Application for Coverage of Coronavirus (COVID-19) Testing Costs

Complete this application to get help paying for certain coronavirus (COVID-19) testing costs. Do not include people on this application who are not seeking coverage for COVID 19 tests. In order to be eligible for COVID-19 Testing Medical Assistance:

Live in North Carolina
Be a U.S. Citizen or U.S. National or have eligible Immigration status
Not be covered by Medicaid, Medicare, or health insurance

The health coverage you will get if you are found eligible using this application will only pay for medical tests for coronavirus no earlier than June 1, 2020 and will end when the public emergency ends. It will not help you pay for other medical costs, including doctor visits, hospital care, or prescriptions.

To see if you are eligible for other health care benefits and services through Medicaid, CHIP or the Marketplace, you should complete a full application at https://medicaid.ncdhhs.gov/beneficiaries/get-started/apply-medicaid-or-health-choice, at your county DSS, online at https://epass.nc.gov/ or go to Healthcare.gov.

CONTACT INFORMATION

One adult in the family should be the contact person. The contact person does not have to be applying for coverage.
If you do not have an address, your mail will go to your local Department of Social Services.

1. First Name	2. Middle Name	3. Last Name	4. Suffix
5. Home Address *(leave blank if you don't have one)*		6. City	7. State	8. Zip
9. Mailing Address *(if different from home address)*		10. City	11. State	12. Zip
13. County of Residence	14. Phone Number	15. Email address	
16. Is this the address for the individuals applying? ☐ YES ☐ NO If no, go to 18		17. Preferred language	
18. Applicant Home Address, if different from 5 above		19. City	State	Zip
20. Applicant Mailing Address, if different from 9 above		21. City	State	Zip

TELL US ABOUT ALL THE PEOPLE WHO WANT TO APPLY

***Person 1**: (You, if you are applying for yourself)*

22. First Name	23. Middle Name	24. Last Name	25. Suffix	26. Date of birth

27. **Social Security Number (SSN) _____**
*We need your SSN if you want to apply for COVID-19 testing coverage and have an SSN or can get one. We use SSNs to check to see who's eligible for help paying for health coverage. For more information on getting an **SSN call 1-800-772-1213 or visit socialsecurity.gov; TTY users should call 1-800-325-0778***

28. Are you a U.S. Citizen or U.S. National? ☐ YES ☐ NO *If Yes, go to 33. If No, go to 29*

29. Are you a naturalized or derived citizen? If *Yes complete a and b If No, go to 30.*..... ☐ YES ☐ NO
a. Alien Number_____ b. Certificate Number_____

30. If you aren't a U.S. Citizen or U.S. National, do you have eligible immigration status?..... ☐ YES ☐ NO
If Yes, Enter document type and ID number below. If no, go to 31.

NEED HELP WITH YOUR APPLICATION? Call us at 1-888-245-0179. Para obtener una copia de este formulario en Español, llame 1-888-245-0179. If you need help in a language other than English, tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-452-2514.

a. Immigration document type _____	b. Status type *(optional)* _____	c. Name as it appears on your immigration document _____
d. Alien or I-94 number		e. Card number or passport number
f. SEVIS ID or expiration date (*optional)*		g. Other (Category code or country of issuance)

31. Have you lived in the US since 1996? ..... ☐ YES ☐ NO

32. Are you, or your spouse or parent, an honorably discharged veteran or an active-duty member of the US military? ..... ☐ YES ☐ NO

33. If Hispanic/Latino, ethnicity (OPTIONAL – check all that apply)
□ Mexican □ Mexican-American □ Puerto Rican □ Cuban □ Other _____

34. Race (OPTIONAL – Check all that apply)
□ White or Caucasian □ Black or African-American □ Asian □ Native Hawaiian □ Other Pacific Islander
□ American Indian or Alaska Native □ Other: _____

35. Have you received a COVID 19 test within the last 3 months? ☐ Yes ☐ NO If yes, please indicate which month(s).
Previous Month _____ 2 Months prior _____ 3 Months prior _____

36. Did you have any medical insurance in the last 3 month(s)? ☐ Yes ☐ NO If yes, please indicate which month(s).
Previous Month _____ 2 Months prior _____ 3 Months prior _____

WHO ELSE WANTS TO APPLY?

