REFUGEE CASH AND MEDICAL ASSISTANCE CASE NARRATIVE/DOCUMENTATION NOTES

Application Number:
Case Manager Name:

Method of receipt:
Date of Application:
What Benefits Applying for:
Date of Interview:
Preferred Language:

Name of Resettlement Agency:
Agency Representative Name:
Agency Phone Number:
Customer Name and Contact Number:

HH Comp
Full Name of household members and Relationships:
HH members Not Included in Payment & Reason:
Type of household (Single or Married):
Is the Applicant Aged, Blind, Disabled or Pregnant:

Verifications
What is the Applicant's statement of CID/Immigration Status:
What Verification(s) of CID/Immigration Status is in NC Fast:
Date of Entry:
Date of Eligibility:
Country of Origin:
Alien Number:
Single or Married Couple:
Full-Time Student Status:
Residency Verifications (applicant statement acceptable):
Illness or incapacitation verification:
Have the household members lived in another state or county within the past year:
How was the household member who lived in another state verified:
Was OVS Run:
Was SAVE Run:
Person Page Clean:

Income [complete calculations below] & Verifications
Whose income counts:
Earned:
Unearned:
If no current income, what was the last source of income:
Verifications in NCF on Application:

Count Only United States Resources above $2,800:
- **Checking Account:**
- **Savings Account:**

1. Pended
Pending for:
8146 A expires on:
5097 expires on:

2. Approval
Payment:
Certification Period:
What notices were sent & attached to IS:

Sanction:
Ongoing IS & PDC Number:
DSS-8194 sent to currently active programs:

3. Denial/Withdrawal:
Reason:
Manual 8109 sent & attached to ISA (prior to denying):
Sanction:
Attachments & Completed Paperwork: **All required attachments and completed paperwork must be uploaded to the application page in NC FAST within three days of disposition.**

ePass(online) Application: (must be attached to the DSS 6241 or 6242)
DSS 6241 Refugee Cash Assistance Application:
DSS 6242 Refugee Medical Assistance Application:
IEG Integrated Evidence Gathering Signature Page:
DSS 6236 Informed Consent for Release Information:
Telephone Signature & Date Time Was Accepted:
DSS 6247 Notification of Refugee Arrival and Intent to Apply for Benefits (if applicable):
DSS 6239A Refugee Mutual Responsibility Agreement discussed and signed (RCA):
DSS 8146A Information Needed to Determine Your Eligibility for WF Cash Assistance:
DSS 8227 Important Information You Need to Know:
DSS 8194 Income Maintenance Transmittal Form:
DSS 10001 Language Services Agreement:
NC FAST 20009 NC Rights & Responsibilities for Public Assistance:
DSS 5022 Refugee Work Registration Certification (RCA):

Note: **I recommend asking the refugee client to provide all immigration documents.**

REFUGEE MEDICAL ASSISTANCE APPLICATION SECTION – ONE

LANGUAGE SERVICES AGREEMENT
For Limited English Proficiency (LEP) Customer
And Sensory Impaired Customer

For Office Use Only

CUSTOMER: _____ DATE: _____

AGENCY: _____PROGRAM: _____

PROGRAM STAFF MEMBER: _____

LANGUAGE SERVICE PROVIDED:
__ Foreign Language Interpreter
__ Sign Language Interpreter
__ Written Translation (list documents) _____
__ Foreign Language Telephonic Service (service name) _____
__ Braille
__ TDD/TTY
__ Assistive Technology device for Sensory Impaired (type) _____
__ Large Print

CUSTOMER STATEMENT

☐ I was offered the services of an interpreter/translator, at no cost to me, by the agency and on the date shown above. I elect to:
__ accept the services of an interpreter/translator provided by the agency, or
__ prefer the use of an assistive technology device provided by the agency, or
__ decline the use of any interpreter/translator services and/or assistive technology device, or
__ provide my own interpreter/translator services or assistive technology device
(Name of provider or product: _____)

☐ I agree to provide information needed by the agency to assist me. I understand that this information is confidential and will be used only for purposes of delivering services to me.

Customer Name (print) _____

Customer Signature: _____ Date: _____

INTERPRETER/TRANSLATOR STATEMENT

☐ I, _____, will accurately interpret the interview/conversation/ information of _____ on _____. I will accurately relay any and all information to and from this customer. As required by G.S. 108A-80, I will protect the confidentiality of all information regarding this customer.

Interpreter Name (print) _____

Interpreter Signature: _____ Date: _____

☐ If Interpreter services are provided by telephone, it will be in accordance with all agency and contractual confidentiality requirements.

TO BE FILED IN CASE RECORD

☐ New ☐ Revised

Notification of Refugee Arrival and Intent to Apply for Benefits

The term "Refugee" refers to Refugees under Section 207, Asylees (granted Asylum) under Section 208, Cuban/Haitian Entrants, Certain Amerasians, Certified Victim of Trafficking, Iraqi/Afghan Special Immigrant Visa (SIV) Holders, Afghan population, individuals with Afghan SI/SQ Parole, Afghan Special Immigrant (SI) Conditional Permanent Residence (CPR) and/or Afghan humanitarian parolees (AHP) admitted to the United States on or after July 31, 2021. Ukrainian Humanitarian Parolee, and other Non-Ukrainian individual displaced from Ukraine as of May 21, 2022, the Additional Ukraine Supplemental Appropriations Act, 2022 (AUSAA)

1. Date: _____

2. To: _____ County Department of Social Services

   Address: _____

   Phone Number: _____ Fax Number: _____

3. From: _____ Email: _____

   Address: _____

   Case Manager Name: _____ Telephone Number: _____

4. Is this agency responsible for Employment Services? ☐ EXEMPT *please refer to Chapter III exemption section of the State Refugee Office Manual*

   ☐ NO. If no, name of referring agency: _____ ☐ YES. If yes, Employment Worker's Name: _____ Email: _____ Number: _____

5. Please be advised that the following individual is being resettled in your county. ATTACH ADDITIONAL SHEET IF NEEDED.

	NAME AND RELATIONSHIP	ALIEN NUMBER	DATE OF BIRTH	DATE OF ARRIVAL	*DATE OF ELIGIBILITY	NATIONALITY	IMMIGRATION STATUS
1							
2							
3							
4							
5							

6. It is anticipated this individual/couple/family will be applying for the following public benefits:

   ☐ Food & Nutrition Services ☐ Refugee Cash Assistance (RCA)

   ☐ Work First/TANF ☐ Refugee Medical Assistance (RMA) ☐ OTHER (specify) _____

   ☐ Medicaid (Pregnant Women **MPW**; Aged, Blind and Disabled **MABD**; Families and Children **MFC;** Infant and Children **MIC**; Medicaid 19 & 20 **MGN**)

7. Do the individual(s) have Social Security Number(s)? ☐ NO ☐ YES, applied for SSN/Card on this date: _____

   ☐ NOT YET, but will apply in the future, expected Month/Year_____

8. Name of any applicant who is currently pregnant: _____

9. Name of applicant who is currently age 65 or older: _____

   Was a Supplemental Security Income (SSI) application submitted? ☐ NO ☐ YES, DATE: _____

   ☐ NOT YET, but will apply in the future, expected Month/Year_____

10. Match Grant Participant? ☐ NO ☐ ******YES, Name of individual(s)_____

    BEGIN DATE: _____ END DATE: _____ (if known) AMOUNT: $_____ (if known)

**By enrolling in Work First or RCA, the option to participate in the Match Grant program is forfeited, automatically. Federal law prohibits participation in both simultaneously.

Instructions for Notification of Refugee Arrival and Intent to Apply for Benefits (DSS-6247)

The purpose of this form is to notify the local department of social services (DSS) of a refugee individual and/or family's arrival and intent to apply for public assistance benefits. The information provided should expedite the application process by assisting the local DSS in being better prepared to take the refugees' application. This form is to be completed by a refugee resettlement agency (local affiliate) or refugee service provider. The form is to be sent to the appropriate section of the DSS in the county where the refugee resides and the application for assistance is made.

Each section MUST be completed in its entirety.

1. **Date**: Enter the date the form is completed.

2. **To**: Indicate the county where the applicant resides. Also, enter the address and telephone number of the county DSS.

3. **From**: Enter the name of the local affiliate (i.e. Catholic Charities, World Relief, Lutheran Services Carolinas, USCRI, etc.), along with the email address, address and telephone number Enter the Case Manager's name and contact number where instructed.

4. **Employment Service Responsibilities:** The Employment Specialist is to place an "X" by the appropriate answer choice. If the local affiliate answer is "Yes", then enter the Employment Worker's name, telephone number, and email. If the answer is "No," then the local DSS Employment Services Department will be responsible for providing employment services. If "EXEMPT" is checked, the individual applying for Refugee Cash Assistance (RCA) meets one of the specified exemptions to the work requirement for RCA.

5. **Individual Applicant Information: This information may be found on the applicant immigration documentation.** Enter the name, alien number, date of birth, date of arrival, date of eligibility, nationality, and immigration status for each applicant. For example, Name: *John Doe*; Alien Number: *123456879*; Date of Birth: *8/12/1952*; Date of Arrival (Entry): *10-1-20XX*; Date of Eligibility: *12-1-20XX;* Nationality: *Burmese*; Immigration Status: *Refugee*.

   * Note: The eligibility date of Afghan Supplemental Appropriations Act (ASA)-eligible populations (SIV holders, SI/SQ Parole, AHP) is October 1, 2021 (if the individual entered the community between July 31, 2021, and September 30, 2021), or the date of entry into the community (for example, the date an Afghan parolee departs an Operation Allies Refuge/Operation Allies Welcome (OAR/OAW) Safe Haven), whichever is later.

   * Note Ukrainian Humanitarian Parolee, and other Non-Ukrainian individual displaced from Ukraine as of May 21, 2022, the Additional Ukraine Supplemental Appropriations Act, 2022 (AUSAA).

6. **Public Assistance**: Place an "X" by all applicable public benefit programs for which the refugee will apply for. If the exact program is not listed, write name of the program beside the word "other."

7. **Social Security Number**: Place an "X" by the appropriate answer choices.

8. **Pregnancy**: Provide the name of any member of the household who is currently pregnant, if applicable.

9. **Age**: Provide the name of any member of the household, who is 65 years of age or older, if applicable, and place an "X" by the appropriate answer choice.

10. **Match Grant**: As indicated, mark the "Yes" block if the case is **currently enrolled** in the Match Grant program. Indicate the months that the Match Grant covers (January 20XX – August 20XX) and the amount if possible. If not currently enrolled, check "NO." Only one selection must be chosen.

    If the individual is a Matching Grant recipient, it is the local affiliate/provider's responsibility to instruct the applicant to decline Work First (WFCA) and Refugee Cash Assistance (RCA). **By enrolling in Work First or RCA, the option to participate in the Match Grant program is forfeited, automatically.** Federal law prohibits participation in both simultaneously.

    Note for local DSS.
    Individuals with Refugees immigration status are eligible for Refugee Cash Assistance (RCA) and Refugee Medical Assistance (RMA) for twelve (12) months from the date of arrival into the United States. Questions about mainstream (TANF, Medicaid, SSI) public benefit programs should be directed to your Continuous Quality Improvement Specialist, or to the Refugee public benefits email refugeeassistance.policy.questions@dhhs.nc.gov.

_____County RMA Case No. _____ Date _____

Refugee Medical Assistance (RMA) Application

This application is used to collect the information needed to determine eligibility for Refugee Medical Assistance.

The term "refugee" will refer to all ORR-eligible groups, who are Qualified Aliens, exempted from a five-year band timeframe and potentially eligible for RMA (refer to Chapter I., section III. for definitions, detailed information, and acceptable documentation regarding each ORR-eligible recipient group). Immigration status for the following include; **Refugee**, admitted under INA § 207; **Asylee**, granted asylum under INA § 208; **Afghan Special Immigrant (SQ or SI) Parole, Afghan Special Immigrant (SI) Conditional Permanent Residence (CPR) and Afghan Humanitarian Parolees (AHP)** individuals granted humanitarian parole by the U.S. Department of Homeland Security, under Operation Allies Refuge/Operation Allies Welcome. **Cuban and Haitian Entrants**, as defined under federal regulations (45 CFR § 401.2); **Amerasian**, individual was fathered by a U.S. citizen under Public Law 100-202 (Act of 12/22/87)**; Victims of Human Trafficking** who have been issued an ORR-certification letter; **Special Immigrant Visa (SIV) Holder** from Afghan or Iraqi nationals granted a**,** by the U.S. Department of Homeland Security for service to the U.S. government. **Ukrainian Humanitarian Parolee, and other non-Ukrainian individual displaced from Ukraine** as of May 21, 2022, the Additional Ukraine Supplemental Appropriations Act, 2022 (AUSAA).

