

BEFORE



Health Insurance  
For Kids and Teens

Hello. It's great that you're applying for Health Check (Medicaid Insurance)/NC Health Choice for Children because it will mean that your kids can have the medical attention they need. You can even get them regular checkups when they're well to make sure they stay that way. That's why this insurance is for CHILDREN AND TEENS up to age 19 (21 in some cases). North Carolina wants every child to get the best possible start on a healthy life.

Spanish applications are available at your local department of social services or by calling 1-800-367-2229.

Si usted desea obtener la forma DMA-5063, solicitud en Español para seguro medico para niños, comuníquese con el Departamento de Servicios Sociales de su localidad. También puede llamar al 1-800-367-2229. Se le atendera en Español.

### Before You Fill Out the Application

Before you fill out the application, there are just a few things that might be helpful for you to know. Health Check (Medicaid Insurance) and NC Health Choice for Children are two very similar insurance programs that provide health insurance for your children. The income information you provide will be used to determine in which of the programs your child is enrolled. BOTH insurance programs provide the same basic and excellent coverage that includes:

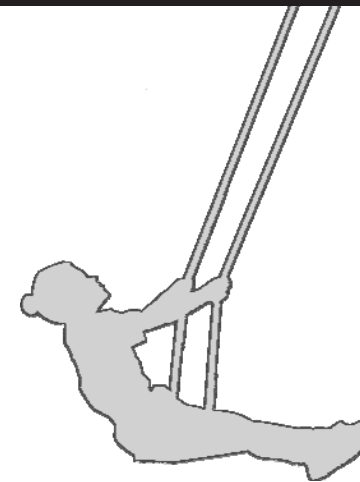
- |                    |                                |
|--------------------|--------------------------------|
| Doctor visits      | Prescriptions                  |
| Checkups           | Eye exams and glasses          |
| Hospital Coverage  | Dental Care                    |
| Mental Health Care | Hearing exams and hearing aids |

There are other benefits of these programs that you can learn about by calling 1-800-367-2229. Based on your income, there may be a low cost enrollment fee of no more than \$100 per family per year. In some cases, you may also make a small co-pay for doctor visits and prescriptions. If this applies to you, you will be notified.

If you would like some help filling out the application, call or go by your local department of social services. You can find their number in your phone book under "County Government" or you can get their number by calling the North Carolina Family Health Resource Line at 1-800-367-2229. Then just mail the application to your local department of social services or, if you prefer, drop off the application at your local social services office where you live.

AFTER

## HEALTH CHECK / NC HEALTH CHOICE FOR CHILDREN APPLICATION



Better health for you and your children, peace of mind for you.



### Free or Low-Cost Health Insurance

(Pregnant women, parents, or other adults may also use this application to apply for Medicaid as a caretaker or for Family Planning Services.)

Si usted desea obtener la forma DMA-5063, solicitud en español para seguro medico para niños, comuníquese con el departamento de servicios sociales de su localidad. También puede llamar a la línea de Recursos de Salud Familiar al 1-800-367-2229. Se le atenderá en español. (You can get a Spanish application at your local department of social services or call 1-800-367-2229.)

### WHAT ARE HEALTH CHECK AND NC HEALTH CHOICE FOR CHILDREN?

Health Check (the Medicaid Insurance Program) and Health Choice are two similar health insurance programs. Your family's income, the number of people in your family and the age of the children determine if you or your children qualify. This information will also be used to determine in which program you or the children will be enrolled.

### WHAT ARE THE BENEFITS?

- Sick visits
- Checkups
- Hospital care
- Counseling
- Prescriptions
- Dental care
- Eye exams and glasses
- Hearing exams and hearing aids
- And more!

**Transportation** - If you or your children are enrolled in Health Check, transportation to medical appointments may be provided through your department of social services. If the children are enrolled in Health Choice, you must provide your own transportation.

**Children with Special Health Care Needs may be eligible for additional services.**

### HOW DO I APPLY?

**It's easy. Just mail or drop off the completed application at the department of social services in the county where you live.** If you would like help filling out the application, call or visit your department of social services. You can find the address and phone number in your phone book under "County Government" or by calling the North Carolina Family Health Resource Line at 1-800-367-2229.

**Be careful to answer all the questions completely so we can process your application more quickly.** If you need more space, please attach additional pages. It can take 45 days or less to process your application. If we need additional information, we will contact you by mail. The sooner we get the information, the sooner we can let you know if your children qualify.

## BEFORE

It can take up to 10 days to process your application. It can also take less time. The process goes faster if you have answered all of the questions on the application. If we need additional information, we will contact you by mail. Remember, the sooner we get the information we need, the sooner we can help.

### Once You're Enrolled

Your child will receive an identification card in the mail. You will want to keep the card handy so you can show it at medical appointments and when you fill prescriptions. They need it to verify your child's coverage. Enrollment for children under 19 is good for one year. You will be contacted for re-enrollment when a review of your case is due.

### Managed Care

If your child is enrolled in Health Check (Medicaid Insurance), your caseworker will contact you so you can choose a doctor for your child.

