Health Check NC Health Choice for Children

(ORIGINAL FORM)

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, comuniquese con el Departamento de Servicios Sociales de su localidad. Tambien 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
- Checkups
- Hospital Coverage
- Mental Health Care
- Prescriptions
- Eye exams and glasses
- Dental 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.

It can take up to 45 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.

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.

bout 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.

ailing Address: _____
City State Zip Code

ome Address:_____
City State Zip Code

ome 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?	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?
	☐ Yes ☐ No						
	☐ Yes ☐ No						
	☐ Yes ☐ No						
	☐ Yes ☐ No						
	☐ Yes ☐ 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.

ome Address:_____
City State Zip Code

ailing Address:_____
City State Zip Code

ome 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?

If there is a parent not living in the home, is that parent required by an agreement to pay for medical insurance?
☐ Yes ☐ No

Does anyone applying for Health Check/NC Health Choice already have another health insurance plan?
☐ Yes ☐ No If yes, please fill in the questions below.

Insurance Company Name	Group/Policy Number	People applying for Health Check/NC Health Choice who are covered
s. Co. Address:		
s. Co. Phone Number:		

If no to question number 8, did they lose health insurance during the last 2 months? This information may be needed to know when your child's NC Health Choice can begin.
☐ Yes ☐ No If yes, why? _____

. Does anyone applying for Health Check/NC Health Choice need help paying medical bills from the past three months?
☐ Yes ☐ No If yes, please complete the information below. We may be able to help pay those bills.

Name of Person with bill	Name of doctor, clinic, hospital where the person was seen	Date of medical treatment

. Has anyone who is applying for Health Check/NC Health Choice been in an accident in the past 3 months and needed medical care?
☐ Yes ☐ No If yes, please tell us who and when. _____

. You may also apply for maternity health insurance for anyone in the home who is pregnant. Do you wish to apply for pregnancy coverage?
☐ Yes ☐ No If yes, for whom? _____
If you are applying for assistance for her, you will need to provide a statement from the doctor that includes the expected of date of delivery and the number of babies expected. **You should send the application form in even if you do not have the statement from the doctor.**

bout Your Family's Income and Expenses - *This section is only for parents and children in the home.*

. Please tell us about the parents and children in the home who work and what their wages are.

Name of Person Working	Employer's Name and Phone Number	Amount Earned Before Deductions (including tips)	How often are you paid?

. Is anyone in the home self-employed? For instance, does he have a farm or his own business or some rental property income?
☐ Yes ☐ No If yes, please include business records showing income and expenses for the last 12 months (or however long they've been in business if less than a year).

. Has anyone recently lost a job?
☐ Yes ☐ No If yes, please complete the following.

Name of person who lost a job	When did the person lose the job?	Employer's name, address and phone number

. Please tell us about any other income the parent or child receives.

Other income	Who gets it?	How **much** do they get?	How **often** do they get it?
ild Support			
cial Security			
employment Insurance			
her (Please explain)			

☐ Yes ☐ No If yes, please fill in the information. Some of these expenses may be used to help you enroll.

Sitter's name, address and phone number	Who is cared for?	Who pays for the care?	How **much** is paid?	How **often** is it paid?
			$	
			$	

. Does a parent living in the home pay child support for a child who is not living in the home?

☐ Yes ☐ No If yes, please fill in the information. Some of these expenses may be used to help you enroll.

Who pays the support?	Who is the support paid to?	Is it court ordered?	How **much** is paid?	How **often** is it paid?
			$	
			$	

ther Information

). You may also want to apply for Medicaid for you and your family members over 18. We will need information about such things as bank accounts, real and personal property, cash value of life insurance, stocks, and bonds. The total of these can't be more than $3,000. Also, depending on your income and medical expenses, you may be responsible for some of your medical bills.

Would you like to apply for this additional health insurance for anyone in the family over the age of 18? If you check yes, you will be contacted for more information.

☐ Yes ☐ No If yes, please give the name of the person or people. _____

Do any of the people listed need help paying medical bills from the past three months?