Does the applicant and/or household member wish to apply for **Refugee Cash Assistance** or **Work First/TANF**? ☐ YES ☐ NO
(If yes, please complete a separate Refugee Cash Assistance application DSS 6241) or Work First Cash Asst. Appl. (DSS 8228)

Does the applicant and/or household member need help completing the application or help during the interview process? ☐ YES ☐ NO
(If yes, please complete DSS-10001, Language Services Agreement.)

PROGRAM SCREENING (ALL ANSWERS MUST BE YES TO BE POTENTIALLY ELIGIBLE)

☐ Yes ☐ No	Does the applicant and household member's immigration status meet the definition of 'refugee' as identified above?
☐ Yes ☐ No	Effective October 1, 2026, applicants and household members (parents of minor children, 20-64 older) in the Office of Refugee Resettlement (ORR)-eligible population are no longer eligible for Mainstream Medicaid programs, except for Cuban and Haitian entrants, who remain eligible for Mainstream Medicaid. Individuals in the ORR-eligible population who are ineligible for Mainstream Medicaid may be evaluated for Refugee Medical Assistance (RMA). Those who meet all RMA eligibility requirements may be approved for RMA.
☐ Yes ☐ No	Is the applicant or any household member pregnant? If yes, how many babies are expected during this pregnancy? _____ If the applicant or household member is part of the Office of Refugee Resettlement (ORR)-eligible population, continue processing the application. Pregnancy does not affect eligibility for Refugee Medical Assistance (RMA). Determine eligibility in accordance with applicable RMA policy.
☐ Yes ☐ No	Currently, the applicants and household members, are **BOTH 64 years of age and younger**? If yes, continue with this application. If the applicant and household member are **BOTH** 65 years or older, stop and evaluate both individuals for Medical Assistance to the Aged, Blind and Disable (MAAAB) under the NC Medicaid State Plan. STOP, evaluate the individual age 65 years or older (MAAAB) and the individual is 64 and younger for (RMA).

Primary Applicant Name: _____ Telephone Number: _____

Address: _____

Mailing Address (if different from above): _____

NC Refugee Resettlement Agency (if applicable): _____

THE FORMS BELOW MUST BE ATTACHED WITH THIS REFUGEE MEDICAL ASSISTANCE APPLICATION, IF APPLICABLE.

☐ Form DSS-6247 (Notice of Intent to Apply for Benefits) given to the local DSS. Only applicable if the refugee applicant is working with a NC Refugee Resettlement Agency

☐ Form DSS-10001 (Language Services Agreement) provided by the local DSS and signed by the applicant.

☐ Form DSS-6236 (Informed Consent for Release of Information) provided by the local DSS and signed by the applicant. Only applicable if the applicant and/or household member authorized a NC Refugee Resettlement Agency and/or a NC Refugee Service Provider to speak/apply for Refugee Medical Assistance (RMA) on the applicant and/or household member's behalf.

The Department of Health and Human Services complies with Federal and State laws, which restrict the use and disclosure of information concerning applicants and recipients of public assistance and comply with applicable provisions of the Social Security Act concerning confidentiality. The Department of Health and Human Services does not discriminate against any person on the basis of race, color, national origin, sex, religion, age, political beliefs, or disability.

PRIMARY APPLICANT

1	Name (First)	Name (Last)	Name (Middle)	Gender	Date of Birth

Marital Status:
☐ Individual/Single
☐ Couple/Married ☐ Family

Country of Origin:
_____

Immigration Status:
☐ Refugee ☐ Special Immigrant Visa (SIV) Holder from Iraq or Afghanistan ☐ Amerasians
☐ Afghan Special Immigrant Parole SQ/SI ☐ Afghan Humanitarian Parolees
☐ Afghan Humanitarian Parole Afghan Special Immigrant (SI) Conditional Permanent Residence (CPR)
☐ Ukraine Humanitarian Parole or Non-Ukrainian individual displaced from Ukraine
☐ Cuban & Haitian Entrant ☐ Victim of Human Trafficking (certification letter)
☐ Asylee: Asylum Date *(Found on the Granted Asylum letter)* _____

Immigration Document(s) Viewed:
☐ I-94 ☐ USCIS Travel Documents ☐ Visa ☐ Passport
☐ Other: _____

Alien Number:
(Typically, a 9-digit number not a Social Security, Passport or VISA number)
_____

Full-time Student:
(In an Intuition of Higher Learning)
☐ Yes, Where_____
☐ No

SECOND APPLICANT

2	Name (First)	Name (Last)	Name (Middle)	Gender	Date of Birth

Marital Status:
☐ Individual/Single
☐ Couple/Married ☐ Family

Country of Origin:
_____

Immigration Status:
☐ Refugee ☐ Special Immigrant Visa (SIV) Holder from Iraq or Afghanistan ☐ Amerasians
☐ Afghan Special Immigrant Parole SQ/SI ☐ Afghan Humanitarian Parolees
☐ Afghan Humanitarian Parole Afghan Special Immigrant (SI) Conditional Permanent Residence (CPR)
☐ Ukraine Humanitarian Parole or Non-Ukrainian individual displaced from Ukraine
☐ Cuban & Haitian Entrant ☐ Victim of Human Trafficking (certification letter)
☐ Asylee: Asylum Date *(Found on the Granted Asylum letter)* _____

Immigration Document(s) Viewed:
☐ I-94 ☐ USCIS Travel Documents ☐ Visa ☐ Passport
☐ Other: _____

Alien Number:
(Typically, a 9-digit number not a Social Security, Passport or VISA number)
_____

Full-time Student:
(In an Intuition of Higher Learning)
☐ Yes, Where_____
☐ No

THIRD APPLICANT

3	Name (First)	Name (Last)	Name (Middle)	Gender	Date of Birth

Marital Status:
☐ Individual/Single
☐ Couple/Married ☐ Family

Country of Origin:
_____

Immigration Status:
☐ Refugee ☐ Special Immigrant Visa (SIV) Holder from Iraq or Afghanistan ☐ Amerasians
☐ Afghan Special Immigrant Parole SQ/SI ☐ Afghan Humanitarian Parolees
☐ Afghan Humanitarian Parole Afghan Special Immigrant (SI) Conditional Permanent Residence (CPR)
☐ Ukraine Humanitarian Parole or Non-Ukrainian individual displaced from Ukraine
☐ Cuban & Haitian Entrant ☐ Victim of Human Trafficking (certification letter)
☐ Asylee: Asylum Date *(Found on the Granted Asylum letter)* _____

Immigration Document(s) Viewed:
☐ I-94 ☐ USCIS Travel Documents ☐ Visa ☐ Passport
☐ Other: _____

Alien Number:
(Typically, a 9-digit number not a Social Security, Passport or VISA number)
_____

Full-time Student:
(In an Intuition of Higher Learning)
☐ Yes, _____
☐ No

Fourth Applicant

4	Name (First)	Name (Last)	Name (Middle)	Gender	Date of Birth

Marital Status:
☐ Individual/Single
☐ Couple/Married ☐ Family

Country of Origin:
_____

Immigration Status:
☐ Refugee ☐ Special Immigrant Visa (SIV) Holder from Iraq or Afghanistan ☐ Amerasians
☐ Afghan Special Immigrant Parole SQ/SI ☐ Afghan Humanitarian Parolees
☐ Afghan Humanitarian Parole Afghan Special Immigrant (SI) Conditional Permanent Residence (CPR)
☐ Ukraine Humanitarian Parole or Non-Ukrainian individual displaced from Ukraine
☐ Cuban & Haitian Entrant ☐ Victim of Human Trafficking (certification letter)
☐ Asylee: Asylum Date *(Found on the Granted Asylum letter)* _____

Immigration Document(s) Viewed:
☐ I-94 ☐ USCIS Travel Documents ☐ Visa ☐ Passport
☐ Other: _____

Alien Number:
(Typically, a 9-digit number not a Social Security, Passport or VISA number)
_____

Full-time Student:
(In an Intuition of Higher Learning)
☐ Yes,_____
☐ No

EARNED INCOME

(Refer to the SRO Program Manual Chapter II. Section III. Application Process Section. C. Processing Requirements.)

Does applicant and/or household member have income from working? ☐ Yes ☐ No If yes, complete the following:

1. Applicant Name: _____ Start Date: _____ Rate of Pay: _____

Employer Name: _____

Employer Address: _____ Telephone Number: _____

Supervisor/Manager Name: _____ Work Schedule/Hrs. per Week: _____

Pay Received This Month (Month of Application Only)	
Date	Gross Amount

2. Applicant Name: _____ Start Date: _____ Rate of Pay: _____

Employer Name: _____

Employer Address: _____ Telephone Number: _____

Supervisor/Manager Name: _____ Work Schedule/Hrs. per Week: _____

Pay Received This Month (Month of Application Only)	
Date	Gross Amount

ADDITIONAL SERVICES

Check (✓) that each of the following was explained and the applicable notice/form/service provided to applicant.

Service(s) Explained	**Referral Yes**	**No**
☐ **Supplemental Security Income (SSI)** - Federal income supplement program designed to help aged, blind, and disabled people, who have little or no income. Referred to this recipient to apply for SSI benefits.	☐	☐
☐ **Food and Nutrition Services (FNS)** - Eligibility for the Food Stamp Program is based on certain non-financial and financial requirements. Referred to this recipient to be evaluated for expedited services. **(Has the individual or married couple transition to LPR Status)**	☐	☐

Check (✓) that each of the following was explained and the applicable notice/form provided to applicant.

☐ Form NC FAST-20009 (Rights and Responsibilities)

I, _____, understand that by signing this form, I am stating that:
(applicant printed name)

✓ I understand the penalties for giving false information, and I have told the truth on this form.

- ✓ I know my rights and what I must do to get assistance.
- ✓ I agree to give information about what I have said.
- ✓ I agree to report changes to the social services agency.
- ✓ I agree to let the social services agency obtain proof of what I have said from any person or another agency.
- ✓ I know the social services agency keeps private anything said about my situation.
- ✓ I know if I do not sign this form, I will not get assistance.

Applicant Signature: _____ **Date:** _____

Witness Signature: (If signed with an "X") _____ **Date:** _____

Authorized Agency (Referenced on DSS-6236): _____

Authorized Agency Representative Print Name: _____

Authorized Agency Representative Signature: _____ **Date:** _____

DSS Case Manager Signature: _____ _____ **Date:** _____

Interpreter Signature: _____ **Date:** _____

ALL APPLICANTS MUST BE INTERVIEW BY A DSS CASE MANAGER

Your Signature and Statement of Understanding

By signing this application I am saying that:

1. I have told the truth on this form.

2. I agree to give information about what I have said so that my application can be processed.

3. I give permission to social services to get proof of what I have said from any person, agency, or business. Other person, agencies, or businesses include but are not limited to: employers, banks, savings and loans, landlords, etc.

4. I understand my expenses may be used to figure my Food and Nutrition Services amount. If I do not tell you about some of my expenses and/or verify them, they may not be used in the budget to calculate the amount of my benefits.

5. I have read and understand the North Carolina Public Assistance Rights and Responsibilities form found at: http://info.dhhs.state.nc.us/olm/forms/dss/ncfast-20009.pdf

_____ _____

Signature **Date**

_____ _____

Witness Signature (if signature above is an 'X') **Date**

_____ _____

Caseworker's Signature **Date**

For Agency Use Only:

Date Mailed:

Date Received in Agency:

County Case Number:

Comments:

North Carolina State Refugee Office
Informed Consent for Release of Information (DSS-6236)

_____
Name of Client

YES NO I give my permission for _____ in North Carolina to obtain information from or release information about my family to the following agencies:

☐ ☐ I. Agency: _____
Purpose for release/obtainment:
_____

☐ ☐ II. Agency: _____
Purpose for release/obtainment:
_____

☐ ☐ III. Agency: _____
Purpose for release/obtainment:
_____

☐ ☐ IV. Agency: _____
Purpose for release/obtainment:
_____

☐ ☐ V. Agency: _____
Purpose for release/obtainment:
_____

There are state and federal statutes and regulations safeguarding your personal information. By signing this document,

- I understand that this information will be used for the sole purpose of coordinating service delivery to me and/or members of my case/family.
- I understand that if other specific information is needed or information needs to be released/obtained by another Agency not listed above, I may be contacted and asked to sign another consent form.
- Information about my case will be kept private and confidential within this network of service providers.
- Information will be shared on an as needed basis only.
- I reserve the right to terminate this consent at any time.
- I understand that my consent is valid for the period of one year from date of signature.

