Family Connection
SOUTH CAROLINA

Attached is the application for TEFRA/Katie Beckett Medicaid Coverage and a cover letter from the South Carolina Department of Health and Human Services (state Medicaid agency) providing information on the TEFRA process.

Be sure to include items listed on the TEFRA Application Checklist with your completed application and mail to:

South Carolina Department of Health and Human Services
Division of Central Eligibility Processing, ATTN: TEFRA
PO Box 100101
Columbia, SC 29202-3101

Interested in talking to another parent who has completed this application who has TEFRA for their child? Want to connect with another parent who has a child with special needs? Please contact Family Connection of South Carolina at 1-800-578-8750 or info@FamilyConnectionSC.org.

TEFRA Application Checklist

Including the following information when you apply may help DHHS in processing your application. Be sure to include these items when you submit the application. Please call the Family Connection office at 1-800-578-8750 with questions.

- ☐ **Application Form – 3400 Healthy Connections Application** This form must be filled out to apply for Medicaid.
- ☐ **3400-A Additional Information for Select Medicaid Programs** Check "TEFRA" in the options at the top of the form. Also, note that when applying for TEFRA, you only need to give information about the applicant's (child's) income and resources.
- ☐ **FM 3218-D ME- Disability Application, Child Under Age 19** It is important to fill out each blank, even to indicate not applicable (N/A).
- ☐ **FM 3218-F ME-Disability Cover Letter and FM 3218-H ME Childhood Application Checklist** These forms offer additional information about details to be included with the Disability Application. **NOTE:** While the Disability Cover Letter says to send the Disability Application to S.C. Vocational Rehabilitation Department, you can submit your entire TEFRA application (including the Disability Application) to DHHS in the ways listed at the bottom of this page. There is not a timeframe for completing the Disability Application when it is completed as part of the TEFRA application.
- ☐ **FM 921-Authorization to Disclose Health Information** Please complete the bottom portion of this form.
- ☐ **FM 3291 ME-TEFRA In-Home Care Certification** Your child's physician must complete this form.
- ☐ **SC Department of Disabilities and Special Needs Permission to Evaluate TEFRA Application Form** Sign and return this form.
- ☐ Copies of any recent medical records (within the last 15 months) you may have regarding your child's health. These are not mandatory but may help speed up the application process.
- ☐ Copies of recent IEP and School Psychological Evaluation for school-age children
- ☐ Proof of any income that your child receives, such as child support or Social Security
- ☐ Proof of any resources available to your child such as bank accounts, savings bonds, trust accounts, life insurance policies, etc.
- ☐ Copies of any health insurance card, front and back, showing that your child is covered. This does not affect Medicaid eligibility. DHHS needs a record of other insurance.
- ☐ Proof of citizenship and identity may be required. DHHS may be able to confirm citizenship and identity without you providing documentation. However, at times they may require you to provide proof. You can provide this information when submitting your application or wait to see if they request it. Note original documents are required when providing proof of citizenship and identity.

You can submit your application by:

1. Taking it to your local DHHS office. To locate your local office call Family Connection at 1-800-578-8750 or visit https://www.scdhhs.gov/site-page/dhhs-county-offices.
2. Mailing it to:
   South Carolina Partners for Health Medicaid
   Division of Central Eligibility Processing
   Post Office Box 100101
   Columbia, SC 29202-3101

Healthy Connections

South Carolina Department of Health and Human Services

Application for Medicaid and Affordable Health Coverage

things to know

Use this application to see what coverage choices you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well.
- A new tax credit that can immediately help pay your premium for health coverage.
- Free or low-cost insurance from Medicaid or the Children's Health Insurance Program (CHIP).

You may qualify for a free or low-cost program even if you earn as much as $94,000 a year (for a family of 4).

Who can use this application?

- Use this application to apply for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- If you're single, you may be able to use a short form. Visit HealthCare.gov.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete the Authorized Representative Form (1282), which can be downloaded at SCDHHS.gov.

Apply faster online

- Apply faster online at SCDHHS.gov or HealthCare.gov.

What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants who need insurance)
- Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and how to get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.** To view the Privacy Act Statement, go to https://www.SCDHHS.gov/internet/pdf/SCDHHSNoticeofPrivacyPractices080107.pdf.

What happens next?

Send your complete, signed application to the address on page 12.
If you don't have all the information we ask for, sign and submit your application anyway. We'll follow-up with you within 1–2 weeks. You'll get instructions on the next steps to complete your application for health coverage. If you don't hear from us, visit SCDHHS.gov or call 1-888-549-0820.
Filling out this application doesn't mean you have to buy health coverage.

Get help with this application

- **Online:** SCDHHS.gov
- **Phone:** Call our Help Center at **1-888-549-0820**.
- **In person:** There may be counselors in your area who can help. **Visit our website** or call **1-888-549-0820** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-888-549-0820**.

NEED HELP WITH YOUR APPLICATION? Visit SCDHHS.gov or call us at **1-888-549-0820**. Para obtener una copia de este formulario en Español, llame **1-888-549-0820**. If you need help in a language other than English, call **1-888-549-0820** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-753-8583**.

STEP 1 Tell us about yourself.

We need one adult in the family to be the contact person for your application.

1. First name, Middle name, Last name and Suffix

2. Home address (Leave blank if you don't have one.) | 3. Apartment or suite number

4. City | 5. State | 6. ZIP code | 7. County

8. Mailing address (if different from home address) | 9. Apartment or suite number

10. City | 11. State | 12. ZIP code | 13. County

14. Phone number | 15. Other phone number

16. Do you want to get information about this application by email? ☐ Yes ☐ No

Email address: _____

17. What is your preferred spoken or written language (if not English)?

Is someone helping you fill out this application?

Complete the following section if you are filling out this form on behalf of the applicant (the person listed in **STEP 1**).

1. Application start date (mm/dd/yyyy)

2. First name, Middle name, Last name, & Suffix

3. Organization Name (if applicable) | 4. ID Number (if applicable)

STEP 2 Tell us about your family.

Who do you need to include on this application?
Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage.)

DO include:
- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

You DON'T have to include:
- Your unmarried partner who doesn't need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

Complete Step 2 for each person in your family.

Start with yourself, then add other adults and children. If you have more than 4 people in your family, you'll need to make a copy of the pages and attach them. You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.

NEED HELP WITH YOUR APPLICATION? Visit SCDHHS.gov or call us at **1-888-549-0820**. Para obtener una copia de este formulario en Español, llame **1-888-549-0820**. If you need help in a language other than English, call **1-888-549-0820** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-753-8583**.

