Prepared by the North Dakota Legislative Council
staff for the Budget Committee on Health Care
August 2001

COORDINATION OF HEALTHY STEPS AND MEDICAID PROGRAMS STUDY - BACKGROUND MEMORANDUM

The committee has been assigned responsibility to:

- Study the coordination of the Healthy Steps and Medicaid programs, pursuant to Section 3 of House Bill No. 1441 (attached as Appendix A), including:

    The development of a single application form for both programs.

    Determining whether the Healthy Steps program should be administered by the state or by the counties.

    The effects of eliminating the asset test for determining Medicaid eligibility.

    The standardization of the definition of "income" for all programs administered by the Department of Human Services.

    The feasibility and desirability of seeking a federal waiver to allow the Healthy Steps program to provide family health insurance coverage through an employer-based insurance policy if the employer-based policy is more cost-effective than traditional coverage for the children.

- Receive an annual report from the Department of Human Services regarding the children's health insurance program, pursuant to North Dakota Century Code (NDCC) Section 50-29-02.

STUDY OF COORDINATION OF HEALTHY STEPS AND MEDICAID PROGRAMS

Healthy Steps Program

The children's health insurance program, named Healthy Steps, was authorized by the 1999 Legislative Assembly to provide health insurance coverage to low-income children not eligible for Medicaid. The income eligibility limit for Healthy Steps is set at family net income at or below 140 percent of the federal poverty level; the children's income eligibility limit for Medicaid is 100 percent of the federal poverty level.

The Department of Human Services contracted with Blue Cross Blue Shield of North Dakota to provide the health insurance coverage for the Healthy Steps program. The first contract covered the period October 1, 1999, through June 30, 2001. Insurance coverage is based on the state employee group health insurance plan, with added coverage for dental and vision services. For the 1999-2001 biennium, the premium rate for most policies was $108.60 per member per month with copayments of $2 for each prescription, $50 for each hospital admission, and $5 for each emergency hospital visit. Copayment requirements are waived for American Indian children, and the premium paid by the state for those policies is slightly higher ($109.56).

The current contract covers the period July 1, 2001, through June 30, 2003. The premium rate for most policies is $126.40 per month; the premium for policies without copayments is $127.50 per month. Copayment requirements are unchanged for the 2001-03 biennium.

As of May 2001, 2,441 children are enrolled in the Healthy Steps program plan. The enrollment consists of 49 percent from rural counties and 51 percent from urban counties. The majority of the children enrolled are white (87.6 percent); American Indian children comprise 9.3 percent of the enrolled population, Hispanics 1.5 percent, and others 1.6 percent.

The federal matching assistance percentage (FMAP) for the Healthy Steps program plan is approximately 79 percent, compared to the Medicaid matching rate of approximately 70 percent, as shown on the following table:

Federal Fiscal Year	Healthy Steps FMAP	Medicaid FMAP
1998	79.30%	70.43%
1999	78.96%	69.94%
2000	79.29%	70.42%
2001	78.99%	69.99%
2002 (estimate)	78.91%	69.87%
2003 (estimate)	78.91%	69.87%

Federal allotments for North Dakota for the Healthy Steps program are as follows:

Federal Fiscal Year	Federal Allocation for Healthy Steps
1998	$5,040,741
1999	$5,016,935
2000	$5,655,883
2001	$6,575,656

States have two years after the year of allotment to spend federal funds for the children's health insurance program. Any funds unused after that time are returned to the federal government for reallocation to the states. Of the $5,040,741 fiscal year 1998 allotment, $1,859,325 was spent and $3,181,416 was returned to the federal government to be redistributed to states. North Dakota subsequently received a redistribution of $2,054,654 from the unspent fiscal year 1998 allocations returned by various states to the federal government. The redistributed amount will

be available through September 30, 2001. Through March 31, 2001, the state has spent $1,025,435 of the redistributed 1998 allocation, leaving an unused balance of $1,029,219, which must be used before September 30, 2001. Any of the fiscal year 1999 allocation unspent as of September 30, 2001, will be returned to the federal Department of Health and Human Services and will be subject to redistribution to the states.

Single Application Form

The committee is directed to study the development of a single application form for both the Healthy Steps and Medicaid programs. Section 1 of House Bill No. 1441 directs the Department of Human Services to provide medical assistance benefits to children and families coverage groups and to pregnant women without consideration of assets **if federal approval is obtained** of amendments to the state children's health insurance program (CHIP) plan. The Department of Human Services testified during the 2001 Legislative Assembly that such a change in eligibility criteria will make Medicaid eligibility for families consistent with Healthy Steps eligibility and may make it feasible for the department to create a combined application form for both programs.

Under current law, eligibility for the Healthy Steps program does not include an asset test; eligibility for Medicaid does. If a family applies for Medicaid and is ineligible, they must complete a separate application for Healthy Steps. If a family completes a Healthy Steps application and it appears the children are Medicaid-eligible, the family must complete a separate Medicaid application. The completion of a single application form would simplify the application process. Copies of the current applications for the Healthy Steps program and Medicaid are attached as Appendices B and C, respectively.

County Administration of Healthy Steps

The committee is directed to study whether the Healthy Steps program should be administered by the state or by the counties. The Department of Human Services currently determines eligibility for the Healthy Steps program; counties determine eligibility for Medicaid. The Legislative Assembly considered provisions in 2001 House Bill No. 1441 that would have required counties to administer the Healthy Steps program. The bill as passed did not include these provisions.

Testimony provided to the 2001 Legislative Assembly by the Department of Human Services and the counties indicated administrative costs for the Healthy Steps program would be higher for the counties than for the state. The estimated cost of county administration for the 2001-03 biennium was reported to be $467,544, of which $98,558 would be from the state general fund, compared to current state administrative costs of approximately $90,000, of which approximately $19,000 is from the state general fund.

In addition, the Department of Human Services estimated that in order for counties to efficiently administer eligibility determination for the Healthy Steps program, computer programming costs of $415,000, of which $124,541 would be from the general fund, would be required to integrate Healthy Steps eligibility into the VISION computer system used by counties to determine Medicaid eligibility.

Effects of Eliminating Asset Test for Medicaid

The committee is directed to study the effects of eliminating the asset test for determining Medicaid eligibility. Testimony provided to the 2001 Legislative Assembly by the Department of Human Services indicated that, based on a 1998 survey, an additional 1,669 individuals would become enrolled in the Medicaid program as a result of the elimination of the asset test, as follows:

	Number of Persons
Children not previously eligible for Medicaid or Healthy Steps	527
Adults not previously eligible for Medicaid	182
Children previously served under the Healthy Steps program but eligible for Medicaid due to elimination of the asset test	960
Total number of new enrollments in Medicaid	1,669

The fiscal note prepared by the Department of Human Services for 2001 House Bill No. 1441 projected that the elimination of the asset test for Medicaid eligibility would have cost an estimated $1,434,972 ($419,639 from the general fund and $1,015,333 from other funds) for the 2001-03 biennium, as follows:

	Estimated Cost (Savings)
Additional Medicaid costs for children (70 percent federal matching rate)	$3,204,309
Additional Medicaid costs for adults (70 percent federal matching rate)	392,928
Healthy Steps program savings due to children becoming eligible for Medicaid (79 percent federal matching rate)	(2,186,265)
Programming costs	24,000
Total estimated all funds cost	$1,434,972
Less estimated other funds cost	1,015,333
Total estimated general fund cost	$419,639

Standardization of Income Definition

The committee is directed to study the standardization of the definition of income for all programs administered by the Department of Human Services. Income eligibility for the Healthy Steps program is based on net income at or below 140 percent of the federal poverty level. Net income is determined by subtracting child care costs and payroll taxes from

gross income. Through March 31, 2002, net income limits in effect are:

Number of People in Family	Maximum Allowable Monthly Net Income
1	$1,003
2	$1,355
3	$1,707
4	$2,060
5	$2,412
6	$2,764
7	$3,117
8	$3,469
9	$3,821
10	$4,174

Establishing eligibility for Medicaid is a more complicated process. For example, the determination of income for an individual who requires nursing care services and who is residing in a nursing facility is calculated by:

- Excluding the following types of income:

  Occasional small gifts.

  Veterans Administration pensions of $90 received by qualifying individuals.

  Certain federal reparation and compensation payments.

- Deducting:

  Mandatory payroll deductions for Social Security and Medicare.

  The nursing care income level ($40 per month).

  Amounts provided to a spouse or family member for maintenance needs.

  Medical expenses for necessary medical or remedial care.

  Medicare and health insurance premiums.

  Long-term care insurance premiums.

  A portion of payments made for services of a guardian or conservator.

- Adding:

  Payments from any source received as a result of medical expenses or increased medical need.

Income eligibility for an individual residing in an individual's own home or in a specialized facility is calculated by:

- Excluding various types of income, including:

  Payments made by the department in connection with foster care of the subsidized adoption program.

  Temporary assistance for needy families (TANF) payments.

  Low-income energy assistance program payments.

  Refugee cash assistance.

  County general assistance.

  Current child support of $50 per month.

  Income earned by a child who is a full-time student.

  Occasional small gifts.

  Income received as a result of participation in the Job Corps program.

  Loan proceeds.

  Income tax refunds.

  Training funds received from vocational rehabilitation.

  Training allowances of up to $30 per week provided through a tribal native employment works program or the job opportunities and basic skills (JOBS) training program.

  Certain federal reparation and compensation payments.

- Deducting:

  Health insurance premiums.

  Medical expenses for necessary or remedial care.

  Food and veterinary expenses for a dog trained to detect seizures.

  Long-term care insurance premiums.

  A portion of remedial care costs for an individual residing in a specialized facility.

  Transportation expenses relating to obtaining medical care.

  Court-ordered child and spousal support payments.

  Child care expenses, if necessary, to engage in employment or training.

  Adult dependent care expenses, if necessary, to engage in employment or training.

  Any income of $20 per month, except income which is based on need.

  A portion of payments made for guardian or conservator services.

  A work or training allowance of $30 per month for each individual in the Medicaid unit who is employed or in training.

  From earned income for all individuals except aged, blind, or disabled applicants:

Mandatory payroll deductions and union dues, or $90, whichever is greater.

Mandatory retirement plan deductions.

From earned income for aged, blind, or disabled applicants, $65 plus one-half of the remaining monthly gross earned income.

Once the level of income is established, eligibility must be determined. Income eligibility levels are different for each type of recipient--the categorically needy, the medically needy, and poverty income individuals.

The categorically needy consists of two categories of individuals:

1. Those who were eligible for aid to families with dependent children (AFDC) (before the AFDC program was replaced by the TANF program), for whom eligibility for Medicaid is a result of meeting AFDC eligibility requirements.
2. The aged, blind, and disabled recipients, for whom eligibility for Medicaid is based on the income level which establishes supplemental security income.

Medically needy individuals receiving nursing care are subject to an income limit of $40 per month, after the adjustments indicated above. Medically needy individuals residing in their own home are subject to the following income limits:

Number of People in Family	Maximum Allowable Monthly Income
1	$369
2	$428
3	$465
4	$556
5	$625
6	$684
7	$721
8	$760
9	$783
10	$810

Poverty income level eligibility is based on the following categories of eligibility:

Eligibility Category	Maximum Income as a Percent of Federal Poverty Level
Pregnant women and children under age 6	133%
Qualified Medicare beneficiaries	100%
Children age 6-18	100%
Extended Medicaid benefits	185%
Qualified disabled and working individuals	200%
Special low-income Medicare beneficiaries	110%

Other programs to be considered include child care assistance, low-income heating assistance, and the TANF program.

Expansion of Healthy Steps to Include Subsidies for Adding Family Coverage to Employer-Based Health Insurance Plans

The committee is directed to study the feasibility and desirability of expanding the Healthy Steps program to provide family coverage through employer-based health insurance plans. A February 13, 1998, letter from the Health Care Financing Administration to state health officials outlines the parameters under which states may use children's health insurance program (CHIP) funds to provide health insurance coverage through employer-sponsored group health plans. The letter outlines the agency's concern that there is a potential for CHIP coverage to be substituted for private group health coverage by individuals and employers currently purchasing such coverage with private funds. The letter expresses a concern that CHIP programs that furnish coverage through employer-sponsored group health plans have greater potential to allow the substitution of private funds with public funds. The letter indicates that states that use CHIP funds to subsidize employer-sponsored group health plans should incorporate provisions in their state CHIP plan that are substantially equivalent to the following:

1. **Six-month waiting period** - To ensure that coverage is targeted to children in families that previously were unable to afford dependent coverage, subsidies through an employer-sponsored group health plan will not be available to a family whose children had employer-sponsored coverage within the previous six months. States may impose a longer required period of uninsurance, but the period may not exceed 12 months. Exceptions may be allowed if the coverage was involuntarily terminated by an employer other than the applicant's current employer. Newborns are not subject to the waiting period.
2. **Required employer contributions** - To discourage employers from lowering their existing contributions for dependent coverage, subsidies for employer-sponsored group health insurance will only be available in cases when the employer contributes at least 60 percent of the cost of the family coverage (60 percent is the median employer contribution nationwide). A lower level of contribution may be considered if a state has additional provisions in place to limit an employer's ability to lower contribution levels.
3. **Limitation on costs** - To ensure that the provision of child health assistance through employer-sponsored group health plans is cost-effective and that the state is not inappropriately subsidizing coverage for the adults in a family, a state's payment for a child enrolled in an employer-sponsored group health plan may not exceed the

payment the state would make to provide coverage for the child through the state's CHIP plan. If subsidized health insurance coverage through employer-sponsored group health plans is provided only to children, no family coverage waiver is needed. If coverage is provided to adults, the state must obtain a family coverage waiver under Section 2105(c)(3) of Title XXI of the Social Security Act. Section 2105(c)(3) provides that federal funds may be paid to a state for the purchase of family coverage under a group health plan if the state establishes that:

a. The purchase of such coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage of the targeted low-income children involved.
b. Such coverage may not be provided if it would substitute for health insurance coverage that would otherwise be provided to the children involved.

4. **Full premium contribution from employer** - To promote cost-effectiveness by reducing the required CHIP contribution to the cost of the premium, families electing to receive child health assistance through an employer-sponsored group health plan will be required to apply for the full premium contribution available from the employer.
5. **Evaluation** - To demonstrate cost-effectiveness, the state must collect information and conduct an evaluation that examines the amount of substitution that has occurred under the program and the effect of these provisions on access to the program.

The National Conference of State Legislatures reported in June 2000 that, as of that date, three states (Massachusetts, Mississippi, and Wisconsin) had instituted programs to provide health insurance coverage through CHIP subsidies of employer-sponsored group health insurance plans.

ANNUAL REPORT REGARDING HEALTHY STEPS PROGRAM

North Dakota Century Code Section 50-29-02 requires the Department of Human Services to present an annual report to the Legislative Council on the children's health insurance program, including enrollment statistics and costs associated with the plan. The Legislative Council has assigned this duty to the Budget Committee on Health Care.

RECENT LEGISLATIVE STUDIES

1995-96 Budget Committee on Human Services

Pursuant to 1995 House Concurrent Resolution No. 3045, the 1995-96 Budget Committee on Human Services conducted a study of the responsibilities of county social services agencies, regional human service centers, and the Department of Human Services. As a result of the study, the committee recommended House Bill No. 1041, which required counties to assume financial responsibility for the costs of administering certain economic assistance programs and required the state to assume financial responsibility for the grant costs of Medicaid, TANF, child care assistance, and basic care and to contribute additional support for administrative costs of counties with Indian land.

