SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

COVID-19 Limited Benefit

things to know

About this program

- Uninsured individuals may use this application to apply for Medicaid coverage in order to cover costs associated with COVID-19 diagnostic testing.
- Services covered are limited to those necessary for diagnostic testing for the COVID-19 virus.
- If you would like to apply for full Medicaid benefits, please request a DHHS Form 3400, Application for Healthy Connections (Medicaid) by calling (800) 549-0820 or apply online at SCDHHS.gov.

What you may need to apply

- Social Security Number (or document numbers if lawfully present)

Why do we ask for this information?

We ask for this 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 **SCDHHS.gov**.

What happens next?

Send your complete, signed application by mail, email or fax. This information is listed at the end of the application. You will get instructions on the next steps to complete your application for COVID-19 testing. If you have questions, call 1-888-549-0820.

Who can use this application?

- Any person who does not have current health insurance coverage.
- Applying will not affect your immigration status or your chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete DHHS Form 1282 - Authorized Representative, which is included at the end of this application.

Get help with this application

- **Online:** **SCDHHS.gov**
- **Phone:** Call our Member Contact Center at **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 **1-888-842-3620**.

STEP 1

Date _____

We need one adult in the family to be the primary contact person for your application. This can be the person applying for coverage for themselves and/or can be a person applying for a family member. We keep all information private and secure, as required by law. We use personal information only to check eligibility for health coverage. If you need to add additional people to this application, make blank copies of page 4 to add them. You are not required to provide immigration status or a Social Security Number (SSN) for the primary contact person if that person does not need health coverage.

Primary Contact Person

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

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

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

8. Mailing address (if different from home address) | 9. Apartment/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)? | 18. Gender ☐ Male ☐ Female | 19. Date of Birth (mm/dd/yyyy)

Is someone helping you fill out this application?

Complete the following section if you are filling out this form on behalf of the primary contact person and/or applicant(s). Otherwise, leave blank.

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

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

22. Organization Name (if applicable)

STEP 1 Information about person needing coverage

If you are the primary contact person completing this section for yourself, enter "Self" for Question 24.

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

24. Relationship to Primary Contact?

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

26. Sex: ☐ Male ☐ Female

27. Social Security Number (SSN)

We need a SSN if this person wants health coverage and has an SSN. We use SSNs to check information to see who's eligible to receive help with health coverage costs related to COVID-19. If you want help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-888-842-3620. If you do not have an SSN, please answer question 30.

28. a. Are you a U.S. citizen? ☐ Yes ☐ No
(Born in U.S., child of U.S. citizen, or former alien now naturalized as a U.S. citizen)

b. Are you a U.S. national? ☐ Yes ☐ No
(Born in unincorporated U.S. Territory who elects to be a national, not a U.S. citizen)

If you answered YES to Question 28 a. or b., SKIP to Question 30.

29. If you aren't a U.S. citizen or national, check here if you have eligible immigration status. ☐

Enter your document type and ID number below. You can also include other immigration-related information in 29.c. If you do not have this information with you, you can still submit the application and we will contact you for any other information we need. This will not hold up the processing of your application.

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

c. Additional immigration information: _____
Examples include: Alien or I-94 number, name as it appears on an immigration document, SEVIS ID or expiration date, or other information.

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

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

30. If you do not have a Social Security Number, have you applied for one? If no, list the reason: ☐ Yes ☐ No

☐ Issued for non-work reasons only ☐ No SSN due to religious reasons ☐ Not eligible for SSN

31. Have you been tested for COVID-19? (OPTIONAL) ☐ Yes ☐ No
If yes, enter the date of your earliest COVID-19 test (OPTIONAL) : _____

32. Are you currently enrolled in any health coverage? ☐ Yes ☐ No

Permission to Release Information

Would you like us to share information about this application with a member of your family or other person of your choice?

By completing this section, you can give permission for the following person to receive information about your application/case, but they won't have the ability to act on your behalf like an authorized representative. You also give SCDHHS permission to release information about this application to this additional person or organization.

Name of person/organization		Phone	
Address	City	State	ZIP
Unit (if applicable)	ID Number (if applicable)		

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STEP 2

Read and Sign. 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 (888) 808-4238 or writing to the Civil Rights Division, SCDHHS, P.O. Box 8206, Columbia, SC 29202-8206.
2. 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.
3. 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.
4. 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.
5. 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.
6. 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.
7. If I think SCDHHS, the agency that administers Healthy Connections, the state's Medicaid program, 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 hearing. I must submit a written request for such a hearing to SCDHHS. I know that I may represent myself or be represented by someone other than myself.
8. 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). I can review the SCDHHS Notice of Privacy Practices online at www.scdhhs.gov/NPP.

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. **By signing, I state that I have read and agree to the rights and responsibilities stated on this application.** I am signing this application under penalty of perjury. This means I have provided true answers to all the questions on this form to the best of my knowledge. I know that if I am not truthful, there may be a penalty under federal law.

Signature **Date (mm/dd/yyyy)**

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

STEP 3 Submit the completed application.

Mail your signed application to:

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

OR Fax your application to:

(888) 820-1204

OR Email your application to:

8888201204@fax.scdhhs.gov

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SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Authorization for Release of Information and Appointment of Authorized Representative for Medicaid Applications/Reviews and Appeals

Name of Medicaid applicant/member	Social Security Number

Appointing an Authorized Representative

Would you like to allow someone to represent you on all matters related to your case?

You can give a trusted person or an organization permission to talk about your application with us, see your information, and act for you on matters related to your application, including getting information about your application and signing your application on your behalf. This person can also act for you on other matters, including reviews, appeals and managed care processes. This person is called an "authorized representative." The Medicaid eligibility worker can release any information regarding your application/review and status to your authorized representative. More than one person or organization can serve as your authorized representative.

You can appoint, withdraw or change an authorized representative at any time. If you ever need to change your authorized representative, contact Healthy Connections. If you are a legally appointed representative for someone on this application, you do not need to complete this section.

Full Name of Authorized Representative or Organization	☐ New ☐ Change ☐ Addition ☐ Remove this person or organization as my authorized representative

Point of Contact If Authorized Representative Is An Organization	Unit* (if applicable)	ID number (if applicable)

City	State	ZIP code

Authorized Representative's phone number	Other phone number

Authorized Representative's email address

Authorized Representative's address (Leave blank if you don't have one)	Apartment or suite number

*It is best to identify a specific unit for large organizations.

OR

Permission to Release Information

Is there anyone that you would like us to share information with about your application?

By completing this section, you can give permission for the following person to receive information about your application/case, but they won't have the ability to act on your behalf like an authorized representative. You also give SCDHHS permission to release information about this application to this additional person or organization.

Name of person/organization		Phone	
Address	City	State	ZIP

Unit (if applicable)	ID Number (if applicable)

Medicaid applicant/member's signature	Date (mm/dd/yyyy)

If signing with an "X," please have two people sign below as witnesses.

Witness: _____ Witness: _____

☐ Member is incapacitated and unable to sign. SCDHHS reserves the right to verify member's inability to sign. Provide reason:

_____

Mail your signed form to: SCDHHS - Central Mail, PO Box 100101, Columbia, SC 29202-3101 **Fax:** (888) 820-1204

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