

M-AF Application – (Supplement 2)

Use for Parent/Caretaker of Child Under 19, Children age 19 or 20, or Children Ineligible for MIC/NC Health Choice.

First	NAME MI	Last	DATE OF BIRTH

RESOURCES (PARENT(S), CHILDREN AGE 19 OR 20, CHILDREN INELIGIBLE FOR MIC)

DO YOU HAVE ANY OF THE FOLLOWING? YES NO

SOURCE	YES	NO	WHOSE / WHERE LOCATED?	VALUE	VERIFICATION
CASH					
CHECKING					
SAVINGS					
CD'S					
STOCKS/BONDS					
FARM/BUSINESS EQUIPMENT					
PERSONAL PROPERTY (i.e. Boats, Campers, etc.)					
OTHER					

MOTOR VEHICLES - YES NO

MAKE	MODEL	YEAR	OWNER	VALUE	VERIFICATION

Tax Office Checked _____ Tax Year _____

LIFE INSURANCE YES NO

OWNER OF POLICY	POLICY NUMBER	NAME OF INSURANCE CO	FACE VALUE	CASH VALUE	NAME OF INSURED

(Use page 4 for additional documentation and work space)

Total Resources

\$ _____

F/C/ BUDGET SHEET

MAF-C / 27.5%

MAF-N, M / MIC

MONTHLY GROSS EARNED INCOME		\$ _____
EITC DEDUCTIONS	(-)	\$ _____
TOTAL	=	\$ _____
X 27.5%	=	_____ (-) \$ _____
TOTAL NET EARNED		\$ _____

CHILD/ALIMONY SUPPORT		\$ _____
DISREGARD	(-)	\$ _____
COUNTABLE SUPPORT	=	\$ _____
ALL OTHER UNEARNED	(+)	\$ _____
TOTAL NET UNEARNED	=	\$ _____

TOTAL EARNED + UNEARNED	=	\$ _____
SUPPORT/ALIMONY PAID BY B.U. MEMBER	(-)	\$ _____
(COURT ORDERED)		
INCOME DEEMED TO WORK FIRST CASE	(-)	\$ _____
TOTAL COUNTABLE INCOME	=	\$ _____

# IN NEEDS UNIT	=	_____
MAF – CN INCOME LEVEL	=	_____
Note: If ineligible using the 27.5% deduction and the \$90 and child/adult deductions are a higher income deduction, complete a second budget . (See budget for MAF-N, M and MIC in next column.		

MONTHLY GROSS EARNED INCOME		\$ _____
EITC DEDUCTIONS	(-)	\$ _____
TOTAL	=	\$ _____
WORK RELATED EXPENSE	(-)	\$ 90.00
CHILD/ADULT CARE	(-)	\$ _____
TOTAL NET EARNED		\$ _____

CHILD/ALIMONY SUPPORT		\$ _____
DISREGARD	(-)	\$ _____
COUNTABLE SUPPORT	=	\$ _____
ANY OTHER UNEARNED	(+)	\$ _____
TOTAL NET UNEARNED	=	\$ _____

TOTAL EARNED + UNEARNED	=	\$ _____
SUPPORT/ALIMONY PAID BY B.U. MEMBER	(-)	\$ _____
(COURT ORDERED)		
INCOME DEEMED TO WORK FIRST	(-)	\$ _____
TOTAL COUNTABLE INCOME	=	\$ _____

# IN NEEDS UNIT	=	_____
MAF/ MIC INCOME LEVEL	=	_____
➤ IF OVER FOR MAF-C , (complete separate budget for Children (MIC), and deductible amt. for adults).		
Total Countable Income		\$ _____
MN Income Level	(-)	_____
Excess	=	\$ _____
X Month(s)		_____

KINSHIP

	KINSHIP	*LIVING WITH	*This factor does not have to be verified for infant during the post partum period.
A.U. NO	Relationship to Casehead	Does the child live with the Specified Relative? **If yes, Enter Name and Relationship of Specified Relative Below.	Verification - Date and Method
1		<input type="checkbox"/> Yes <input type="checkbox"/> No _____	
2		<input type="checkbox"/> Yes <input type="checkbox"/> No _____	
3		<input type="checkbox"/> Yes <input type="checkbox"/> No _____	
4		<input type="checkbox"/> Yes <input type="checkbox"/> No _____	
5		<input type="checkbox"/> Yes <input type="checkbox"/> No _____	

****SHOW RELATIONSHIP OF SPECIFIED RELATIVE IF NOT PARENT:**

Name: _____

Relationship:

CHILD SUPPORT REQUIREMENTS

<p>Does the caretaker who is applying for herself have good cause for non-cooperation? (Review DSS-8104, if appropriate)</p> <p><input type="checkbox"/> YES, give date and verification below</p> <p><input type="checkbox"/> NO, give date and verification below</p> <p>_____</p> <p>_____</p>

NOTE: Refer to IV-D a pregnant woman who is ineligible for MPW and is receiving Medicaid under MAF when she is receiving assistance for children other than the unborn. Do not refer her to IV-D if there are no other children receiving Medicaid.

The information contained above and on the Medicaid/NCHC application is an accurate report of my income and resources.

Applicant

Date

WORKSPACE/DOCUMENTATION: