FINANCIAL ELIGIBILITY APPLICATION

Purchase of Medical Care Services
DHHS – Controller's Office
1904 Mail Service Center • Raleigh, NC 27699-1904

FOR POMCS USE ONLY

1. Last Name First Name MI

2. Patient SS # ___ ___ ___

3. Date of Birth Month Day Year

4. Sex ☐ 1. Male ☐ 2. Female

5. Race ☐ 1. White ☐ 2. Black ☐ 3. American Indian ☐ 4. Asian ☐ 5. Native Hawaiian/Other Pacific Islander ☐ 6. Unknown

Ethnicity: Hispanic or Latino Origin? ☐ Yes ☐ No ☐ Unknown

6. Preferred Language _____ Select from the list on the back of this form

7. County of Residence

8. Address Street or RFD

9. City State Zip Code

10. Telephone Number: Home Work

11. Program

12. Case Number

13. NC Resident ☐ Yes ☐ No If **yes**, select one of the following:
(Applicants to the HIV Medications Program need only answer Y/N)
☐ 1. US citizen who lives in NC and intends to make NC his permanent home
☐ 2. Non citizen who has applied for US citizenship. INS documentation required
☐ 3. Non citizen who has a permanent resident visa or has applied for one (INS documentation required)
☐ 4. Migrant farmworker according to the federal definition
Migrant (Farmworker) Health Program Eligibility Application (DHHS 3753) required
Note: Migrant farmworker status meets the residency requirement for all POMCS programs

14. **Countable** Family Members
Number of Adults _____
Number of Children _____
Total Number 0

15. Earliest Requested Date of Program Coverage
Month Day Year

INCOME FORMULAS: Regular (**R**) – Continuously employed wage earners list income for the 12 months before the date of application **or** the requested date of coverage, whichever is earlier. Unemployment (**U**) – Wage earners unemployed at the time of application or for 30 consecutive days during the previous 12 months list income for 6 months before and after the date of application **or** the requested date of coverage, whichever is earlier. Cancer Program is based on gross income.

16. Complete for **All** Countable Family Members

Name	Relationship to Patient	Income Formula (R or U)	List all Employers or Sources of Income/Reason for None for **12 Month Period**	Dates From	Dates To	Gross Income	Income After Tax *(Not for Cancer Program)*

17. Explanations: Dates unemployed; means of support if income is low; etc.

18. **Annual Gross Income** (Stop Here for Cancer Program) $ 0.00
Federal, State & Soc. Sec. Tax
Income After Taxes $0.00
Total Income After Taxes (Sum of Both Lines) $ 0.00
Medical expenses paid or incurred during past 12 months not covered by a third party nor requested for program coverage $_____
Other deductions: (Specify)_____ $_____
Total Deductions $ 0.00
Annual Net Income (All Other Programs) $ 0.00

19. Eligibility for Other Programs Medicaid ID # _____
Medicare: Part A ☐ Yes ☐ No Part B ☐ Yes ☐ No Medicare # _____
VA Benefits: Are you a veteran? ☐ Yes ☐ No
Did you actively serve in any branch of the military for over 180 days? ☐ Yes ☐ No
Did you receive an honorable or general discharge? ☐ Yes ☐ No

20. Was patient's problem caused by an accident? ☐ Yes ☐ No
If yes, liability compensation is ☐ Pending ☐ Awarded ☐ Ruled Out
Give attorney's name, address and phone number in block #17.

21. HEALTH INSURANCE COVERAGE Provide complete insurance information and copies of insurance cards for **all** countable family members.

Company_____
Policy No._____
Claims Address_____
_____ Telephone_____
Policyholder_____
Is patient covered? ☐ Yes ☐ No Is this an **HMO**? ☐ Yes ☐ No

Company_____
Policy No._____
Claims Address_____
_____ Telephone_____
Policyholder_____
Is patient covered? ☐ Yes ☐ No Is this an **HMO**? ☐ Yes ☐ No

22. I hereby certify that I have read or the interviewer has read to me the terms and conditions contained on the back of this form and that I agree to comply with them. I also certify that I have been provided opportunity to ask the interviewer questions about these terms and conditions and that I understand the answers I was given.

Applicant's Signature Relationship to patient Date

23. I certify that I have explained the terms and conditions contained on the back of this form to the applicant and have witnessed his signature.

Type or Print Interviewer's Name Agency Name Date

Interviewer's Signature Street Address/P.O. Box Phone

City/State/Zip Code

See instructions on back.

INSTRUCTIONS

Purpose: To collect information required for the determination of program eligibility.

An interviewer completes this form when a service authorization is requested unless a current form is already on file. Once determined, eligibility generally extends for 12 months. The exception is new applications received during the annual renewal periods for the HIV Medication (January-March) and Kidney (April-June) programs. These may extend for up to 15 months. A new form is required when changes in countable family members and/or income occur.

Preparation: Consult Purchase of Medical Care Services manual for information on residency requirements, income calculation and expense documentation. Income may be entered in the column labeled "Gross Income" or the one labeled "Income After Taxes". The same income should not be entered in both columns.

Instructions for Completing Certain Items on this Form:

6. Select one of the following languages and enter the 2 letter code in block 6 on the front of this form.

Arabic (AR)	Gujarati (GU)	Miao (MI)	Serbo-Croatian (SC)
Cambodian (CA)	Hindi (HI)	Mon-Khmer (MK)	Spanish (SP)
Chinese (CH)	Hmong (HM)	**Other (OT)**	Tagalog (TA)
English (EN)	Hungarian (HU)	Persian (PE)	Thai (TH)
French (FR)	Italian (IT)	Poland (PO)	Urdu (UR)
French Creole (FC)	Japanese (JA)	Portuguese (PG)	Vietnamese (VI)
German (GE)	Korean (KO)	Portuguese Creole (PC)	
Greek (GR)	Laotian (LA)	Russian (RU)	

14. **Countable family members** are related to the applicant by blood, marriage or adoption, live in the same household **and** share a financial responsibility.

16. **Earned income** must be documented if medical expense deductions exceed $3,000 or an inpatient stay is requested. Medical expense deductions must be documented in full when they exceed $3,000.

18. **Deductible medical expenses** are those paid or incurred by a countable family member during the 12 months prior to the earliest date of service. Expenses paid for by another party or requested for coverage by a program cannot be used as deductions. The Cancer Program is based on gross income and does not allow for deductions of any kind.

Submit this application and documentation as required to the following address: DHHS Office of the Controller, Purchase of Medical Care Services, 1904 Mail Service Center, Raleigh NC 27699-1904.

Additional forms may be ordered by faxing a request to 919-733-0352 or calling 919-855-3672.

TERMS AND CONDITIONS FOR APPLICANT

I agree to notify the interviewer within 30 days about any changes in the patient's address, financial resources, expenses, family situation, or health insurance coverage that might affect his or her eligibility for Department payment programs. I certify that the information I have provided is a true and complete statement of facts according to my best knowledge and belief. I understand that information provided may be checked by a state reviewer, and I agree to provide the financial records required to carry out this investigation. I also understand that my employer may be asked to verify information concerning my income.

I assign insurance benefits to the Department. I agree to repay the Department any money I receive from insurance or liability settlements for services or appliances which the Department purchased for me. I understand that such payments should be made to the Department within 45 days of the date that I receive them and that the amount paid to the Department should not exceed the amount the Department paid the provider. I further agree that failure to repay assigned insurance benefits to the Department is a reason for denial of future service requests to the Department until such amounts have been repaid.

I understand that my eligibility for Medicaid will be checked. I hereby authorize and agree to a free exchange of information between the Division of Medical Assistance and the Department of Health and Human Services relating to financial information and the amount of services provided by either program

I hereby authorize the interviewer and service providers to release to the Department and its affiliate programs the information provided on this form and also the medical records of the patient which pertain to medical services or appliances for which reimbursement is being sought from the Department.

I also authorize release of this information to the county health department where the patient resides and/or receives services. I also authorize release of the information on this form to all health departments and hospitals in North Carolina. These disclosures shall be made for purposes of determining the patient's eligibility for Department payment programs and for conducting program evaluation.

I voluntarily give my consent to the terms of this release. My consent shall be valid for a period of one year. I further understand that I may revoke my consent at any time. Such revocation does not affect the validity of my consent for information disclosed prior to the revocation.

I understand that I may appeal the denial of this financial eligibility application. Information on how to appeal the denial can be obtained by writing to the N.C. DHHS Office of the Controller, Purchase of Medical Care Services, 1904 Mail Service Center, Raleigh NC 27699-1904. I understand that payment by the Department for health care provided to the patient is dependent upon the patient meeting all financial and medical requirements, timely submission of authorization requests and claims, and the availability of funds.

WEBSITE: www.ncdhhs.gov/control/pomcs/pomcs.htm