1997-98 Welfare Reform Committee and Insurance and Health Care Committee

Both the Welfare Reform Committee and the Insurance and Health Care Committee received reports from the Department of Human Services during the 1997-98 interim regarding the establishment of a state children's health insurance program in two phases:

- Phase I - Expand the Medicaid program to include children up to 18 years old with a family income at or below 100 percent of the federal poverty level.
- Phase II - Provide private insurance coverage for uninsured children who are not Medicaid-eligible and who meet family income requirements.

1999-2000 Budget Committee on Health Care

Section 12 of 1999 Senate Bill No. 2012 established a children's health insurance program and directed the Department of Human Services to present an annual report on the program to the Legislative Council. This duty was assigned to the Budget Committee on Health Care.

The committee received various reports during the 1999-2000 interim regarding the status of the program. The committee learned that although the department had taken steps to simplify the complexity of the Medicaid eligibility application form, the asset test adds complexity to the application. The committee also learned that if the asset test for children and pregnant women is eliminated from Medicaid eligibility requirements, the department could combine the Healthy Steps and Medicaid applications. The committee also learned that although income eligibility for the Healthy Steps program is determined on an annual basis, it is determined on a monthly basis for the Medicaid program. The committee considered but did not recommend a bill draft that would have:

- Eliminated the asset test for Medicaid eligibility for children and pregnant women.
- Changed the Medicaid income review period from monthly to annually for children and pregnant women.

The committee recommended 2001 House Bill No. 1036, which failed to pass. The bill would have

provided for a quarterly rather than annual review period for children and pregnant women receiving Medicaid benefits; the fiscal note indicated a general fund cost of $374,737 for the 2001-03 biennium.

RELATED 2001 LEGISLATION

House Bill No. 1036, which failed to pass, would have required the Department of Human Services to review on a quarterly, rather than annual, basis the income eligibility of children and pregnant women receiving medical assistance.

House Bill No. 1441 provides that the Department of Human Services should seek an amendment to its children's health insurance state plan to provide maximum federal reimbursement for the cost of removing the asset test for the Medicaid program. If the state plan amendments receive federal approval, the department shall remove the asset test requirements for the Medicaid program through June 30, 2003. The bill also:

- Allows the department to accept and spend any gift, grant, or donation for the Healthy Steps program.
- Provides for a Legislative Council study of the coordination of the Medicaid and Healthy Steps programs.

Senate Bill No. 2414, which failed to pass, would have provided for the coverage of child delivery under the children's health insurance program and would have eliminated the family cap under the TANF program.

PROPOSED STUDY PLAN

The following is a study plan the committee may want to consider in its study of the coordination of the Healthy Steps and Medicaid programs:

1. Receive annual reports from the Department of Human Services regarding the Healthy Steps program, as required by NDCC Section 50-29-02, including enrollment statistics and costs.
2. Review information from other states regarding county or state administration of the children's health insurance program, the elimination of the asset test for Medicaid eligibility, and the expansion of the children's health insurance program to include subsidies for adding family coverage to employer-based group health plans.
3. Receive information from the Department of Human Services, county social services agencies, and other interested organizations, entities, and individuals regarding the costs and benefits of:
   a. Developing a single application form for the Healthy Steps and Medicaid programs;
   b. Providing for county administration of the Healthy Steps program;
   c. Eliminating the asset test for determining Medicaid eligibility;
   d. Standardizing the definition of income for all programs administered by the Department of Human Services; and
   e. Obtaining a federal waiver to allow the Healthy Steps program to provide family health insurance coverage through an employer-based insurance policy.
4. Develop recommendations and any related bill drafts regarding the coordination of the Healthy Steps and Medicaid programs.
5. Prepare a final report to the Legislative Council.

ATTACH:3

Fifty-seventh Legislative Assembly of North Dakota
In Regular Session Commencing Tuesday, January 9, 2001

HOUSE BILL NO. 1441
(Representatives Niemeier, Boucher, Cleary, Kerzman)
(Senator Bercier)

AN ACT to create and enact a new subsection to section 50-24.1-02.6 and a new section to chapter 50-29 of the North Dakota Century Code, relating to medical assistance benefits and the children's health insurance program; to provide for a legislative council study; to provide for a continuing appropriation; to require maximizations of federal reimbursement; to provide for an effective date; and to provide for an expiration date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new subsection to section 50-24.1-02.6 of the North Dakota Century Code is created and enacted as follows:

The department of human services shall provide medical assistance benefits to children and families coverage groups and pregnant women without consideration of assets.

SECTION 2. A new section to chapter 50-29 of the North Dakota Century Code is created and enacted as follows:

Grants - Gifts - Donations - Continuing appropriation. The department may accept any gift, grant, or donation, whether conditional or unconditional, for the purpose of providing funds for the children's health insurance program. The department may contract with public or private entities and may expend any moneys available to the department to obtain matching funds for the purposes of this chapter. The department shall seek grants from the academy for health research and health policy state coverage initiative and from any other entity that may award such grants. All moneys received as a gift, grant, or donation under this section are appropriated as a standing and continuing appropriation to the department for the purpose of providing funds for the children's health insurance program.

SECTION 3. LEGISLATIVE COUNCIL STUDY. During the 2001-02 interim, the legislative council shall consider studying the coordination of the medical assistance and the children's health insurance programs, including the development of a single application form for both programs, whether the children's health insurance program should be administered by the state or the counties, the effects of eliminating the asset eligibility requirement for the medical assistance program, the standardization of the definition of "income" for all programs administered by the department of human services, and the feasibility and desirability of seeking a federal waiver to allow the children's health insurance program plan to provide coverage for a family through an employer-based insurance policy if an employer-based insurance policy is more cost-effective than the traditional plan coverage for the children. The legislative council shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the fifty-eighth legislative assembly.

SECTION 4. FEDERAL REIMBURSEMENT. The department of human services shall seek an amendment to its state plan to maximize federal reimbursement through the program to provide health assistance to low-income children funded through title XXI of the federal Social Security Act, for the removal of the asset test for the medical assistance program.

SECTION 5. EFFECTIVE DATE - EXPIRATION DATE. Section 1 of this Act becomes effective upon certification by the department of human services to the governor and the legislative council that the state plan amendments to the children's health insurance program have received federal approval. In no case, however, may section 1 of this Act become effective before January 1, 2002. If section 1 of this Act becomes effective, the section is effective through June 30, 2003, and after that date is ineffective.

Healthy Steps
Children's Health Insurance Plan

NORTH DAKOTA HEALTHY STEPS INSURANCE APPLICATION

PREMIUM **FREE** HEALTH INSURANCE

General Requirements

To be eligible for enrollment, a child must meet the following requirements:

1. A son or daughter, stepchild, legally adopted child, or a child between the ages of 0 through 18 years old for whom you or your living spouse are legally appointed guardian.

2. A resident of the state of North Dakota.

3. Cannot be covered under any other health insurance coverage, and cannot be eligible for Medicaid. (Indian Health Service is not a health insurance coverage.)

4. Household income must be within Healthy Steps guidelines. (See table)

- The number of people in the family includes the parents, children and unborns.

- Add together all the income received by all family members. Deduct child care out-of-pocket expenses and taxes. If your income is below or slightly more than the income level amounts, your children may qualify.

APPLICATION INSTRUCTIONS

QUESTION 1: Write in the information about the person who is applying for the child(ren). This should be the person the department can contact for any questions concerning the application.

QUESTION 2: Write in the names and ages of ALL other adults including spouse age 19 and older living in your household who are related to you or to your child(ren). If individual is employed, indicate if they are or are not a student. Indicate relationship to the child(ren).