☐ Yes ☐ No If yes, who? _____

_____

_____ County Department of Social Services

I attest that all statements recorded on this document are true and correct to the best of my knowledge.
I either read, or had read to me, all attachments to this application and I understand my rights and responsibilities as an applicant/recipient.
I authorize the release of any information necessary to establish my family's eligibility. I understand that this information may include medical or non-medical information including information from doctors, hospitals, employers, and insurance companies.
This authorization may be reproduced.

_____

_____ _____

Signature of person completing application Date

efore you return your application:

- ☐ Did you fill in the form completely?
- ☐ Did you sign the form?
- ☐ You keep pages 1-2. Return pages 3-6 to your local county department of social services.

f you need help completing this form, please call or go by your local department of ocial services office. You can find their number in your phone book under "County overnment" or you can get their number by calling the North Carolina Family Health esource Line at 1-800-367-2229.

pecial Health Care Needs

ıe federal government requires the State to provide information about children with special health care needs. In order to identify ıose children, we need for you to complete the following questions. If your child does have special health care needs ıe two-month waiting period that some families have before they can get NC Health Choice may not apply. **If you don't answer ıese questions, the county will still enroll your child in Health Check/NC Health Choice if eligible.**

Does your child(ren) currently need medicine prescribed by a doctor other than vitamins? ☐Yes ☐No

. Does your child(ren) need this medicine because of ANY medical, behavioral, or other health condition that has lasted or is :pected to last at least 12 months? ☐Yes ☐No

If you answered yes, please list the child(ren). _____

Does your child(ren) need more medical care, mental health, or educational services than usual or routine for most children of the ıme age? ☐ Yes ☐ No

ı. Does your child(ren) need these services because of ANY medical, behavioral or health condition that has lasted or is expected last at least 12 months? ☐ Yes ☐ No

If you answered yes, please list the child(ren). _____

Is your child(ren) limited or prevented in any way in his/her ability to do the things most children the same age can do? ☐ Yes ☐ No

ı. Is this because of ANY medical, behavioral or health condition that has lasted or is expected to last at least 12 months? ☐ Yes ☐ No

If you answered yes, please list the child(ren). _____

Does your child need special therapy, such as physical, occupational or speech therapy? ☐ Yes ☐No

ı. Does your child need this therapy because of ANY medical, behavioral or other health condition that has lasted or is expected to st at least 12 months? ☐ Yes ☐ No

If you answered yes, please list the child(ren). _____

Does your child(ren) currently have any kind of emotional, developmental or behavioral difficulty for which he or she needs eatment or counseling? ☐ Yes ☐No

ı. Does your child(ren) need this treatment or counseling because of ANY medical, behavioral or other health condition that has sted or is expected to last at least 12 months? ☐Yes ☐No

If you answered yes, please list the child(ren). _____

hild Support

ıe Child Support Agency can help you to get financial and medical help for your child from the child's absent parent. By working with ıe Child Support Agency, paternity can be established and support obligations can be established and enforced through the courts.

ıere are other benefits to working with Child Support. There may be other financial benefits for your child including Social ecurity, pension benefits, veteran's benefits and possible inheritance. Also, your child may benefit by having a bond between parent ıd child. Finally, your child may benefit by getting important medical history information.

ou may want to voluntarily work with Child Support. If you want Child Support's help in establishing paternity or in getting a support der through the court, check the box below. Someone will contact you if you check the box.

☐ Yes, I would like to cooperate with Child Support.

ıanguage Your Family Prefers to Speak

ıe federal government requires the State to provide information about the language your family prefers to speak. Please complete ıe information below for yourself and each child for whom you need help. **If you don't answer these questions, the county will still ıroll your child in Health Check/NC Health Choice if eligible.**

Person's Name	Language They Prefer to Speak (Circle One)
	English Spanish Other (please specify) _____
	English Spanish Other (please specify) _____
	English Spanish Other (please specify) _____
	English Spanish Other (please specify) _____
	English Spanish Other (please specify) _____
	English Spanish Other (please specify) _____