STEP 2: PERSON 1 (Start with yourself)

Complete Step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 2 for more information about whom to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix _____ 2. Relationship to you? **SELF**

3. Date of birth (mm/dd/yyyy) _____ 4. Sex: ☐ Male ☐ Female 5. Social Security number (SSN) _____

We need this if you want health coverage and have an SSN. Providing your SSN can be helpful if you don't want health coverage since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit **socialsecurity.gov**. TTY users should call 1-800-325-0778.

6. **Do you plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ YES. If yes, please answer questions a–c. ☐ NO. If no, SKIP to question c.

a. Will you file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

b. Will you claim any dependents on your tax return? ☐ Yes ☐ No

If yes, list name(s) of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____

How are you related to the tax filer? _____

7. Are you pregnant or recently pregnant? ☐ Yes ☐ No If yes, a. How many babies are expected? _____ b. What is your due date? _____

c. If recently pregnant, enter the date the pregnancy ended: _____

d. Were you enrolled in Medicaid on the last day of pregnancy? ☐ Yes ☐ No

8. **Do you need health coverage?** *(Even if you have insurance, there might be a program with better coverage or lower costs.)*

☐ YES. If yes, answer all the questions below. ☐ NO. If no, SKIP to the income questions on page 4. Leave the rest of this page blank.

9. Do you have a disabling physical, mental, or emotional health condition that causes limitations in activities? ☐ Yes ☐ No

10. Do you need to live in a medical facility or nursing home or need nursing services at home? ☐ Yes ☐ No

11. Are you receiving treatment for any of the following? ☐ Yes ☐ No
• Breast Cancer • Cervical Cancer • Atypical Breast Hyperplasia • Precancerous Cervical Lesion (CIN 2/3)

12. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No

13. **If you aren't a U.S. citizen or U.S. national, do you have eligible immigration status?** ☐ Yes ☐ No
If YES, fill in your document type and ID number below.

a. Immigration document type: _____ b. Document ID number: _____

c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No

d. Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

14. Do you want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

If YES, enter your total monthly income for the last 3 months. Last Month: $_____ 2 Months Ago: $_____ 3 Months Ago: $_____

15. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? ☐ Yes ☐ No

16. Are you a full-time student? ☐ Yes ☐ No

17. Were you in foster care in South Carolina at age 18 or older? ☐ Yes ☐ No

18. Are you currently living in a foster home? ☐ Yes ☐ No

19. Are you currently living in a DJJ group home? ☐ Yes ☐ No

20. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply)**

☐ Mexican ☐ Mexican-American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other: _____

21. **Race (OPTIONAL—check all that apply)**

☐ White
☐ Black/African-American
☐ American Indian or Alaska native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander
☐ Other: _____

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STEP 2: PERSON 1 (Continue with yourself)

Current job & income information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 22.

☐ **Not Employed**
SKIP to question 34.

☐ **Self-Employed**
SKIP to question 33.

CURRENT JOB 1:

22. Employer name and address _____

23. Employer phone number _____

24. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____ 25. Average hours worked each week _____ 26. Start date _____

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper)

27. Employer name and address _____

28. Employer phone number _____

29. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____ 30. Average hours worked each week _____ 31. Start date _____

32. **In the past year, did you:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

33. **If self-employed, answer the following questions:**
a. Type of work _____

b. How much net income (profits once business expenses are paid will you get from this self-employment this month?)
$ _____

34. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.
NOTE: You don't need to tell us about child support, veteran's payments or Supplemental Security Income (SSI).

☐ None

☐ Unemployment $ _____ How often? _____
☐ Pensions $ _____ How often? _____
☐ Social Security $ _____ How often? _____
☐ Retirement acc'ts $ _____ How often? _____
☐ Alimony received $ _____ How often? _____

☐ Net farming/fishing: $ _____ How often? _____
☐ Net rental/royalty: $ _____ How often? _____
☐ Other income:
☐ Type: _____ $ _____ How often? _____
☐ Type: _____ $ _____ How often? _____

35. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.
If PERSON 1 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.
NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 33b).

☐ Alimony paid $ _____ How often? _____
☐ Student loan interest $ _____ How often? _____

☐ Other deductions: $ _____ How often? _____
Type: _____

36. **YEARLY INCOME:** **Complete only if PERSON 1's income changes from month to month. If you don't expect changes to PERSON 1's monthly income, add another person on the following pages.**

PERSON 1's total income this year
$ _____

PERSON 1's total income next year (if you think it will be different)
$ _____

THANKS! This is all we need to know about you.

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STEP 2: PERSON 2

Complete Step 2 for your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 2 for more information about whom to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix

2. Relationship to you?

3. Date of birth (mm/dd/yyyy)

4. Sex: ☐ Male ☐ Female

5. Social Security number (SSN)

We need this if PERSON 2 wants health coverage and has an SSN.

6. Does PERSON 2 live at the same address as you? ☐ Yes ☐ No

If no, list address:

7. **Does PERSON 2 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ YES. If yes, please answer questions a–c. ☐ NO. If no, SKIP to question c.

a. Will PERSON 2 file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse:

b. Will PERSON 2 claim any dependents on your tax return? ☐ Yes ☐ No

If yes, list name(s) of dependents:

c. Will PERSON 2 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer:

How is PERSON 2 related to the tax filer?

8. Are you pregnant or recently pregnant? ☐ Yes ☐ No If yes, a. How many babies are expected? _____ b. What is your due date? _____

c. If recently pregnant, enter the date the pregnancy ended: _____

d. Were you enrolled in Medicaid on the last day of pregnancy? ☐ Yes ☐ No

9. **Does PERSON 2 need health coverage?** *(Even if you have insurance, there might be a program with better coverage or lower costs.)*

☐ YES. If yes, answer questions 10-22 below. ☐ NO. If no, SKIP to the income questions on page 6. Leave the rest of this page blank.