QUESTION 3: Write in your child's full name (Last, first, middle initial). The child's mother's full name and the child's father's full name. Tell us your child's gender by marking an 'X' for male or female. Tell us what race your child is by indicating American Indian or Alaskan Native (I), Asian (A) or Pacific Islander (P), Black (B) (not of Hispanic origin), Hispanic (H), or White (W) (not of Hispanic origin). Tell us your child's birth date by entering month, day and year. Enter your child's Social Security Number.

Put an 'X' in the yes or no box to tell us if the child is an US Citizen. If the child you are requesting Healthy Steps for is not a US Citizen, please provide us with proof of citizenship status.

For an unborn child, write "unborn" for child's name and write in the child's expected date of birth - other information can be left blank.

QUESTION 4: Put an 'X' in the yes or no box to tell us if your household assets exceed the amount indicated. Do not include the home you are living in, one automobile, your personal effects and property you use to produce income.

QUESTION 5: List any information concerning health insurance coverage your children have or did have in the last six months. Indicate who was covered under the insurance.

QUESTION 6: Enter **ALL INCOME** your household receives. **ATTACH PROOF OF ALL INCOME.** For regular earnings provide copies of last months paystubs. If your household has more than two earned incomes, please provide additional information on a separate sheet. If you are self-employed, provide copies of Page 1 and 2 of 1040 and Schedule C, E, F or K (if applicable) of your federal income tax returns for the last three years. If you have not been self-employed for a full three years, send us copies of the years you have been.

QUESTION 7: Write in the amount of **out-of-pocket** expenses you pay per child for child care while you are working or going to school.

QUESTION 8 and 9: If you are responsible for any court ordered alimony or child support, indicate by marking with an 'X'. If yes, write in the amount.

QUESTION 10: Put an 'X' in the yes or no box to tell us if your child(ren) are currently covered under North Dakota Medicaid, and if 'yes', write in the child(ren)'s name.

QUESTION 11: Please tell us how you heard about 'Healthy Steps'.

QUESTION 12: Please tell us where you take your children for medical appointments.

QUESTIONS 13 and 14: Please read and sign the statement. **Mail the application to the address listed. If you have questions, call 1-800-755-2604.**

Send Completed Application Including Copies of Income to: North Dakota Healthy Steps
600 E. Boulevard Ave. Dept 325
Bismarck, ND 58505-0261

These limits are effective through March 31, 2002. Income limits increase around April of each year. These income levels are [Net] Income Amounts. (Take Home Pay)

Number of people in family (Count parent(s) and children)	Income levels to qualify for ND Healthy Steps	
	Maximum Allowable Monthly NET Income	Maximum Allowable Annual NET Income
1	$1,003	$12,026
2	$1,355	$16,254
3	$1,707	$20,482
4	$2,060	$24,710
5	$2,412	$28,938
6	$2,764	$33,166
7	$3,117	$37,394
8	$3,469	$41,622
9	$3,821	$45,850
10	$4,174	$50,078

- For family households over ten people, increase the monthly income amount by $359 for each additional person or increase the annual income amount by $4,228.

Question 4 - Explanation of Assets Used to Identify Potential Medicaid Eligibility.

Don't Count:

Your income
Property used to produce income (example: farm)
One vehicle
Your home
Personal effects

Things to Count:

Checking account balance
Savings account balance
Cash value of any IRA's, CD's, trusts or
annuities, life insurance policy
Value of all vehicles not work related or used to produce income
Value of items such as camper, boat or motorcycles

MEMBERSHIP APPLICATION FOR NORTH DAKOTA HEALTHY STEPS INSURANCE PROGRAM

ND DEPARTMENT OF HUMAN SERVICES/Medical Services
SFN 214 (Rev. 03-2001)

1. Person Applying for the Child or Children **PLEASE PRINT**

Full Name: (Last, First, MI)		Home Phone:		Work Phone:	
Home Address: (Street)	Apt. #:	City:	State:	Zip:	County:
Mailing Address: (If different from above - Street)	Apt. #:	City:	State:	Zip:	County:

2. Are any other individuals in your household over age 19 living with you? If so, list their names and the relationship to the children.

Name	Age	Student		Relationship to Child(ren)
		Yes	No	

3. Tell us the names of every child under age 19 in your household including unborns. (Unborn children are included in determining household number). Provide child's SSN (Optional). If the child you are requesting assistance for is not a US citizen, provide verification of citizenship status.

Child's Name (Last, First, MI)	Mother's Name (Last, First, MI)	Father's Name (Last, First, MI)	Gender		Race	Child's Date of Birth	Child's Social Security Number	US Citizen	
			M	F				Yes	No

4. Healthy Steps is intended to serve children who do not qualify for Medicaid. Healthy Steps does not have an asset test; Medicaid does. **Do your household assets exceed $6,000 for household of two or $6,025 for three (add $25 for every additional household member)? Do not include one auto, the home you are living in, clothing, household effects or income producing property.** ☐ Yes ☐ No **(See insert for further explanation)** If "No", depending upon your income and expenditures, you may be eligible for Medicaid through your local county social services.

5. Tell us about any health insurance coverage the children already have. (Indian Health Service is not Health Insurance Coverage)

Health Insurance Company:

If no health insurance, when and why did the coverage end?

6. TELL US HOW MUCH INCOME YOUR FAMILY HAS. ATTACH PROOF OF ALL INCOME. We need proof of all of your income. For earnings, provide copies of pay stubs for the last month. If you do not have pay stubs, you may provide a letter from your employer. If your household has more than two jobs, please list all requested information on a separate sheet. **(IF YOU ARE SELF EMPLOYED, SEND COPIES OF PAGE 1 AND 2 OF 1040 AND SCHEDULE C, E, F, OR K (IF APPLICABLE) OF YOUR LAST THREE YEARS FEDERAL INCOME TAX FORM.)** If you are not sure what to send, call our toll-free number 1-800-755-2604.
Enter GROSS pay, not take-home pay. Enter zero (0) if you or your spouse are not employed.

Your Income From Employment(s)	Other Adult's Income From Employment
Employer Name:	Employer Name:
Amount earned each pay period **before** taxes: (Gross) $	Amount earned each pay period **before** taxes: (Gross) $
☐ Weekly ☐ Every 2 wks ☐ Twice a Month ☐ Monthly	☐ Weekly ☐ Every 2 wks ☐ Twice a Month ☐ Monthly
PLEASE ATTACH COPIES OF ALL WAGE STATEMENTS COVERING ONE FULL MONTH	**PLEASE ATTACH COPIES OF ALL WAGE STATEMENTS COVERING ONE FULL MONTH**
Hours worked each week:	Hours worked each week:

6. (Continued) **PLEASE ATTACH PROOF OF ALL INCOME IDENTIFIED BELOW**

Other Income	Amount	How Often Do You Get This Income?	Which Family Member Gets This Income?
Child Support	$		
Alimony	$		
Social Security Payment	$		
Unemployment Benefits	$		
Rental Income	$		
Other (Please explain)	$		

7. **Do you pay someone to take care of your child(ren) while you are at work or school?** ☐ Yes ☐ No
If yes, enter child's name and the amount of **out-of-pocket** expenses you pay:

Child's Name	Amount Per Month
	$
	$
	$

8. **Do you pay court ordered alimony?** ☐ Yes ☐ No If "YES", how much per month? $

9. **Do you pay court ordered child support?** ☐ Yes ☐ No If "YES", how much per month? $

10. **Are any of your children receiving Medicaid?** ☐ Yes ☐ No If "YES", which children?

Child's Name	Medicaid ID Number

11. **How did you find out about this program?**
☐ **TV** ☐ **Newspaper** ☐ **Radio** ☐ **Other**

Tell us where you got this application?