_____ _____
Signature of Client (or Parent, Guardian, or Legally Appointed Representative) Date

I certify that the information contained in this release form has been explained to the Client:

_____ _____
Witness or Interpreter Date

The above form shall be completed in duplicate, with a copy provided to the client.

Release revoked:

I revoke my consent for release of information above as of the date of my signature. I understand that this withdrawal of consent applies only to any information which has not previously released or obtained.

_____ _____
Signature of Client (or Parent, Guardian, or Legally Appointed Representative) Date

_____ _____
Witness or Interpreter Date

Instructions for Completing the
NC State Refugee Office Informed Consent for Release of Information Form (DSS-6236)

Purpose:	The purpose of the Informed Consent for Release of Information Form is to ensure that the refugee client has complete understanding of his/her right to not allow information about them to be released or obtained by outside entities without their written consent.
Instructions:	The above form shall be completed in duplicate, with one copy provided to the client. For any Agency field left blank, N/A must be written. The form should be filled out and signed for each client receiving services from your agency. Minor clients must have a parent or guardian consent.
Client Name:	Fill in the client's name that pertains to the information that is being asked to be released or obtained.
Permission:	Fill in the agency name that is asking for the client's information to be released or obtained.
I. Agency:	Enter the COUNTY that would be providing financial assistance to the client (ex. Wake County Social Services), or any other agency that is providing services to the client. Under *Purpose for release/obtainment,* enter the reason why the information needs to be released or obtained (ex. financial information for cash and other benefits). Client must check the appropriate yes/no box to allow or disallow the release of information to this specific agency.
II. Agency:	Enter the COUNTY that would be providing health services for that client (ex. Buncombe County Health Dept.), or any other agency that is providing services to the client. Under *Purpose for release/obtainment,* enter the reason why the information needs to be released or obtained (ex. medical records). Client must check the appropriate yes/no box to allow or disallow the release of information to this specific agency.
III. Agency:	If needed, enter any other agency that is providing services to the client (ex. Greensboro Technical Community College). Under *Purpose for release/obtainment,* enter the reason why the information needs to be released or obtained. Client must check the appropriate yes/no box to allow or disallow the release of information to this specific agency.
IV. Agency:	If needed, enter any other agency that is providing services to the client (ex. potential employer(s)). Under *Purpose for release/obtainment,* enter the reason why the information needs to be released or obtained. Client must check the appropriate yes/no box to allow or disallow the release of information to this specific agency.
V. Agency:	If needed, enter any other agency that is providing services to the client (ex. Durham Public Schools). Under *Purpose for release/obtainment,* enter the reason why the information needs to be released or obtained. Client must check the appropriate yes/no box to allow or disallow the release of information to this specific agency.

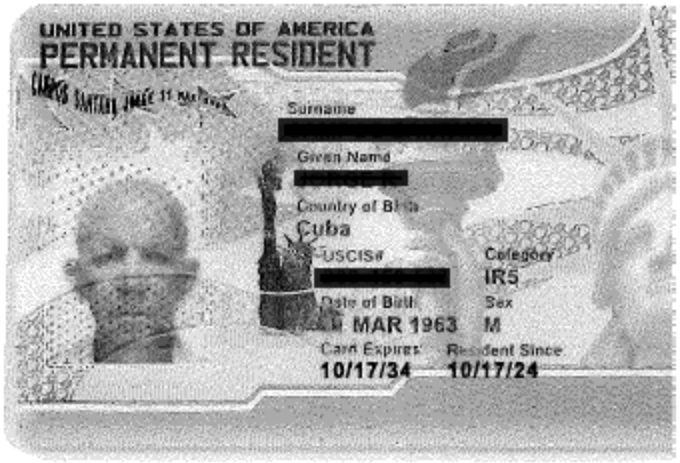
Agreement

Client Signature:	Client or legal representative must sign and date the top portion of the signature area if the client agrees to allow her/his information to be released or obtained. Clients under 18 need the signature of a parent or guardian.
Witness/ Interpreter:	A witness or interpreter must sign and date on the lines provided certifying that the information in this release form has been explained to the client.

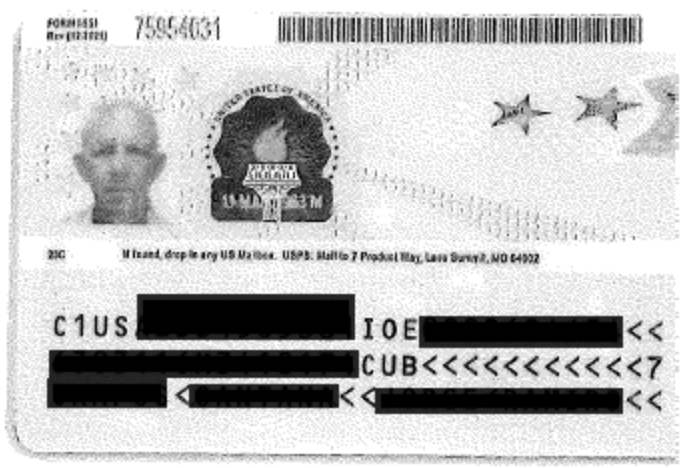
Release Revoked

Client Signature:	Client or legal representative must sign and date the bottom portion of the signature area if the client does not allow h/his information to be released or obtained.
Witness/ Interpreter:	A witness or interpreter must sign and date on the lines provided certifying that the information in this release form has been explained to the client.

IMMIGRATION DOCUMENTS SAMPLES SECTION – TWO

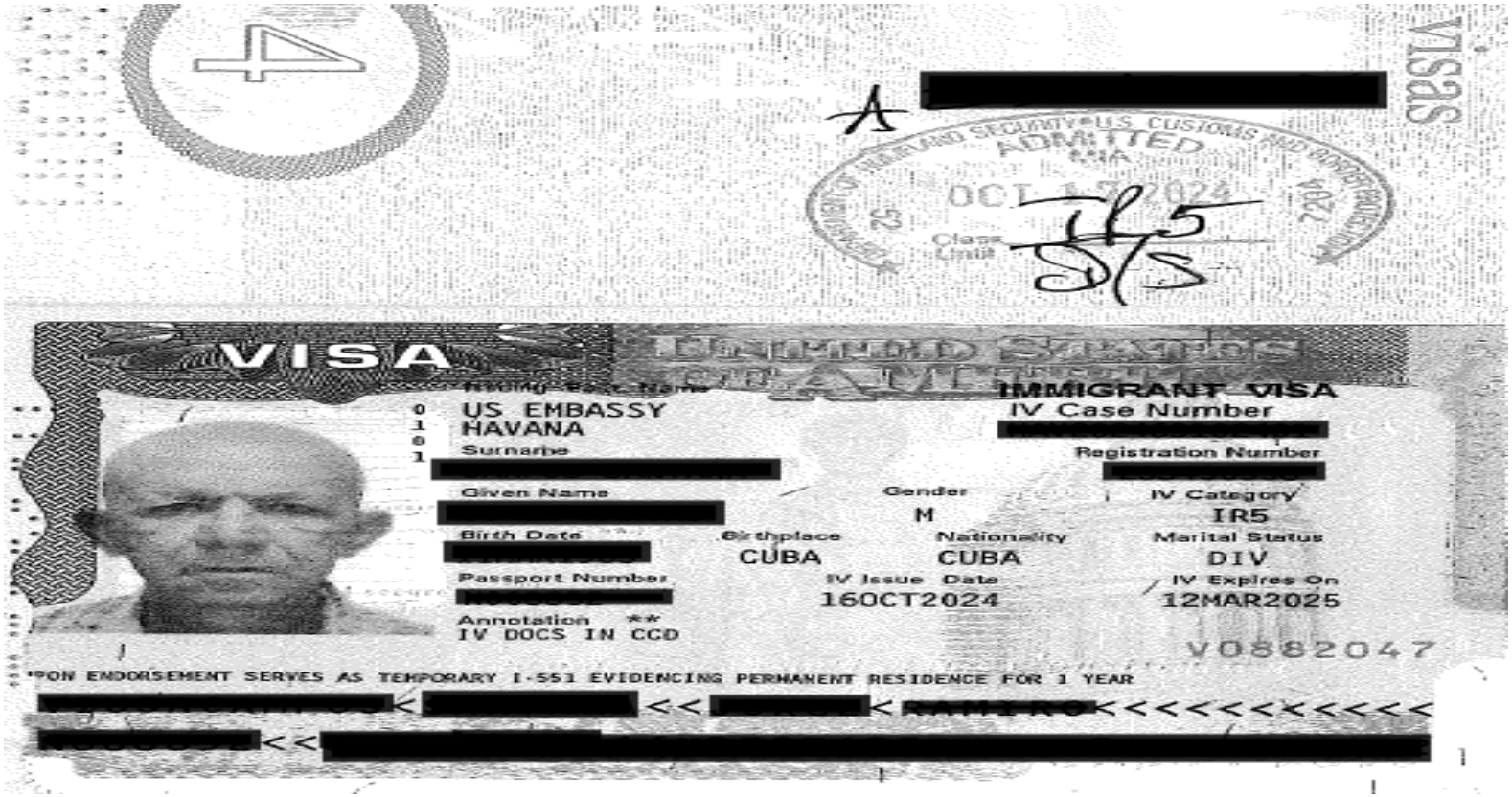


Front of LPR USCIS# A123456789



Back of Card 1. C1US A#123456789 2. Start IOE 13 digits/number

Visa Passport



Visa Passport # N0123456 Registration Number: A#123456789

U.S. Department of Homeland Security

Order of Release on Recognizance

File No: [redacted]

Date: May 16, 2024

Event No: [redacted]

Name: [redacted]

You have been arrested and placed in removal proceedings. In accordance with section 236 of the Immigration and Nationality Act and the applicable provisions of Title 8 of the Code of Federal Regulations, you are being released on your own recognizance provided you comply with the following conditions:

☒ You must report for any hearing or interview as directed by the Department of Homeland Security or the Executive Office for Immigration Review.

☒ You must surrender for removal from the United States if so ordered.

☒ You must report in (writing) (person) to _____
(Name and Title of Case Officer)

at AS INDICATED ON THE ATTACHED OREC G-56 on _____ at _____
(Location of DHS Office) (Day of each week or month) (Time)

If you are allowed to report in writing, the report must contain your name, alien registration number, current address, place of employment, and other pertinent information as required by the officer listed above.

☒ You must not change your place of residence without first securing written permission from the immigration officer listed above.

☒ You must not violate any local, State, or Federal laws or ordinances.

☒ You must assist the Department of Homeland Security in obtaining any necessary travel documents.

☐ Other: _____

☐ See attached sheet containing other specified conditions (Continue on separate sheet if required)

NOTICE: Failure to comply with the conditions of this order may result in revocation of your release and your arrest and detention by the Department of Homeland Security.

CARLOS AGUILAR
Date: 2024.05.16 21:29:24 -07'00'
0663167740.CBP
(Signature of DHS Official)

Acting/Patrol Agent in Charge
(Printed Name and Title of Official)

Alien's Acknowledgment of Conditions of Release on Recognizance

I hereby acknowledge that I have (read) (had interpreted and explained to me in the ENGLISH language) and understand the conditions of my release as set forth in this order. I further understand that if I do not comply with these conditions, the Department of Homeland Security may revoke my release without further notice.

ALFREDO GARIBAY
Date: 2024.05.16 21:38:10 -07'00'
0076256911.CBP
(Signature of Immigration Officer Serving Order)

(Signature of Alien)

05/16/2024
(Date)

Cancellation of Order

I hereby cancel this order of release because: ☐ The alien failed to comply with the conditions of release.

☐ The alien was taken into custody for removal.

(Signature of Immigration Officer Canceling Order)

(Date)

Form I-220A (Rev. 08/01/07) N

DEPARTMENT OF HOMELAND SECURITY
U.S. Immigration and Customs Enforcement

OREC G-56

Subject ID: [redacted]

File Number: [redacted] DOB: [redacted]

Name: [redacted]

Date: 05/16/2024

Home Address: FAILED TO PROVIDE ADDRESS EOIR-33 DOCKET NEW YORK, NEW YORK 10017

Please present this notice to your local ICE office upon request

OFFICE LOCATION	Find ICE reporting locations by visiting our website at **www.ice.gov/check-in** or by scanning the below provided QR Code. If you need additional assistance with finding an ICE office location, please contact us at 1-888-351-4024.
DEADLINE	Within 60 days of your release, you must schedule a date to report to your local ICE office using the ICE Appointment Scheduler. Instructions for accessing this Scheduler are listed below.
REQUEST	ICE Deportation Officer for continued processing and consideration for enrollment in ATD.
REASON FOR APPOINTMENT	You have been released into the United States at the discretion of the U.S. Customs and Border Protection and are now subject to certain reporting requirements. Once you schedule a report date with ICE, you will then be required to report in person, as indicated through the scheduler. Once you report to ICE, ICE will evaluate and advise you of future reporting requirements.
BRING WITH YOU	Identification document (birth certificate, government-issued identity documents such as a driver's license or cédula) and all immigration documents.