10. Does PERSON 2 have a disabling physical/mental/emotional health condition that causes limitations in activities? ☐ Yes ☐ No

11. Does PERSON 2 need to live in a medical facility or nursing home or need nursing services at home? ☐ Yes ☐ No

12. Is PERSON 2 receiving treatment for any of the following? ☐ Yes ☐ No
• Breast Cancer • Cervical Cancer • Atypical Breast Hyperplasia • Precancerous Cervical Lesion (CIN 2/3)

13. Is PERSON 2 a U.S. citizen or U.S. national? ☐ Yes ☐ No

14. **If PERSON 2 isn't a U.S. citizen or U.S. national, does PERSON 2 have eligible immigration status?** ☐ Yes ☐ No
If YES, fill in PERSON 2's document type and ID number below.

a. Immigration document type: b. Document ID number:

c. Has PERSON 2 lived in the U.S. since 1996? ☐ Yes ☐ No

d. Is PERSON 2, their spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

15. Does PERSON 2 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

If YES, enter your total monthly income for the last 3 months. Last Month: $_____ 2 Months Ago: $_____ 3 Months Ago: $_____

16. Does PERSON 2 live with at least one child under 19, and is PERSON 2 the main person taking care of this child? ☐ Yes ☐ No

17. Is PERSON 2 a full-time student? ☐ Yes ☐ No

18. Was PERSON 2 in foster care in South Carolina at age 18 or older? ☐ Yes ☐ No

19. Is PERSON 2 currently living in a foster home? ☐ Yes ☐ No

20. Is PERSON 2 currently living in a DJJ group home? ☐ Yes ☐ No

21. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply)**

☐ Mexican ☐ Mexican-American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other:

22. **Race (OPTIONAL—check all that apply)**

☐ White ☐ American Indian or Alaska native ☐ Filipino ☐ Vietnamese ☐ Guamanian or Chamorro
☐ Black/African-American ☐ Asian Indian ☐ Japanese ☐ Other Asian ☐ Samoan
☐ Korean ☐ Native Hawaiian ☐ Other Pacific Islander
☐ Chinese ☐ Other:

Now, tell us about any income from PERSON 2 on the next page.

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STEP 2: PERSON 2

Current job & income information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 23.

☐ **Not Employed**
SKIP to question 35.

☐ **Self-Employed**
SKIP to question 34.

CURRENT JOB 1:

23. Employer name and address _____

24. Employer phone number _____

25. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____ 26. Average hours worked each week _____ 27. Start date _____

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper)

28. Employer name and address _____

29. Employer phone number _____

30. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____ 31. Average hours worked each week _____ 32. Start date _____

33. **In the past year, did PERSON 2:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

34. **If self-employed, answer the following questions:**
a. Type of work _____

b. How much net income (profits once business expenses are paid will you get from this employment this month?)
$ _____

35. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often PERSON 2 gets it.
NOTE: You don't need to tell us about child support, veteran's payments or Supplemental Security Income (SSI).

☐ None

☐ Unemployment $ _____ How often? _____
☐ Pensions $ _____ How often? _____
☐ Social Security $ _____ How often? _____
☐ Retirement acc'ts $ _____ How often? _____
☐ Alimony received $ _____ How often? _____

☐ Net farming/fishing: $ _____ How often? _____
☐ Net rental/royalty: $ _____ How often? _____
☐ Other income:
☐ Type: _____ $ _____ How often? _____
☐ Type: _____ $ _____ How often? _____

36. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.
If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.
NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 34b).

☐ Alimony paid $ _____ How often? _____
☐ Student loan interest $ _____ How often? _____

☐ Other deductions: $ _____ How often? _____
Type: _____

37. **YEARLY INCOME: Complete only if PERSON 2's income changes from month to month. If you don't expect changes to PERSON 2's monthly income, add another person on the following pages.**

PERSON 2's total income this year
$ _____

PERSON 2's total income next year (if you think it will be different)
$ _____

THANKS! This is all we need to know about PERSON 2.

Go to the next page to provide information about PERSON 3 if necessary.

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STEP 2: PERSON 3

Complete Step 2 for your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 2 for more information about whom to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix

2. Relationship to you?

3. Date of birth (mm/dd/yyyy)

4. Sex: ☐ Male ☐ Female

5. Social Security number (SSN)

We need this if PERSON 3 wants health coverage and has an SSN.

6. Does PERSON 3 live at the same address as you? ☐ Yes ☐ No

If no, list address: _____

7. **Does PERSON 3 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ YES. If yes, please answer questions a–c. ☐ NO. If no, SKIP to question c.

a. Will PERSON 3 file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

b. Will PERSON 3 claim any dependents on your tax return? ☐ Yes ☐ No

If yes, list name(s) of dependents: _____

c. Will PERSON 3 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____

How is PERSON 3 related to the tax filer? _____

8. Are you pregnant or recently pregnant? ☐ Yes ☐ No If yes, a. How many babies are expected? _____ b. What is your due date? _____

c. If recently pregnant, enter the date the pregnancy ended: _____

d. Were you enrolled in Medicaid on the last day of pregnancy? ☐ Yes ☐ No

9. **Does PERSON 3 need health coverage?** *(Even if you have insurance, there might be a program with better coverage or lower costs.)*

☐ YES. If yes, answer questions 10-22 below. ☐ NO. If no, SKIP to the income questions on page 8. Leave the rest of this page blank.

10. Does PERSON 3 have a disabling physical/mental/emotional health condition that causes limitations in activities? ☐ Yes ☐ No
11. Does PERSON 3 need to live in a medical facility or nursing home or need nursing services at home? ☐ Yes ☐ No
12. Is PERSON 3 receiving treatment for any of the following? ☐ Yes ☐ No
    • Breast Cancer • Cervical Cancer • Atypical Breast Hyperplasia • Precancerous Cervical Lesion (CIN 2/3)
13. Is PERSON 3 a U.S. citizen or U.S. national? ☐ Yes ☐ No
14. **If PERSON 3 isn't a U.S. citizen or U.S. national, does PERSON 2 have eligible immigration status?** ☐ Yes ☐ No
    If YES, fill in PERSON 3's document type and ID number below.

    a. Immigration document type: _____ b. Document ID number: _____

    c. Has PERSON 3 lived in the U.S. since 1996? ☐ Yes ☐ No

    d. Is PERSON 3, their spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

15. Does PERSON 3 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

    If YES, enter your total monthly income for the last 3 months. Last Month: $_____ 2 Months Ago: $_____ 3 Months Ago: $_____

16. Does PERSON 3 live with at least one child under 19, and is PERSON 3 the main person taking care of this child? ☐ Yes ☐ No
17. Is PERSON 3 a full-time student? ☐ Yes ☐ No
18. Was PERSON 3 in foster care in South Carolina at age 18 or older? ☐ Yes ☐ No
19. Is PERSON 3 currently living in a foster home? ☐ Yes ☐ No
20. Is PERSON 3 currently living in a DJJ group home? ☐ Yes ☐ No
21. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply)**

☐ Mexican ☐ Mexican-American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other: _____

22. **Race (OPTIONAL—check all that apply)**

☐ White	☐ American Indian or Alaska native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black/African-American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
☐ Chinese	☐ Other: _____	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander

Now, tell us about any income from PERSON 3 on the next page.

NEED HELP WITH YOUR APPLICATION? Visit SCDHHS.gov or call us at **1-888-549-0820**. Para obtener una copia de este formulario en Español, llame **1-888-549-0820**. If you need help in a language other than English, call **1-888-549-0820** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-753-8583**.

STEP 2: PERSON 3

Current job & income information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 23.

☐ **Not Employed**
SKIP to question 35.

☐ **Self-Employed**
SKIP to question 34.

CURRENT JOB 1:

23. Employer name and address _____

24. Employer phone number _____

25. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____ 26. Average hours worked each week _____ 27. Start date _____

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper)

28. Employer name and address _____

29. Employer phone number _____

30. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____ 31. Average hours worked each week _____ 32. Start date _____

33. **In the past year, did PERSON 3:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

34. **If self-employed, answer the following questions:**
a. Type of work _____

b. How much net income (profits once business expenses are paid will you get from this self-employment this month?)
$ _____

35. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often PERSON 3 gets it.
NOTE: You don't need to tell us about child support, veteran's payments or Supplemental Security Income (SSI).

☐ None

☐ Unemployment $ _____ How often? _____
☐ Pensions $ _____ How often? _____
☐ Social Security $ _____ How often? _____
☐ Retirement acc'ts $ _____ How often? _____
☐ Alimony received $ _____ How often? _____
☐ Net farming/fishing: $ _____ How often? _____
☐ Net rental/royalty: $ _____ How often? _____
☐ Other income:
☐ Type: _____ $ _____ How often? _____
☐ Type: _____ $ _____ How often? _____

36. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.
If PERSON 3 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.
NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 34b).

☐ Alimony paid $ _____ How often? _____
☐ Student loan interest $ _____ How often? _____
☐ Other deductions: $ _____ How often? _____
Type: _____

37. **YEARLY INCOME: Complete only if PERSON 3's income changes from month to month.**
If you don't expect changes to PERSON 3's monthly income, add another person on the following pages.

PERSON 3's total income this year
$ _____

PERSON 3's total income next year (if you think it will be different)
$ _____

THANKS! This is all we need to know about PERSON 3.

Go to the next page to provide information about PERSON 4 if necessary.

NEED HELP WITH YOUR APPLICATION? Visit SCDHHS.gov or call us at **1-888-549-0820**. Para obtener una copia de este formulario en Español, llame **1-888-549-0820**. If you need help in a language other than English, call **1-888-549-0820** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-753-8583**.

STEP 2: PERSON 4

Complete Step 2 for your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 2 for more information about whom to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix

2. Relationship to you?

3. Date of birth (mm/dd/yyyy)

4. Sex: ☐ Male ☐ Female

5. Social Security number (SSN)

We need this if PERSON 4 wants health coverage and has an SSN.

6. Does PERSON 4 live at the same address as you? ☐ Yes ☐ No

If no, list address: _____

7. **Does PERSON 4 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ YES. If yes, please answer questions a–c. ☐ NO. If no, SKIP to question c.

a. Will PERSON 4 file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

b. Will PERSON 4 claim any dependents on your tax return? ☐ Yes ☐ No

If yes, list name(s) of dependents: _____

c. Will PERSON 4 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____

How is PERSON 4 related to the tax filer? _____

8. Are you pregnant or recently pregnant? ☐ Yes ☐ No If yes, a. How many babies are expected? _____ b. What is your due date? _____

c. If recently pregnant, enter the date the pregnancy ended: _____

d. Were you enrolled in Medicaid on the last day of pregnancy? ☐ Yes ☐ No

9. **Does PERSON 4 need health coverage?** *(Even if you have insurance, there might be a program with better coverage or lower costs.)*

☐ YES. If yes, answer questions 10-22 below. ☐ NO. If no, SKIP to the income questions on page 10. Leave the rest of this page blank.

10. Does PERSON 4 have a disabling physical/mental/emotional health condition that causes limitations in activities? ☐ Yes ☐ No

11. Does PERSON 4 need to live in a medical facility or nursing home or need nursing services at home? ☐ Yes ☐ No

12. Is PERSON 4 receiving treatment for any of the following? ☐ Yes ☐ No
• Breast Cancer • Cervical Cancer • Atypical Breast Hyperplasia • Precancerous Cervical Lesion (CIN 2/3)

13. Is PERSON 4 a U.S. citizen or U.S. national? ☐ Yes ☐ No

14. **If PERSON 4 isn't a U.S. citizen or U.S. national, does PERSON 4 have eligible immigration status?** ☐ Yes ☐ No
If YES, fill in PERSON 4's document type and ID number below.

a. Immigration document type: _____ b. Document ID number: _____

c. Has PERSON 4 lived in the U.S. since 1996? ☐ Yes ☐ No

d. Is PERSON 4, their spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

15. Does PERSON 4 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

If YES, enter your total monthly income for the last 3 months. Last Month: $_____ 2 Months Ago: $_____ 3 Months Ago: $_____

16. Does PERSON 4 live with at least one child under 19, and is PERSON 4 the main person taking care of this child? ☐ Yes ☐ No

17. Is PERSON 4 a full-time student? ☐ Yes ☐ No

18. Was PERSON 4 in foster care in South Carolina at age 18 or older? ☐ Yes ☐ No

19. Is PERSON 4 currently living in a foster home? ☐ Yes ☐ No

20. Is PERSON 4 currently living in a DJJ group home? ☐ Yes ☐ No

21. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply)**

☐ Mexican ☐ Mexican-American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other: _____

22. **Race (OPTIONAL—check all that apply)**

☐ White
☐ Black/African-American
☐ American Indian or Alaska native
☐ Asian Indian
☐ Chinese
☐ Other: _____
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander

Now, tell us about any income from PERSON 4 on the next page.

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STEP 2: PERSON 4

Current job & income information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 23.

☐ **Not Employed**
SKIP to question 35.

☐ **Self-Employed**
SKIP to question 34.

CURRENT JOB 1:

23. Employer name and address _____

24. Employer phone number _____

25. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____ 26. Average hours worked each week _____ 27. Start date _____

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper)

28. Employer name and address _____

29. Employer phone number _____

30. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____ 31. Average hours worked each week _____ 32. Start date _____

33. **In the past year, did PERSON 4:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

34. **If self-employed, answer the following questions:**
a. Type of work _____

b. How much net income (profits once business expenses are paid will you get from this self-employment this month?)
$ _____

35. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often PERSON 4 gets it.
NOTE: You don't need to tell us about child support, veteran's payments or Supplemental Security Income (SSI).

☐ None

☐ Unemployment $ _____ How often? _____
☐ Pensions $ _____ How often? _____
☐ Social Security $ _____ How often? _____
☐ Retirement acc'ts $ _____ How often? _____
☐ Alimony received $ _____ How often? _____

☐ Net farming/fishing: $ _____ How often? _____
☐ Net rental/royalty: $ _____ How often? _____
☐ Other income:
☐ Type: _____ $ _____ How often? _____
☐ Type: _____ $ _____ How often? _____

36. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.
If PERSON 4 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.
NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 34b).

☐ Alimony paid $ _____ How often? _____
☐ Student loan interest $ _____ How often? _____

☐ Other deductions: $ _____ How often? _____
Type: _____

37. **YEARLY INCOME:** **Complete only if PERSON 4's income changes from month to month.**

PERSON 4's total income this year
$ _____

PERSON 4's total income next year (if you think it will be different)
$ _____

THANKS! This is all we need to know about PERSON 4.

If you have more than four people to include, ask for and complete DHHS Form 3400-01 for each additional person.

NEED HELP WITH YOUR APPLICATION? Visit SCDHHS.gov or call us at **1-888-549-0820**. Para obtener una copia de este formulario en Español, llame **1-888-549-0820**. If you need help in a language other than English, call **1-888-549-0820** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-753-8583**.

STEP 3 American Indian or Alaska Native (AI/AN) family member(s)

1. Are you or is anyone in your family American Indian or Alaska Native?

☐ **If NO,** skip to Step 4.

☐ **YES. If YES,** ask for and complete SCDHHS Form 3400-Appendix B (American Indian or Alaska Native Family Member).

STEP 4 Your family's health coverage

Answer these questions for anyone who needs health coverage.

1. **Is anyone enrolled in health coverage now from the following?** If available, please provide a copy of the insurance card.

☐ **YES.** If yes, check the type of coverage and write the person(s)' name(s) next to the coverage they have. ☐ **NO.**

☐ Medicaid _____

☐ CHIP _____

☐ Medicare _____

Claim number: _____

Date Medicare coverage started: _____

☐ TRICARE (Don't check if you have direct care of Line Of Duty)

_____

☐ VA health care programs: _____

☐ Peace Corps: _____

☐ Employer insurance _____

Name of health insurance: _____

Policy number: _____ Start Date: _____

Is this COBRA coverage? ☐ Yes ☐ No

☐ Is this a retiree health plan? ☐ Yes ☐ No

☐ Other health insurance _____

Name of health insurance: _____

Policy number: _____ Start Date: _____

Is this a limited-time benefit plan (like a school accident policy)?

☐ Yes ☐ No

2. **Is anyone listed on this application offered health coverage from a job?** Check yes even if the coverage is from someone else's job, such as a parent or spouse.

☐ **YES. If YES**, you'll need to complete and include Appendix A. Is this a state employee benefit plan? ☐ Yes ☐ No

☐ **NO. If NO**, continue to Step 5.

STEP 5 Read and sign this application.

Please read the following rights and responsibilities. If you disagree with a statement, your eligibility for programs may be impacted. A signature is required to complete the application process and submit your application to the agency.

1. I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, or disability. I can file a complaint of discrimination by calling (803) 898-2605 or writing to the Office for Civil Rights, SCDHHS, P.O. Box 8206, Columbia, SC 29202-8206.
2. I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell the agency and may not have to cooperate.
3. I assign and give my rights to any payments from a liable third party to the SCDHHS up to the payment amount that Healthy Connections has made for my medical care. This assignment applies to any of my minor children who may be injured. These payments may include payments from health insurance, legal settlements, or other third parties. I also understand that I have a duty to cooperate in identifying and providing information to assist Healthy Connections in pursuing third parties who may be liable to pay for care and services.

(Rights and responsibilities continued on next page)

4. I understand that I must cooperate fully with state and federal workers if my case is reviewed. I also understand that, as a condition of eligibility, I must apply for and take steps to obtain any other benefits, including but not limited to annuities, pensions, retirement, disability and other benefits.
5. As an applicant/beneficiary for Medicaid services, I understand that there are two groups of people that are affected by estate recovery:
   - A person of any age who was a patient in a nursing facility, intermediate care facility for the intellectually disabled, or other medical institution at the time of death, and who was required to pay most of his/her income for the cost of care; or
   - A person who was 55 years of age or older when he/she received medical assistance consisting of nursing facility services, home and community based services, and hospital and prescription drug services provided to individuals in nursing facilities or receiving home community-based services.

   I understand that upon receiving any of these services, the Department of Health and Human Services will file a claim against my estate (all personal and real property owned by me at my death) for the amount Medicaid has paid for my services.
6. I know that I must tell SCDHHS within 10 days if any information I listed on this application changes and is different than what I wrote on this application. I understand that a change in my information could affect the eligibility for member(s) of my household.
7. The information I provide on this application and in future interaction with SCDHHS will be used to check my eligibility for help paying for health coverage, if I choose to apply. If the information I provide doesn't match electronic data, I may be asked to send proof. I know that, unless I specifically ask to be excluded, information collected will be securely stored in order to be sure that services provided to my family and me are sufficient and necessary.
8. If I think SCDHHS, the agency that administers Healthy Connections, the state's Medicaid and CHIP programs, has made an error I can appeal its decision. To appeal means to tell someone at SCDHHS that I think the action is wrong, and ask for a fair review of the action. I must submit a written request for such a hearing to SCDHHS. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.
9. I know that personal health information I provide or that is later gathered by SCDHHS is covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and I will receive a Notice of Privacy Practices along with my Healthy Connections Card(s).

Does any child on this application have a parent living outside of the home? ☐ Yes ☐ No

I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not,

_____ is incarcerated.

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow Medicaid or the Health Insurance Marketplace to use income data, including information from tax returns. Medicaid will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next:

☐ 5 years (the maximum number of years allowed), or for a shorter number of years:

☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ Don't use information from tax returns to renew my coverage.

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative, you may sign here, as long as you have provided the information required on DHHS Form 1282 - Authorized Representative.
By signing, I state that I have read and agree to the rights and responsibilities stated on this application.

Signature	Date (mm/dd/yyyy)

Please print this form, then sign it on the line above before submitting.

STEP 6 Mail the completed application.

Mail your signed application to:

SCDHHS - Central Mail
PO Box 100101
Columbia SC 29202-3101

If you want to register to vote, you can complete a voter registration form at **scvotes.org**.

NEED HELP WITH YOUR APPLICATION? Visit **SCDHHS.gov** or call us at **1-888-549-0820**. Para obtener una copia de este formulario en Español, llame **1-888-549-0820**. If you need help in a language other than English, call **1-888-549-0820** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-753-8583**.

Healthy Connections

South Carolina Department of Health and Human Services

Additional Information for Select Medicaid Programs

You recently applied for Medicaid with the State of South Carolina. Please complete and return this form so we can process your application. We need more information to see if you may be eligible for one or more of the following programs:

☐ **Medicare Savings Programs (MSP) that include the following:**

- Aged, Blind, Disabled (ABD),
- Qualified Medicare Beneficiaries (QMB),
- Specified Low Income Medicare Beneficiaries (SLMB), and
- Qualifying Individuals (QI)

☐ **Optional State Supplementation (OSS)**

☐ **Working Disabled (WD)**

☐ **Inmate Services**

☐ **TEFRA, (also known as Katie Beckett)**

You only need to tell us about your child's income and resources for TEFRA.

All of the rights and responsibilities agreed to when the original application was signed are still in effect. If there are any questions about those rights and responsibilities or this form, please call us toll free at 1-888-549-0820 for help.

1. Who is applying for assistance?

	Social Security Number	Date of Birth (mm/dd/yyyy)
a. Name (First, Middle, Last)		
b. Name (First, Middle, Last)		
c. Name (First, Middle, Last)		
d. Name (First, Middle, Last)		
e. Name (First, Middle, Last)		

2. Most forms of income we need to know about are on your application. Please check if you or someone in your household has any of the following types of income and tell us about that income in the table below.

☐ **Child Support**

☐ **Money From Friends and Relatives**

☐ **Veterans Assistance**

☐ **Workers Comp/Long Term or Short Term Disability**

a. Person Receiving Money	Income Source/Type	How Often Received	Amount Received
b. Person Receiving Money			
c. Person Receiving Money			
d. Person Receiving Money			
e. Person Receiving Money			

3. Please check the box beside any of the things shown that you or someone in your home owns or are buying. Tell us about it in the table. When you return this form, you must send proof of these assets or resources.

☐ Cash on Hand ☐ Checking Account ☐ Savings Account ☐ Burial Plot
☐ Certificate of Deposit ☐ Annuities/Trusts ☐ Stocks and Bonds ☐ Home Property
☐ Other Property ☐ Life/Burial Insurance ☐ Burial Contracts ☐ Vehicles
☐ Retirement Accounts ☐ Other: _____

	Owned by	Tell Us About The Asset Include the name of bank or funeral home, and any account numbers or other information used to identify the asset.	Current Value or Balance
a.			
b.			
c.			
d.			
e.			
f.			

4. Are you or the person you are applying for currently in a Community Residential Care Facility?
(Community Residential Care Facilities may also be called Boarding Homes or Assisted Living Centers)

☐ Yes ☐ No

If YES, what is the name of the facility? _____ Date entered: _____

Questions 5 through 7 are only for those people who are currently inmates at a correctional facility. If you are an inmate at a correctional facility, please provide the following information.

5. Name of correctional facility: _____ **Date incarcerated:** _____

a. Name of hospital where services received | Date of admission (mm/dd/yyyy) | Date of Discharge (mm/dd/yyyy)

Address where you lived before incarceration

6. If you have been incarcerated for longer than 30 days, you can skip this question and go to question #7.

a. Did you work or receive earnings before you were incarcerated? ☐ Yes ☐ No
b. If living with your spouse before you were incarcerated, was your spouse employed? ☐ Yes ☐ No

7. Tell us about your income before you were incarcerated. Enter GROSS amounts (this information will need to be verified by staff of correctional facility).

a. Type of income | Amount Paid | How often paid

b. Type of income | Amount Paid | How often paid

c. Type of income | Amount Paid | How often paid

Staff of the correctional facility can attest to income or earnings received from or through the facility. The following signature attests to incomes verified in question 7.

Correctional Facility Staff Person: _____ Date: _____

Phone Number: _____

Healthy Connections

South Carolina Department of Health and Human Services

Child Disability Report - Checklist

Along with your Medicaid Application, completion of all enclosed forms is required. Forms with incomplete information will result in delays or could result in a denial of the claim.

If you need assistance completing the forms in this packet, please call the Healthy Connections Member Services Center at **888-549-0820**. Use the following checklist as a guide to ensure the forms are properly completed.

Disability Report or Continuing Disability Report (Form 3218-D or 3266-D)

- ☐ Complete in BLUE OR BLACK INK.
- ☐ Provide correct social security number, date of birth, address, and phone number for child.
- ☐ Provide contact information for additional adult familiar with child's condition.
- ☐ Complete information on child's school and/or day care.
- ☐ List all of the doctors, hospitals, and treating facilities where child has been treated for a medical condition(s) in the last 15 months.
- ☐ Provide a copy of the death certificate or death summary from the hospital if applying on behalf of an individual who has died.
- ☐ Answer every question and return all the pages of these forms.
- ☐ Mark as "N/A" if a question does not apply to you.

Authorization to Disclose Health Information (Form 921)

- ☐ Complete in BLUE OR BLACK INK.
- ☐ Sign and date by parent or legal guardian
- ☐ If applicant is age 12 to 18, he/she must sign in addition to the parent or legal guardian
- ☐ **If there is a legally appointed representative or power of attorney document, *please include a copy with completed and signed form.***

Healthy Connections

South Carolina Department of Health and Human Services

Medicaid Disability Report

Date:_____

The South Carolina Vocational Rehabilitation Department (SCVRD) – Disability Determination Services State Claims Office assists with processing SC Department of Health and Human Services (DHHS) Medicaid disability claims. SCVRD also contacts medical treatment sources where you have been seen and requests copies of your medical records.

- **Please complete the enclosed two forms:**
  - **Disability Report**
  - **Authorization to Disclose Health Information (Form 921)**
- **Please answer every question and return all the pages of these forms.**
- **Mark as "N/A" if a question does not apply to you.**

If there is a legally appointed representative or power of attorney documentation, please include a copy with your completed and signed application.

Mail To:

SCDHHS - Central Mail
PO Box 100101
Columbia SC 29202-3101

An addressed envelope is included for your convenience.

IMPORTANT: If you have not applied for Social Security Disability Benefits or Supplemental Security Income Benefits (SSI) within the last 12 months, be sure to apply online (socialsecurity.gov), at the Social Security office, or by phone as soon as possible.

If you have questions about completing this form, please call the Healthy Connections Member Services Center toll free at:
(888) 549-0820

If you do not return the completed Medicaid Application, Disability Report, and the Authorization to Disclose Health Information form, we cannot determine your disability or Medicaid eligibility.

Healthy Connections
South Carolina Department of Health and Human Services

Disability Report - Child Under Age 19

Send to: SCDHHS - Central Mail
PO Box 100101
Columbia SC 29202-3101

*If you need assistance, please call the Healthy Connections Member Services Center toll free at **(888) 549-0820**.*

FOR DHHS USE ONLY		**Number of pages received and scanned: _____**
□ Child Initial	□ Retro Only	
Household Number: _____	Application Date: ___ / ___ / ___	Retro: _____

Please fully complete this form and return with the signed Authorization to Disclose Health Information form in the provided envelope. It is very important that you provide complete addresses and phone numbers for your medical sources. If the form is not completed fully, it will delay the processing of your Medicaid Disability claim.

It is critical that the enclosed Authorization to Disclose Health Information form is signed **IN BLACK OR BLUE INK** by the PARENT OR LEGAL GUARDIAN of the minor child. **If there is a legally appointed representative or power of attorney documentation, please include a copy with your completed and signed form.**

CHILD'S INFORMATION

Child's Last Name: _____ Child's First Name: _____ Middle Initial: ___

Child's SSN#:_____-_____-_____ Child's Previous Name (if applicable): _____

Date of Birth:_____/_____/_____ Date of Death (If Applicable):_____/_____/_____

Street Address: _____ City: _____ State: ____ ZIP: _____

PARENT/GUARDIAN INFORMATION

Parent / Guardian: _____

Relationship to Applicant: _____ Phone:_____-_____-_____

Parent / Guardian's Address: ___ _____ City: _____ State: ____ ZIP: _____

What is your child's disability?

Explain how the child's disability affects his/her ability to function. (You may add additional pages, if needed.)

Please provide the name of someone who knows about your child's condition (not a doctor or teacher). Examples: neighbor, grandparent, etc.

Name of Contact: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Relation to Child: _____

SCHOOL/TRAINING INFORMATION

Is the child currently attending school (or preschool)? ☐ Yes ☐ No If yes, please complete the following: Current Grade: _____ Primary Teacher's Name: _____

Name of School: _____

Address: _____

Is the child in a special education program? ☐ Yes ☐ No School Phone Number: _____

If yes, please list teacher's name: _____

At school, does the child receive:

☐ Yes	☐ No	Occupational Therapy?	Therapist Name:	_____
☐ Yes	☐ No	Speech Therapy?	Therapist Name:	_____
☐ Yes	☐ No	Physical Therapy?	Therapist Name:	_____
☐ Yes	☐ No	ABA Therapy?	Therapist Name:	_____
☐ Yes	☐ No	Other Services?	Service Provider Name:	_____

If you have a copy of student's IEP, please include a copy with completed application.

Does the child attend a day care or after school program? ☐ Yes ☐ No

Name of Program: _____ Type of Program: _____

Phone Number: _____ - _____ - _____ Teacher/Program Provider: _____

Street Address: _____ City: _____ State: ____ ZIP: _____

Please provide a complete address for all medical and service providers so we may request medical educational and treatment records. If you need additional space, use the "remarks" section or attach additional pages.

MEDICAL TREATMENT: List ALL doctors seen in a clinic or doctor's office in the last 15 months.

1. Doctor's Name: _____ Clinic Name: _____

   Address: _____ Phone: _____

   _____ Reason for Visit: _____

   _____ Date Last Seen: _____

2. Doctor's Name: _____ Clinic Name: _____

   Address: _____ Phone: _____

   _____ Reason for Visit: _____

   _____ Date Last Seen: _____

3. Doctor's Name: _____ Clinic Name: _____

   Address: _____ Phone: _____

   _____ Reason for Visit: _____

   _____ Date Last Seen: _____

List ALL **hospitals, emergency rooms, or urgent care facilities** the child has visited in the last **15 months**. List the name of facility only; we do not need individual names of doctors.

1. Facility Name: _____ (Circle all that apply) INPATIENT*OUTPATIENT

   Address: _____ Phone: _____

   _____ Reason for Visit: _____

   _____ Date Last Seen: _____

2. Facility Name: _____ (Circle all that apply) INPATIENT*OUTPATIENT

   Address: _____ Phone: _____

   _____ Reason for Visit: _____

   _____ Date Last Seen: _____

3. Facility Name: _____ (Circle all that apply) INPATIENT*OUTPATIENT

   Address: _____ Phone: _____

   _____ Reason for Visit: _____

   _____ Date Last Seen: _____

4. Facility Name: _____ (Circle all that apply) INPATIENT*OUTPATIENT

   Address: _____ Phone: _____

   _____ Reason for Visit: _____

   _____ Date Last Seen: _____

List ALL **THERAPY PROVIDERS (outside of school setting)** that the child has visited in the last **15 months**. In this section please list all **Occupational Therapy, Physical Therapy, Speech Therapy**, etc. *Please provide complete contact information for each provider.* ***If services are coordinated through BabyNet, it is still necessary that you provide us with the contact information for each individual provider, as we are not always able to obtain records from BabyNet directly.***

1. Provider Name: _____

   Address: _____ Phone: _____

   _____ Type of Provider: _____

   _____ Date Last Seen: _____

2. Provider Name: _____

   Address: _____ Phone: _____

   _____ Type of Provider: _____

   _____ Date Last Seen: _____

3. Provider Name: _____

   Address: _____ Phone: _____

   _____ Type of Provider: _____

   _____ Date Last Seen: _____

4. Provider Name: _____

   Address: _____ Phone: _____

   _____ Type of Provider: _____

   _____ Date Last Seen: _____

5. Provider Name: _____

   Address: _____ Phone: _____

   _____ Type of Provider: _____

   _____ Date Last Seen: _____

List any additional places where you have had tests or imaging (blood work, xrays, CTs, etc) performed in the last 15 months **if facility has not already been listed above**.

1. Facility Name: _____ Date Last Seen: _____

   Address: _____ Phone: _____

   _____ Test/Image: _____

   _____ _____

2. Facility Name: _____ Date Last Seen: _____

   Address: _____ Phone: _____

   _____ Test/Image: _____

   _____ _____

REMARKS

Use this space to provide additional information that may help make a decision on your disability claim.

Please remember to sign and return the Authorization to Disclose Health Information form, Form 921.

South Carolina Department of Health and Human Services (SCDHHS)
Eligibility, Enrollment and Member Services
Toll-free (888) 549-0820

Authorization to Disclose Health Information

For Office Use Only – **TO BE COMPLETED BY SCDHHS**			
Applicant/Beneficiary Name *(First)* *(Middle)* *(Last)*			
Social Security No.	**Date of Birth**	**Household No./App ID** _ _ _ _ _ _ _ _ _	

**** PLEASE READ BOTH PAGES OF THIS FORM BEFORE SIGNING BELOW.****

I voluntarily authorize and request disclosure (including written, verbal, and electronic interchange) of:

WHAT: ***All my medical records, education records and other information related to my ability to perform tasks. This includes specific permission to release the following:***

1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including, but not limited to:
   - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell anemia
   - Human Immunodeficiency Virus (HIV) infection, including Acquired ImmunoDeficiency Syndrome (AIDS) or tests for HIV or sexually-transmitted diseases
   - Gene-related impairments, including genetic test results
2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living and affects my ability to work
3. Copies of education tests or evaluation, including individualized educational programs, triennial assessments, psychological and speech evaluations, teacher observations and evaluations, and any other records that can help evaluate function
4. Information created within 12 months after the date this authorization is signed, as well as past information.

FROM WHOM:
- **All** medical sources (hospitals, clinics, labs, physicians, psychologists, etc.), including mental health, correctional, and addiction treatment and VA health care facilities
- All educational sources (schools, teacher records, administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners
- Employers
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SCDVR (as needed) for additional information to identify the subject (e.g., other names used), the specific source, or the material to be used.

_____

_____

_____

_____

TO WHOM: The State agency authorized to process my case (usually called "SCVRD") including contract copy services, doctors, or other professionals consulted during the disability determination process.

PURPOSE: I agree to the disclosure of my health information to determine if I meet the disability criteria in order to establish my eligibility for Medicaid benefits

EXPIRES WHEN: This authorization is binding for 12 months from the date signed below.

I UNDERSTAND THAT:
- I may write to The South Carolina Department of Health and Human Services to revoke this authorization at any time.
- There are some circumstances where the information may be re-disclosed to other parties involved with the Medicaid eligibility determination.
- I may receive a copy of this form upon request.
- I may ask the source to allow me to inspect or get a copy of the material to be disclosed.

Applicant Signature (Person Applying for Benefits OR Parent/Guardian if Applicant is Under Age 18):	**Relationship to Applicant:**
Legal Representative Signature (if Applicant is Unable to Sign Due to Health):	**Date:**
Child Signature (Required if Applicant is Age 12 to 18):	☐ **Power of Attorney or legal guardian documentation is attached if signed by a Legal Representative.**
Witness:	**Witness if signed with an "X":**

AUTHORIZATION FOR RELEASE OF INFORMATION TO SC VOCATIONAL REHABILITATION DEPARTMENT (SCVRD)

We need your written authorization to help get the information required to process your application for benefits. Laws and regulations require that sources of personal information have a signed authorization before releasing it to us. Also, laws require specific authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing Form 921. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. Some sources of information require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations.

You have the right to revoke this authorization at any time, except to the extent a source of information has already relied on it to take an action. To revoke, send a written statement to the South Carolina Dept. of Health and Human Services, Enrollment and Member Services, P.O. Box 8206, Columbia, S.C. 29202-8206. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you. SCDHHS can tell you if we identified any sources you didn't tell us about. Information disclosed prior to revocation may be used by SCDHHS to decide your claim.

IMPORTANT INFORMATION, INCLUDING NOTICE REQUIRED BY THE PRIVACY ACT

All personal information collected by SCDHHS/SCVRD is protected by the Privacy Act of 1974. Once medical information is disclosed to SCDHHS/SCVRD, it is no longer protected by the health information privacy provisions of 45 CFR part 164 (mandated by the Health Insurance Portability and Accountability Act (HIPAA). SCDHHS/SCVRD retains personal information is strict adherence to the State regulations 19-903, 19-933, 19-963, and 19-983.

We use the information obtained with this form to determine your eligibility for benefits. In some cases, your information may also be reviewed by SCDHHS personnel and contractors that process your appeal of a decision and may be used in any related administrative, civil, or criminal proceedings.

Signing this form is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on your claim and could result in denial or loss of benefits.

South Carolina Department of Disabilities and Special Needs

Permission to Evaluate TEFRA Medicaid Applicant

I, _____ (print name of applicant), have applied for Medicaid eligibility as part of the national Tax Equity and Fiscal Responsibility Act (TEFRA) through the South Carolina Department of Health and Human Services (SCDHHS). As part of this Medicaid eligibility determination process, I understand that the South Carolina Department of Disabilities and Special Needs (SCDDSN) will determine whether I meet the level of care criteria for an Intermediate Care Facility for the Mentally Retarded (ICF/MR). I further understand that this is not a request to determine my eligibility for care, treatment, training, or residential services from SCDDSN. However, I also understand that I may make a separate request for eligibility for SCDDSN services.

I give permission for SCDDSN to review any available medical, educational, and/or other records pertaining to me in order to determine whether I meet ICF/MR level of care criteria. I understand that I may be asked to sign one or more separate authorization forms for release of this information to SCDDSN.

I understand that this document will remain in effect until such time as SCDHHS makes a Medicaid eligibility decision under TEFRA including actions under appeal. I understand that I may terminate this permission in writing to SCDDSN or its designated representative at any time.

_____ _____

Applicant's Signature Date

or

_____ _____

Legal Guardian's Signature Date

(For applicant under 18 yrs. or legally incompetent)

04/14/2008

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Post Office Box 100101
Columbia, South Carolina 29202-3101

TEFRA IN-HOME CARE CERTIFICATION

This form is to be completed by the applicant's physician. Certification that the applicant may be cared for in a home setting, even though his/her medical condition may warrant acute or institutional care, is a requirement for Medicaid eligibility under the TEFRA program and in no way holds the physician responsible for the applicant's in-home care.

To: DHHS, Medicaid Eligibility Worker
PO Box 128
State Park, SC 29147

From: _____, M.D.

As of the date listed below, I agree that it is appropriate to provide care at home for

_____
(Child's full name)

_____ _____
(Physician's signature) (Date)

_____
(Physician's address)

_____ _____
(City, State, Zip Code) (Area Code/Telephone Number)

ROUTING INSTRUCTIONS:

- **Forward the completed form to the Medicaid eligibility worker at the address listed above.**
- **Form must be filed in the applicant's Medicaid case folder.**

NOTE: Questions regarding the completion of this statement or the TEFRA program should be directed to the Bureau of Eligibility Policy and Oversight within the South Carolina Department of Health and Human Services, (803) 898-2635.