



North Carolina Health Insurance Risk Pool, Inc.
dba Inclusive Health
Inclusive Health Assist
Application for Premium Subsidy

Please mail or forward application to:

Inclusive Health Assist

P.O. Box 2302

Mt. Clemens, MI 48046-2302

www.inclusivehealth.org

If you are not a member of Inclusive Health, you must apply for and be approved by us in order to be eligible for Inclusive Health Assist. Please review the eligibility requirements prior to completing this application. We will consider your application once we have received all required information. You must use black or blue ink to complete this form. You must staple all required documents to the application. If you have questions while completing the application, please call 866-665-2117. **Do not fax your application.**

SECTION I:

If you are a current Inclusive Health member, you may be eligible for reduced Inclusive Health premiums and plan cost sharing. In order to qualify, your total household income, including income from any available Social Security benefit, must be at or below the following levels, which vary by the size of your household:

Household Size*	Inclusive Health Income Eligibility		Household Size*	Inclusive Health Income Eligibility	
	43% monthly premium discount	20% monthly premium discount		43% monthly premium discount	20% monthly premium discount
1	\$10,890 - \$21,779	\$21,780 - \$32,670	4	\$22,350 - \$45,059	\$45,060 - \$67,410
2	\$14,710 - \$29,419	\$29,420 - \$44,130	5	\$26,170 - \$52,339	\$52,340 - \$78,510
3	\$18,530 - \$37,059	\$37,060 - \$55,590	6	\$29,990 - \$59,979	\$59,980 - \$89,970

*Your household size is the total number of exemptions claimed on your tax return.
 For household size larger than 6, call Inclusive Health at 866-665-2117.

SECTION II:

Applicant Name: Last	First	Middle Initial	Date of Birth	Phone Number ()
Street Address	City	County	State	Zip Code
Email Address				
Social Security Number of Applicant			Name and Social Security Number of Head of Household	

1. Please list the total number of exemptions claimed on your 2010 tax return filed for your household: _____

2. Please list the total number of individuals currently in your household: _____

3. Please tell us about your yearly household income as reflected on your 2010 tax return. If you are married, your spouse lives in your household, and you did not file a joint tax return that year, complete columns A, B and C.

		A	B	C
		Your Return	Spouse's Return	Total
1	Enter your adjusted gross income (AGI) from Form 1040, line 38; Form 1040A, line 22; or Form 1040NR, line 37, figured without taking into account the amount from Form 1040, line 32; Form 1040A, line 17; or Form 1040NR, line 32	\$	\$	\$
2	Enter any student loan interest deduction from Form 1040, line 33; Form 1040A, line 18; or Form 1040NR, line 33	\$	\$	\$
3	Enter any tuition and fees deduction from Form 1040, line 34 or Form 1040A, line 19	\$	\$	\$
4	Enter any domestic production activities deduction from Form 1040, line 35, or Form 1040NR, line 34	\$	\$	\$
5	Enter any foreign earned income exclusion and/or housing exclusion from Form 2555, line 45, or Form 2555-EZ, line 18	\$	\$	\$
6	Enter any foreign housing deduction from Form 2555, line 50	\$	\$	\$
7	Enter any excludable savings bond interest from Form 8815, line 14	\$	\$	\$
8	Enter any excluded employer-provided adoption benefits from Form 8839, line 26	\$	\$	\$
9	Add lines 1 through 8 and list the "Total" amount for Column C here			\$
10	Please tell us what your yearly household income will be this year:			\$

The Inclusive Health Assist program is made possible by limited Federal grant funding. As a result, the program may be discontinued at any time. Participation is limited. You are not guaranteed acceptance into the program by applying. IH Assist recipients will be notified in writing of their acceptance into the program. For more information, visit www.inclusivehealth.org or to speak to a Customer Service representative, call (866) 665-2117.

SECTION III:

Required Documentation: If you are applying for the Inclusive Health Assist program, please attach copies of your 2010 Federal Income Tax Form 1040, 1040EZ, 1040A or 1040NR (excluding schedules and other attachments) and send to: Inclusive Health, P.O. Box 2302 Mt. Clemens, MI 48046-2302.

If your last year's household income was more than the amounts listed in Section I, but has either been reduced this year or if you did not file a tax return for last year, complete this application and provide, in addition to the information required in Section II, any of the following applicable proofs of income for the most recent three month period.

1. Copy of the two (2) most recent pay stubs, representing current household income, along with a signed statement explaining how often you receive a paycheck. If a pay stub is not available, get a signed statement from your employer that lists your gross monthly income and the dates received, or
2. For self employment or rental income, send your most recent three (3) months profit and loss statements, along with the Schedule C from last year's federal income tax return, or
3. If you have non-salary income such as disability or retirement including Social Security, send copies of Social Security award letters or bank statements showing direct deposits from disability or retirement.
4. If you are not employed, submit documentation of any other income such as the two (2) most recent unemployment or severance payments, along with a letter from your former employer or government agency listing the dollar amount and duration of this income.
5. If you receive alimony or child support, submit a copy of a check or signed statement from the recipient.
6. If you have income from interest, dividends, annuities, IRA distributions or capital gains, include statement from your investment firm or financial institution.

SECTION IV:

By my signature below, I agree to the following statements:

1. The foregoing statements and answers are completed, accurate and true to the best of my knowledge and belief;
2. My Inclusive Health Premium Subsidy will not be effective until the application and any required documentation are received and approved. If received by the 15th of the month, the first date that the premium subsidy can become effective is the first day of the month following approval by Inclusive Health.
3. I understand that any inaccurate, false, or fraudulent misstatements may lead to rescission of the premium subsidy as of the original issue date.
4. By signing this application, I hereby consent to the release of tax return information to Inclusive Health from the North Carolina Department of Revenue or the Internal Revenue Service for the sole purpose of verifying income requirements for purposes of Inclusive Health Assist eligibility.
5. I understand that the information provided on this application is considered confidential and is solely for the use of Inclusive Health and its designated representatives for the purposes of eligibility, payment, treatment, and health care considerations (including care coordination and quality assurance). I understand that information obtained will remain subject to the protections of the Health Insurance Portability and Accountability Act's standards and practices.
6. I understand that this release is valid for 30 months from the date of signature. I understand that I am entitled to receive a copy of this release and that I may revoke this authorization by providing written notice to Inclusive Health or CoreSource. I understand that if I revoke this authorization, it may affect my enrollment.
7. I understand that Inclusive Health Assist is not an entitlement and can be discontinued at any time.

Signature of Applicant: X _____

Signature of Parent or Legal Guardian: X _____
(on behalf of a minor or legally incompetent)

Date: _____

Please make sure that all information requested is complete. Any applications that are incomplete will not be processed and will be returned for additional information.