South Carolina Department of Health and Human Services
SCHIP/Medicaid Application for a Newborn

Mother's Name (First, Middle Initial, Last):	**Social Security Number**:	**Date of Birth**:
Home Address (Also list mailing address if different) **City State Zip Code**		**County**: **Telephone Number**: ( )
Do you have other health insurance? ☐ Yes ☐ No Insurance Company: _____ Plan ID#: _____ Eligibility Worker Name (if known): _____ County: _____		Did the mother have a permanent sterilization procedure? ☐ Yes ☐ No
List the Names and Dates of Birth for any other Children:		

Child's Name (First, Middle Initial, Last):	**Date of Birth**:	Has application been made for a SSN for the child? ☐ Yes ☐ No Is the child a member of the mother's household? ☐ Yes ☐ No
Sex: ☐ Female ☐ Male	**Race**: ☐White ☐African American ☐Mexican ☐Native American/American Indian ☐Refugee Entrant ☐Cuban ☐Puerto Rican ☐Hispanic ☐Asian American/Oriental ☐Other	
Name of Facility of Birth: _____ County of Facility of Birth: _____ **Citizenship and Identity must be verified for the child. An extract from the hospital medical records that show biographical information for the child including place and date of birth can be used to establish U.S. citizenship. The DHHS Form 3298, Statement of Child's Identity, may be completed by the mother to verify the child's identity.**		

Does the Mother have any income? ☐Yes ☐No If "Yes," List below:

Type and Source of Income	Gross Amount (Before any taxes or deductions)	How Often Received

List any assets or resources that the mother may own:

Asset/Resource	Company name, address, and phone #; Account/Policy number; and/or Description	What is the value?	How much is owed?
		$	
		$	
		$	
		$	

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Rights and Responsibilities

1. I know that my children under age 19 who are eligible for Medicaid can have free health checkups under a special prevention program called Early and Periodic Screening, Diagnosis and Treatment (EPSDT).
2. I know that the information I have given is confidential. I understand that, except as specified below, information including medical information can be released only for purposes directly related to the administration of the Healthy Connections Program. At times, the Department of Health and Human Services (DHHS) will release information to organizations that they hire to carry out specific purposes, but those organizations will have agreed to be bound by the same guidelines for release of information. Furthermore, I know that personal health information I provide or that is later gathered by DHHS is covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and I will be receiving a Notice of Privacy Practices along with my Healthy Connections Card(s).
    a. I know that, in accordance with the federal rules governing the Medicaid and Healthy Connections Kids Programs, any information I have given must be reviewed and verified by DHHS staff. Also, I understand that I must cooperate fully with state and federal workers if my case is reviewed. No additional permission by me is needed to get verification or other information.
    b. I know that, in accordance with the federal rules governing the Medicaid Program, DHHS staff must provide information about my family and me to a computer system called the State Income and Eligibility Verification System (IEVS). This computer system allows DHHS to compare the information about my family and me with information from other agencies, and allows other state (including agencies from other states) and federal agencies to use information gathered on this application to verify eligibility and determine benefit amounts for their programs. Other agencies include, but are not limited to, the Internal Revenue Service, Social Security Administration, and Employment Security Commission, other states' Medical Assistance programs, and the TANF and Food Stamp agency (Department of Social Services (DSS), in this state). Immigration status will be verified with the Department of Homeland Security (DHS).
    c. I know that, unless I specify otherwise, information about my family and me may be shared by DHHS for the purpose of making a proper referral of my case to other sources of services or treatment, in accordance with federal and state law. When possible, I, or my responsible party, will be asked to agree. However, I further understand that in the case of mandatory reporting, DHHS must report, and cannot honor my specification to the contrary.
    d. I know that, unless I specifically ask not to be included, information about services (including medical services) provided to my family and me will be stored in a data warehouse operated by the South Carolina Budget and Control Board, Office of Research and Statistics, and that other state agencies that provide services to me or my family will be allowed to access that information in order to be sure that services provided to my family and me are sufficient and necessary.
3. I know that my Social Security Number, which I am required to provide, under §1137(a) (1) of the Social Security Act [42 U.S.C. 1320b-7(a) (1)], may be used or released in connection with the exceptions in Item 2, above.
4. I know that according to Federal law and US Department of Health and Human Services (HHS) policy, DHHS cannot discriminate on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, I should contact HHS by writing to The HHS Director, Office of Civil Rights, Room 506F, 200 Independence Avenue, SW, Washington, DC 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). HHS is an equal opportunity provider and employer.
5. I know that the Medicaid Program do not pay medical expenses that a third party, such as a private health insurance company or someone who injures me, is supposed to pay. I therefore assign and give my rights to any payments from a liable third party to the DHHS 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 hospital and health insurance policies or payments received as a settlement from an accident.
6. Completion of a Medical Support Referral Form is required on an absent parent(s) if the custodial parent/caregiver relatives want Medicaid coverage.
7. I must report any and all changes in my income, deductions, resources, living arrangements, members of the household, or other information that will affect medical help within ten (10) days of the date of the change(s). I understand that if I fail to notify the department promptly, I may lose benefits and be subjected to penalties or prosecution.

   If eligibility is for my child(ren) only, I am not required to report any changes in my situation, except for change of address. If I report any other changes in my situation, it will not affect their eligibility for benefits until the next scheduled review.
8. I know that I may request a hearing if I believe an error has been made in processing my application.

☐ **I have read the Rights and Responsibilities, or they have been read to me.**
(If possible, both the Applicant and Authorized Representative should sign.)

Applicant's Signature: _____ Date: _____

Signature of Authorized Representative: _____ Date: _____

Provider representative furnishing information: _____

Telephone number: _____ Date: _____