1. Last Name First Name MI

2. Patient SS#

3. Date of Birth (MM/DD/YYYY)

4. Gender ☐ 1. Male ☐ 2. Female ☐ 3. Transgender

4a. Transgender Subcategory
☐ 1. Male to Female ☐ 2. Female to Male ☐ 3. Unknown

5. Race ☐ 1. White ☐ 2. Black or African American
☐ 3. American Indian or Alaska Native ☐ 4. Asian
☐ 5. Native Hawaiian/Pacific Islander ☐ 6. Unknown
☐ 7. More Than One Race

5a. Race Subcategory
Asian: ☐ 1. Asian Indian ☐ 2. Chinese ☐ 3. Filipino ☐ 4. Japanese ☐ 5. Korean ☐ 6. Vietnamese ☐ 7. Other Asian
NH/PI: ☐ 1. Native Hawaiian ☐ 2. Guamanian or Chamorro ☐ 3. Samoan ☐ 4. Other Pacific Islander

6. Ethnicity ☐ 1. Hispanic/Latino(a) ☐ 2. Non-Hispanic ☐ 3. Unknown

6a. Ethnicity Subcategory
Hispanic: ☐ 1. Mexican, Mexican American, Chicano/a ☐ 2. Puerto Rican ☐ 3. Cuban ☐ 4. Other Hispanic, Latino/a or Spanish Origin

7. Preferred Language ☐

(Select one of the languages below and enter the 2 letter code in the block above)

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

8. Incarcerated? ☐ Yes ☐ No
Local County Jail (Name)

9. County of Residence 10. County Code

N.C. Department of Health and Human Services
Division of Public Health
Purchase of Medical Care Services
1907 Mail Service Center
Raleigh, NC 27699-1907

DHHS 3014-ADAP

Financial Eligibility Application

11. Program **ADAP**

12. Current POMCS/ADAP Case Number

13. Applicant's Address (Must match documentation provided)

14. City State Zip Code

15. Applicant's Telephone Number (Include Area Code)
(Home/Cell) (Work)

16. Applicant's Mailing Address (even if same as in #13-#14)
☐ Check if the address is the same
Care of, if applicable
Address (Street or RFD)
City State Zip Code

17. N.C. Resident ☐ Yes ☐ No

18. **Countable** Family Members
Number of Adults
Number of Children
Total Number

INCOME FORMULAS: Regular **(R)**—Continuously employed wage earners list income for the 12 months before the date of application or the requested date of coverage, whichever is earlier. Unemployment **(U)**—Wage earners unemployed at the time of application or for 30 consecutive days during the previous 12 months list income for 6 months before and after the date of application or the requested date of coverage whichever is earlier. **Must report Gross and Net Income.**

19. Complete for All Countable Family Members Name	Relationship to Patient	Income Formula (R or U)	List all Employers or Sources of Income/Reason for None for **12 Month Period**	Dates From	Dates To	**Gross Income**	**Income After Taxes**

20. Explain Means of Support: (Check each item that is applicable)

☐ Community Support ☐ Medical Assistance
☐ Family Support ☐ Migrant Worker
☐ Food Stamps/EBT ☐ Transportation Assistance
☐ Housing Assistance ☐ Utility Assistance
☐ Other, specify: _____
☐ Unemployed, specify dates: _____

22. Has the applicant applied for: (Check either Yes or No to each item)

Medicaid: ☐ Yes ☐ No
Medicare: ☐ Yes ☐ No ☐ NA: Automatically Enrolled
Enrolled in Medicare Part D: ☐ Yes ☐ No (If yes, go to box 24)
SS LIS Application: ☐ Yes ☐ No ☐ NA
If yes for LIS, provide date: (MM/DD/YYYY)

21. **Annual Gross Income**	
Federal, State & Social Security Tax	
Total Income After Taxes (Difference Between Both Lines)	
Medical expenses paid or incurred during past 12 months not covered by a third party nor requested for program coverage	
Other deductions: (Specify, or deduction(s) will not be counted)	
Total Deductions	
Annual Net Income	

