

VERIFICATION/ELIGIBILITY DETERMINATION FOR MEDICAL ASSISTANCE APPLICATIONS ADULT CATEGORIES

DMA-5008 (6/03)

_____ Date

_____ Applicant Name

_____ Application Number

_____ Co. Case Number

_____ Applicant Name

_____ Application Number

_____ Co. Case Number

I. RIGHTS OF CLIENT (to be read and explained)

You have the right to:
Apply for assistance and, if found not eligible reapply at any time.
Have any person, not to exceed 3, participate in the interview for determination of eligibility.
Have any information given to the agency kept in confidence.
Withdraw from the assistance program at any time.
Receive assistance, if found eligible.
Be informed of information needed to determine your eligibility.

Appeal to the county department of social services and to the Division of Social Services for a hearing if:
You were denied the right to apply or reapply for assistance on the same day you or your representative went to the county department of social services.
You were not informed in writing of your right to apply without delay.
You believe you were encouraged to withdraw your application for assistance.
Your application was not acted upon timely.
Your application was denied and you believe the decision is not correct.
You believe your assistance is incorrect based on the county's interpretation of State regulations.
You believe the county failed to act promptly on your request to review your case.

The N.C. Department of Health and Human Services does not discriminate on the basis of race, color, national origin, sex, religion, age or disability in employment or the provision of services.

RESPONSIBILITIES OF CLIENT (to be read and explained)

- I agree to let my income maintenance caseworker know within 10 days following any change in my situation. I will notify my income maintenance caseworker concerning any change in address, employment, property, resources, expenses or needs, living arrangements or number in the family or at any other time when I am in doubt whether a particular change in circumstances should be reported. In addition, I will notify my income maintenance caseworker immediately when the amount of my assistance is greater than the amount to which I am entitled.
- I understand that it is against the law to willfully withhold information or make false statements and that I am subject to prosecution if I do. I certify that the information I have provided (concerning my situation or that of the person(s) for whom I am making application) is a true and complete statement of facts according to my best knowledge and belief. I understand that all statements will be thoroughly investigated by the county department of social services. I understand that the information on this form may be checked by a State or Federal reviewer, and I agree to this investigation and understand that I must cooperate with the reviewer. I understand I must provide the county department of social services as well as State and Federal officials, upon request, the information necessary to determine eligibility. I further agree that my medical and financial records may be made available to the agency and the State. I understand that the information provided may be stored in a computer Data Bank. I have received a copy of the "Medicaid Notice of Privacy Practices."
- I understand that any Medicaid ID card I receive is to be used only for the persons listed on the ID card. I understand that it is against the law to give my ID card to someone whose name is not listed on it and that I may be prosecuted for fraud if I let someone else use my ID card.
- I understand that if any resources (including the homesite, other real property, cash, bank accounts, and other investments) are transferred out of the applicant's name without receiving fair market value for the resources, it could result in a period of ineligibility for long-term medical care, such as in a nursing facility, or for in-home care. I have reported all resource transfers when making this application and will report any new transfers to my worker within 10 days.
- I understand I must furnish all social security numbers used by me and/or anyone listed on this application to determine my/our eligibility for assistance. I 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), 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 I have the right to withdraw my application or have my assistance terminated.
- 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.
- I understand that this assignment of rights continues as long as I or anyone listed on this application received Medicaid or any cash assistance program and is based on federal regulations (42 CFR 433.147-148).
- Any child or spousal support (money) which is paid directly to me must be reported to the county department of social services and will be counted as income when determining eligibility for Medicaid benefits and/or the amount of any cash assistance check.
- I understand that if Medicaid pays for nursing facility care, in-home health services, or services provided under the Community Alternative Program (CAP), Medicaid may become a creditor of my estate and my estate may be subject to recovery to repay Medicaid.
- I hereby certify that I and all of the persons for whom I am making an application are living in North Carolina with the intention of remaining.
- I have received an explanation of family planning services, health screening for adults, and other services available through the department of social services.
- Transportation services have been explained and offered.
- In addition to your income maintenance caseworker who handles your Medicaid, the Department of Social Services has social workers to help with other needs you might have. Would you like to talk with a social worker?
 YES NO

I certify that my citizenship status is _____

VOTER REGISTRATION: You may now register to vote or update your voter registration record while applying for benefits, redetermining eligibility, or reporting a change in address.