One Year Asylum Application Deadline: If you believe you may be eligible for asylum, you must file Form I-589, Application for Asylum and for Withholding of Removal. The Form I-589, Instructions, and information on where to file the Form can be found at **www.uscis.gov/i-589**. Failure to file Form I-589 within one year of arrival may bar you from eligibility to apply for asylum pursuant to section 208(a)(2)(B) of the Immigration and Nationality Act.

FAILURE TO CONTACT THE LOCAL ICE OFFICE AS INSTRUCTED MAY RESULT IN YOUR ARREST AND/OR A LOSS OF THE RIGHT TO ANY POSSIBLE RELIEF. THANK YOU FOR YOUR COOPERATION.

Navigate the ICE Check-in page

To find information about ICE office locations, scheduling appointments to appear at an ICE office, check court dates with EOIR and registering a change of address, visit: **www.ice.gov/check-in**

To schedule an appointment (if needed), visit: **www.ice.gov/check-in** and select **"Schedule or Change Appointment"**

Address changes must be made within 5 business days of moving. To change your address, visit: **www.ice.gov/check-in** and follow instructions for **"Update Address"**

Bring all your immigration documents to your appointment. I-94, I-862, or I-385 if you have them.

Bring a form of identification to your appointment. Driver's license, passport, or birth certificate if you have them.

Scan for ICE ERO Check-in Page

ERO

Homeland Security

TRAVEL AUTHORIZED

Your travel authorization has been approved and you are now authorized to travel to the United States under the Uniting for Ukraine (U4U) process to seek parole. You must meet all requirements for boarding an aircraft. This document does not grant you parole. Upon arrival to the United States, a U.S. Customs and Border Protection (CBP) officer will make the determination on parole once you arrive at a port of entry.

You are responsible for arranging your own travel to the United States. You are highly encouraged to travel to the United States via air. Please be prepared to show this status page to airline personnel along with your passport and other appropriate identification. If you are traveling with a child under 18 years old, you should be prepared to provide proof that the child is traveling with a parent or legal guardian. For their protection, children who are not accompanied by a parent or legal guardian may be placed in the custody of the Department of Health and Human Services (HHS).

Name: [redacted]

Date of Birth	Alien Number	Passport Number	Status	Expiration Date
Oct 24, 2004	[redacted]	[redacted]	Authorization Approved	Sep 7, 2024

RECEIVED SEP 17 2024

Employment Authorization Card

Surname: Last Name **Given Name:** First Name **USCIS:** A#123-456-789

Category Card# IOE1234567890

For: [redacted]

U.S. Customs and Border Protection
Securing America's Borders

Most Recent I-94

Admission (I-94) Record Number : [redacted] 123456789A5
Most Recent Date of Entry: 2024 June 30
Class of Admission : DT
Admit Until Date : 06/29/2026
Details provided on the I-94 Information form:

Last/Surname : [redacted]
First (Given) Name : [redacted]
Birth Date : [redacted]
Document Number : [redacted] Passport # S123456 or Alien number A#213456789
Country of Citizenship : Cuba

Get Travel History

- Effective April 26, 2013, DHS began automating the admission process. An alien lawfully admitted or paroled into the U.S. is no longer required to be in possession of a preprinted Form I-94. A record of admission printed from the CBP website constitutes a lawful record of admission. See 8 CFR § 1.4(d).
- If an employer, local, state or federal agency requests admission information, present your admission (I-94) number along with any additional required documents requested by that employer or agency.
- Note: For security reasons, we recommend that you close your browser after you have finished retrieving your I-94 number.

OMB No. 1651-0111
Expiration Date: 07/31/2024

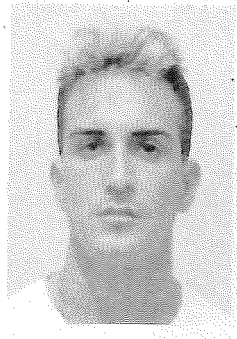
For inquiries or questions regarding your I-94, please click here

Accessibility | Privacy Policy

OBSERVACIONES
REMARKS

PASAPORTE

REPÚBLICA DE CUBA



TIPO / TYPE
P

CODIGO DEL PAIS / COUNTRY CODE
CUB

N°. DE PASAPORTE / PASSPORT N°.
[redacted] PP # S123456

APELLIDOS / SURNAMES
[redacted]

NOMBRES / GIVEN NAMES
[redacted]

NACIONALIDAD / NATIONALITY
CUBANA

N°. DE IDENTIDAD / ID N°.
[redacted]

FECHA DE NACIMIENTO / DATE OF BIRTH
[redacted]

FECHA DE EMISION / DATE OF ISSUE
03/DIC/DEC/2021

LUGAR DE NACIMIENTO / PLACE OF BIRTH
CAMAGÜEY CUB

FECHA DE VENCIMIENTO / DATE OF EXPIRY
03/DIC/DEC/2027

SEXO / SEX
M

LUGAR DE EXPEDICION / PLACE OF ISSUE
LA HABANA

FIRMA DEL TITULAR/HOLDERS SIGNATURE
[redacted]

P<[redacted]<[redacted]<[redacted]<[redacted]<<<<<<<<<<<<

[redacted]<[redacted]<<<76

DEPARTMENT OF HOMELAND SECURITY

NOTICE TO APPEAR

In removal proceedings under section 240 of the Immigration and Nationality Act: Event No: [redacted]

Subject ID : [redacted] FIN #: [redacted]

SIGMA Event: [redacted] DOB: [redacted]

File No: [redacted]

In the Matter of: [redacted]

Respondent: [redacted] currently residing at:

[redacted]

(Number, street, city, state and ZIP code) (Area code and phone number)

[x] You are an arriving alien.

[ ] You are an alien present in the United States who has not been admitted or paroled.

[ ] You have been admitted to the United States, but are removable for the reasons stated below.

The Department of Homeland Security alleges that you:

1. You are not a citizen or national of the United States;
2. You are a native of CUBA and a citizen of CUBA;
3. You applied for admission on 06/30/2024 at SAN YSIDRO, CA, USA;
4. You are an immigrant not in possession of a valid unexpired immigrant visa, reentry permit, border crossing card, or other valid entry document required by the Immigration and Nationality Act;

On the basis of the foregoing, it is charged that you are subject to removal from the United States pursuant to the following provision(s) of law:

See Continuation Page Made a Part Hereof

[ ] This notice is being issued after an asylum officer has found that the respondent has demonstrated a credible fear of persecution or torture.

[ ] Section 235(b)(1) order was vacated pursuant to: [ ] 8CFR 208.30 [ ] 8CFR 235.3(b)(5)(iv)

YOU ARE ORDERED to appear before an immigration judge of the United States Department of Justice at:

333 S MIAMI AVE STE 700,
MIAMI, FL, US 331301904

(Complete Address of Immigration Court, including Room Number, if any)

on July 20, 2026 *(Date)* at 01:00 PM *(Time)* to show why you should not be removed from the United States based on the charge(s) set forth above.

STEWART, Jason A

CBP OFFICER

(Signature and Title of Issuing Officer)

Digitally Acquired Signature

Date: June 30, 2024

SAN YSIDRO, CALIFORNIA

(City and State)

United States Department of State
Bureau of Population, Refugees, and Migration
Washington, D.C. 20520-5824

Date Issued: 05 Nov 2024

The Transportation Company And Transportation Security Administration

Document ID: [redacted]

RE: [redacted] **External Case ID:** [redacted]

[redacted]

US Address: [redacted]

Sir/Madam:

Pursuant to the accompanying travel packet (for international flights) or the form I-94 (for U.S. domestic flights), the Department of Homeland Security/U.S. Citizenship and Immigration Services has approved the application to apply for admission to the United States of the below-named alien(s) under section 207(c)(1).

USDHS/CBP/USDHS/CBP/USDHS/CBP/USDHS
Admitted as a refugee/dependent of a refugee
for an indefinite period pursuant to
Section 207(c)(2)
of the Immigration & Nationality Act
If you DEPART the United States,
you will need PRIOR PERMISSION
to return. 13013
EMPLOYMENT AUTHORIZED.
12/20/2024 WAS 37746
Date, Port, and CBP officer number

Client Name [redacted]

A [redacted] A123456789

Male: Principal Applicant

DOB: [redacted]

COB/NAT: Eritrea/
Eritrea

An airline, or airport security agency, may accept this letter as assurance that the above-named alien(s) may be transported to and within the United States without liability under section 273(b) of the Immigration and Nationality Act. This letter also serves to confirm that the above-named individual(s) applied for a Social Security number(s) via form I-765, as of their date of entry to the United States.

Sincerely,

Kelly Gauger

Kelly Gauger
Office of Refugee Admissions
Bureau of Population, Refugees, and Migration
U.S. Department of State

Not valid unless this document contains a Document ID.

Expiration Date: 05 Nov 2025

Case ET-10154575 (1 Members)

DPR 001 19 DEC 2024 ETHIOPIA

FORMS
SECTION – THREE

Request for Information

To: _____ **County Case No.** _____

Address: _____ **District No.** _____

_____ **Worker's Name:** _____

Date: _____ **Telephone Number** _____

We need additional information to process your Medicaid/Special Assistance application/re-enrollment. Provide this information by to ensure that your application/re-enrollment is processed promptly. If you need more time, contact us.

If you cannot get the items checked below, there are other items we can use. Continue reading about other items we can accept. We were unable to verify your information electronically.

☐ _____ will be required to meet a deductible to receive full Medicaid based on a gross monthly income amount of _____ from _____ If this income is incorrect, you may contact your Medicaid caseworker.

The countable income exceeds the maximum income limit for full Medicaid. To be eligible for full Medicaid, __must meet a Medicaid deductible. The amount of the deductible for the months of _____ through _____ is $_____.

☐ _____ will be required to meet a deductible to receive full Medicaid in the following retroactive month(s) based on the gross income. If this income amount is incorrect, you may contact your Medicaid caseworker.

The amount of your deductible for the retroactive month(s):

_____ based on gross income of $_____ from _____ is $_____

_____ based on gross income of $_____ from _____ is $_____

_____ based on gross income of $_____ from _____ is $_____

☐ Two- or three-month deductible based on gross monthly income of $_____ from _____. for the months of_____ through _____ is $_____

☐ Provide medical bills for _____ from _____ to present and any old unpaid medical bills or your statement of anticipated medical expenses (eg surgery) expected within the 6-month certification period to meet the deductible amount listed above.

☐ Review, complete, sign, and return the enclosed Medicaid renewal form. If something has changed, mark through and write in correct information. If you need help or want to avoid mailing costs, you can answer these questions by phone by calling your worker within 30 days.

☐ Verification from physician if multiple births are expected.

☐ FL-2 completed by doctor for _____

☐ Proof of income for _____ from the month(s) of _____

☐ Proof of self-employment income and expenses from _____ tax return documents for the year_____

☐ Bank account numbers or statement(s) for _____ showing balance for the

months of _____

☐ Bank Consent form/Release of Information forms signed by _____

☐ Life insurance policies or the name of the insurance companies and policy numbers for _____

☐ Copy of the terms of the annuity for _____

☐ Proof that North Carolina Medicaid Program is named as a Remainder Beneficiary for an annuity for _____

☐ Name and contact information for issuer of annuity _____

☐ Social Security Number for _____

☐ Documentation of immigration status for _____

☐ Apply for Unemployment Benefits for _____

☐ Apply for Social Security Disability for _____

☐ DHB-5028, Consent for Release of Information, signed by _____

☐ Health Insurance card or the name of the company and policy number for _____

☐ Proof of Citizenship and Identity for _____

☐ Proof of State Residence for _____

☐ Proof of homesite equity for _____

☐ Documentation to rebut a transfer of assets sanction or to prove a transfer of assets sanction will cause an undue hardship or both.
(See attachment) _____

☐ Resources for _____ exceed the maximum resource limit for _____ Medicaid. Resources counted:

_____ valued at _____>

_____ valued at _____>

_____ valued at _____>

_____ valued at _____>

_____ valued at _____>

☐ See attachment for additional resources and amounts

If this amount is incorrect or you disagree with the value, you may contact your Medicaid worker. You also have the right to rebut the value of your assets or spend them down to the asset level.

