

FORMS

Number	Name	Revision Date
DHHS 126	Confidential Complaint	06/2007
DHHS 205	Medicaid Refunds	01/2008
DHHS 931	Health Insurance Information Referral Form	01/2008
	EFT Authorization Agreement	01/2014
	Duplicate Remittance Advice Request Form	04/2014
	Claim Reconsideration Form	12/2016
	Sample Remittance Advice	04/2014
	Sample Turn Around Document (TAD)	
CRCF-01	Notice of Admission, Authorization & Change of Status for Community Residential Care Facility	06/2014
CRCF-02	Communication Form	
DHHS 1728-ME	SSI Recipient Request for Optional State Supplementation	07/2002
	Annual Competency Evaluation Documentation	
	Potential In-Service Topic List	
	Resident Weekly Care Log	
	Consent Form	
	Community Residential Care Facility Accessibility Checklist (six pages)	
	Pre-Enrollment Screening Tool for the Optional Supplemental Care for Assisted Living Participants (OSCAP)	
	OSCAP Provider Information Update Form	
DHHS 1282	Authorization for Release of Information and Appointment of Authorized Representative for Medicaid Applications/Reviews and Appeals	05/2016
DHHS 3400	Application for Medicaid and Affordable Health Coverage w/Authorized Representative (16 pages)	06/2016
DHHS 3401	Application for Nursing Home, Residential or In-Home Care w/Authorized Representative (10 pages)	06/2016



**STATE OF SOUTH
CAROLINA
DEPARTMENT OF HEALTH
AND HUMAN SERVICES**

CONFIDENTIAL COMPLAINT

SEND TO: DIRECTOR, DIVISION OF PROGRAM INTEGRITY
DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. BOX 100210, 1801 MAIN STREET, COLUMBIA, SOUTH CAROLINA 29202-3210

PROGRAM INTEGRITY

THIS REPORT IS DESIGNED FOR THE REPORTING OF POSSIBLE ABUSE BY MEDICAID PROVIDERS AND/OR RECIPIENTS. USE THE SPACE BELOW TO EXPLAIN IN DETAIL YOUR COMPLAINT. PLEASE IDENTIFY YOURSELF AND WHERE YOU CAN BE REACHED FOR FUTURE REFERENCES. UNLESS OTHERWISE INDICATED, ALL INFORMATION SHOULD BE PRINTED OR TYPED.

YOUR COMPLAINT WILL REMAIN CONFIDENTIAL.

SUSPECTED INDIVIDUAL OR INDIVIDUALS:

NPI or MEDICAID PROVIDER ID: (if applicable)

MEDICAID RECIPIENT ID NUMBER: (if applicable)

ADDRESS OF SUSPECT:

LOCATION OF INCIDENT:

DATE OF INCIDENT:

COMPLAINT:

NAME OF PERSON REPORTING: (Please print)

SIGNATURE OF PERSON REPORTING:

DATE OF REPORT

ADDRESS OF PERSON REPORTING:

TELEPHONE NUMBER OF PERSON REPORTING:

SIGNATURE: (SCDHHS Representative Receiving Report)

**South Carolina Department of Health and Human Services
Form for Medicaid Refunds**

Purpose: This form is to be used for all refund checks made to Medicaid. This form gives the information needed to properly account for the refund. If the form is incomplete, the provider will be contacted for the additional information.

Items 1, 2 or 3, 4, 5, 6, & 7 must be completed.

Attach appropriate document(s) as listed in item 8.

1. Provider Name: _____

2. Medicaid Legacy Provider #
(Six Characters)

OR

3. NPI#

& Taxonomy

4. Person to Contact: _____

5. Telephone Number: _____

6. Reason for Refund: [check appropriate box]

- Other Insurance Paid (please complete a – f below and attach insurance EOMB)
 - a** Type of Insurance: () Accident/Auto Liability () Health/Hospitalization
 - b** Insurance Company Name _____
 - c** Policy #: _____
 - d** Policyholder: _____
 - e** Group Name/Group: _____
 - f** Amount Insurance Paid: _____