I have read the statements on this form and agree to them all. Prior to signing this form should you have any questions, please ask the worker conducting this interview.

II. Applicant's/Representative's Signature (First, MI, Last)

Applicant's Signature (First, MI, Last)

Witness (If client cannot write) Worker's Signature

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Applicant's Signature (First, MI, Last)

Witness (If client cannot write) Worker's Signature

Dist. No. Co. Case No.

MAABD

**Medical Assistance To The Aged/Blind
And Disabled-Verification Document**

MAABD- Dual Eligibility Q B

MQB-Q only MQB-B only MQB-E

County _____ Date _____

Aid/Program Category M _____	* A – Applicant A1/A2 – Couple Case	S – Non a/r spouse; RS – Recipient (SSI, AFDC) Spouse	P – Non a/r parent; RP – Recipient Parent	Classification
* V.	FIRST NAME OF APPLICANT AND FRP	M.I.	LAST NAME	SOCIAL SECURITY NUMBER (optional for non – a/r)
Address Of Household:				Phone Number:
Address Of Applicant In LTC:				Mentally Incompetent? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name, Address And Phone No. Of Representative, If Not Applicant: <input type="checkbox"/> Guardian <input type="checkbox"/> POA				Name Of POA/Guard., IF Not Rep:
Directions To Home/Other Information:				Address And Phone Number:
Applicant's/Representative Statement Of What Is Needed:				
Preneed	<input type="checkbox"/> Yes <input type="checkbox"/> No	Retro In Months Of: _____	Unpaid Bills In Months Of:	
Prospective	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No		

Note: IMC must explain old bills and retro policy when asking if retroactive coverage is needed.

* Date Of Birth	Place	How Verified			
* Marital Status	How Verified	* Marital Status	How Verified	* Marital Status	How Verified

VI. TPR/Medicare

TPR: Policy Name	Number	Type of Coverage	Date Of Issuance

How Verified:

DMA-2041 Completed _____ Date

* RSDI Claim Number	Med. A	Med. B	Household Composition: Relationship to applicant(s)
	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	Name Relationship FRP? <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	Name Relationship FRP? <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	Name Relationship FRP? <input type="checkbox"/> Yes <input type="checkbox"/> No

How Verified: (Medicare A enrollment *must* be verified for MQB-B & E.)

VII. RESIDENCE/CITIZENSHIP (indicate for each *applicant* using A, A1, A2)

Applicant _____ is living in N.C. with the intention of remaining, permanently or for an indefinite period.

Applicant _____ is incompetent and living in N.C.

Applicant _____ is a U.S. citizen.

Applicant _____ is a qualified alien, not under or past the 5-year ban, who may be eligible for full coverage.

Applicant _____ is a qualified alien, within the 5-year ban who may be eligible for only coverage of emergency services.*

Applicant _____ is a non-qualified alien, who may be eligible for only coverage of emergency services.*

How Verified: (Include workplace, if ALIEN.)

* Aged, blind or disabled non-qualified and some qualified aliens are restricted to emergency services only. Duration of emergency is established by DMA.

Date DMA was notified of application: _____ Date medical information requested from hospital _____

Date medical information sent to DMA _____

Emergency approved.

Date decision of emergency services received from DMA _____

Emergency denied.

Date(s) DMA approved for
Emergency medical care _____

VIII. Disability/Blindness

Does Applicant(s) under 65 receive RSDI disability, or State Aid to the Blind?*

If already determined disabled, accept SSA's decision. If SAB recipient, verify per SAB register.

For Those Not Determined Disabled:

1. Complete DMA-5009 - Social History
2. Complete DMA-5028, Authorization to Disclose Information, for each provider listed on DMA-5009.
2. Date DMA-4037 sent to DDS: _____
3. Date disability verified: _____
4. DSB-2202 for MAB applicants.

Yes, a/r already determined to be disabled/blind.

* Document how disability/blindness was verified.