12. **Who does your child(ren) see for routine medical care?**

13. Mail this completed, signed form, together with proof of income to:

North Dakota Healthy Steps
600 E Boulevard Ave Dept 325
Bismarck ND 58505-0261

OR Application can be dropped off at:

Medical Services
Third Floor Judicial Wing Room 309
State Capitol Building
Bismarck ND 58505

If you need more information, please call this toll-free number: 1-800-755-2604.

Your Rights and Responsibilities

1. I know that the information I have given is confidential subject to the above authorization for the release of information I have given to the Department and the insurance carrier. I understand that if any information is released to the Department from the insurance carrier, the Department is still bound to keep individually-identifying information confidential.
2. I know that any information I have given may be reviewed and verified by State staff. Also I understand that I must cooperate fully with ND state and federal workers if my case is reviewed. No additional permission is needed to get verification or other information.
3. I know that this application will be considered without regard to race, color, sex, age, disability, religion, national origin or political belief.
4. In compliance with the Federal Privacy Act of 1974, the disclosure of the individual's Social Security Number on this form is used as an identification number by the department/agency for file control and record keeping.

Please sign this statement:
I certify that the information I have provided above is true to the best of my knowledge and I give permission for the State of North Dakota to make any necessary contacts to check my statements. I have read the list of my rights and responsibilities that is printed below. I know that I could be penalized if I knowingly give false information. By signing this application, I authorize the Department and the insurance carrier providing the Healthy Steps plan insurance to release to each other information regarding any services or benefits I receive under the plan if I am deemed eligible.

Signature of Applicant:	Date:

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APPENDIX C

APPLICATION FOR MEDICAID, TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF), FOOD STAMPS, AND CHILD CARE ASSISTANCE

PART I

- You may apply for any or all of these programs with this application.
- You must complete Part 2 of this application. If you are applying for Medicaid, Food Stamps, or Child Care Assistance you must also complete Part 3 through Part 7.
- You must complete an interview for Food Stamps and Temporary Assistance for Needy Families (TANF). Medicaid and Child Care Assistance do not require a face to face interview.
- We will make a decision on your application for TANF and Food Stamps within **30 days** after it is received. We will make a decision on your application for Medicaid and Child Care Assistance within **45 days** (90 days for Medicaid if a disability decision is pending) after it is received.

On the back of this page is a list of things you will need to provide. You may have a friend, relative, or someone else help you to complete this application. The county social service office can also help you.
Return Application To:

THINGS YOU WILL NEED TO PROVIDE

☐ **ALIEN OR CITIZENSHIP STATUS** - By signing Part 7 of the application, you are attesting to the citizenship or alien status of all household members seeking benefits. Documentation of citizenship or alien status must be provided (For example: Resident Alien Card (Form I-551); Employment Authorization Card (Form I-688A); Temporary Resident Card (Form I-688); Arrival-Departure Record (Form I-94), or for Medicaid and TANF applicants, a birth certificate).

☐ **ASSETS** - Bring records that show the **current** value of all your assets. (For example: checking and savings account balances, certificates of deposit, stock/bonds, IRA, 401K, KEOGH plans, life insurance, burial plan, mineral royalty/lease agreement, trust documents, real property, etc.)

☐ **EXPENSES** - Bring current records for the following expenses:

- Child/Dependent Care
- Medical expenses (If applying for **Food Stamps** only, you do not need to report medical expenses for household members under age 60 unless they are disabled)
- Health Insurance Premiums (If applying for **Food Stamps** only, you do not need to report health insurance premiums for household members under age 60 unless they are disabled)
- Court Ordered Payments (For example: child support, health insurance premiums, vendor payments, alimony, etc.)
- Utility/Shelter Expenses (Only if applying for **Food Stamps**)

☐ rent/mortgage	☐ home owner's insurance	☐ housing assistance contract
☐ telephone bill	☐ heating and cooling costs	☐ property taxes
☐ lease agreement	☐ other utility bills	

☐ **IDENTITY/AGE** - Bring records that prove the identity of household members applying for benefits. (For example: birth certificate, driver's license, work or school ID).

☐ **INCOME** - Bring records that show your Gross Income. (For example: wage stubs, a statement by the employer, Social Security, SSI, Workers Compensation, and pension award letters, self-employment income records, verification of child support/alimony payments, rental property income, lease income, etc.)

☐ **RESIDENCE** - Bring records that show where you live. (For example: rent receipts, utility bills, etc.)

☐ **SOCIAL SECURITY NUMBERS** - Bring a Social Security number or show that you have applied for a Social Security number for all household members seeking benefits.

☐ **VERIFICATION OF PREGNANCY** - A pregnant woman applying for **Medicaid** or **TANF**, must bring a doctor's statement of when her child will be born.

YOUR WORKER MAY BE ABLE TO HELP YOU OBTAIN THESE THINGS IF NEEDED.

YOU MUST:

- Bring all information we need to determine your eligibility.
- Report changes within **10 days** of becoming aware of the change for **Food Stamps** and **Medicaid** and **5 days** for **TANF**. (For example: pregnancy, baby's birth, someone leaving or moving into your house, a new job, a change of income or assets, a new address.)
- Cooperate with Department of Human Services staff if your case is reviewed.
- Cooperate with child support officials in establishing paternity and in establishing and enforcing medical support for deprived children if you receive **Medicaid**. This rule does not apply if you are pregnant.
- Cooperate with child support officials in establishing paternity and in establishing and enforcing child support if you receive **TANF**.

YOU HAVE A RIGHT TO:

- File Part 2 of this application immediately if it contains the applicant's name, address, and the signature of a responsible household member or authorized representative.
- Equal treatment regardless of race, color, age, disability, religion, political belief, gender, or national origin.
- Have the information you give us kept private.
- Request a fair hearing if you disagree with any decision to deny, reduce, or terminate benefits. Hearings must be requested within 30 days for Medicaid, TANF, Child Care Assistance, or within 90 days for Food Stamps.

THE DEPARTMENT OF HUMAN SERVICES HAS A RIGHT TO:

- Use your Social Security number to check with other organizations, such as banks, and government agencies to verify your eligibility.
- Deny your application and report you for fraud if you give us false information.

ASSIGNMENTS:

- When you receive **Medicaid,** you give to the State of North Dakota any rights to medical support and to payment for medical care from any third party for services received. You must help the state in pursuing any third party who may have a responsibility to pay for care or services. You must also report any payments you receive for medical care within 10 days of receiving the payment.
- When you receive **TANF**, you give to the State of North Dakota your right to child support.

PENALTY WARNINGS:

- **MEDICAID**: State and Federal law provide for fine, imprisonment, or both for any person who withholds or gives false information to obtain assistance to which he or she is not entitled.

  A caretaker of children in Medicaid cases who does not cooperate in establishing a child's paternity or in establishing and enforcing medical support may lose Medicaid benefits.

- **TANF**: Any member of your household who is found by a State or Federal court, or State Administrative Hearing, on the basis of a plea of guilty or no contest, to have intentionally given false information or withheld information will be barred from TANF for (12) months for the first violation; twenty-four (24) months for the second violation; and permanently for the third violation. The individual can also be fined up to $250,000, imprisoned for up to twenty (20) years, or both.

  Any individual convicted in State or Federal court of having made a fraudulent statement or representation with respect to the place of residence or identity of the individual in order to receive assistance simultaneously from two or more states shall be disqualified from receiving benefits for a period of 10 years.

  Any individual convicted under State or Federal law of any offense which is classified as a felony by the law of the jurisdiction involved and which has an element the possession, use, or distribution of a controlled substance (as defined in section 102(6) of the Controlled Substances Act (21 U.S.C. 802(6)) shall be disqualified permanently from receiving TANF benefits.

  A TANF recipient who does not cooperate with child support officials, in establishing a child's paternity or in establishing and enforcing child support, may cause the family's TANF benefits to be lost.

  A TANF recipient who does not cooperate in looking for work, preparing for employment, and keeping a job may cause the family's TANF benefits to be reduced.