- Medicare
 - () Full payment made by Medicare
 - () Deductible not due
 - () Adjustment made by Medicare

Requested by DHHS (please attach a copy of the request)

Other, describe in detail reason for refund:

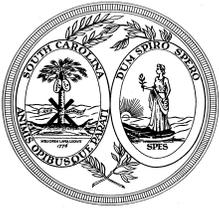
7. Patient/Service Identification:

Patient Name	Medicaid I.D.# (10 digits)	Date(s) of Service	Amount of Medicaid Payment	Amount of Refund

8. Attachment(s): [Check appropriate box]

- Medicaid Remittance Advice (required)
- Explanation of Benefits (EOMB) from Insurance Company (if applicable)
- Explanation of Benefits (EOMB) from Medicare (if applicable)
- Refund check

Make all checks payable to: South Carolina Department of Health and Human Services
Mail to: SC Department of Health and Human Services
Cash Receipts
Post Office Box 8355
Columbia, SC 29202-8355



**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID HEALTH INSURANCE INFORMATION REFERRAL FORM**

Provider or Department Name: _____ Provider ID or NPI: _____

Contact Person: _____ Phone #: _____ Date: _____

I ADD INSURANCE FOR A MEDICAID BENEFICIARY WITH NO INSURANCE IN THE MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) – ALLOW 25 DAYS

Beneficiary Name: _____ Date Referral Completed: _____

Medicaid ID#: _____ Policy Number: _____

Insurance Company Name: _____ Group Number: _____

Insured's Name: _____ Insured SSN: _____

Employer's Name/Address: _____

II CHANGES TO AN INSURANCE RECORD THAT IS IN THE MMIS – MIVS SHALL WORK WITHIN 5 DAYS

- _____ a. beneficiary has never been covered by the policy – close insurance.
- _____ b. beneficiary coverage ended - terminate coverage (date) _____
- _____ c. subscriber coverage lapsed - terminate coverage (date) _____
- _____ d. subscriber changed plans under employer - new carrier is _____
- new policy number is _____
- _____ e. beneficiary to add to insurance already in MMIS for subscriber or other family member.
(name) _____

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.

Submit this information to Medicaid Insurance Verification Services (MIVS).

Fax:	or	Mail:
803-252-0870		Post Office Box 101110
		Columbia, SC 29211-9804

**III NEW POLICY NUMBERS FOR INSURANCE IN THE MMIS WITH THE SUBSCRIBER SSN
(SCDHHS is collecting new unique policy numbers and plans to replace existing insurance records through MMIS online modification as computer resources are available.)**

Medicaid Beneficiary ID: _____ SSN: _____

Carrier Name/Code: _____ New Unique Policy Number: _____

Submit this information to South Carolina Department of Health and Human Services (SCDHHS).

Fax:	or	Mail:
803-255-8225		Post Office Box 8206, Attention TPL
		Columbia, SC 29202-8206

**South Carolina Department of Health and Human Services
Electronic Funds Transfer (EFT) Authorization Agreement**

PROVIDER INFORMATION

Provider Name _____
Doing Business As Name (DBA) _____
Provider Address
Street _____
City _____ State/Province _____
Zip Code/Postal Code _____ Medicaid Provider Number _____
Provider Federal Identification Number (TIN) or
Employer Identification Number (EIN) _____
National Provider Identifier (NPI) _____
Provider EFT Contact Information
Provider Contact Name _____
Telephone Number _____ Telephone Number Extension _____
Email Address _____

FINANCIAL INSTITUTION INFORMATION

Financial Institution Name _____
Financial Institution Address _____
Street _____
City _____ State/Province _____
Zip Code/Postal Code _____
Financial Institution Routing Number _____
Type of Account at Financial Institution (select one) Checking Savings
Provider's Account Number with Financial Institution _____
Account Number Linkage to Provider Identifier (select one)
 Provider Tax Identification Number (TIN)
 National Provider Identifier (NPI)

REASON FOR SUBMISSION: New Enrollment Change Enrollment Cancel Enrollment

I (we) hereby authorize the Department of Health and Human Services to initiate credit entries and to initiate, if necessary, debit entries for any credit entries in error to my account indicated above and the financial institution named above, to credit and/or debit the same to such account. These credit entries will pertain only to the Department of Health and Human Services payment obligations resulting from Medicaid services rendered by the provider.

I (we) understand that credit entries to the account of the above named payee are done with the understanding that payment will be from federal and/or state funds and that any false claims, statements or documents or concealments of a material fact, may be prosecuted under applicable federal or state laws.

I (we) certify that the information shown is correct. I (we) agree to provide thirty (30) days written notice to the address shown below prior to revoking or revising this authorization.

All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any Medicaid direct deposits are made.

Written Signature of Person Submitting Enrollment _____

Printed Name of Person Submitting Enrollment _____

Submission Date _____

TO PROCESS YOUR EFT ENROLLMENT OR CHANGE EXISTING INFORMATION, PLEASE RETURN THIS COMPLETED FORM ALONG WITH VERIFICATION OF YOUR ELECTRONIC DEPOSIT INFORMATION ON YOUR FINANCIAL INSTITUTION'S LETTERHEAD TO:

**Department of Health and Human Services
Medicaid Provider Enrollment
P.O. BOX 8809, COLUMBIA, S.C. 29202-8809
FAX (803) 870-9022**

SPECIAL INSTRUCTIONS: For questions regarding the status of your EFT enrollment, please contact the Provider Service Center at 1-888-289-0709. Please refer to the Electronic Funds Transfer (EFT) section of the Provider Enrollment manual found on the SCDHHS Provider web page for instructions on how to complete updates to your EFT information.

Effective January 01, 2014, providers have the capability to link their EFT payment transaction with their electronic remittance advice (ERA) via a matching EFT Reassociation Trace Number. This trace number will automatically be included in your SCDHHS electronic remittance advice. In order for this matching reassociation trace number to appear in your EFT notification, you must contact your financial institution and request the addition of this information. Any questions regarding this matching trace number and your ERA can be directed to the Provider Service Center at 1-888-289-0709.

**South Carolina Department of Health and Human Services
Duplicate Remittance Advice Request Form**

Purpose: This form is to be used for all requests for duplicate remittance advices from South Carolina Medicaid. The form must be completed in its entirety in order to honor the request. If the form is incomplete, the form will be returned requesting the additional information.

Please contact the SCDHHS Medicaid Provider Service Center (PSC) at 1-888-289-0709 or submit an online inquiry at <http://www.scdhhs.gov/contact-us> for instructions on submission of your request.

1. Provider Name: _____
2. Medicaid Legacy Provider # _____ (Six Characters)
NPI# _____ & Taxonomy _____
3. Person to Contact: _____ 4. Telephone Number: _____
5. Requesting:
 Remittance Advice Pages Edit Correction Form (ECF)
Pages Only*

(*) ECFs are available only for Remittance Advice dates prior to January 17, 2014. Please note that SCDHHS no longer accepts ECFs for processing as of April 1, 2014.

6. Please list the date(s) of the remittance advice for which you are requesting a duplicate copy:

Note: Remittance advices are available electronically through the Web Tool. Please check the Web Tool for the availability of the remittance advice date before submitting your request.

7. Street Address for delivery of request:
Street: _____
City: _____
State: _____
Zip Code: _____

8. Charges for duplicate remittance advice(s) are as follows:
Request Processing Fee - \$20.00
Page(s) copied - .20 per page

I understand and acknowledge that a charge is associated with this request and will be deducted from my provider's payment by debit adjustment on a future remittance advice.

Authorizing Signature

Date

Submit your Claim Reconsideration request to:

Fax: 1-855-563-7086

or

Mail: South Carolina Healthy Connections Medicaid
 ATTN: Claim Reconsiderations
 Post Office Box 8809
 Columbia, SC 29202-8809

CLAIM RECONSIDERATION FORM

Instructions: Complete this form within 30 days of receipt of the remittance advice reflecting the denied claim, and attach all documentation in support of your request. Allow up to 60 days for a written response. Claim disputes must first be initiated through the Provider Service Center (PSC). Enter the PSC Communication ID in the required field below. For questions, contact the PSC at 1-888-289-0709.

Section 1: Beneficiary Information

Name (Last, First, MI): _____

Date of Birth: _____

Beneficiary Medicaid ID: _____

Section 2: Provider Information

Specify your affiliation: Physician Hospital Other (DME, Lab, Home Health Agency, etc.): _____

NPI: _____ Medicaid Provider ID: _____ Facility/Group/Provider Name: _____

Return Mailing Address: _____
Street or Post Office Box State ZIP

Contact: _____ Email: _____ Telephone #: _____ Fax #: _____

Section 3: Claim Information

Communication ID: _____ CCN: _____ Date(s) of Service: _____

Section 4: Claim Reconsideration Information

What area is your denial related to? (Please select below)

- | | |
|---|--|
| <input type="checkbox"/> Ambulance Services | <input type="checkbox"/> Nursing Facility Services |
| <input type="checkbox"/> Clinic Services | <input type="checkbox"/> Optional State Supplementation (OSS) |
| <input type="checkbox"/> Community Long Term Care (CLTC) | <input type="checkbox"/> Pharmacy Services |
| <input type="checkbox"/> Community Mental Health Services | <input type="checkbox"/> Physicians, Laboratories, and Other Medical Professionals |
| <input type="checkbox"/> Durable Medical Equipment (DME) | Specify: _____ |
| <input type="checkbox"/> Early Intervention Services | <input type="checkbox"/> Private Rehabilitative Therapy and Audiological Services |
| <input type="checkbox"/> Federally Qualified Health Center (FQHC) | <input type="checkbox"/> PRTF CHANCE Waiver |
| <input type="checkbox"/> Enhanced Services | <input type="checkbox"/> Psychiatric Hospital Services |
| <input type="checkbox"/> Home Health Services | <input type="checkbox"/> Rehabilitative Behavioral Health Services (RBHS) |
| <input type="checkbox"/> Hospice Services | <input type="checkbox"/> Rural Health Clinic (RHC) |
| <input type="checkbox"/> Hospital Services | <input type="checkbox"/> Targeted Case Management (TCM) |
| <input type="checkbox"/> Licensed Independent Practitioner's Rehabilitative Services (LIPS) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Local Education Agencies (LEA) | |

Section 5: Desired Outcome

Request submitted by:

Print Name: _____

Signature: _____

Date: _____

REPORT NH4545R1
DATE 06/25/2013

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
COMMUNITY RESIDENTIAL CARE
FOR MONTH OF JUNE

PAGE 1

CRCF NO. RC0099 Happy Home
111 Valley St
Lexington

SC 29687

E N T E R C H A N G E S

LINE	COUNTY	RECIPIENT NAME	RECIPIENT ID NO	MONTHLY INCOME	DATE OF SERVICE MO/YR	CRCF DAYS	OSCAP DAYS	CHANGED CRCF DAYS	CHANGED OSCAP DAYS	DELETE FROM NEXT MONTH'S TAD
01		Mary Smith	1234567801		02/03	28				
02		Sam Perkins	9786543201		02/03		28			
03										
04										
05										
06										
07										
08										
09										
10										
11										
12										

- 1) IF THE ABOVE INFORMATION IS CORRECT AND THERE HAVE BEEN NO ADMISSIONS OR DISCHARGES, SIGN AND DATE AS INDICATED BELOW.
 - 2) IF THERE HAS BEEN A NEW OSS APPROVED ADMISSION TO YOUR FACILITY DURING THE MONTH OF JUNE, ENTER A NEW LINE FOR THAT RESIDENT WITH THE NAME, ID NUMBER, DATE OF ADMISSION, AND NUMBER OF DAYS IN YOUR FACILITY.
 - 3) IF THE FACILITY HAS RECEIVED AUTHORIZATION FROM SCDHHS TO PROVIDE INTEGRATED PERSONAL CARE (IPC) SERVICES TO ANY OSS RESIDENT, REDUCE THE NUMBER OF CRCF DAYS BY THE NUMBER OF DAYS THE RESIDENT WAS AUTHORIZED FOR AND RECEIVED IPC SERVICES AND INSERT THE NUMBER OF DAYS THE RESIDENT RECEIVED AUTHORIZED IPC SERVICES IN THE IPC DAYS COLUMN.
 - 4) IF THERE HAS BEEN A DISCHARGE/DEATH FROM YOUR FACILITY DURING THE MONTH OF JUNE, INDICATE THE NUMBER OF DAYS, NOT COUNTING THE DATE OF DISCHARGE/DEATH THAT THE RESIDENT WAS IN YOUR FACILITY IN THE COLUMN TITLED "CHANGED CRCF DAYS". IF THE RESIDENT WAS AUTHORIZED FOR AND RECEIVED IPC SERVICES, ENTER THE NUMBER OF DAYS, NOT COUNTING THE DATE OF DISCHARGE/DEATH THAT THE RESIDENT WAS IN YOUR FACILITY AND WAS AUTHORIZED FOR AND RECEIVED IPC SERVICES IN THE "CHANGED IPC DAYS" COLUMN.
 - 5) IF ANY OF THE RESIDENTS LISTED WILL NOT BE IN YOUR FACILITY NEXT MONTH, ENTER AN 'X' IN THE COLUMN TITLED 'DELETE FROM NEXT MONTH'S TAD'.
- I CERTIFY THAT THE INFORMATION SHOWN ON THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THIS INFORMATION WILL BE USED TO GENERATE PAYMENTS OF STATE FUNDS, AND I UNDERSTAND THAT SUBMITTING FALSE OR MISLEADING INFORMATION IS AGAINST THE LAW AND COULD RESULT IN CRIMINAL PROSECUTION.

things to know



General Information

DHHS FORM CRCF-01 is utilized by Community Residential Care Facilities and/or SCDHHS Medicaid Eligibility Workers. The DHHS CRCF 01 is authorization by the Department of Health and Human Services for payment and reimbursement for OSS services rendered to the eligible patient. A separate form must be prepared for each eligible patient receiving Provider services. **The form must be completed electronically. Handwritten forms will not be accepted.**



Detailed Instructions

Reason for Submission: Identify the reason for submission (Initial, Status Change, Termination)

A. Section I – Identification of Provider and Patient

This section will be completed in its entirety by the originating party. The provider information must be completed. **This form will not be processed without the correct Medicaid ID of the recipient and the correct provider number.**

B. Section II – Will be completed by the OSS CTLC office.

C. Section III - Type of Coverage and Statistical Data

The provider of services and/or the SC DHHS Medicaid Eligibility worker may initiate this section. The section is used to show the transfers/readmissions from other facilities or hospitals, termination, and medical/non-medical bed holds.

D. Section IV – Authorization and Change of Status

Only the SC DHHS Medicaid Eligibility Worker is responsible for the completion of this section. The SC DHHS Medicaid Eligibility Approval Authority /Supervisor of a SC DHHS Authorized Representative must sign and date each form for all new admissions, income change, and discharges that affect income liability.

The Provider of Services will normally initiate these forms. The SC DHHS Medicaid Eligibility Worker initiates them for all income changes and certain terminations. The provider of services must forward the forms to the appropriate SC DHHS Medicaid Eligibility Worker only when signature authorization in Section IV is required. Send to SCDHHS - Central Mail, P.O. Box 100101, Columbia, SC 29202.



Distribution, Preparation and Routing of Form

- A. Copy Submitted by Provider for claims processing MCCS
- Copy Retained and kept on file by SC DHHS Medicaid Eligibility
- Original Retained and kept on file by the Provider of Services

B. The Provider of Services must attach a copy of this form to the current month's billing for each change in the status of a patient. Send all CRCF-01 forms together for each patient. Mailing address for 18th of month claims:

Claims Receipt- CRCF
 Claims Section
 Post Office Box 67
 Columbia, SC 29202-0067

RESET FORM

Reason for Submission: Choose One

Section I. Identification of Applicant/Resident (CRCF Staff)			
1. Applicant/Resident's Name (First, Middle, Last)		2. Birth Date (MO-DY-YY)	3. Medicaid No. (10 digits) [][][][][][][][][][][][]
4. CRCF Name		6. County of Residence	7. Social Security No. [][][]-[][]-[][][][]
5. CRCF Street Address		8. CRCF Provider ID# R C [][][][]	9. Date of Request
City	State		
10. Authorized Representative's Name		12. Authorized Representative's Street Address	
11. Authorized Representative's Phone No.		City	State ZIP
Section II. Verification of OSS Slot Authorization and CRCF Admission (Completed by CLTC)			
1. Date Applicant Entered CRCF	2. Authorization Date	3. CLTC Worker Name	4. <input type="checkbox"/> Applicant Did Not Enter CRCF
Section III. Completed by CRCF Facility			
(A) Transferred to: CRCF		Transfer Date: _____	
Name of new CRCF or institution: _____			
(B) Terminated/Discharged		because no longer financially eligible	Termination Date: _____
Specify reason for case termination or other change in status if not covered by above items: _____			
(C) Bed Holds Medical Absence		Start Date _____	End Date _____
* REMINDER: DATE OF ADMISSION IS BILLED.		Start Date _____	End Date _____
DATE OF DISCHARGE IS NOT.		Start Date _____	End Date _____
Section IV. Verification of Medicaid Status (Completed by DHHS EEMS - Eligibility)			
1. Application Date _____ MO-DD-YYYY	2. Medicaid Status		<input type="checkbox"/> Denied: Incomplete app.
	<input type="checkbox"/> SSI Recipient		<input type="checkbox"/> Financially Ineligible
	<input type="checkbox"/> Financially eligible awaiting OSS slot authorization		
(A) Authorization to Begin Payment _____ MO-DD-YYYY			
(B) Resident's Countable Income Effective _____ \$ _____ Personal Needs Amount \$ _____ MO-YYYY			
Section V – Signature			
_____ Eligibility Worker Name (Print)			
_____ Authorized Eligibility Worker Signature			_____ Date

Date

Dear
CLTC #

Your financial eligibility has been approved for the Optional State Supplementation (OSS) program. As of the above date, you may select a licensed community residential care facility (CRCF) that participates in the OSS program. If you need assistance locating OSS enrolled CRCF's in South Carolina please visit www.nfbl.sc.gov. Please take this notification to the CRCF you selected. This letter is valid for 30 calendar days from the date of the letter. If you are not admitted by _____, you must reapply for OSS at your DHHS County Office or electronically at https://phoenix.scdhhs.gov/cltc_referrals/new. The CRCF must complete the bottom portion of this form on the day you are admitted and return it to the address listed below.

SECTION II

TO BE COMPLETED BY A LICENSED COMMUNITY RESIDENTIAL CARE FACILITY ENROLLED IN THE OSS PROGRAM:

Instruction for CRCF: Complete and return this form to the following CLTC area office:

South Carolina Department of Health and Human Services
OSS Program - J7
Po BOX 8206
Columbia, SC 29202-8206

Please note that a delay in returning this form, incorrect information or blanks in Section II will result in a delay of the OSS Payment to your facility.

CRCF Name: _____
CRCF Provider Number: RC _____
Date resident entered Facility: _____
Dated Completed: _____
Signature and Title of CRCF Official: _____

Signature and Date of OSS-Staff _____

SCDHHS CRCF-02 Form

Language Service – If your primary language is not English, language assistance services are available to you, free of charge. Call 1-888-549-0820 (TTY: 1-888-842-3620).

si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al

1-888-549-0820 (TTY: 1-888-842-3620).

كول ريفاروتت هيو غلگلا قده عاونمها تخدمج هيو (888-549-0820) (ههسلو مصولها فنتسه (888-842-3620).

South Carolina Department of Health and Human Services
SSI RECIPIENT REQUEST
FOR OPTIONAL STATE SUPPLEMENTATION (OSS)

1. I, _____, am currently eligible for Supplemental Security Income (SSI).
2. I live or plan to live in a Community Residential Care facility (CRCF).
3. I need help with paying the cost of living in a CRCF.
4. I request this help through the Optional State Supplementation (OSS) program.

