## APPLICATION FOR TEMPORARY MEDICAID FOR HURRICANE EVACUEES

## **Contact Information in North Carolina:**

Name:	
First Middle Las	
Who are you living with while in North Carolina?	
	(Name)
(Address, City, State, Zip)	(Telephone Number)
I hereby certify that I am a victim of a federally dec	lared disaster area in
	as a result of Hurricanes Katrina or Rita.
(City, County/Parish & State of Disaster)	
reby certify that I and the persons listed on the application	on for whom I am applying, are currently receivin
	on for whom I am applying, are currently receivin
reby certify that I and the persons listed on the application licaid benefits in	
licaid benefits in	dicaid ID Number)
licaid benefits in (City & State of Disaster) (Med	dicaid ID Number)
licaid benefits in (City & State of Disaster) (Med OR	dicaid ID Number)

My Address in Disaster Area\_\_\_\_\_

(Street Address)

(City, State, Zip)

I understand that my eligibility to receive Medicaid in North Carolina is temporary and may be terminated anytime at the sole discretion of the state.

Have you applied to receive services from the Federal Emergency Management Agency (FEMA)?

(Yes/No)

Signature of Applicant or Legal Guardian

Date