  A TANF recipient who does not cooperate in obtaining a health screening for children may cause the family's TANF benefits to be reduced.

- **FOOD STAMP PROGRAM:**
  - → Do not give false, inaccurate or incomplete information.
  - → Do not buy ineligible items such as alcohol or tobacco with Food Stamp benefits.
  - → Do not trade or sell your EBT card.
  - → Do not use or have in your possession other people's EBT cards or Food Stamp benefits.

  Any member of your household may be removed from the Food Stamp Program for:
  - One year for intentionally breaking a Food Stamp rule;
  - Two years for a second violation; or a first conviction for buying, selling, or trading Food Stamps for a controlled substance.
  - Lifetime for intentionally breaking a Food Stamp rule a third time; or a second conviction for buying, selling, or trading Food Stamps for a controlled substance; or conviction for buying, selling or trading Food Stamp benefits worth $500 or more. If a court of law finds a household member guilty of trading Food Stamps for firearms, ammunition, or explosives, the individual is permanently barred from the program.

  In addition, any household member may be removed by a court for an additional 18 months; or prosecuted and fined up to $250,000 or imprisoned up to 20 years or both.

  A Food Stamp recipient who does not cooperate in looking for work, preparing for employment, or keeping a job may cause the family to lose Food Stamp benefits.

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APPLICATION FOR ASSISTANCE - PART 2

Case Number:
Date Received:
Interview Date:

NAME: First	Middle Initial	Last

Address Where You Live:			Mailing Address: (If Different)		
City:	State:	Zip Code:	City:	State:	Zip Code:
Home Telephone Number: ( )	Work or Message Number: ( )		What assistance are you requesting? ☐ Food Stamps ☐ TANF ☐ Medicaid ☐ Child Care Assistance		

Fill in all spaces for everyone who currently lives with you, whether you consider them household members or not. Also list anyone who is temporarily absent. List yourself first, then your spouse, your children (including unborn children), then other adults and children living in your home. If you need additional space, please continue on a separate sheet of paper. If you are only applying for Medicaid, you do not need to provide the social security number and citizenship status for those who you do not want covered.

HOUSEHOLD MEMBERS (ENTER LEGAL NAME) FIRST MIDDLE LAST	SOCIAL SECURITY NUMBER	BIRTHDATE	SEX	RELATIONSHIP TO PERSON COMPLETING APPLICATION	RACE (Optional) *	HISPANIC (Optional) (Yes or No)	US CITIZEN (Yes or No)	MARITAL STATUS **
				SELF				

* **RACE CODES:** **WH** - White **AI** - American Indian/Alaska Native **BL** - Black **AP** - Asian **HP** - Native Hawaiian/Pacific Island

** **MARITAL STATUS CODES:** **MA** - Married **NM** - Never Married **DI** - Divorced **SE** - Separated **WI** - Widowed

Other names used by any household members (maiden name, prior married name, etc.)

Does any household member have unpaid medical bills for any of the past 3 months for which you would like assistance? ☐ Yes ☐ No	If yes, which month(s):
Is any household member disabled (including children)? ☐ Yes ☐ No	If yes, who?

Is any household member temporarily out of the home? ☐ Yes ☐ No	If yes, who?	Date of expected return:

Please Check Assistance Received in the Past	**If Received, By Who in Household**	**When?**	**County**	**State**
☐ TANF or AFDC				
☐ Medicaid				
☐ Food Stamps				
☐ Cash/General Assistance				
☐ Child Care Assistance				

Do you live on an Indian Reservation or Service Area? ☐ Yes ☐ No	List the name and enrollment number for each household member who is enrolled in an Indian Tribe:
Was any household member certified to receive commodities distributed by a tribal program either this month or last month? ☐ Yes ☐ No	

OVER PLEASE

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SIGNATURE - APPLICATION FOR ASSISTANCE (FOR ALL PROGRAMS)

Signature of Applicant:	Date:
Other Signature (spouse, guardian or other adult):	Date:

COMPLETE THIS SECTION FOR FOOD STAMPS ONLY

If there is more than one adult in the household, list the name of the adult you want to be the head of household for Food Stamp purposes:	
Is any household member a boarder (paying someone to provide meals)? ☐Yes ☐No	
Does anyone in your household purchase and prepare meals separately? ☐ Yes ☐ No	If yes, who?
Do you have an Electronic Benefit Transfer (EBT) card? ☐Yes ☐ No	If yes, from what county or state did you receive it?

You may receive Food Stamps within seven (7) days with a completed application. Failure to attach proof of identity may delay processing of this application.

Will your household's gross income for the month of application be less than $150?	☐ Yes	☐No
Does your household have less than $100 in cash, checking, savings, CD's, etc?	☐ Yes	☐No
Is anyone in your household a migrant or seasonal farm worker?	☐ Yes	☐No

INCOME AND ASSETS:

		AGENCY USE
Gross income expected this month:	$	
Money in cash, checking, savings, CD's, etc.:	$	

SHELTER EXPENSES:

Current Rent/Mortgage	$
Current monthly utilities:	$

AUTHORIZED REPRESENTATIVE: You can designate someone to be an authorized representative. This person can apply for benefits for you. This person will have unrestricted access to your Food Stamps. Any funds misspent by the representative will not be replaced. Please complete the following if you wish to have an authorized representative.

Name:	Address:		
	City:	State:	Zip Code:
Name:	Address:		
	City:	State:	Zip Code:

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AGENCY USE
Date Received:
Case Number:

APPLICATION FOR ASSISTANCE - PART 3

COMPLETE THIS SECTION IF APPLYING FOR MEDICAID OR FOOD STAMPS

Name:	Scheduled Appointment: (Date/Time)
If you miss your appointment and you still wish to apply for Food Stamps, please contact the County Social Service Office to schedule a second appointment	

ASSET INFORMATION

LIFE INSURANCE:

Does anyone have life insurance? ☐ Yes ☐ No If yes, complete the following:

NAME AND ADDRESS OF COMPANY	FACE VALUE	CASH VALUE	OWNER OF POLICY	NAME OF PERSON INSURED	POLICY NUMBER

VEHICLES:

List vehicles owned, jointly owned, or being purchased for all household members. (Car, truck, motor home, snowmobile, motorcycle, 3 wheeler/4 wheeler, etc.) List even if not running or not in your possession. Include vehicles registered through Tribal Motor Vehicle or another state.

OWNER(S)	YEAR	MAKE/MODEL	VALUE	AMOUNT OWED	LICENSED?
			$	$	☐ Yes ☐ No
			$	$	☐ Yes ☐ No
			$	$	☐ Yes ☐ No
			$	$	☐ Yes ☐ No
			$	$	☐ Yes ☐ No
			$	$	☐ Yes ☐ No

TRANSFERS:

If Applying for Medicaid: Has any household member sold, given away or transferred anything of value within the past **5 years?** ☐ Yes ☐ No

If Applying for Food Stamps: Has any household member sold, given away or transferred anything of value within the past **3 months?** ☐ Yes ☐ No

If yes to either question, fill in the following:	Date Sold or Transferred:	Value:
Description:		Amount of Money Received:

AGENCY USE

OTHER ASSETS:

For all household members, including children, identify all assets owned, shared, or being purchased. If you need additional space, please continue on a separate sheet of paper.