Title II/SSI disability/blindness Approved by SSA effective _____ Disability effective _____

Other _____ Date of Appeal _____

Reversal _____

IX. Food Stamp Referral

Is the MA applicant an applicant/recipient for Food Stamps? Yes No

If Yes, DSS-8194 sent to FS unit at Application. _____
Date

DSS-8194 or DSS-8108/8109 sent to FS unit at Disposition. _____
Date

Health Check: Offer each component and document response for each for child under 21.

(A for accepted. D for declined. U for undecided.)

Name

Medical

Dental

Supportive
Services

Health Check explained face to face on _____
Date

Health Check pamphlet (DMA-4078) given on _____
Date

X. Resource Interview For All Financially Responsible Persons (check each item owned by a/r or FRP)

Identify FRP: A1/A2, RS, S, RP, or P 1. Real Property 1a. Type of ownership:	*A Y <input type="checkbox"/> N <input type="checkbox"/>	* Y <input type="checkbox"/> N <input type="checkbox"/>	* Y <input type="checkbox"/> N <input type="checkbox"/>	Applicant or representative's statement/worker comments: [] Tenancy in common or Heir Property: Excluded from Reserve [] Life Estate: Excluded from Reserve [] Remainder Interest/Negotiable Promissory Note: Will Value be rebutted? [] Yes [] No [] Tenancy by Entirety/Single Owner: Continue to 1b., 1c., 1d. [] Mineral/Timber Rights/Tobacco Allotment
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1b. Homesite and all contiguous: Excluded. Intent to return? [] Yes [] No

1c. Excluded Based on Usage? [] Yes [] No; continue to 1d.

[] Used in a business/trade/farming operation: Excluded
 [] Used to produce goods/services: Excluded

[] Non-business rental property interest: Is it rented?
 [] Yes _____ per _____ [] No: Will it be rented?

Income: _____
 Does it meet 6%? If yes, exclude:
 up to \$6,000 total equity

1d. Equity Value: Are any loans against any property interest? If yes, document source and amount:

1e. Rebuttal of Real Property Value: Does the applicant or FRP hold a promissory note, Remainder Interest, or other property interest with equity value which Results/may result in excess reserve? If yes, discuss rebuttal evidence.

	*A	*		*		
	Y	N	Y	N	Y	N
2. Bank Accounts/CASH						
2a. Personal C/S						
2b. Patient Account						
2c. CD's/Money Market						
2d. Operating Capital of a business						
2e. Any funds intended for burial?						
3. Stocks/bonds/Mutual Funds US Saving Bonds						
4. IRA/Other Retirement						
5. Trust Fund or Annuity						Date established:
6. Receipt of Lump sum						
7. Safe Deposit Box						
8. Personal Property						
8a. Motor Vehicle						
8b. Motor/Mobile Home						(includes camper)
8c. Other						(Includes motorcycles, boats, etc.)

8d. Excluded Based on Usage? [] Yes [] No

[] Used in a business/trade/farming operation: Excluded
 [] Used to produce goods/services: Exclude up to \$6,000 equity

8e. Equity Value: Are any loans against any property interest? If yes, document source and amount:

8f. Rebuttal: Does the applicant or FRP own personal property with equity value which results/may result in excess reserve? If yes, discuss rebuttal evidence.

	*A	*		*		
	Y	N	Y	N	Y	N
9. Burial Assets						Explain Burial Exclusion
9a. Life Insurance which accrues CV						Designated for burial? [] Y: Date: _____
9b. Term/Burial Ins.						
9c. Burial contract						
Irrevocable?						
Revocable?						
9d. Burial Annuity						
10. Net proceeds from: Discontinued business						
11. Insurance Settlement						(Complete accident report for TPR)

XI. Resources: Documentation and Calculation

*Indicate FRP: A1/A2, RS, S, RP, P

A. Liquid Assets	*A	*	*	Joint/Name	Account No.	Bank/Company	Amount
Cash/Checking							
Savings							
Stocks/Bonds							
CD's/IRA's							
Trust/Promissory Note							
Other							

Totals of Liquid Assets

Date and Method of Verification:

Total _____ month of _____

Total

B. Insurance: If Face Value for each FRP does not exceed \$10,000, Cash Value for that FRP is not counted.

Owner *	Name of Insured	Insurance Company Name	Policy Number	Face Value	Cash Value

Y Cash Value Applied To Burial Exclusion?
 N

Totals For Insurance

Date And Method Of Verification:

***C. Burial Exclusion: \$1,500.00 for each FRP**

Type Of Asset	Value	\$1,500	Balance Remaining In B.E.	Excess
Irrevocable Trust				
Face Value Of Life Insurance If F.V. is Less Than \$10,000				
Revocable Contract				
Cash Value Of Designated Life Ins. When F.V. is more than \$10,000				
Cash Designated for Burial				

*Explain Retro Burial Exclusion Policy.
 Date statement of intent signed _____

Page Subtotal

D. Personal Property (Cars, etc.) Type	Owner	Indicate FRP	Exclude		VVI Value	Rebuttal			Equity
			Yes	No		Yes	No	Value	

Exclude the motor vehicle with the highest equity value.
 Count the equity of all other motor vehicles.
 Equity = CMV minus encumbrances.
 CMV is VVI value or rebuttal value.

Total Countable Equity

Document basis of exemption:

E. REAL PROPERTY INTEREST: Document locations(s), total acreage, and tax value for all property interests including those excluded. For countable property interests, also record encumbrances and equity.									
OWNER A, S, P	NAME OF OWNER	DESCRIPTION	EXCLUDE		TAX VALUE	REBUTTAL			EQUITY
			YES*	NO		YES	NO	VALUE	

Exclude the motor vehicle with the highest equity value.
 Count the equity of all other motor vehicles.
 Equity = CMV minus encumbrances.
 CMV is the VVI value or rebuttal value.

IF excluded document the basis for the exclusion:

TOTAL EQUITY OF COUNTABLE
REAL PROPERTY

XIII. TRANSFER OF RESOURCES

Evaluate applicants for transfer of resources during the "look back period." Refer to MA-2240, Transfer of Resources, for definition of the "look back period."

Has any resource been transferred, given away, or sold for less than the CMV? [] Yes [] No

If Yes: Uncompensated Value: _____ Date of Transfer _____

Was the transfer allowable? [] Yes [] No

If No, what is the sanction period? From: _____ through _____

If Yes, describe why it was allowable:

XII. Documentation Of Required Matches

On-Line	*A	*	Date Checked	No Hit	Hit	Print-Out Attached	
						Yes	No
ESC/UI							
Bendex							
SDX							
DOT (See pg. 7)							
MCI							
TPQY/SOLQ							

Tax Office Checked _____ Tax Year _____

Register of Deeds Checked _____ through _____

ESC/UI Quarterly Match: _____

_____ Date

SDX/Bendex Sheets: _____

Beer: _____

FRR: _____

XIV. INCOME INTERVIEW AND DOCUMENTATION FOR APPLICANT (S) & FRP *DESIGNATE A1/A2, RS, S, RP, OR P.

A. Source: Unearned	Yes (X)	No (X)	Amt. For Each FRP			Date And Method Of Verification
			*A	*	*	
Social Security						Claim# _____
SSI/Work First for RS, RP						
Retirement: Railroad/ State/Other						Retirement Acct # _____
VA Benefit/ A&A and UME (excluded)						VA File# _____
Civil Service Annuity/Other Retirement/Pensions						CSA# _____
Unemployment/ Disability Insurance						
Worker's comp./ Sick Pay (unearned after 6 mos.)						
Support/Alimony						
Work Release/ Military Allotment						
Contributions Cash/Inkind						
Educational Loans Grants/Scholarships						
Income From Trusts						
Dividends/Interest						
Roomers and Boarders						<u>Operational Costs:</u> _____ <u>Net:</u> _____
Rentals						<u>Operational Costs:</u> _____ <u>Net:</u> _____
Other _____						

Total Unearned:



Separate couple month of entry to LTC:

Total Countable For _____ \$ _____ Effective Date _____

*Designate A1/A2, RS, S, RP, or P.