☐ Other _____

In addition to the information requested above, **it is very important that you inform us of any changes in your situation since your last review.**

Do you need help or more time to get the information to complete your application/re-enrollment?

Call your Medicaid caseworker _____ at _____ OR
Sign and return this form to DSS.

☐ I need help getting the information to complete my application / re-enrollment.

☐ I need more time to get the information

I know that the information on this application is needed to determine eligibility for help paying for health coverage and/or Medicaid/NCHC and will be checked against electronic databases, Internal Revenue Service (IRS), Social Security, Department of Homeland Security, consumer reporting agencies, financial institutions, and/or other government agencies.

Applicant's Name _____ Telephone Number _____
Address _____

OTHER ITEMS WE CAN ACCEPT TO PROCESS YOUR MEDICAID APPLICATION/RE-ENROLLMENT

If you are unable to get the items checked or the items described below, please contact your caseworker immediately. Your caseworker will help you.

Reporting Changes

Don't forget to report all changes to your county department of social services within 10 calendar days (5 calendar days for Special Assistance). If you don't know whether a change is important, ask your caseworker. If you do not truthfully report information and changes, you **may be guilty of a misdemeanor or felony.**

MEDICAL BILLS

If you do not have all of your medical bills, you can provide:

1. Receipts from medical providers.
2. Statements from medical providers.
3. Cancelled checks to medical providers.
4. Names, addresses, phone numbers of medical providers.
5. Private health insurance receipts, premium books, name of agent.
6. "Explanation of Benefits" letters (EOB) from Medicare and/or private health insurance.
7. To show proof of over-the-counter drugs, provide a dated receipt and box top showing the name and price of the item purchased.
8. To show proof of medical transportation costs, provide a receipt or statement from the person if someone else took you to the doctor, drug store, or other medical facility.

PROOF OF OTHER INCOME

Such as Veteran's benefits, Railroad Retirement, other retirement income, rental income, farm income

1. Copy of check.
2. Award letter or other document from the source of income.
3. A statement from the source of the income or from person in charge of dispensing income(trust funds, etc.).
4. Records of payment received from roomers/boarders.
5. Records from the person paying you room/board.
6. Tax records.
7. Records of farm income.
8. Landlord's records of rental income.
9. Records of self-employment or rental income.
10. A signed statement from your bank, real estate agent, or person renting from you stating how much money you get.

WAGES

If you don't have wage stubs provide one of the following:

1. A statement or form completed by your employer.
2. Personal business records for self-employment.

PROOF OF CHILD CARE OR ADULT CARE

If you are applying for certain Family and Children's Medicaid programs there is a $200 per month limit for childcare for a child under age two and $175 per month limit for care for a child aged two or older and for an adult. You can provide:

1. Statement or receipt from person or the facility providing care. Statement or form indicating whether you are charged a flat fee or an hourly rate.
2. Your record of payment made for child or adult who is your dependent.

PROOF OF OPERATIONAL EXPENSES

If you don't have receipts to prove expenses for rental property or self-employment, provide one of the following:

1. Personal records of expenses such as ledger sheets, check stubs, or tax records.
2. Associations, ASCS Office, and purchase of farm products.
3. Written statements from people who sell you supplies.
4. Written statements from people who provide you with services so that you can earn money.
5. Written statement from real estate agent.

HEALTH INSURANCE

If you don't have your health insurance card, you may provide the name of the insurance company and the policy number.

IMPORTANT INFORMATION YOU NEED TO KNOW

If you need help to understand English, please let us know. We will get either an interpreter or interpreter service to help us talk with you. This is a free service. We can still take your application today. Getting an interpreter will not delay your application or benefits.

This application may ask you to tell us the social security number and immigration status of everyone living in your household who is applying for assistance. This notice tells you when you must give us this information and what will happen if you cannot give us the required information.

CITIZENSHIP and IMMIGRATION STATUS

- Anyone who wants to receive Medicaid, Health Choice, Food and Nutrition Services or Work First benefits must tell us about their citizenship and immigration status.

SOCIAL SECURITY NUMBER

- Anyone who wants to receive Medicaid, Health Choice, Food and Nutrition Services or Work First benefits must also give us their social security number. If you do not have a social security number, we can help you get one. This will NOT delay your application.

- Social Security numbers will NOT be used to report anyone to U.S. Citizenship and Immigration Services (USICS).

OTHER FAMILY MEMBERS MAY GET BENEFITS IF YOU CANNOT

- If you or any other members of your household are unable to provide proof of eligible immigration status or a valid social security number, that person will be ineligible for benefits. Other household members can still get benefits if they are eligible. You will still need to tell us about your family's income and answer the other questions on the application form.

- BATTERED IMMIGRANTS
  Battered immigrants with verification of their battered status from USCIS or the Executive Office of Immigration Review may be eligible to receive Medicaid, Health Choice, Food and Nutrition Services or Work First benefits. The non-abusive parent of a battered child may also be eligible, regardless of whether the child is an immigrant or a US citizen.

EMERGENCY MEDICAID

- Anyone applying only for emergency Medicaid does not have to provide his or her social security number or information on his or her citizenship or immigration status.

CHANGE IN IMMIGRATION STATUS

- Receiving Medicaid, Health Choice, or Food and Nutrition Services benefits does not affect an immigrant's ability to become a Legal Permanent Resident (obtaining a Green Card). An exception to this is the use of long-term institutional care, such as a nursing home.

- Receiving Work First or Supplemental Security Income (SSI) could cause problems for immigrants who are trying to obtain a Green Card, especially if this benefit is your family's only income.

- Refugees and persons granted asylum may receive any benefit, including Work First, without affecting their chances of obtaining a Green Card or becoming a U. S. citizen.

I have read and understood this form: _____

Signature of Applicant/Recipient **Date**

The North Carolina Division of Social Services does not discriminate against any person on the basis of race, color, national origin, disability, sex, or age in the admission, treatment, or participation in its programs, services and activities, or in employment.

DSS-8227 (rev. 05/13)
Economic and Family Services
Original: Applicant/Recipient
Copy: Case file

North Carolina Rights and Responsibilities for Public Assistance

Section 1: Applicant Rights and Responsibilities

If you are applying for or receiving assistance in North Carolina, you have the following rights and responsibilities.

Your Rights:

- Apply for and, if eligible, receive assistance. If your application is denied or withdrawn, reapply at any time. If the Subsidized Child Care Assistance Program in your county does not have funding available, you may be given an option to be placed on the waiting list.
- Have all information you provide to the agency kept in confidence and remain private unless required by law. Be advised that information provided to this agency may be stored in a computer database.
- Have an interpreter or translator services at no cost to you when communicating with the agency.
- Get help in completing an application and/or help getting the information needed to determine eligibility.
- Apply for assistance for new or additional household members at any time.
- Withdraw an application or request termination of ongoing benefits at any time. Receive written notice of any information needed to determine your eligibility and the outcome of your application or any changes in your benefits.
- Receive your assistance until notice of termination has expired or until it is withheld by appropriate action.
- Be advised that racial and ethnic data is obtained on participating household members. This information is voluntary. Neither your eligibility nor benefit/assistance amount will be affected if you choose not to provide it.
- In accordance with federal civil rights laws and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Programs that receive federal financial assistance from the U.S. Department of Health and Human Services (HHS), such as Temporary Assistance for Needy Families (TANF), and programs HHS directly operates are also prohibited from discrimination under federal civil rights laws and HHS regulations. Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or who have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.
- For the purposes of FNS: Benefits or level of benefits are not affected if ethnicity or race is not answered. When the information is not provided the agency will collect the information by observation during the interview. Giving this information will help ensure program benefits are distributed without regard to race, color or national origin (this information is used for statistical purposes only).
- Do not need a permanent address as long as you plan to stay in North Carolina. For Subsidized Child Care Assistance and FNS, you must reside in the county in which you apply.
- Ask questions regarding program rules and requirements.
- Ask for a hearing from the county department of social services and the state Division of Social Services. Hearing requirements may be different for each program. Refer to Section 3: Hearing Rights.

Your Responsibilities:

- Provide all information requested and certify that all information provided concerning your situation and all persons for whom you are applying or receiving benefits for is true and complete.
- Report timely to the county department of social services if you receive incorrect benefits or assistance.
- Report changes in your situation timely to the county department of social services as required by program policy. If you are unsure if you need to report something or not, call your caseworker. Reporting requirements may be different for each program. Refer to Section 4: Program Rights and Responsibilities.
- Provide the county department of social services or the local purchasing agency, state and federal officials, upon request, information needed to determine eligibility.
- Cooperate with local, state and federal personnel in Quality Control reviews.
- Understand that any Medical ID card, Electronic Benefits Transfer (EBT) card, or Child Care Voucher received is to be used only for the person(s) listed on the card/voucher. It is against the law to give your Medical ID, EBT card, or Child Care Voucher to someone else and you could be prosecuted for fraud.
- Apply for all benefits to which you may be entitled (such as Unemployment Benefits, Social Security benefits, Veteran's

- benefits, etc.) including receiving the maximum benefit for which you are eligible, when applying for or receiving Medical Assistance, Cash Assistance, or Special Assistance.
- Report any child or spousal support paid directly to you. This information must be reported and will be counted as income, for some programs, in determining your eligibility.

Section 2: Information You Need To Know

Fraud

- Under North Carolina law, persons must provide all information needed to decide if they can receive benefits/assistance.

- If you knowingly provide false information or withhold information, you can be lawfully punished for fraud.
- You may be asked to repay the benefits/assistance that was paid incorrectly.
- If anyone is convicted of giving false information regarding their residence, in order to receive Work First or Food and Nutrition Services benefits in more than one place, they will be ineligible to receive these benefits for 10 years.

Identity/Citizenship

- You must tell us about and provide documents, if required by program policy, for the citizenship and immigration status of all persons in your household applying for, or receiving, benefits/assistance to determine eligibility. Signing this form states, under penalty of perjury, you have told the truth of the information on the application, including the information concerning citizenship and alien status for all the members applying for benefits/assistance. Non-applicant household members are not required to provide immigrant or citizenship status. This means if you are not applying for someone in your home you are not required to give us their immigrant or citizenship status. For Subsidized Child Care Assistance, if citizenship is questionable, you will be required to provide verification of your current status.
- You must be a United States Citizen or qualified immigrant/eligible alien to receive benefits/assistance. Exceptions may apply to Medical Assistance in emergency situations and to Subsidized Child Care Assistance for Child Protective Services and Foster Care.
- Information given to use in verifying your immigration status will be used in matching information with a web-based service called the Systematic Alien Verification for Entitlements (SAVE). If additional information is required, we may check with the United States Citizenship and Immigration Services (USCIS).

Child Support/Assignment of Rights

- As a condition of eligibility for some benefit programs the law requires a caretaker of a child receiving public assistance to cooperate with the Social Services and Child Support Enforcement agencies to establish a support case. Medicaid does not require a caretaker to cooperate with Child Support Enforcement unless he is applying/receiving for him/herself. Subsidized Child Care Assistance does not require that you cooperate with Child Support Enforcement.
- The medical or child support paid to Child Support Enforcement is used to repay the Work First Family Assistance or Medicaid benefits you receive for your child (ren).
- You may claim good cause for not cooperating. Please notify your caseworker if you think you have good cause.
- I understand this assignment of rights continues for as long as anyone I am applying for receives Work First or Medicaid.

Social Security Numbers

- Non-applicant household members are not required to provide a social security number. You must tell the county department of social services all the social security numbers used by all applicants. Subsidized Child Care Assistance does not require you to provide a Social Security Number(s).
- These numbers will be matched electronically with other government agency records (but not the Bureau of Citizenship and Immigration Services) to verify information. This includes the Social Security Administration, Internal Revenue Service, the Division of Employment Security, out-of-state welfare agencies and any other necessary agencies to verify information needed to determine eligibility. You have the right to request your application be withdrawn or denied, or request assistance be terminated if you do not want this done.
- Providing a Social Security Number is required by the Food and Nutrition Act of 2008 for applicants seeking benefits.
- Persons applying for Emergency Medicaid services only are not required to provide a social security number.
- The caseworker can help if assistance is needed in obtaining a social security number.

Estate Recovery (Medical Assistance Only)

- Federal and State laws require the Division of Medical Assistance (DMA) to file a claim against the estate of certain individuals to recover the amount paid by the Medicaid program during the time the individual received assistance with certain medical services. Ask your caseworker for specific information regarding which services are applicable to estate recovery.