### Funding Limits

NC Health Choice is a federal and state funded program that may be stopped if federal funds are not provided for its continuation. Health Check (Medicaid Insurance) is an entitlement program and has no funding limits.

### Rights and Responsibilities

- Health Check (Medicaid Insurance)/NC Health Choice cannot discriminate because of race, color, nationality, sex, religion, age, disability or political belief.
- The privacy of this information is protected by law.
- You can ask for a fair hearing if you think any decisions made in your case are unfair, incorrect or are made too late.
- If you knowingly provide false information or if you withhold information and your children get health insurance for which they are ineligible, you can be lawfully punished for fraud and may be asked to repay the programs for any medical bills and/or premiums that were paid incorrectly.
- If Health Check (Medicaid Insurance)/NC Health Choice for Children pays for health care for your children, you give permission to the state of North Carolina to collect payments from anyone who is supposed to pay for that care and to share medical information about your children with any insurance company to get the medical bills paid.
- You agree to tell the department of social services within 10 days if there are any changes in where you live, where you get your mail or about your health insurance coverage.
- You agree to tell the department of social services if anyone covered under Medicaid Health Insurance is involved in an accident.
- For NC Health Choice for Children, your child cannot have other comprehensive health insurance for 2 months before applying for NC Health Choice for Children. There are exceptions if your child has special health care needs or if your child loses health insurance for reasons that can't be controlled. There are no restrictions for Health Check (Medicaid Insurance).
- If we find that your family is eligible for Health Check (Medicaid Insurance), we will need the Social Security numbers for the eligible family members. Please know that the numbers of those members will be given to other government agencies (but not INS) to get information needed to determine eligibility.

## AFTER

### WHAT ELSE DO I NEED TO KNOW ABOUT HEALTH CHECK AND HEALTH CHOICE?

#### Will My Children Get Insurance Cards?

**YES!** Your children will receive insurance cards in the mail. Please keep the card handy so you can show it at medical appointments and when you fill prescriptions.

#### How Do I Choose a Doctor?

The department of social services will help you choose your doctor.

#### Will I Need to Re-enroll ?

**YES!** You will need to re-enroll to continue benefits. For most children this is done once a year. You will be contacted when it is time to re-enroll.

#### Will I Have to Pay Enrollment Fees and a Co-pay?

Depending on your income, you may have to pay an enrollment fee of \$50 to \$100 per family per year. In some cases, you also may have a small co-pay for doctor visits and prescriptions. If the fee and/or co-pay apply to you, you will be notified.

#### Will My Children Be Enrolled Immediately?

Health Check (the Medicaid Insurance Program) has no funding limits, so there is no waiting list. If your children are eligible for Health Choice, they may have to go on a waiting list before being enrolled if federal or state funds are not sufficient to serve more children.

### WHAT ARE MY RESPONSIBILITIES?

- ✓ You agree to tell the department of social services within 10 days if there are any changes in the information you provided on your application.
- ✓ A state or federal reviewer may check the information on this form. You agree to participate in the review and will cooperate with the reviewer.
- ✓ If you knowingly provide false information or if you withhold information and you or your children get health insurance for which they are not eligible, you can be lawfully punished for fraud and may be asked to repay the programs for any medical bills and/or premiums that were paid incorrectly.
- ✓ You agree to tell the department of social services if anyone with Health Check (the Medicaid Insurance Program) is in an accident.
- ✓ If Health Check (the Medicaid Insurance Program)/Health Choice pays for health care for you or your children, you give permission to the state of North Carolina to collect payments from anyone who is supposed to pay for that care. You also agree to share medical information about your children with any insurance company to get the medical bills paid.
- ✓ For a person to be enrolled in Health Check (the Medicaid Insurance Program)/Health Choice, you must provide his/her social security number or apply for a number. Please know that these numbers will be matched by computer with other government agency records (but not the Bureau of Citizenship and Immigration Services) to verify information. If you decide not to give the numbers, the person cannot be enrolled.
- ✓ For Health Check, provide proof of identity and U.S. citizenship or information for the county DSS to obtain the proof for those applying for benefits. For refugees and legally qualified immigrants, provide proof of legal status for those applying.

### WHAT ARE MY RIGHTS?

- ✓ Health Check (the Medicaid Insurance Program)/Health Choice cannot discriminate on the basis of race, color, nationality, sex, religion, age, disability in employment or the provision of services.
- ✓ By law, all information that you provide remains private.
- ✓ You can ask for a hearing if you think any decisions are unfair, incorrect or are made too late.

### WHO CAN ANSWER MY QUESTIONS?

Contact the department of social services in the county where you live or call the NC Family Health Resource Line at 1-800-367-2229.

**Before you return the application, please make sure to do the following:**

Read pages 1 and 2. Tear them off and keep for your records.

Complete the questions on pages 3 through 6.

**Sign the application on page 5.**

**BEFORE**

NC Health Choice for Children/Health Check (Medicaid Insurance) Application

\_\_\_\_\_ County Department of Social Services

Please complete and return pages 3 to 6 to your local department of social services.

**about You and the Family**

Tell us about yourself.