		YES	NO	TOTAL VALUE	AMOUNT OWED	OWNER(S) OF ASSETS	LOCATION/ DESCRIPTION
CA	Cash on Hand						
	Bank Accounts:						
BA	Business Account						
CD	Certificate of Deposit						
PC	Checking/Credit Union Account						
IM	Individual Indian Monies Account						
SV	Savings/Credit Union Account						
	Burial:						
BP	Burial Plot						
BS	Burial Space Items (Casket, Urn, etc.)						
MV	Marker/Vault						
PB	Prepaid Funeral Plan (Not Life Insurance)						
	Business Related:						
BI	Business Inventory/Equipment						
FA	Farm Equipment, Livestock, Stored Grain						
IT	Income Producing Tools/Equipment						
	Retirement:						
AN	Annuity Account						
IR	Retirement Fund, IRA, KEOGH, 401K, etc.						
	Other Assets:						
HO	Home/Mobile Home (Owner Occupied)						
MH	Mobile Home (Not Owner Occupied)						
RR	Real Property (Not up for Sale)						
RP	Real Property (Up for Sale)						
LE	Life Estate/Life Lease						
MR	Mineral Rights (Oil, Gas, Gravel, Coal, etc.)						
NO	Notes or Contracts for Deed						
BT	Boat/Motor/Personal Watercraft						
CP	Camper						
TL	Trailer (any kind)						
BO	Savings Bonds						
ST	Stocks/Bonds/Mutual Funds						
TR	Trust						
SD	Safety Deposit Box						
OT	Other						

Do you expect any changes in assets next month? ☐ Yes ☐ No	If yes, explain:

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INCOME INFORMATION

UNEARNED INCOME:

Do any household members (including children) have any of the following income? Check yes or no for each item. If yes, enter the total amount of income, before deductions, in the "Amount" column. **PROOF OF ALL INCOME MUST BE PROVIDED.**

TYPE OF UNEARNED INCOME	YES	NO	RECEIVED BY WHOM	HOW OFTEN RECEIVED	AMOUNT THIS MONTH	AMOUNT NEXT MONTH
BIA General Assistance						
Bingo/Gambling Winnings						
Child Support or Alimony						
Contract Sale or Rental Income						
Financial Aid for Students						
Income from Roomer/Boarder						
Individual Indian Monies (IIM)						
Insurance/Lawsuit Settlement						
Interest/Dividend Income						
Money from Friends, Relatives or Others						
Oil/Mineral Rights/Royalties						
Pension/Retirement Benefits Claim #						
Railroad Retirement Benefits Claim #						
Social Security Benefits Claim #						
Supplemental Security Income - SSI						
TANF						
Unemployment Benefits						
Veteran's/Military Benefit Claim #						
Workers Compensation Claim #						
Other: (Specify)						

Has anyone applied for benefits not yet received? (For example: Social Security, SSI, Workers Comp) ☐ Yes ☐ No	If yes, please explain:

EARNED INCOME AND EMPLOYMENT INFORMATION:

SELF-EMPLOYMENT: Is any household member self-employed? ☐ Yes ☐ No

If yes, name of business:	Type of business:

A complete copy of the most current Federal Income Tax form must be provided. If you do not have a current tax return that includes the self employment business, provide income and expense ledgers.

OTHER EARNED INCOME: Is any household member (including children) working? ☐Yes ☐No
If yes, complete this section. List information about full-time, part-time, seasonal, or temporary employment for all household members. If space is needed to list more jobs, enter them on a separate sheet of paper. **Proof of all income must be provided.**

Household Member's Name	Employer's Name	Gross Amount This Month	Gross Amount Next Month	Hours Worked Per Week	Salary/ Hourly Wage	Amount of Tips/ Commission	How Often Paid	Day(s) of Week/ Month Paid	Date of Next Paycheck

STUDENT STATUS

Is any household member a student? ☐ Yes ☐ No If yes, complete this section for each student.

STUDENT	GRADE	WHERE ATTENDING SCHOOL	* STUDENT STATUS CODE	STUDENT	GRADE	WHERE ATTENDING SCHOOL	* STUDENT STATUS CODE

*** Student Status Codes:**
PT - Part Time/Half Time **FT** - Full Time **HG** - Half Time Graduate **FG** - Full Time Graduate **CP** - Correspondence

EXPENSES

You will not receive a deduction for any allowable expense you fail to report and verify.

Does any household member pay court ordered child support, health insurance premiums, or vendor payments? ☐Yes ☐No

Who are the payments for:	Court ordered amount:	Amount you pay:
Does your household have child care expenses? ☐Yes ☐No	Billed amount:	Amount you pay:

Are you receiving Child Care Assistance? ☐ Yes ☐ No	Have you applied for Child Care Assistance? ☐ Yes ☐ No
Do you expect any changes in these expenses next month? ☐Yes ☐No	If yes, please explain:
Does anyone help you pay any of these expenses? ☐Yes ☐ No	If yes, please list what expenses, who is paying, and how much is paid:

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FOOD STAMPS - PART 4

COMPLETE THIS SECTION IF APPLYING FOR FOOD STAMPS
IF NOT APPLYING FOR FOOD STAMPS GO TO PART 5

SPONSOR INFORMATION

Does any alien/refugee living in your home have a sponsor? ☐ Yes ☐ No ☐ Not Applicable If yes, complete the following:

Person(s) Sponsored	Name of Sponsor or Agency	Sponsor's or Agency's Address	Sponsor's Telephone Number

CRIMINAL HISTORY INQUIRY

Have you or any member of your household been convicted of buying or selling Food Stamp benefits of $500 or more?			☐ Yes ☐ No
Have you or any member of your household, since August 22, 1996, been found to have fraudulently represented his or her identity or place of residence in order to receive multiple Food Stamp benefits?			☐ Yes ☐ No
If yes, enter date of conviction:	State:	County:	
Are you or any member of your household subject to an arrest warrant issued by an authority outside North Dakota's jurisdiction?			☐ Yes ☐ No
If yes, enter date of warrant:	State:	County:	
Have you or any member of your household been convicted of any crime for which jail or parole time remains to be served?			☐ Yes ☐ No
If yes, enter date of conviction:	State:	County:	
Have you or any member of your household been convicted of a felony, for an "act" committed after August 22, 1996, involving the possession, use, or distribution of a controlled substance?			☐ Yes ☐ No
If yes, enter date of conviction:	State:	County:	

DISQUALIFICATIONS:

Have you or any member of your household ever been disqualified from the Food Stamp Program? ☐ Yes ☐ No
If yes, complete the following:

NAME OF PERSON(S) DISQUALIFIED	WHERE DID IT HAPPEN? COUNTY	STATE	DATE DISQUALIFIED	LENGTH OF DISQUALIFICATION PERIOD? (Example, 6, 12, 24 months, or permanently)

EMPLOYMENT INFORMATION

Has any household member left a job within the last 60 days? ☐ Yes ☐ No

If yes, who:	When?	Employer:

Reason: ☐ Laid off ☐ Fired ☐ Refused work ☐ On leave of absence ☐ Injury ☐ Quit work ☐ On strike ☐ Illness ☐ Other (Specify)

EMPLOYMENT INFORMATION: (Continued)

Has any household member chose to reduce hours of employment?		☐Yes ☐No
If yes, who:	When?	Reason:
Is any household member unable to work?		☐Yes ☐No
If yes, who:		Reason:

EXPENSE INFORMATION

Does your household have any of the following expenses? Check yes or no for each item and list amounts.
Proof of expenses must be provided. You will not receive a deduction for any allowable expense you fail to report and verify.