***Person 2**: Tell us about other family members applying for coverage of coronavirus testing costs. Attach copies of this application for additional applicants.*

37. First Name	38. Middle Name	39. Last Name	40. Suffix	41. Date of birth

42. **Social Security Number (SSN)** _____
*We need Person 2's SSN if they want to apply for COVID-19 testing coverage and has an SSN or can get one. We use SSNs to check to see who's eligible for help paying for health coverage. For more information on getting an **SSN call 1-800-772-1213 or visit socialsecurity.gov; TTY users should call 1-800-325-0778***

43. Is Person 2 a U.S. Citizen or U.S. National? *If YES, go to 48. If NO, go to 44*..... ☐ YES ☐ NO

44. Is Person 2 a naturalized or derived citizen? *If Yes, complete a and b. If No, go to 45*..... ☐ YES ☐ NO
a. Alien Number: b. Certificate Number:

45. If Person 2 isn't a US Citizen or U.S National, do they have eligible immigration status?..... ☐ YES ☐ NO
If Yes, Enter document type and ID number below. If no, go to 46

a. Immigration document type	b. Status type *(optional)*	c. Write your name as it appears on your immigration document
d. Alien or I-94 number		e. Card number or passport number
f. SEVIS ID or expiration date *(optional)*		g. Other *(Category code or country of issuance)*

46. Has Person 2 lived in the US since 1996?..... ☐ YES ☐ NO

47. Is Person 2, or their spouse or parent, an honorably discharged veteran or an active-duty member of the US military? ..... ☐ YES ☐ NO

48. If Hispanic/Latino, ethnicity (OPTIONAL – check all that apply)
□ Mexican □ Mexican-American □ Puerto Rican □ Cuban □ Other _____

49. Race (OPTIONAL – Check all that apply)
□ White or Caucasian □ Black or African-American □ Asian □ Native Hawaiian □ Other Pacific Islander
□ American Indian or Alaska Native □ Other: _____

50. Has Person 2 received a COVID 19 test within the last 3 months? ☐ Yes ☐ NO If yes, please indicate which month(s).
Previous Month _____ 2 Months prior _____ 3 Months prior _____

51. Did person 2 have any medical insurance in the last 3 month(s)? ☐ Yes ☐ NO If yes, please indicate which month(s).
Previous Month _____ 2 Months prior _____ 3 Months prior _____

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TELL US ABOUT OTHER HEALTH COVERAGE

Does anyone applying on this application currently have health coverage? ..... ☐ YES ☐ NO ☐ DON'T KNOW
If yes, please indicate who on the blank line.

☐ Medicaid/NC Health Choice for Children _____

☐ Medicare (traditional Medicare or Medicare Advantage) _____

☐ Employer or other health insurance _____

VOTER REGISTRATION

If you are NOT registered to vote where you live now, would you like to register to vote here today? ☐ YES ☐ NO

If you want to register to vote, you can complete a voter registration form at www.ncsbe.gov. Apply 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 filling out the voter registration application form, we will help you. The decision either to see 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 Board of Elections.

YOUR RIGHTS AND RESPONSIBILITIES

- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting hhs.gov/ocr/office/file.
- If anyone on this application is eligible for Medicaid, I grant to the state Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties.
- We need the information on this application to check your eligibility for help paying for coverage of COVID-19 testing costs. We'll check your answers using information in our electronic databases and databases from Social Security, and the Department of Homeland Security. If the information doesn't match, we may ask you to send us more information.

WHAT SHOULD I DO IF I THINK MY ELIGIBILITY NOTICE IS WRONG?

If you don't agree with what you qualify for you can ask for an appeal. Please review your eligibility notice to find appeals instructions specific to each person in your household who applies for coverage, including how many days you have to request an appeal. Here's important information to consider when requesting an appeal:

- You can have someone request or participate in your appeal if you want to. That person can be a friend, relative, lawyer, or other individual. Or, you can request and participate in your appeal on your own.
- If you request an appeal, you may be able to keep your eligibility for coverage while your appeal is pending.
- If you need health services right away and a delay could seriously jeopardize your health, you can ask for a fast (expedited) appeal.

SIGNATURE:

By signing, you are swearing that everything you wrote on this form is true as far as you know.
We will keep your information secure and private.

Signature	Date

Mail the completed and signed application to:

DHHS/DHB
2501 Mail Service Center
ATTN: COVID Medicaid Application
Raleigh, NC 27699

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