Print Form

MAGI Household/Tax Information Notice

_____COUNTY DEPARTMENT OF SOCIAL SERVICES (DSS)

Date: _____

To: _____

Address: _____

_____

Case ID No: _____ Worker: _____

In order to be considered for Family & Children's Medicaid or North Carolina Health Choice, please answer the following questions about yourself and family members and individuals on your tax return. This information is necessary to process your review. Please contact _____County DSS at _____if you have any questions or need assistance with providing this information.

The following individuals are due for review of Medicaid/NCHC eligibility:

_____

Report Information to Your County Department of Social Services.
You can report information in person, by phone or by mail.
Report information to _____County - DSS Office, or call _____.
Information must be reported by _____ (30 days from the above date). If it is not returned to the county by the 30th day from the date of this notice, it could result in termination of your case.

I. Tell us about yourself:

Do you expect to file a tax return? Yes ☐ No ☐

Do you expect to be claimed as a tax dependent? Yes ☐ No ☐

If yes – by whom _____

II. Tell us about your family members and tax dependents. This includes individuals that are <u>not</u> currently Medicaid eligible but would like to apply for health insurance coverage:

Name _____

Does this person expect to file a tax return? Yes ☐ No ☐

Does this person expect to be claimed as a tax dependent? Yes ☐ No ☐

If yes – by whom _____

Name _____

Does this person expect to file a tax return? Yes ☐ No ☐

Does this person expect to be claimed as a tax dependent? Yes ☐ No ☐

If yes – by whom _____

Name _____

Does this person expect to file a tax return? Yes ☐ No ☐

Does this person expect to be claimed as a tax dependent? Yes ☐ No ☐

If yes – by whom _____

Name _____

Does this person expect to file a tax return? Yes ☐ No ☐

Does this person expect to be claimed as a tax dependent? Yes ☐ No ☐

If yes – by whom _____

Name _____

Does this person expect to file a tax return? Yes ☐ No ☐

Does this person expect to be claimed as a tax dependent? Yes ☐ No ☐

If yes – by whom _____

If additional space is needed, please attach a separate sheet.

III. Tell us more about the individuals that would like to apply for health insurance coverage:

Name _____

Social Security Number_____

Date of Birth _____

How is this person related to you?_____

This person is _____Male _____Female

Is this person a U.S. citizen or U.S. national? Yes ☐ No ☐

If yes, skip to "***additional information" below.***

If no, answer the following questions:

If this person has eligible immigration status, what is the document type

_____and ID number_____

___ Check here, if this person has lived in the U.S. since 1996.

___ Check here, if this person, his or her spouse, or a parent is a veteran or an active duty member in the U.S. military.

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Additional Information

___ Check here, if this person lives with at least one child under the age of 19, and is the main person taking care of this child.

___ Check here, if this person is 18 years or younger and has a parent living outside of the household.

___ Check here, if this person wants help paying for medical bills from the last three months.

Name _____

Social Security Number_____

Date of Birth _____

How is this person related to you _____

This person is _____Male _____Female

Is this person a U.S. citizen or U.S. national? Yes ☐ No ☐

If yes, skip to "***additional information" below.***

If no, answer the following questions:

If this person has eligible immigration status, what is the document type

_____and ID number_____

___ Check here, if this person has lived in the U.S. since 1996.

___ Check here, if this person, his or her spouse, or a parent is a veteran or an active duty member in the U.S. military.

Additional information

___ Check here, if this person lives with at least one child under the age of 19, and is the main person taking care of this child.

___ Check here, if this person is 18 years or younger and has a parent living outside of the household.

___ Check here, if this person wants help paying for medical bills from the last three months

Name _____

Social Security Number_____

Date of Birth _____

How is this person related to you _____

This person is _____Male _____Female

Is this person a U.S. citizen or U.S. national? Yes ☐ No ☐

If yes, skip to "***additional information" below.***

If no, answer the following questions:

If this person has eligible immigration status, what is the document type

_____and ID number_____

___ Check here, if this person has lived in the U.S. since 1996.

___ Check here, if this person, his or her spouse, or a parent is a veteran or an active duty member in the U.S. military.

Additional information

___ Check here, if this person lives with at least one child under the age of 19, and is the main person taking care of this child.

___ Check here, if this person is 18 years or younger and has a parent living outside of the household.

If additional space is needed, please attach a separate sheet.

IV. Tell us more about the people listed on this form:

A. Pregnancy: Is anyone due for review pregnant? If yes, who? What is the expected due date?
_____

B. **Income:** Is there anyone in the household that has income? If yes, complete the chart below. *(Include income from Jobs, Self-Employment, Alimony, Unemployment, Social Security Benefits, Retirement, Pension, American Indian Alaskan Native Income, Foreign Income, Investment Income, Interest, Farming or Fishing Income, Rental or Royalty Income, Capital Gains, Scholarship, Title, Lump Sum Amount, and Alien Sponsor. Do not include Child Support, Workers Compensation, Supplemental Security Income or VA Benefits.)*

Person Receiving Income	Income Type	Gross Amount	How Often Received	Start Date

C. Is anyone in your family no longer receiving income? If yes, who, when and what type?

D. Deductions: Is there anyone in the family that has deductions? If yes, complete the chart below.

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(Allowable deductions include: Alimony Paid, Educator Expenses, Tuition/Fees, Student Loan Interest, Health Savings Account Contributions, IRA Contributions, Moving Expenses, and Penalty on Early Withdrawal of Savings. For those with Self Employment, allowable deductions also include Rent/Royalty Expenses, Certain Business Expenses of Reservists, Performing Artists, and Fee Basis Government Officials, Deductible Part of Self Employment Tax, Domestic Production Activities Deduction, Health Insurance Deduction, and SEP, SIMPLE, and Qualified Plans.)

Person Paying Deduction	Deduction Type	Amount	Frequency	Start Date

E. Medical Insurance: Is there anyone due for review who has Medical Insurance? If yes, complete the chart below.

Person Covered	Policy Holder	Policy Number	Insurance Company	Type of Coverage	Start Date

F. If anyone who is renewing or applying for health insurance coverage lives in a long term care facility, group home, or nursing home, or regularly gets medical care, personal care, or health services at home or in another community setting (like adult day care), write his or her name here.

Name(s)_____

G. If anyone who is renewing or applying for health insurance coverage is between the ages of 18 and 26 and was in foster care at age 18, write his or her name here.

Name(s)_____

If additional space is needed to report changes, please attach a separate sheet.

V. Signature

I am signing this renewal form under penalty of perjury. That means that I have provided true answers to all the questions on this form to the best of my knowledge, and I know that I may be subject to penalties under federal law if I provide false or untrue information.

Beneficiary/Authorized Representative	Date