistance)			
6. Does PERSON 4 plan to file a federal income tax return NEXT YEAR? (They can still apply for health insurance even if they don't file a federal income tax return)			
<input type="checkbox"/> Yes If yes, please answer question a-c <input type="checkbox"/> No If no, skip to question c.			
a. Will PERSON 4 file jointly with a spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of spouse: _____			
b. Will PERSON 4 claim any dependents on their tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list name (s) of dependents: _____			
c. Will PERSON 4 be claimed as a dependent on someone else's tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list the name of the tax filer: _____ Is PERSON 4 related to this tax filer? If so, how? _____			
7. Does PERSON 4 need health coverage? (Even if they have insurance, there might be a program with better coverage or lower costs.)			
<input type="checkbox"/> Yes , If yes, answer all the questions below 			
<input type="checkbox"/> No , If no, SKIP to the income question on page 14. Leave the rest of this section blank 			
8. Is PERSON 4 a U.S. citizen or U.S. National? <input type="checkbox"/> Yes <input type="checkbox"/> No			
9a. If PERSON 4 is not a U.S. citizen or U.S. national, do they have eligible immigration status?			
<input type="checkbox"/> Yes. Fill in their document type and ID number below:			
a. Immigration document type: _____			
b. Document ID number: _____			
c. Date of entry into the U.S.: _____			
d. Is PERSON 4, their spouse or parent a veteran or an active-duty member of the U.S. Military? <input type="checkbox"/> Yes <input type="checkbox"/> No			
10. If Hispanic/Latino, ethnicity (OPTIONAL – check all that apply)			
<input type="checkbox"/> Mexican <input type="checkbox"/> Mexican-American <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Other: _____			
11. Race (OPTIONAL – Check all that apply)			
<input type="checkbox"/> White or Caucasian <input type="checkbox"/> Black or African-American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian			
<input type="checkbox"/> Other Pacific Islander			
<input type="checkbox"/> American Indian or Alaska Native (If so, complete Appendix B)			
<input type="checkbox"/> Other: _____			



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12. Does PERSON 4 live at the same address as you? If no, list address: _____		13. Is PERSON 4 a resident of North Carolina? <input type="checkbox"/> Yes <input type="checkbox"/> No
14. Is PERSON 4 pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many babies are expected during this pregnancy? _____		
15. Does PERSON 4 live with at least one child under the age of 18 and are they the main person taking care of that child? <input type="checkbox"/> Yes <input type="checkbox"/> No		16. Was PERSON 4 in Foster Care in North Carolina when they turned 18? <input type="checkbox"/> Yes <input type="checkbox"/> No
17a. Is PERSON 4 disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	17b. Is PERSON 4 aged 65 or older? <input type="checkbox"/> Yes <input type="checkbox"/> No	17c. Is PERSON 4 blind? <input type="checkbox"/> Yes <input type="checkbox"/> No
18. Does PERSON 4 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)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
19. Does PERSON 4 need help paying for medical bills in the last 3 months <input type="checkbox"/> Yes <input type="checkbox"/> No		

Please answer the following questions if PERSON 4 is age 22 or younger:

20. Did PERSON 4 have insurance through a job and lose it within the past 3 months? Yes No
a. If yes, end date: _____ b. Reason the insurance ended: _____



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STEP 2 – Person 4

Current Job & Income Information

21. Is Person 4 (check one)

Employed

If you're currently employed, tell us about your income. Start with question 22.

Self-Employed

Skip to Question 31.

Not employed

Skip to Question 32.

CURRENT JOB 1:

22. Employer name and address

23. Employer phone number:
() -

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

\$ _____

25. Average hours worked each WEEK: _____

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

26. Employer name and address

27. Employer phone number:
() -

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

\$ _____

29. Average hours worked each WEEK: _____

30. In the past year, did PERSON 4:

Change Jobs Stop Working Start working fewer hours None of these

31. 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 from this self-employment this month? _____

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

NOTE: PERSON 4 does not need to tell us about child support, veteran's benefits, or Supplemental Security Income (SSI).

None \$ _____ How Often _____

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: _____



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

If PERSON 4 pays 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.

Don't include a cost that PERSON 3 already considered in your answer to net self-employment (question 31b)

- Alimony Paid \$ _____ How Often _____
 - Student Loan Interest \$ _____ How Often _____
 - Other Deductions \$ _____ How Often _____ Type: _____
-

34. **YEARLY INCOME:** Complete only if PERSON 4's income changes from month to month. If you don't expect changes to PERSON 4's monthly income, add another person or skip to the next section. 

PERSON 4's total income this year \$ _____

PERSON 4's total income next year (if you think it will be different) \$ _____

THANKS! This is all we need to know about PERSON 3

If you have more people to include, make a copy of STEP 3 PERSON (page 6 thru 9) and complete for each additional person



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STEP 3

American Indian or Alaska Native (AI/AN) family member(s)

1. Are you or anyone you are requesting assistance for an American Indian or Alaska Native?

- If yes, complete Appendix B.
- If no, complete Step 4

STEP 4 – Your Family’s Health Coverage

Answer these questions for anyone who needs health insurance

1. Is anyone enrolled in health coverage now from the following?

- Yes**
- No**

If yes, check the type of coverage and write the person(s) name(s) next to the coverage they have:

- Medicaid: _____
- N.C. Health Choice (NCHC) _____
- Medicare: _____
- TRICARE (Don't check if you have Direct Care or Line of Duty)
- VA health care programs: _____
- Peace Corps: _____

Other: _____

Name of Health Insurance: _____
Policy Number: _____
Type of Coverage: _____

2. Is anyone listed on this application offered health insurance from a job? Check yes even if the coverage is from someone else's job, such as a parent or spouse.

- Yes** If yes, you'll need to complete and include Appendix A
- No** If no, continue to step 5.

3. Have you or anyone requesting assistance been in an accident in the past 12 months? Yes No

4. Does any child on this application have a parent living outside the home? Yes No



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STEP 5– 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 1-888-245-0179 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 1-888-245-0179. 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 6 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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