Total Countable For _____ \$ _____ Effective Date _____

XIV. Income Interview and Documentation (Cont.)

B. Source: Earned	Yes (X)	No (X)	Amt. For Each FRP			Date And Method Of Verification
			*A_____	*	*	
Wages/Salaries (Attach computation)						(Sick Pay Is Earned For First 6 Mos.)
Net Self-Employment/Business (after operational)						
Farm Income/Seasonal Employment						
Earned Income Credit						
ADAP/Workshop						Total Gross Earned:

For Married Applicant, Attach Sup. A (9/95)

XV. Deductible Computation For Single Applicant Only -

For Child, Attach Supp. E (1/95)

Evaluate For 1/3 Reduction: If the A/R lives in the household of a person who is not financially responsible for the A/R: does the A/R pay an equal share of all the household expenses?

	Month(s)	Month(s)	Month(s)
1. TOTAL UNEARNED INCOME (Minus Pass-Along)			
2. \$20.00 General Exclusion (Subtract \$0, from VA pension)	- \$20.00	- \$20.00	- \$20.00
3. NET UNEARNED INCOME (Line 1 minus Line 2)			
4. GROSS EARNED (Go to line 12 if no earned)			
5. Operational expenses for self-employment/business	-	-	-
6. Subtract remainder of \$20 General Exclusion	-	-	-
7. Subtotal (Line 4 minus lines 5 and 6)			
8. Subtract \$65 Earned Income Deduction	- \$65.00	- \$65.00	- \$65.00
9. Subtotal (Line 7 minus line 8)			
10. Subtract 1/2 of line 9	-	-	-
11. NET EARNED INCOME			
12. TOTAL NET INCOME (Line 3 plus line 11)			
13. INDIVIDUAL INCOME LIMIT (CN/MN/MQB/MWD)	-	-	-
14. If excess ineligible for CN/MQB/MWD. If excess for MN, use to determine deductible amount.			
15. Number of Months in period or months budgeted PLA	X	X	X
16. EXCESS INCOME FOR THE PERIOD = MEDICAID DEDUCTIBLE Rounded to the nearest whole dollar.			

Evaluate each adult deductible case for MQB coverage. Combined excess income for the certification period, rounded to the nearest dollar, is the amount of the deductible. Attach DMA-5036 for documentation of when the deductible is met.

<p style="text-align: center;"><u>Maintenance Allowance Adjustment</u></p> <input type="checkbox"/> Full Medicaid/Deductible met. <input type="checkbox"/> MQB (Q,B, or E) <input type="checkbox"/> Case Change from MAABD to MQB Deductible not met.	<p>Deductible – Combine excess income for the certification period and round to the nearest dollar.</p> <div style="border: 1px solid black; width: 100px; height: 40px; margin: 10px 0; display: flex; align-items: center; justify-content: center;">\$</div> <p style="text-align: center;">For the period</p> <p style="text-align: center;">_____ through _____</p> <div style="border: 1px solid black; width: 100px; height: 40px; margin: 10px 0; display: flex; align-items: center; justify-content: center;">\$</div> <p style="text-align: center;">For the period</p> <p style="text-align: center;">_____ through _____</p>
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For LTC Applicant, Attach Supp. B

XVI. Workspace/Documentation

Carolina Access Recipient _____
(Primary Care Provider)

XVII. All Statements recorded in this document are correct and represent my best knowledge and belief about the circumstances of all persons listed on this application.

Signature of Applicant/Representative Date

Signature of Witness Date

Disposition Of Application	Reason
<input type="checkbox"/> Denied/Withdrawn: Retro <input type="checkbox"/> Denied/Withdrawn: Prospective <p style="text-align: right;">Date</p>	
<input type="checkbox"/> Pended <p style="text-align: right;">6 mos. Date</p>	
<input type="checkbox"/> Approved: Retro <input type="checkbox"/> Approved: Prospective <p style="text-align: right;">Date</p>	

MQB only:

MAABD:

MWD only:

- Eligible MQB-Q
- Eligible MQB -B
- Eligible MQB-E
- Ineligible MQB

- Dual Eligible
- Eligible, deductible pending MAABD
- Eligible, MQB, MAABD
- Ineligible MAABD

- Eligible MWD
- Ineligible MWD

IMC _____

Date _____