North Carolina Ryan White Pt.B/HMAP Recertification Self-Attestation

NC HMAP requires an update to your eligibility every six (6) months. Please answer all questions below and provide any required documents for changes in your income, insurance status or residency.

MAIL TO: NC Department of Health and Human Services, Division of Public Health
Purchase of Medical Care Services
1907 Mail Service Center
Raleigh, NC 27699-1907

Section 1: HMAP Sub-Program

Indicate the sub-program that existing clients are served by or choose a sub-program for applicants based on insurance status.

Select Only **ONE:**

☐ 1. UMAP (No Insurance/Underinsured) ☐ 2. SPAP (Medicare D)

☐ 3. ICAP (Qualified Health Plan (Marketplace) COPAY ONLY) ☐ 4. PCAP (Marketplace Insurance PREMIUM and COPAY)

Section 2: Applicant Information

If client has moved, please include a copy of driver's license with new residential address, utility bill, rental agreement, or other documentation of new address.

Last Name	First Name	MI

Date of Birth (MM/DD/YYYY)	Client Case Number	Telephone Number

Residential/Home Address	Apartment/Unit #

City	State	Zip Code	County	County Code
	NC			

Do you want mail sent to your residential address? ☐ 1. Yes ☐ 2. No. **Fill in preferred mailing address below.**

Mailing Address: _____City:_____ State:_____ Zip Code: _____

Section 3: Agency Information

Agency/Contact	Address	Phone

City	State	Zip Code	County

Section 4: Household Income Information

Follow these rules for household.

- If **you file taxes**, your household members are you, your spouse and anyone you claim as a dependent on your tax return.
- If you do **NOT file taxes** and **NO ONE CLAIMS YOU** as a dependent on their tax return, your household members are your spouse and your natural /legal/adopted children or stepchildren living in the same house as you.

If client income has changed since last recertification, please include appropriate documentation of a tax return form, paystubs, Social Security award letter, or other documentation to prove updated income.

☐ My household income has not changed

☐ My household income has changed since last recertification

☐ I have no household income

Section 5: Insurance Policy Information

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Has client insurance status changed since last recertification? ☐ No ☐ Yes

If yes, please indicate insurance type **AND** include copy of card:
☐ Medicaid
☐ Medicare Part D
☐ ACA/Federal Market Place *
☐ Private/Employer Insurance
*If client is seeking monthly premium assistance for any ACA Marketplace Plan, please include additionally a copy of premium invoice and proof the advance premium tax credit was applied in full via the Marketplace.

Section 6: Terms and Conditions for Applicant

I certify that the information I have provided is a true and complete statement of facts according to my best knowledge and belief. I understand that information provided may be checked by a state reviewer, and I agree to provide the financial records required to carry out this investigation. I also understand that my employer may be asked to verify information concerning my income.

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

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

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

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

I also authorize release of enrollment, eligibility and utilization records to my physicians, my case manager, other medical providers, the contracted pharmacy, Pharmacy Benefits Managers, third party administrators, health insurers or other service providers to facilitate program services.

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

I understand that I may appeal the denial of this financial eligibility application. Information on how to appeal the denial can be obtained by writing to Purchase of Medical Care Services, 1907 Mail Service Center, Raleigh NC 276991907. I understand that payment by the Department for health care provided to me is dependent upon me meeting all financial and medical requirements, timely submission of authorization requests and claims, and the availability of funds.

SECTION 7: Signatures

I hereby certify that I have read, or the interviewer has read to me the terms and conditions described within and that I agree to comply with them. I also certify that I have been provided an opportunity to ask the interviewer questions about these terms and conditions and that I understand the answers I was given.

Applicant's Signature	Relationship to Applicant	Current Date (MM/DD/YYYY)
_____	_____	_____

I certify that I have explained the terms and conditions contained within and have witnessed his/her signature.

Interviewer's Signature	Current Date (MM/DD/YYYY)
_____	_____