TITLE IV-E TITLE XIX APPLICATION-FOSTER CARE

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
FOSTER CARE
SFN 641 (9-2004)

Clear Fields

OFFICE USE ONLY
Date Received
Case Number

Name of Child			County
Address	City	State	Zip Code

The following brochures were given to the child's representative

☐ Health Tracks ☐ Foster Care Medicaid ☐ Family Planning ☐ Child Support Enforcement ☐ Civil Rights

1. HOUSEHOLD MEMBERS - List the child, child's parents and any siblings the child lived with prior to entering care.

Name	Relationship to Child in Care	Social Security Number	Date of Birth	Sex	Race*	Indian Enrollment Number	US Citizen?	Hispanic?	Resident of ND?
				☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
				☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
				☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
				☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
				☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

*** RACE CODES**

WH - White **AI** - American Indian or Alaskan Native **BL** - Black **AP** - Asian or Pacific Islander **HP** - Native Hawaiian/Pacific Island

Are either the child's father or mother disabled or unemployed/underemployed?

☐ No ☐ Yes - Complete Supplement to SFN 642, Attachment A.

Explain Disability

If the child did not live with the child's mother, where does the child's mother live?

If the child did not live with the child's father, where does the child's father live?

2. ASSETS

Does anyone listed above have any of the following: bank accounts, burial funds, trust accounts, individual Indian monies, stocks/bonds, property, vehicles, life insurance, or other assets?

☐ No ☐ Yes - list the household member, the type of asset, and the value of the assets in the space below

Household Member	Type of Asset	Value

3. UNEARNED INCOME

Does anyone listed above receive any unearned income such as: social security, SSI, individual Indian monies, child support, veterans, etc?

☐ No ☐ Yes - list the household member, the type of income, and the amount in the space below.

Household Member	Type of Income	Amount

4. EARNED INCOME

Is anyone listed in #1 on Page 1 employed?

☐ No ☐ Yes - list the household member, the name of the employer, the gross earnings, the frequency of pay, the number of hours worked per week, and child care costs if applicable in the space below.

Household Member	Name of Employer	Gross Earnings	How Often Paid	Hours Per Week	Child Care Costs

5. THIRD PARTY LIABILITY (TPL)

Does any household member have health insurance coverage?

☐ No ☐ Yes - Complete the following

Name of Company			Name of Group		
Address			Address		
City	State	Zip Code	City	State	Zip Code
Effective Date	Policy Number		Group Number		
Type of Coverage ☐ Hospital ☐ Dental ☐ Other (specify): ☐ Doctor ☐ Vision			Is the insurance a result of a court order? ☐ No ☐ Yes Persons Covered		
Name of Policy Holder			Monthly Premium		

6. HEALTH TRACKS

Does the child need screening services under Health Tracks? ☐ No ☐ Yes	Will the child need help in scheduling Health Tracks appointments? ☐ No ☐ Yes	Will the child need transportation to Health Track services? ☐ No ☐ Yes

CERTIFICATION OF CITIZENSHIP OR ALIEN STATUS

Congress amended the Immigration Reform and Control Act (Public Law 99-603) requiring that every person applying for Medicaid provide a declaration of citizenship or alien status; and that the county social service board verify with the Immigration and Naturalization Service the status of aliens seeking benefits.

All individuals for whom Medicaid is requested must provide proof of their United States citizenship to the county social service board. Each person who is not a citizen will need to show documentation from the Immigration and Naturalization Service (INS) as proof of immigration status. This proof will be verified by the county social service board through INS. Information received from INS may affect your child's eligibility. Failure to complete the certification below will result in denial of benefits.

Under penalty of perjury, I certify that:

☐ This dependent child is a United States citizen.

☐ This dependent child is an alien who is currently registered with the Immigration and Naturalization Service (INS) and legally authorized to be in the United States.

CONFIDENTIALITY STATEMENT
Federal and state laws and regulations limit the use and disclosure of confidential information concerning applicants and recipients of Medicaid programs to purposes directly relating to the administration of this program.

The Privacy Act of 1974 (P.L. 93-579, Section 7) requires the following information be provided when individuals are requested to disclose their social security numbers. Disclosure of the social security number is voluntary and it is requested for identification purposes. Failure to disclose this information will not affect participation in this program.

YOUR RIGHTS AND RESPONSIBILITIES
CHANGES - I understand the agency needs to know of certain changes in income, assets, persons entering or leaving my home, and address changes. I understand that I must report these changes to the agency within ten (10) days.

FAIR HEARINGS - I understand that if I disagree with a decision made regarding my case, I have the right to ask for a fair hearing. Should I wish to request a fair hearing, I can receive instructions on how to do so by contacting the county social service board.

HOME VISITS - I understand that a Department representative may make a scheduled home visit and may contact other people in order to verify my eligibility for assistance.

VERIFICATION - I understand that information may be verified by federal, state, or local officials, and that information may be submitted to the Immigration and Naturalization Service. I also understand that information I give will be verified by computer cross-matching with other agencies and private sectors. I understand that when federal and state personnel verify the information on this application, if what I reported is found to be incorrect, my child's Medicaid case may be denied or terminated, and I may be subject to criminal prosecution.

PENALTIES FOR FRAUD
Federal regulations require state Medicaid agencies to inform recipients of the federal penalties for fraud under Section 1090 of the Social Security Act.

SECTION 1909 OF THE SOCIAL SECURITY ACT; (Penalties)

(a) Whoever -

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefits or payment under a state plan approved under this title,

(2) at any time knowingly and willfully made or causes to be made any false statements or representation of a material fact for use in determining rights to such benefits or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $10,000 or imprisoned for not more than one year, or both.

ASSIGNMENT:

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.

ASSIGNMENT OF SUPPORT RIGHTS

Under North Dakota law, eligibility for foster care automatically creates an assignment of all support rights for the child named above to the North Dakota Department of Human Services. This assignment covers all support rights (accrued, present, pending and continuing) for all persons named above, whether arising from an order of a court, administrative agency or otherwise. This assignment will remain in effect until terminated by the North Dakota Department of Human Services, as assignee.

SIGNATURE

State and Federal law provide for fine, imprisonment, or both for any person guilty of obtaining assistance to which he is not entitled by willfully withholding or giving false information. I certify under penalty of perjury that the information given by me on this form is correct and complete to the best of my knowledge. I agree to inform the County Social Service Board within ten (10) days of changes in income, assets, number of persons in household, address or living arrangements which might affect my child's right to receive assistance. My signature on this form authorizes the use of social security number(s) for the use in administering any program for which I applied.

Signature	Telephone Number	Date

DATA FOR UNEMPLOYED PARENT PROGRAM

Name of Child	MOTHER	FATHER
Name of Parent		
Earnings in Last 24 Months		
Hours Worked — This Month		
Hours Worked — Last Month		
Hours Worked — Expected Next Month		
Provide work or full-time student history for the past five years. Count time spent in CWEP, JOBS or any other work and training program. Start with the most recent job or school attendance. List name and address of each employer or school and begin and end dates of employment or school attendance and indicate earnings during each period of time.		

Did anyone lose or refuse employment in 30 days prior to the child entering care?

☐ No ☐ Yes Who lost their job? Date Job was Lost:

Reason the Job was Lost

Has anyone quit a job in the last 30 days?

☐ No ☐ Yes Who quit their job?

Has anyone received unemployment during the last 12 months?

☐ No ☐ Yes Who received unemployment?