

NC Medicaid 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? <input type="checkbox"/> YES <input type="checkbox"/> NO If no, go to 18				17. Preferred language		18. Date of Birth	19. Gender <input type="checkbox"/> M <input type="checkbox"/> F
20. Applicant Home Address, if different from 5 above				21. City		State	Zip
22. Applicant Mailing Address, if different from 9 above				23. City		State	Zip

TELL US ABOUT ALL THE PEOPLE WHO WANT TO APPLY

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

24. First Name		25. Middle Name		26. Last Name		27. Suffix	28. Date of Birth	29. Gender <input type="checkbox"/> M <input type="checkbox"/> F
30. Social Security Number (SSN) _____ <i>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</i>								
31. Are you a U.S. Citizen or U.S. National? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, go to 36. If No, go to 32								
32. Are you a naturalized or derived citizen? If Yes complete a and b If No, go to 33..... <input type="checkbox"/> YES <input type="checkbox"/> NO								
a. Alien Number _____				b. Certificate Number _____				
33. If you aren't a U.S. Citizen or U.S. National, do you have eligible immigration status?..... <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If Yes, Enter document type and ID number below. If no, go to 34.</i>								

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 1-800-851-6099.

DHB-5200CV

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) _____	
34. Have you lived in the US since 1996? <input type="checkbox"/> YES <input type="checkbox"/> NO		
35. Are you, or your spouse or parent, an honorably discharged veteran or an active-duty member of the US military? <input type="checkbox"/> YES <input type="checkbox"/> NO		
36. If Hispanic/Latino, ethnicity (OPTIONAL – check all that apply) <input type="checkbox"/> Mexican <input type="checkbox"/> Mexican-American <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Other _____		
37. Race (OPTIONAL – Check all that apply) <input type="checkbox"/> White or Caucasian <input type="checkbox"/> Black or African-American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Other: _____		
38. Have you received a COVID 19 test within the last 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> NO If yes, please indicate which month(s). Previous Month _____ 2 Months prior _____ 3 Months prior _____		
39. Did you have any medical insurance in the last 3 month(s)? <input type="checkbox"/> Yes <input type="checkbox"/> 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.

40. First Name	41. Middle Name	42. Last Name	43. Suffix	44. Date of birth	45. Gender <input type="checkbox"/> M <input type="checkbox"/> F
46. 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					
47. Is Person 2 a U.S. Citizen or U.S. National? <i>If YES, go to 52. If NO, go to 48</i> <input type="checkbox"/> YES <input type="checkbox"/> NO					
48. Is Person 2 a naturalized or derived citizen? <i>If Yes, complete a and b. If No, go to 49</i> <input type="checkbox"/> YES <input type="checkbox"/> NO a. Alien Number: _____ b. Certificate Number: _____					
49. If Person 2 isn't a US Citizen or U.S National, do they have eligible immigration status?..... <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If Yes, Enter document type and ID number below. If no, go to 50</i>					
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)				
50. Has Person 2 lived in the US since 1996?..... <input type="checkbox"/> YES <input type="checkbox"/> NO					
51. Is Person 2, or their spouse or parent, an honorably discharged veteran or an active-duty member of the US military? <input type="checkbox"/> YES <input type="checkbox"/> NO					
52. If Hispanic/Latino, ethnicity (OPTIONAL – check all that apply) <input type="checkbox"/> Mexican <input type="checkbox"/> Mexican-American <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Other _____					
53. Race (OPTIONAL – Check all that apply) <input type="checkbox"/> White or Caucasian <input type="checkbox"/> Black or African-American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Other: _____					
54. Has Person 2 received a COVID 19 test within the last 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> NO If yes, please indicate which month(s). Previous Month _____ 2 Months prior _____ 3 Months prior _____					
55. Did person 2 have any medical insurance in the last 3 month(s)? <input type="checkbox"/> Yes <input type="checkbox"/> 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
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Mail the completed and signed application to:

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

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