CURRENT EXPENSES	YES	NO	TOTAL AMOUNT	AMOUNT YOU PAY
Rent/Mortgage (circle one)				
Lot Rent				
Do you pay separately for the use of a garage?				
Is anyone working off any part of the rent?				
Does any government agency pay any part of your rent?				
Property taxes (not included in mortgage)				
Homeowners insurance (not included in mortgage)				
Electricity				
Do you have an air conditioner?				
Are you responsible for air conditioning costs?				
Heating costs (gas/propane/electric, etc.)				
If you pay for heating or cooling, do you wish to use the Standard Utility Allowance?				
Do you receive or intend to apply for fuel assistance (LIHEAP)?				
Water/sewer/garbage				
Telephone				
Expenses for a home you don't live in				
Health insurance premiums (list only for persons age 60 or over or who receive disability benefits)				
Medical expenses (List only for persons age 60 or over or who receive disability benefits)				

Do you expect any changes in expenses next month?	☐Yes ☐No
If yes, explain:	
Does anyone help you pay these expenses?	☐Yes ☐No
If yes, list what expenses, who is paying, and how much is paid:	

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MEDICAID - PART 5

COMPLETE THIS SECTION IF APPLYING FOR MEDICAID - IF NOT APPLYING FOR MEDICAID GO TO PART 6

I/We have lived in North Dakota since: (Month, Day, Year)

Do you intend to remain in North Dakota? ☐ Yes ☐ No

If anyone in the household is a stepparent, indicate date of marriage:

Does anyone have medical problems due to an accident? ☐ Yes ☐ No

Date of accident:

Type of accident:

Does anyone in the household have a pending legal action from which they may receive money or medical benefits (including inheritance)? ☐ Yes ☐ No

Is any household member a veteran, a dependent or spouse of a veteran? ☐ Yes ☐ No

If yes, who:

MEDICAL EXPENSES

Does any household member have unpaid medical bills for any of the past 3 months for which you would like assistance? ☐ Yes ☐ No
If yes, **provide proof** of income, assets, and unpaid medical bills for each prior month requested.

Does anyone have unpaid medical bills older than 3 months? ☐ Yes ☐ No
If yes, **provide proof** of unpaid amounts that you owe, the date of service, the type of service, and the provider of the service.

Does anyone help pay your medical costs? ☐ Yes ☐ No

If yes, explain:

HEALTH INSURANCE

Has any household member turned down medical coverage from a current employer because of the cost? (Medicaid may be able to help pay the cost of this insurance) ☐ Yes ☐ No

Do you have Medicare? ☐ Yes ☐ No

Type of coverage (check all that apply) ☐ Part A ☐ Part B

Medicare number:

Does your spouse have Medicare? ☐ Yes ☐ No

Type of coverage (check all that apply) ☐ Part A ☐ Part B

Medicare number:

Is anyone covered by other health insurance? ☐ Yes ☐ No

If yes, complete the following:

Person(s) Covered	Policy Holder Name and Address	Health Insurance Name and Address	*Type of Coverage	Effective Date	Policy Number	Group Number	Monthly Premium

***Types of Coverage: (List all that apply)**

A - Hospital
B - Doctor
C - Major Medical/Lab/Xray
D - Dental
E - Vision
F - Nursing Home
G - Cancer
H - Champus/TriCare
I - HMO Insurance
J - Court Ordered
M - Medicare Supplement
N - Drug Insurance
P - Accident
P - Workers Compensation
V - Veterans

Does anyone outside the household pay the premium? ☐ Yes ☐ No

If yes, who:

Does anyone expect any changes in health insurance coverage? ☐ Yes ☐ No

If yes, explain:

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MEDICAID - PART 5a

COMPLETE PART 5a IF APPLYING FOR MEDICAL COVERAGE FOR FAMILIES WITH CHILDREN
IF THIS SECTION DOES NOT APPLY TO YOU, GO TO PART 7

ABSENT PARENT INFORMATION

You must answer the items in **bold text**. The remaining items are optional, however, the information would be helpful.

CHILD(REN)'S NAME	ABSENT PARENT(S)			
	FATHER		MOTHER	
	Name:		**Name:**	
	Address:		Address:	
	Social Security Number:		Social Security Number:	
	Date of Birth:		Date of Birth:	
	Reason for Absence:		**Reason for Absence:**	
	Paternity Established? ☐ **Yes** ☐ **No**			
	Employer:		Employer:	
	Court Order Number:	Where Filed:	Court Order Number:	Where Filed:
	Name:		**Name:**	
	Address:		Address:	
	Social Security Number:		Social Security Number:	
	Date of Birth:		Date of Birth:	
	Reason for Absence:		**Reason for Absence:**	
	Paternity Established? ☐ **Yes** ☐ **No**			
	Employer:		Employer:	
	Court Order Number:	Where Filed:	Court Order Number:	Where Filed:
	Name:		**Name:**	
	Address:		Address:	
	Social Security Number:		Social Security Number:	
	Date of Birth:		Date of Birth:	
	Reason for Absence:		**Reason for Absence:**	
	Paternity Established? ☐ **Yes** ☐ **No**			
	Employer:		Employer:	
	Court Order Number:	Where Filed:	Court Order Number:	Where Filed:
	Name:		**Name:**	
	Address:		Address:	
	Social Security Number:		Social Security Number:	
	Date of Birth:		Date of Birth:	
	Reason for Absence:		**Reason for Absence:**	
	Paternity Established? ☐ **Yes** ☐ **No**			
	Employer:		Employer:	
	Court Order Number:	Where Filed:	Court Order Number:	Where Filed:

MEDICAID - PART 5a (Continued)

NORTH DAKOTA HEALTH TRACKS

We encourage children and young people under the age of 21 who are eligible for Medicaid to participate in a free health program called North Dakota Health Tracks. This program emphasizes prevention and offers a comprehensive well-child examination.

List anyone under age 21 that you would like to receive the Health Tracks Screening:

Do you want someone to help you schedule a screening appointment? ☐Yes ☐No	Do you want someone to help you arrange transportation for a screening? ☐Yes ☐No

PRIMARY CARE PROVIDER

List the Primary Care Provider (doctor, clinic or HMO) for each person in the household. (Not needed for refugees, disabled persons, or anyone age 65 or older)

Household Member	Name of Provider	Household Member	Name of Provider

CHILD CARE ASSISTANCE - PART 6

COMPLETE THIS SECTION IF APPLYING FOR CHILD CARE ASSISTANCE
IF NOT APPLYING FOR CHILD CARE ASSISTANCE, GO TO PART 7

CHILD CARE

Reasons for needing child care: ☐ Employment ☐ Training/School (Provide class schedule) ☐ Other: ____________

Child(ren)'s Name	Child Care Provider's Name	Child Care Provider's Address

Before payment for child care assistance can be made, a provider must be:

- Licensed or self-certified with the State of North Dakota; or
- Licensed or self-certified with the States of Minnesota, South Dakota, or Montana if in a bordering city in one of those states; or
- Licensed or self-certified with a military base; or
- Registered with a tribe; or
- An approved relative

SIGNATURE AND AUTHORIZATION - PART 7

COMPLETE THIS SECTION IF APPLYING FOR MEDICAID OR FOOD STAMPS

INFORMATION AND REFERRAL

Information and referral services have been explained to me. My household is eligible, has been NOTIFIED and is authorized to receive information and referral. My household has been provided these brochures:

☐ TANF	☐ Civil Rights	☐ ND Health Tracks	☐ Fuel Assistance
☐ Medicaid	☐ Family Planning	☐ Emergency Services	☐ Healthy Steps
☐ Food Stamps	☐ Child Support	☐ Primary Care Provider Program	☐ Other ________
☐ Child Care Assistance	☐ WIC	☐ Medicaid Estate Recovery	________

PLEASE READ

- I have received, reviewed and understand the information contained in Part 1 of the application informing me of my rights and responsibilities.
- I understand that if I withhold information or give false information to obtain assistance, I could be fined, imprisoned, or both.
- The information provided by me on this application is correct and complete to the best of my knowledge.
- I agree to report to the County Social Service Office within **ten** (10) days any changes in income, assets, or living arrangements which may affect eligibility to receive Medicaid or Food Stamps.

AUTHORIZATION TO RELEASE INFORMATION

I/We authorize any person having custody or knowledge of the information relating to me or other household members to furnish any requested information, including confidential information, to any authorized agent of the North Dakota Department of Human Services. This release will remain valid until revoked in writing. A copy of this authorization is as valid as the original.

Signature of Applicant:	Date:
Other Signature: (spouse, guardian or other adult)	Date: