

1. Last Name		First Name	MI	FINANCIAL ELIGIBILITY APPLICATION Purchase of Medical Care Services DHHS—Division of Public Health 1904 Mail Service Center, Raleigh, NC 27699-1904 www.ncdhhs.gov/control/pomcs/pomcs.htm	FOR POMCS USE ONLY	
2. Patient SS #						
3. Date of Birth (M/D/YYYY)		4. Gender <input type="checkbox"/> 1. Male <input type="checkbox"/> 2. Female <input type="checkbox"/> 3. Transgender		12. Program ADAP		13. POMCS Case Number
5. Race <input type="checkbox"/> 1. White <input type="checkbox"/> 2. Black <input type="checkbox"/> 3. American Indian <input type="checkbox"/> 4. Asian <input type="checkbox"/> 5. Native Hawaiian/Other Pacific Islander <input type="checkbox"/> 6. Multi-racial				14. NC Resident <input type="checkbox"/> Yes <input type="checkbox"/> No		
6. Ethnicity: Hispanic or Latino Origin? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				15. Countable Family Members Number of Adults Number of Children Total Number		
7. Incarcerated? <input type="checkbox"/> Yes <input type="checkbox"/> No Local Jail (Name) Federal Halfway House (Name)				16. Preferred Language (Select one of the languages below and enter the 2 letter code in the block above)		
8. County of Residence				Arabic (AR) Cambodian (CA) Chinese (CH) English (EN)		
9 Address Street or RFD				French (FR) French Creole (FC) German (GE) Greek (GR)		
10. City State Zip Code				Gujarati (GU) Hindi (HI) Hmong (HM) Hungarian (HU)		
11. Telephone Number: Home Work				Italian (IT) Japanese (JA) Koran (KO) Laotian (LA)		
				Miao (MI) Mon-Khmer (MK) Other (OT) Persian (PE)		
				Polish (PO) Portuguese (PG) Russian (RU) Serbo-Croatian (SC)		
				Russian (RU) Spanish (SP) Tagalog (TA) Thai (TH)		
				Urdu (UR) Vietnamese (VI)		

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. Must report Gross and Net Income.

17. 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		Gross Income	Income After Tax
					From	To		

18. Explanations: Dates unemployed; means of support if income is low; etc. (e.g., 20% of the federal poverty level)	19. Annual Gross Income (include Annual Gross Income and Annual Net Income) Federal, State & Soc. Sec. Tax Total Income After Taxes (Difference Between Both Lines) 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 Annual Net Income
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20. Eligibility for Other Programs: Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No Medicaid ID # Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No Medicare Part D: <input type="checkbox"/> Yes <input type="checkbox"/> No Medicare # SS LIS Application <input type="checkbox"/> Yes <input type="checkbox"/> No Date of LIS Applic. <input type="checkbox"/> N/A (Client is =>150% of FPL)	
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21. PRESCRIPTION DRUG 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? <input type="checkbox"/> Yes <input type="checkbox"/> No Does insurance have a cap? <input type="checkbox"/> Yes <input type="checkbox"/> No	Company Policy No. Claims Address Telephone Policyholder Is patient covered? <input type="checkbox"/> Yes <input type="checkbox"/> No Does insurance have a cap? <input type="checkbox"/> Yes <input type="checkbox"/> No

INSTRUCTIONS

Purpose: To collect information required for the determination of ADAP/HIV Medications Program eligibility. An interviewer completes this form when a service authorization is requested unless a current form is already on file. Once determined, eligibility extends for 15 months (January-March). 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. Both Net and Gross Income are required for ADAP.

Instructions for Completing Certain Items on this Form:

7. If applicant is incarcerated, check the box and indicate where applicant is currently residing (local jail or federal halfway house).
****NOTE:** Patients who are incarcerated in state or federal prisons cannot participate in the ADAP Program.
15. **Countable family members** are related to the applicant by blood, marriage or adoption, live in the same household **and** share a financial responsibility.
17. **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. Use this area to document additional information to establish low income classification. Low income is defined as 20% of the current federal poverty level.
19. **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 and ADAP are based on gross income and do not allow for deductions of any kind.
20. Medicare, Medicaid status and, if applicable, Social Security eligibility information for a low income subsidy are required for all applicants.

Fax or mail (do not do both) this application and documentation to: DHHS Division of Public Health, Purchase of Medical Care Services, 1904 Mail Service Center, Raleigh NC 27699-1904. Fax (919) 715-5221

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 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.

I hereby certify that I have read or the interviewer has read to me the terms and conditions described above 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 (M/D/YYYY)
I certify that I have explained the terms and conditions contained above to the applicant and have witnessed his/her signature.		
Type or Print Interviewer's Name	Agency Name	Date (M/D/YYYY)
	Street Address/P.O. Box	Phone (xxx) xxx-xxxx
Interviewer's Signature	City/State/Zip Code	