Name First, Middle Initial, Last	Date of Birth Month/day/year	Sex	Race *List as many from below as apply	Hispanic or Latino ethnicity? Yes/No

\*American Indian, Alaskan Native, Asian, Black or African American, Native Hawaiian, Pacific Islander, White

Tell us your address and phone number.

Mailing Address: \_\_\_\_\_  
City State Zip Code

Home Address: \_\_\_\_\_  
City State Zip Code

Home Phone: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Please list for us all the children under age 21 who live in the home. **Answer the citizenship question only if you are applying for Health Check/NC Health Choice for the child.**

Child's Name First name, middle initial, last name	Do you want to apply for Health Check/NC Health Choice for child? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Birth Mth/day/yr	Race *List as many from below as apply	Hispanic or Latino ethnicity? Yes/No	Sex	Is this child a US citizen? Yes/No	How is this child related to you?
	<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						

\*American Indian, Alaskan Native, Asian, Black or African American, Native Hawaiian, Pacific Islander, White

If the children live at a different address than you gave in #2, please tell us their address and phone number.

Home Address: \_\_\_\_\_  
City State Zip Code

Mailing Address: \_\_\_\_\_  
City State Zip Code

Home Phone: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Please list the names of the parents **who live with the children** and who are not listed in #1. Do not list names of parents not living with the children.

Name of parent/caretaker First name, middle initial, last name	Date of birth Mth/day/yr	Sex	Race *List as many as apply from below	Hispanic or Latino ethnicity? Yes/No	Child's Name	Parent or caretaker relationship to child

\*American Indian, Alaskan Native, Asian, Black or African American, Native Hawaiian, Pacific Islander, White

Is there a family member who is living away from the home temporarily? We want to count each family member to be sure you receive full benefits.  Yes  No If yes, tell us who that is.

Full Name	Reason for Absence	When do you expect him/her back?



**AFTER**

For Office Use Only		
County DSS: _____		
Date Received: _____		
Case #: _____		
<input type="checkbox"/> Mail in	<input type="checkbox"/> DSS	<input type="checkbox"/> Health Dept

**APPLICATION**

Please complete. Then send pages 3-6 to your local department of social services. If this application is being completed by or for a pregnant woman who has no other children living with her or you are applying for Family Planning, complete this application as if the pregnant woman or you is already a parent.

**Tell Us About the Family**

1. Who are all the children under age 21 who live in the home? ▾

Fill out this information **even** for children who will not be applying for Health Check/Health Choice. Social Security number, proof of identity, and citizenship status are required **only** for those applying for Health Check.

Name of child (first, middle initial, last)	Applying for this child (Y, N)	Date of birth (mo/day/yr)	Sex (M, F)	*Race (Use codes below. List all that apply.)	**Hispanic/Latino (Y, N) If yes, specify using codes below.	Is Child a U.S. citizen? (Y, N)	Social Security Number (SSN)

\*Asian= A American Indian or Alaska Native= I Native Hawaiian or other Pacific Islander= P Caucasian or White= W Black or African-American= B  
\*\* Hispanic Puerto Rican= P Hispanic Cuban= C Hispanic Mexican= M Hispanic Other= H

2. Where do you & the children live? ▾ (If different, please put your address on a separate sheet and return with this application.)

Address: _____	Mailing address (if different): _____
City: _____ State: _____ Zip Code: _____	City: _____ State: _____ Zip Code: _____
Home phone: ( ) _____	Daytime phone: ( ) _____

3. Who are the parents living with the children? If the children do not live with their parents, who are the adults living in the home who care for the children? ▾

Name of parent or adult (first, middle initial, last)	Date of birth (mo/day/yr)	Sex (M, F)	*Race (Use codes in 1. above. List all that apply.)	**Hispanic/Latino (Y, N) If yes, use codes in 1. above.	Children's names and parent or adult relationship to the children (John - Mother, Mary - Stepmother)

a. Do you want to apply for pregnancy coverage for any of the people listed in #3 above? ▶▶  Yes  No

If you are applying for pregnancy assistance, you need to provide a statement from the doctor that includes the delivery date and the number of babies expected. However, send in the application form even if you do not have the statement from the doctor yet.

If yes, for whom: \_\_\_\_\_ Relationship: \_\_\_\_\_ SSN \_\_\_\_\_

b. Do you want to apply for Medicaid for any of the people listed in #3 above? If you want to apply, you will be contacted for information about bank accounts, real and personal property, cash value of life insurance, stocks, bonds, etc. The total of these must be less than \$3,000. Also, if you are eligible, you may be responsible for some of your medical bills. ▶▶  Yes  No

Applicants must provide their Social Security numbers and may have to give information to the child support office.

If yes, for whom: \_\_\_\_\_ Relationship: \_\_\_\_\_ SSN \_\_\_\_\_

c. Do you want to apply for family planning services for any people ages 19 and older listed above? ▶▶  Yes  No

Applicants must provide their Social Security numbers.

If yes, for whom: \_\_\_\_\_ Relationship: \_\_\_\_\_ SSN \_\_\_\_\_