23. PRIVATE INSURANCE: Provide complete insurance information and copies of insurance cards **for all countable family members.**
Not Appplicable ☐
Insurance Company:
RXBIN:
RXPCN:
RXGRP:
Policyholder:
Is patient covered? ☐ Yes ☐ No
Does insurance have a cap? ☐ Yes ☐ No
If yes, provide amount and submit documentation: $

24. MEDICARE PART D COVERAGE: Provide complete information.
Not Appplicable ☐
Insurance Company:
RXBIN:
RXPCN:
RXGRP:
Policyholder:

Instructions for Financial Eligibility Application

All fields must be completed or application will be pended.

Purpose: This form is used to collect financial information required for determination of ADAP eligibility. Once determined, eligibility extends for nine months. A new form is required when changes in countable family members and/or income occur. Processing time is reduced when this form is legible. If requested, additional information must be received within six months. Incomplete forms will be pended.

Instructions for Completing Certain Items on this Form:

2. Please leave SS# blank if applicant does not have one.
4. If Transgender is chosen, HRSA requires applicant to choose Transgender Subcategory (see 4a).
5. If Asian or Native Hawaiian or Pacific Islander is chosen, HRSA requires applicant to choose a Race Subcategory (see 5a).
6. If Hispanic/Latino is chosen, HRSA requires applicant to choose an Ethnicity Subcategory (see 6a).
8. If the applicant is incarcerated; check yes, provide the name of the county jail and provide the jail's address in boxes 13 and 14.

****NOTE: Patients incarcerated in state or federal prisons are not eligible for ADAP.**

16. If applicant/patient provides an alternate mailing address — all correspondence will be sent to that address.
18. **Countable Family Members** are related to the applicant by blood, marriage or adoption, live in the same household and share a financial responsibility. The applicant must be included in the count.
21. **Deductible Medical Expenses** are those paid or incurred by a countable family member during the 12 months prior to the earliest date of service. Expenses paid for by another party or requested for coverage by a program cannot be used as deductions. Medical expense deductions that exceed $3,000 must be documented in full.
22. Medicare, Medicaid status and, if applicable, Social Security eligibility information for a low income subsidy are required for all applicants. If yes is checked for SS LIS Application, the date must be included.
24. If the applicant has a Medicare Part D plan please use information from the applicant's Part D card.

Mail (do not Fax) this application and documentation to:
DHHS, Division of Public Health, Purchase of Medical Care Services, 1907 Mail Service Center, Raleigh, NC 27699-1907

TERMS AND CONDITIONS FOR APPLICANT — *Must be signed and dated or the application will be pended.*

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

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

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

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

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

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

I understand that I may appeal the denial of this financial eligibility application. Information on how to appeal the denial can be obtained by writing to Purchase of Medical Care Services, 1907 Mail Service Center, Raleigh NC 27699-1907. I understand that payment by the Department for health care provided to me is dependent upon me meeting all financial and medical requirements, timely submission of authorization requests and claims, and the availability of funds.

<table>
<tr><td colspan="3">I hereby certify that I have read or the interviewer has read to me the terms and conditions described above and that I agree to comply with them. I also certify that I have been provided an opportunity to ask the interviewer questions about these terms and conditions and that I understand the answers I was given.</td></tr>
<tr><td>Applicant's Signature</td><td>Relationship to Patient</td><td>Current Date (MM/DD/YYYY)</td></tr>
<tr><td colspan="3">I certify that I have explained the terms and conditions contained above to the applicant and have witnessed his/her signature.</td></tr>
<tr><td>Type or Print Interviewer's Name</td><td rowspan="2">Agency Name

Street Address/P.O. Box

City/State/Zip Code</td><td rowspan="2">Current Date (MM/DD/YYYY)

Phone (###) ###-####</td></tr>
<tr><td>Interviewer's Signature</td></tr>
</table>