

**North Carolina Department of Health and Human Services
Division of Social Services
State Abortion Fund Eligibility Certification**

Date DSS-6847 Signed: ____/____/____ Client Name: _____
Mo Day Yr First MI Last

SIS ID# _____ DOB: ____/____/____

Social Worker: _____ County Name: _____ County #: _____

Instructions: Complete Sections I and II for **all** clients. In order to be eligible for the State Abortion Fund, a client must be a resident of North Carolina, be eligible for Health Support Services, have an income below the federal poverty level as revised annually, and **not** be eligible for Medicaid.

I. Basic Eligibility Criteria: (CHECK ONE)

- ____ A. Eligible on the basis of Income
____ B. Income Eligible Minor (under 18 years of age)

II. Specific Eligibility Criteria: (CHECK ONE)

- ____ A. Victim of rape or incest as documented in the case record
____ B. Client's life would be endangered if pregnancy continued, based on one physician's written statement that is filed in the case record. Written statement was provided by at least one physician licensed to practice medicine in North Carolina.

Worker Signature: _____ Date: _____

Distribution: Division of Social Services, Family Support and Child Welfare Services
County Case File (original)

INSTRUCTIONS FOR COMPLETING FORM

Complete Two (2) copies of the form in accordance with the instructions on the front of the form.

1. The “Date DSS-6847 Signed” is to be the date the Director or his designee signs the DSS-6847 form. It will be the same date or later than the date of the DSS-6211 and the DSS-6212 forms because authorization of funds cannot be done prior to the required counseling and the determination of eligibility.
2. Review Sections I and II to make sure that there is one, and only one, item checked in each of the Sections. In Section I, check the appropriate criteria for basic eligibility. Check only item B if the client is a minor. In Section II, check item 1 or 2 as appropriate.