Medical Assistance/Assignment of Rights (Medical Assistance Only)

- North Carolina must be named remainder beneficiary for annuities purchased after November 1, 2007.
- Understand that by accepting medical assistance for yourself or other members of your household, you agree to give back to the State any and all money that is received from any insurance company for payment of medical and/or hospital bills for which the medical assistance program has or will make payment.

Reviews

- A review of eligibility may be completed periodically depending on the type of assistance you are receiving.
- If you get a notice of review or a report, you must fill out, sign and return all forms and requested verifications to the county department of social services by the deadline date printed on the form as instructed. Assistance could terminate or be delayed if review or report is not completed and returned timely.
- If you are required to have an interview and fail to do so it will result in a delay or denial of assistance. For Child Care services, failure to complete a requested interview will result in termination of Child Care services. You are responsible for rescheduling a missed interview and for providing required verification information.

Section 3: Hearing Rights

Your Rights to a Hearing:

- You have the right to a hearing if you were denied or discouraged from applying for benefits. For Subsidized Child Care Assistance, you cannot request a hearing if the county where you reside has no available funds.
- You have the right to a hearing if you disagree with the decision made on your Medicaid, Food and Nutrition Services case.
- You have the right to request a hearing if your application is denied or your case is terminated, your benefit is changed, or your case is not acted upon timely. Program requirements are listed in Section 4: Program Rights and Responsibilities.
- For WFFA, Subsidized Child Care Assistance, Medical, Special Assistance, and Energy the standard time to request a hearing is 60 days from the date of your notice. For Food and Nutrition Services the standard time to request a hearing is 90 days from the date of your notice.
- You can request a hearing in person, by telephone or in writing. Contact your caseworker to ask for a hearing. When required by policy a local hearing will be held within 5 days of your request unless you ask for it to be postponed. The hearing can be postponed, for good reasons, for as much as 10 calendar days. If you think the decisions from the local hearing officer is wrong, call or write your caseworker WITHIN 15 DAYS to ask for a second hearing. The second hearing is before a state hearing official.
- If you ask for a hearing for FNS, a local conference is optional and not required.
- If you ask for a hearing for Work First and you live within certain counties, the second hearing is before a county official.
- For Subsidized Child Care Assistance, State and Local hearings can only be requested at the county level.
- If you are requesting a hearing about disability, there is no local hearing. A state hearing officer holds the disability hearing.
- You may have someone speak for you at your hearing, such as a relative or a paralegal or attorney obtained at your expense. Free legal services may be available in your community. Contact your nearest Legal Aid or Legal Services office or call 1-866-219-5262 toll free.
- You (or the person speaking for you) can view your record at any time, except for third-party information. If you ask, you may also see additional information to be used at the hearing.
- If you have additional questions or concerns, contact your caseworker for information, or call DHHS Customer Service Center toll free at 1-800-662-7030. TDD/Voice for the hearing impaired is also available through the DHHS Customer Service Center number. The DHHS Customer Service Center is available Monday through Friday 8 a.m. to 5 p.m. except for state holidays. A bilingual information and referral specialist is available to translate for persons with limited English proficiency.

Section 4: Program Rights and Responsibilities

Subsidized Child Care Assistance

- The time standard for completing and processing a Subsidized Child Care Assistance application is 30 calendar days from the date of the application.

Your Rights:

- Receive a redetermination notice at least 30 days prior to the end of your current Subsidized Child Care Assistance certification period.

Your Responsibilities:

- Report changes to your child care worker within ten (10) business days of when changes occur including:
    - Change of contact information including address and telephone number.
    - Increase in income that exceeds 85% SMI (this should NOT include irregular income fluctuations) based on the SMI chart posted on the DCDEE website.
    - Non-temporary change in the status of the recipient as working or attending a job training or education program or any other non-temporary change in their need for child care.
    - Change in recipient's choice of provider is needed or wanted. ○ Recipient needs or wants to end child care services
- Report absences to your child care worker when your child(ren) is/are absent from the child care arrangement more than five (5) days during a month or if your child will no longer be enrolled at the center or home.
- Pay the parental fees determined by your child care worker to your child's provider. Failure to pay these fees regularly and on time can result in termination of child care services. You will not be eligible for child care services until the parental fees are paid. Also, you should request a receipt from the provider each time you pay child care fees.
- Respond to all contact from the county DSS or local purchasing agency (LPA) regarding your continued eligibility within the requested time frame. Failure to respond may result in the termination of services. If your child care services are terminated and you continue to need help paying for child care, you must request that your name be added to the child care waiting list if one exists.
- Provide the required information so that eligibility for Subsidized Child Care Assistance can be determined. If written information is not available, signing this form gives permission to the worker to verify the information, such as income, by telephone or through other documents on file in the county department of social services (DSS) or other agencies.
- If you make a false statement or representation regarding a material fact with the intent to deceive, or fail to disclose a material fact, and as a result obtain, attempt to obtain, or continue to receive child care subsidy, then you may be found guilty of the offense of fraudulent misrepresentation per North Carolina General Statute 110-107. Subsidy fraud is a crime in the State of North Carolina. Anyone who intentionally makes a false statement or withholds information in order to receive child care subsidy money can be criminally prosecuted and even receive jail time under North Carolina Law.
- If you have a first instance of fraudulent misrepresentation, you must repay the amount of child care subsidy for which you were ineligible to receive, and you shall be permanently ineligible to participate in the Subsidized Child Care Assistance Program. You have the right to appeal the decision made.
- If you are convicted of fraudulent misrepresentation by a court of competent jurisdiction, you will also be permanently ineligible to participate in the Subsidized Child Care Assistance Program and the sanction imposed cannot be appealed.

Work First Family Assistance

- The time standard for completing and processing a Cash Assistance application is 45 calendar days from the date of application. Exceptions to this 45-day time standard may apply; your caseworker will explain if applicable.
- North Carolina General Statue 108A-29.1, requires substance use screening and testing for the illegal use of controlled substances, if there is reasonable suspicion, for each adult applicant or recipient as a condition of eligibility to receive assistance. The substance use screening and testing requirement does not apply to:
    - Child only cases with a non-parent caretaker as the case head; or ○ Dependent children; or
    - Supplemental Security Income (SSI) recipients. This includes SSI recipients who are custodial parents

Your Rights:

- Request a screening at any time to identify potential disabilities or other barriers that may impact program participation.
- You have the right for the eligible household members to receive cash assistance if you are disqualified or sanctioned, due to a confirmed positive substance use test and/or failure to be screened or tested for substance use.

Your Responsibilities:

- Help the caseworker develop your Mutual Responsibility Agreement (MRA)/Outcome Plan and carry out the agreed-upon actions.
- Use your benefit amount in the best interest of your family. If you do not use it correctly, another person may be appointed to receive the benefit on your behalf and use it for you and your family.
- You cannot use or access the cash benefits on your EBT card in any casino or gambling establishment, liquor store or any establishment that provides adult oriented entertainment.
- If you quit or lose a job without good cause, the family will be ineligible for Work First Cash Assistance for a period of three months. The Job Quit penalty does not apply to Child only cases with a non-parent caretaker as the case head.
- Report changes in your situation within 10 calendar days from the date of the change. **Note:** Temporary absence of a child expected to be away more than 90 days must be reported within 5 days of the change. If you do not report a temporary absence your benefit will be reduced or terminated, as the child is no longer eligible to receive Cash Assistance unless there is a good cause for the absence.
- If you get Cash Assistance, you may need to complete a report of your household's income and situation every 3 months. If you get this report, you must fill it out and return it to the county department of social services by the deadline date printed on the form. If you get the report and fail to complete and return it, your benefits could stop.
- If anyone in your home is found guilty of an Intentional Program Violation for giving false information, they could be disqualified from receiving benefits, fined and/or placed in jail.
- **Disqualification periods are:**
  - **12 months for the first violation**
  - **24 months for the second violation**
  - **Permanently for the third violation**

Information You Need to Know:

The Work First Program complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, religion, disability, or sex. The Work First Program does not exclude people or treat them differently because of race, color, national origin, age, religion, disability, or sex.

Work First Program:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: ○ Licensed sign language interpreters
  - ○ Written information in other formats (large print, audio, accessible electronic formats, other formats) ○ Provides free language services to people whose primary language is not English, such as: ▪ Qualified interpreters
    - ▪ Information written in other languages

If you need these services, contact your local Department of Social Services

The U.S. Department of Health and Human Services (HHS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity). HHS does not exclude people or treat them differently because of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity).

If you believe that Department of Health and Human Services (HHS) has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW

Room 515F, HHH Building Washington,
D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Medical Assistance

- The time standard for completing and processing a Medical Assistance application is 45 calendar days from the date of application. Exceptions to this 45-day time standard may apply; your caseworker will explain if applicable.

Your Rights:

- Apply for retroactive Medicaid for up to 3 months prior to the date of your application.
- Request Medicaid transportation to your primary care physician or other medical appointments if receiving certain Medicaid coverage.
- Apply for a deceased individual.

Your Responsibilities:

- Report changes in your situation within 10 calendar days from the date of the change.
- Report if you or a household member receiving Medical Assistance is in an accident.
- Provide third-party insurance information if applicable.
- Understand that any medical or financial records must be made available to the agency and the state by any provider from whom you and/or your children have received medical care services. You agree to the release of those records by those providers when requested by the agency and the state. The privacy of this information is protected by law.
- Understand you are giving the State of North Carolina permission to collect payments and share information with insurance companies or anyone else who is supposed to pay for your medical bills.
- Request medical transportation as far in advance of your appointments as possible.
- Understand if any resources 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. All transfer of resources must be reported when making this application and any new transfers must be reported to the caseworker within 10 calendar days.

Special Assistance

- The application processing time standard for Special Assistance is 45 days for individuals age 65 or older and 60 days for applicants who are under age 65.

Your Rights:

- If approved for Special Assistance, you have the right to spend the Special Assistance benefit as needed when it is considered to be in your best interest of your health and safety. A substitute payee may be appointed for those individuals who cannot manage the payment. If you are receiving payment because you reside in an adult care home "best interest" means paying for your adult care home. <u>If you are receiving Special Assistance In-Home, "best interest" is to use the payment for purposes related to your health and safety.</u>

Your Responsibilities:

- Report changes to your caseworker within 5 calendar days following the change in situation.

Refugee Assistance

- The time standard for completing and processing a Refugee Assistance application is 30 calendar days from the date of application. Exceptions to this 30-day time standard may apply; your caseworker will explain if applicable.

Your Rights:

- Receive a written description of your rights as a client of the Refugee Service provider and the provider's obligations to you.
- Receive a written summary of rules, expectations and other factors for the use of services, hours the services are available, termination of services and how to register complaints, grievances or appeals.

Your Responsibilities:

- Participate in the development of and follow your Employability Plan and Family Self Sufficiency Plan.
- Report changes in your situation within 10 calendar days of when the change is known.

Food and Nutrition Services

Information You Need to Know:

- For information regarding the Teen Pregnancy Prevention Initiative contact your local Health Department or call the DHHS Customer Service Center at 1-866-719-0141. For information regarding services provided for Healthy Marriages contact your local agency.
- The time standard for completing and processing a Food and Nutrition Services application is 30 calendar days from the date of the application. Applications meeting the expedited services criteria should be processed within 7 calendar days from the date of the application. If you are applying for FNS and SSI at the same time from an institution the filing date is the date of release from the institution.

Your Rights:

- Receive a discount on your telephone bill in certain situations. Contact your phone company for more information.
- Receive benefits in a timely manner.
- Receive a change report form telling what changes you are required to report.

Your Responsibilities:

- Use the Food and Nutrition Services to buy only food items for home consumption. Improper use of the Food and Nutrition benefits could result into fines of up to $250,000, imprisonment up to 20 years and/or being permanently disqualified from receiving Food and Nutrition benefits. You may also be ineligible for Food and Nutrition Services for an additional 18 months if court ordered.
- Do not trade or sell Food and Nutrition benefits.
- Do not use your Food and Nutrition benefits for someone else.
- Do not use your Food and Nutrition benefits to pay on any kind of credit account or to pay for food purchased on credit you will lose your benefits.
- If you use your food assistance benefits to buy nonfood items, such as alcohol, and cigarettes you will lose your benefits.
- **Don't** use someone else's Food and Nutrition Services for yourself.
- DO cooperate with state and federal personnel in a Quality Control review.
- If you lie, withhold or give wrong information knowingly this could reduce your benefits, or you may have to repay benefits, or may be subject to criminal prosecution or not able to get benefits for twelve or twenty-four months.
- If a court finds you guilty of trading Food and Nutrition Services for controlled substances, you will lose Food and Nutrition Services for 12 months the first time.
- If a court finds you guilty of buying, selling, or trading benefits $500 more than, trading benefits for firearms, drug trafficking, ammunition, or explosives after August 22, 1996 you may lose Food and Nutrition Services forever.
- If a court finds you guilty of trading Food and Nutrition Services for controlled substances, you will lose Food and Nutrition Services forever the second time.

Energy Assistance

- The time standard for completing and processing a Low-Income Energy Assistance Program (LIEAP) application is two business days after the receipt of all requested information.
- The time standard for completing and processing a Crisis Intervention Program (CIP) application is one business day if it is a life-threatening crisis and two business days for a non-life-threatening crisis.

Your Rights:

- The right to receive a utilities moratorium through the North Carolina Utilities Commission regarding disconnection/termination of services. Participating companies can be verified through the local department of social services.

Your Responsibilities:

- Understand it is against the law to make false statements and if done will be subject to prosecution.
- Return all requested information within 10 business days from the date of the request for the LIEAP program.
- Do not trade or sell Energy benefits through any Energy supplier for other goods or services.
- Give authorization for your utility company to release information regarding energy usage and bill payment for the last 12 months to agencies associated under LIEAP and CIP.
- Give the agency permission to verify any information necessary to determine your eligibility for LIEAP and CIP.

Section 5: Program Statements of Non-Discrimination Food and Nutrition Services

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:

1. **mail:**
   Food and Nutrition Service, USDA
   1320 Braddock Place, Room 334 Alexandria,
   VA 22314; or
2. **fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **email:**
   FNSCIVILRIGHTSCOMPLAINTS@usda.gov

This institution is an equal opportunity provider.

Energy Assistance

No person shall on the ground of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity) from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity funded in whole or in part with funds made available under this title. Any prohibition against discrimination on the basis of age under the Age Discrimination Act of 1975 or with respect to an otherwise qualified handicapped individual as provided in section 504 of the Rehabilitation Act of 1973 also shall apply to any such program or activity.

To file a complaint of discrimination you may contact:

Carlotta Dixon, MHS, CPM Section
Chief
Title VI/ADA-Civil Rights Coordinator
NC Division of Social Services-Program Compliance
North Carolina Department of Health and Human Services

919-527-6421 Office
919-334-1198 Fax
Carlotta.Dixon@dhhs.nc.gov

820 South Boylan Avenue, McBryde Building
Raleigh, North Carolina 27603

If you are not satisfied with the outcome of the decision made by the state office, you may contact the agency listed below.

Department of Health and Human Services/Administration for Children and Families
Office of Community Services/Division of Energy Assistance
Low Income Home Energy Assistance Program (LIHEAP)
Mary E. Switzer Building, 5th Floor
330 C Street, SW
Washington, D.C. 20201
Phone Number: (202) 401-9351 Fax
Number: (202) 401-5661

Section 6: Voter Registration

If you want to register to vote or to update your registration, you can complete a voter registration form at www.ncsbe.gov/nvra/01, ask your caseworker or contact your local DSS for a voter registration form. **Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.** If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the North Carolina State Board of Elections, PO Box 27255, Raleigh NC 27611-7255 or you may call the toll free number, 1-866-522-4723.

Section 7: Acknowledgment of Rights and Responsibilities

I understand my rights and responsibilities as explained in the previous sections.

Applicant Signature:_____Date_____
Representative:_____Date:_____Caseworker:_____Date:_____

INCOME
SECTION - FOUR
SAMPLE

CO. FILE	DEPT.	CLOCK	VCHR.NO	062
918 693588	876844	37661	82214	

Sample Company Name
Los Angeles, CA 90016

Social Security Number: XXX-XX-8963
Taxable Marital Status: Single
Exemptions / Allowances: 0
Employee ID: CRO7363

Earnings Statement

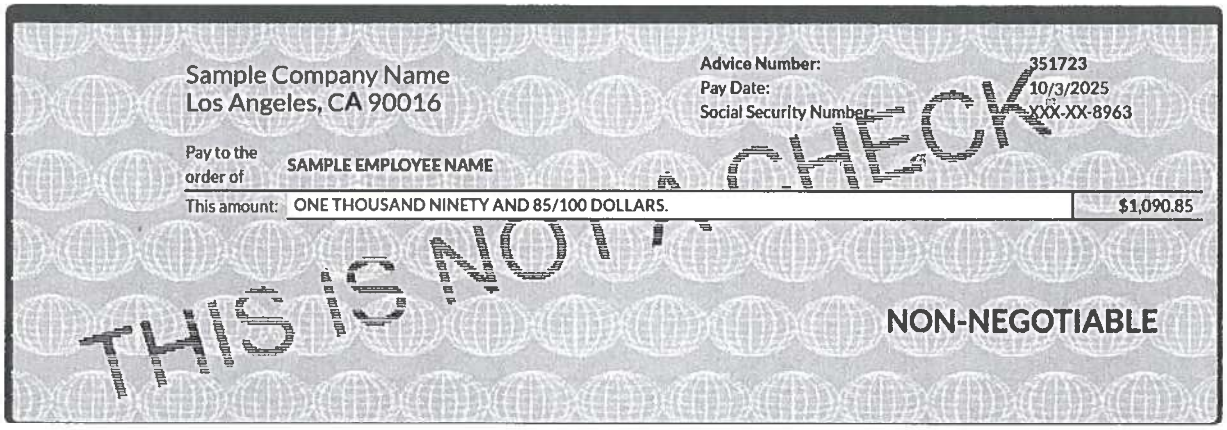
Period Beginning: 9/24/2025
Period Ending: 9/30/2025
Pay Date: 10/3/2025

Sample Employee Name
251 Miramar Street Upland, CA 91784

Earnings	Rate	Hours	Amount	Year To Date
Regular	21.00	40.00	840.00	23,520.00
Overtime Hourly	25.00	20.00	500.00	500.00
Holiday Pay			0.00	0.00
Gross Pay			**1,340.00**	24,020.00

Deductions	Statutory		
	FICA MED TAX	-19.43	544.04
	FICA SS TAX	-83.08	2,326.24
	FED TAX	-98.34	2,753.52
	CA ST TAX	-32.22	902.16
	CA SDI	-16.08	450.24
	Other		
	HEALTH INS	-0.00	0.00
	DENTAL INS	-0.00	0.00
	Net Pay	**$1,090.85**	
	Check	-$1,090.85	
	Net Check	**$0**	

Other Benefits and Information	This Period	Year To Date



This sample paystub includes hourly earnings, taxes, benefits, net pay, and a non-negotiable check issue company in Los Angeles, California.

WAGE VERIFICATION FORM

_____ Department of Social Services

DATE: _____

TO: _____
_____
_____
_____

Case Name: _____
Case No.: _____
Case ID: _____
Dist. No.: _____

Employee Name:_____
SSN (optional):_ _ _ _ **(last four digits only)**

This person has applied for social services assistance. By signing the application, permission was given to contact you to verify certain information. Please verify employment information for the above. Return this form by _____.

This form must be completed by the employer.

Please answer the questions for boxes that are checked.

[ ] Is this person currently employed by you or your company? [ ] Yes [ ] No

Beginning date of employment: _____
Date first check received or anticipated: _____
How many days did the individual work during the first pay period? _____
How many days will the individual normally work during a pay period? _____

Do you expect any changes in income? [ ] Yes [ ] No If yes, explain _____
_____

[ ] Pay Rate: $_____ Estimated number of hours to be worked weekly: _____

[ ] Please complete the following information for the months of _____

Date Pay Received Month & Day	Number of Hours	Rate of Pay	Bonus or Vacation Pay	**Gross Pay**	Tips	EITC

CONTINUED ON NEXT PAGE

NOTICES
SECTION - FIVE

Guilford County DSS
2001 Mail Service Center
Greensboro, NC 27410

Case Identifier: 100000257
Worker: NFEligibility Worker
Date Generated: 04-13-2022

Guilford County DSS
2001 Mail Service Center
Greensboro, NC 27410

Refugee Testone
333 main st
Cary, NC 27519

Notice of Application Approval

This letter is to notify you that your application has been processed.
Please read all the information carefully because it is very important to you.

APPLICATION APPROVAL:

Aid Program Category:Refugee Cash Assistance.
Case Reference:100000259
On:04-13-2022, you applied for:Refugee Cash Assistance.
Your application for Refugee Cash Assistance is approved for:Refugee Testone.
Payment Amount:181.00 Payment Month:April Benefit Period:04-13-2022-11-30-2022.
The Refugee Cash Assistance policy used to approve this application is in Chapter III of the Refugee Manual.

Aid Program Category:Refugee Medical Assistance.
Case Reference:100000258
On:04-13-2022, you applied for:Refugee Medical Assistance.
Your application for Refugee Medical Assistance is approved for:Refugee Testone.
Benefit Period:04-01-2022 - 11-30-2022.
The Refugee Medical Assistance policy used to approve this application is in Chapter II of the Refugee Manual.

PLEASE CONTINUE READING FOR IMPORTANT INFORMATION REGARDING YOUR RIGHTS TO A HEARING.

YOUR RIGHT TO A HEARING AFTER THE CHANGE IS MADE

Even after your benefits stop or are changed, you have sixty (60) calendar days, that is until 06-12-2022, to ask for a hearing. If you do not ask for a hearing by then, you cannot have a hearing. You may reapply for benefits at any time. To protect your rights, you may both reapply and ask for a hearing.

Calling your worker may fix the problem. Did you miss an appointment or fail to return a form or other information?

You can: 1. Call your caseworker to reschedule your appointment or see what you can do.
2. Return the form or other information immediately. Be sure you answer every question. Be sure you provide any proof of income.
3. If your case has already been closed, call your caseworker to see what you can do.

Did you not do something your caseworker asked you to do?

You can call your caseworker to explain why and try to solve the problem.

Did your caseworker make a mistake or has your situation changed?

Call your caseworker right away.

Is there still a problem? You can ask for a hearing.

If you think we are wrong, or you have new information, you have the right to a hearing. You must ask for this hearing within 60 days (or 90 days if you have a good reason for delay). This hearing is a meeting to review your case and give you the correct benefits if it was wrong.

Call or write your caseworker to ask for a hearing. A local hearing will be held within 5 days of your request unless you ask for it to be postponed. The hearing can be postponed, for good reasons, for as much as 10 calendar days. Then, if you think the decision in the local hearing is wrong, call or write your caseworker WITHIN 15 DAYS to ask for a second hearing. The second hearing is before a state hearing official. If you ask for a hearing on Work First and you live in certain counties, the second hearing is before a county official.

Did you know you have the right to be represented?

You may have someone speak for you at your hearing, such as a relative or a paralegal or attorney obtained at your expense. Free legal services may be available in your community. Contact your nearest Legal Aid or Legal Services office or call 866- 219-5262 toll free.

If you have additional questions or concerns, contact your caseworker for information, or call the DHHS Customer Service Center toll free at 800- 662-7030. TDD/Voice for the hearing impaired is also available through the number. The hours are 8:00am-5:00pm, Monday-Friday, excluding State holidays.

Did you know you have the right to see your record?

If you ask, your caseworker will show you (or the person speaking for you) your benefits record before your hearing. If you ask, you may also see other information to be used at the hearing. You can get free copies of this information. You may see this information again at your hearing.

Do you understand your rights?

Do you understand how to get a hearing? If you have any questions, please contact your caseworker as soon as possible.

Beware of Fraud!

Don't forget to report all changes to your county department of social services within 10 calendar days. If you don't know whether a change is important, ask your caseworker. If you do not truthfully report information and changes, you may be guilty of a misdemeanor or felony.

Notice to Cash Assistance Clients Whose Benefits Have Stopped:

Unless you ask the Child Support Enforcement Agency to stop the child support services, you will continue to receive them. If you choose to stop services, but later reapply for services within thirty (30) days, you will not be charged an application fee. Contact your county department of social services for the name and telephone number of the Child Support Enforcement Agency in your county.

Please tell us if you need assistance because you do not speak English or have a disability.

Free language assistance and/or other aids and services are available upon request. To receive free interpreter services, call 866-719-0141 or call your local DSS office. After the recorded message, you will reach an operator who will provide you with an interpreter. If you have a disability and need communication assistance, call 866-719-0141 or Relay Services: 711.

North Carolina Division of Social Services (NC DSS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, sex, religion, creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by U.S. Health and Human Services.

NOTICE OF BENEFITS

North Carolina
_____County Social/Human Services Agency

_____

_____

_____

Date: _____

ICS or PDC#:_____

APPLICATION APPROVALS

On _____, you applied for: _____.

❑ Your application for _____is **approved** for:

Payment Amount:		**Payment Month:**	

The State rules used to approve this application are in _____of the _____ _____.

_____ benefits from _____ to _____ are **denied** because you did not meet the following rule(s):_____. The State rules used to make this decision are in _____ which says: _____.

❑ Medicaid is **approved** starting _____ and ending _____**.**

❑ Your Medicaid covers all necessary medical services. If you get Medicare from the Social Security Administration, Medicaid will pay your Medicare A and B premiums, deductible, and coinsurance beginning: _____.

❑ Your Medicaid pays only your Medicare A and B premiums, deductible, and coinsurance for Medicare approved services.

❑ Your Medicaid only pays for services related to pregnancy and for conditions that may complicate the pregnancy.

❑ Your coverage is limited to Family Planning assistance.

❑ Retroactive Medicaid coverage is approved for the month(s) of _____.

❑ Your patient monthly liability for long-term care is:

Patient Monthly Liability:		**Effective Date:**	

The State rules used to approve this application are in _____ of the _____ _____.

❑ Medicaid benefits from _____ to _____ are **denied** because you did not meet the following rule(s): _____.

The State rules used to make this decision are in _____which says that: _____ _____.

Individuals who are ineligible for Medicaid or NC Health Choice or individuals who are eligible for a Medicaid program that is not considered minimal essential coverage, may be eligible for assistance in purchasing insurance at the Federal Marketplace. Application information is sent to the Federal Marketplace via secure electronic transfer for those who may be eligible for assistance and will be contacted by someone at the Federal Marketplace, if further information is needed. For more information visit Healthcare.gov or call 1-800-318-2596.

CONTINUING ELIGIBILITY

❑ Your _____ **continues.** The State rules used to make this decision are in __ _____ of the _____.

Signature: _____ Telephone No. _____

DSS-8108 (rev. 07/19)
Economic and Family Services
DHB/Eligibility Services

PLEASE READ YOUR HEARING RIGHTS ON THE BACK OF THIS NOTICE.

YOUR RIGHT TO A HEARING: If you think we're wrong, you have until _____, which is 60 days from the date of this notice, to ask for a hearing.

Calling your worker may fix the problem! Did you miss an appointment or fail to return a form or other information?

You can:

1. Call your caseworker to reschedule your appointment or see what you can do.
2. Return the form or other information immediately. Be sure you answer every question. Be sure you provide any proof of income.
3. If your case has already been closed, call your caseworker to see what you can do.

Did you not do something your caseworker asked you to do?
You can call your caseworker to explain why and try to solve the problem.

Did your caseworker make a mistake or has your situation changed?

Call your caseworker right away.

Is there still a problem? You can ask for a hearing. If you think we are wrong, or you have new information, you have the right to a hearing. You must ask for this hearing within 60 days (or 90 days if you have a good reason for delay). This hearing is a meeting to review your case and give you the correct benefits if it was wrong. Call, write or contact via ePass (Medicaid Only) your caseworker to ask for a hearing. A local hearing will be held within 5 days of your request unless you ask for it to be postponed. The hearing can be postponed, for good reasons, for as much as 10 calendar days. Then, if you think the decision in the local hearing is wrong, call or write your caseworker WITHIN 15 DAYS to ask for a second hearing. The second hearing is before a state hearing official.

NC Medicaid Hearing Information
If you believe a standard hearing could seriously jeopardize your life or health or could threaten your ability to attain, maintain or regain maximum function, you may request an expediated hearing. An expedited hearing will be held within 3 days unless you ask for it to be postponed. You will be required to provide documentation from a person who has knowledge of your situation (such as a doctor, nurse or social worker) to support your request. If you do not provide documentation, your appeal will be held on a standard schedule.

If you are requesting a hearing about a medical disability determination, call, write or contact via ePass your caseworker for a hearing. There is no local hearing. A state hearing officer holds the medical disability hearing. If you believe a standard hearing could seriously jeopardize your life or health or could threaten your ability to attain, maintain or regain maximum function, you may request an expedited medical disability hearing if you have medical records (such as physical examination, laboratory findings, etc.) to support your request. A doctor's note providing an opinion about your health without submission of supporting medical records is not sufficient to justify an expedited fair hearing. If you do not provide medical records, your appeal will be handled on a standard schedule.

Did you know you have the right to be represented?
You may have someone speak for you at your hearing, such as a relative, paralegal or attorney obtained at your expense.

Free legal services may be available in your community. Contact your nearest Legal Aid or the Legal Aid Helpline at 1-866-219-5262, toll free.

If you have additional questions or concerns, contact your caseworker for information, or call DHHS Customer Service Center, toll free at 1-800-662-7030. TDD/Voice for the hearing impaired is also available through the number. The hours are 8:00am-5:00pm, Monday – Friday, excluding State holidays.

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If you ask, your caseworker will show you (or the person speaking for you) your benefits record before your hearing. If you ask, you may also see other information to be used at the hearing. You can get free copies of this information. You may see this information again at your hearing.

Do you understand your rights?
Do you understand how to get a hearing? If you have any questions, please contact your caseworker as soon as possible.

Medicare Medicaid Recipients
Prescription drug coverage for Medicare individuals who also have Medicaid is only covered through a Prescription Drug Plan (PDP). You must be enrolled in a PDP to receive prescription drug coverage. PDP co-payments differ from Medicaid co-payments. For questions about a PDP, co-payment, or assistance with enrolling, you may call 1-800-MEDICARE.

Beware of Fraud!
Don't forget to report all changes to your county department of social services within 10 calendar days (5 calendar days for Special Assistance). If you don't know whether a change is important, ask your caseworker. If you do not truthfully report information and changes, you may be guilty of a misdemeanor or felony.

Notice to Work First Cash Assistance Clients Whose Benefits Have Stopped: Unless you ask the Child Support Services office to stop the child support services, you will continue to receive them. If you choose to stop services, but later reapply for services within thirty (30) days, you will not be charged an application fee. Contact your county social/human services agency for the telephone number of the Child Support Services office.

North Carolina Division of Social Services (NC DSS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, sex, religion, creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by U.S. Health and Human Services

North Carolina _____ County Department of Social Services

YOUR APPLICATION FOR BENEFITS IS BEING DENIED OR WITHDRAWN

Date Mailed _____

_____
Name

_____
Address

_____

_____

We are taking action on your application. Please read all pages of this form carefully for important information.

Your application for _____ **is** _____

because: _____

_____

_____

☐ If this block is checked, you will get a separate letter about your Medicaid benefits.

The state regulations requiring this action are found in _____

Individuals who are ineligible for Medicaid or NC Health Choice or individuals who are eligible for a Medicaid program that is not considered minimal essential coverage, may be eligible for assistance in purchasing insurance on the Federal Marketplace. Application information is sent to the Federal Marketplace via secure electronic transfer for those who may be eligible for assistance and will be contacted by someone at the Federal Marketplace if further information is needed. For more information, visit Healthcare.gov or call 1-800-318-2596.

HEARING RIGHTS: If you disagree with this decision, you have a right to a hearing to review this decision. Call your worker at the number below within 60 days to ask for a hearing. The 60th day is _____. If you do not ask for a hearing by this date, you cannot have a hearing unless you have a good reason for missing this deadline. You may reapply for benefits at any time. To protect your rights, you may BOTH reapply AND ask for a hearing.

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_____
Caseworker Name and Phone Number

_____
Address

_____

_____

FOR OFFICE USE ONLY:

County Case #_____

Case ID # _____

Aid Program/Category _____

PLEASE CONTINUE READING FOR IMPORTANT INFORMATION ABOUT YOUR RIGHT TO A HEARING.

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Did you not do something your caseworker asked you to do? You can call your caseworker to explain why and try to solve the problem.

Did your caseworker make a mistake or has your situation changed? Call your caseworker right away.

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Call or write your caseworker to ask for a hearing. A local hearing will be held within 5 days of your request unless you ask for it to be postponed. The hearing can be postponed, for good reasons, for as much as 10 calendar days. Then, if you think the decision in the local hearing is wrong, call or write your caseworker WITHIN 15 DAYS to ask for a second hearing. The second hearing is before a state hearing official.

If you ask for a hearing on Work First and you live in certain counties, the second hearing is before a county official.

If you are requesting a hearing about disability, call or write your caseworker to ask for a hearing. There is no local hearing. A state hearing officer holds the disability hearing.

NC Medicaid Hearing Information

If you think we are wrong, or you have new information, you have the right to a hearing. You must ask for this hearing within 60 days (or 90 days if you have a good reason for the delay). This hearing is a meeting to review your case and give you the correct benefits if it was wrong. You may call, write, send electronically, or via ePass to your caseworker a request for a hearing. A local hearing will be held within 5 days of your request unless you ask for it to be postponed. The hearing can be postponed, for good reasons, for as much as 15 calendar days. Then, if you think the decision in the local hearing in wrong, you may call, write, send electronically, or via ePass WITHIN 15 calendar DAYS to ask for a second hearing. The second hearing is before a state hearing official.

If you believe a standard hearing could seriously jeopardize your life or health or could threaten your ability to attain, maintain, or regain maximum function, you may request an expedited hearing. An expedited hearing will be held within 3 days unless you ask for it to be postponed. You will be required to provide documentation from a person who has knowledge of your situation (such as doctor, nurse, or social worker) to support your request. If you do not provide documentation, your appeal will be held on a standard schedule.

If you are requesting a hearing about a medical disability determination, call, write, send electronically, or via ePass to your caseworker a request for a hearing. There is no local hearing. A state hearing officer holds the medical disability hearing. If you believe a standard hearing could seriously jeopardize your life or health or could threaten your ability to attain, maintain, or regain maximum function. You may request an expedited medical disability hearing if you have medical records (such as physical examination, laboratory findings, etc.) to support your request. A doctor's note providing an opinion about your health without the submission of supporting medical records is not sufficient to justify an expedited fair hearing. If you do not provide medical records, your appeal will be handled on a standard schedule.

Did you know you have the right to be represented? You may have someone speak for you at your hearing, such as a relative, paralegal or attorney obtained at your expense. **Free legal services may be available in your community.** Contact your nearest Legal Aid or the Legal Aid Helpline at 1-866-219-5262, toll free.

If you have additional questions or concerns, contact your caseworker for information, or call DHHS Customer Service Center, toll free at 1-800-662-7030. TDD/Voice for the hearing impaired is also available through the number. The hours are 8:00am-5:00pm, Monday – Friday, excluding State holidays.

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Do you understand your rights? Do you understand how to get a hearing? If you have any questions, please contact your caseworker as soon as possible.

Medicare Medicaid Recipients
Prescription drug coverage for Medicare individuals who also have Medicaid is only covered through a Prescription Drug Plan (PDP). You must be enrolled in a PDP to receive prescription drug coverage. PDP co-payments differ from Medicaid co-payments. For questions about a PDP, co-payment, or assistance with enrolling, you may call 1-800-MEDICARE.

Beware of Fraud!
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North Carolina_____ County Department of Social Services

Notice of Modification, Termination, or Continuation of Public Assistance

Date Mailed _____

_____
Name

_____
Address

A change is about to take place in your benefits. Please read all pages of this form carefully.

What The Change Is: _____

☐ **If this block is checked, you will receive a separate notice about your Medicaid.**

Why The Change Will Be Made: _____

When The Change Will Happen: _____

Medicaid Payment of Your Medicare Premium Will _____

If you receive Medicare, Medicare is responsible for your prescriptions.

The State Regulations Requiring This Change Are Found In _____

Individuals who are ineligible for Medicaid or NC Health Choice or individuals who are eligible for a Medicaid program that is not considered minimal essential coverage, may be eligible for assistance in purchasing insurance on the Federal Marketplace. Application information is sent to the Federal Marketplace via secure electronic transfer for those who may be eligible for assistance and will be contacted by someone at the Federal Marketplace if further information is needed. For more information, visit Healthcare.gov or call 1-800-318-2596

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In some cases, you may choose to get your benefits until your hearing. If you want a hearing, read the instructions included on this form.

☐ *If this block is checked*, your benefits will be changed without further notice. You may request a hearing by the date above.

☐ *If this block is checked,* and if you contact your caseworker by _____ to ask for a hearing, your benefits will continue at the present level until the first hearing decision, unless you waive this right. If your benefits continue and the hearing shows the changes were correct, you may have to repay the benefits you received while waiting for the hearing decision. Continuation of benefits DOES NOT apply to North Carolina Health Choice.

FOR OFFICE USE ONLY:
County Case # _____
Case ID # _____
Aid Program/Category _____

_____
Caseworker Name and Phone Number

_____
Address

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