The following statements explain your rights and responsibilities. If you do not understand some of the statements, you should discuss the statement(s) with the worker during the interview. You are responsible for giving complete and accurate information.

I understand that I must report any and all changes in my income, living arrangements or other information which will affect my eligibility for OSS within 10 days of the date of the change(s).

I understand that my case record is confidential and no information will be released from it unless properly authorized by me or as provided for under state/federal laws.

I understand that any information I have given is subject to being reviewed by staff members of the Department of Health and Human Services. Also, I understand that I must cooperate fully with state and federal workers if my case is selected for a complete review.

I understand that this request will be considered without regard to race, color, sex, age, handicap, religion, national origin or political belief.

I understand that I may request a hearing if I am not satisfied with the action taken on my case or if I feel that I have been discriminated against.

I certify that I have read or had read to me all the statements on this form and that the information given is true and complete to the best of my knowledge. I understand that if I have deliberately given any false information or have withheld any information regarding my situation, I am liable for prosecution for fraud and/or perjury. I hereby give the Department permission to verify, without additional consent from me, information discovered by the Department or given by me that is needed to determine my eligibility for OSS.

Applicant/Responsible Party's Signature: _____ Date: _____

Applicant's Social Security Number: _____ Telephone: _____

Applicant's Address: (Name of facility if already residing in CRCF)

Worker's Signature: _____ Date: _____

South Carolina Department of Health and Human Services
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FOR OPTIONAL STATE SUPPLEMENTATION (OSS)

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I certify that I have read or had read to me all the statements on this form and that the information given is true and complete to the best of my knowledge. I understand that if I have deliberately given any false information or have withheld any information regarding my situation, I am liable for prosecution for fraud and/or perjury. I hereby give the Department permission to verify, without additional consent from me, information discovered by the Department or given by me that is needed to determine my eligibility for OSS.

Applicant/Responsible Party's Signature: _____ Date: _____

Applicant's Social Security Number: _____ Telephone: _____

Applicant's Address: (Name of facility if already residing in CRCF)

Worker's Signature: _____ Date: _____

ANNUAL COMPETENCY EVALUATION DOCUMENTATION

REQUIRED TRAINING/COMPETENCY EVALUATION FOR UNLICENSED STAFF PROVIDING OR SUPERVISING CARE

Staff Name: _____ SS#: _____

Position: _____ LPN/RN Conducting Training/Evaluation: _____

Competency Area	Competency Level	Date	Nurse Initials
Hand washing and basic infection control procedures	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		
Assisting the resident with dressing	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		
Assisting the resident with dressing having weak/affected arm	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		
Assisting the resident with transferring	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		
Assisting the resident with ambulation	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		
Assisting the resident with a wheelchair and wheelchair safety	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		
Assisting the resident with bathing	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		
Assisting the resident with personal grooming	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		
Assisting with mouth care and cleaning of dentures	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		
Assisting the resident with toileting	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		
Assisting the resident with eating	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		
Providing continence care	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		
Providing a bed bath	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		
Taking and recording vital signs	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		
Addressing behavioral symptoms	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		
Observing, recording and reporting tasks	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		
Identifying and reporting problems/changes	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		
Applying T.E.D. Hose	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		

The competency evaluation must be completed by all staff prior to providing direct care to OSCAP participants and annually thereafter. It is the responsibility of the OSCAP provider to ensure all resident assistants and supervising staff are competent to perform the tasks identified in each resident's individual care plan. The facility administrator and/or any staff person with daily supervisory responsibilities for the resident assistants must complete the training necessary for the competency evaluation. Evidence of training/competency must be maintained in the personnel records by the OSCAP provider, and be available to a SCDDHS representative upon request. The training and competency evaluation for OSCAP is in addition to DHEC training requirements for licensure.

LPN Signature: _____ Date: _____

RN Signature: _____ Date: _____

POTENTIAL IN-SERVICE TOPIC LIST

OPTIONAL SUPPLEMENTATION FOR ASSISTED LIVING PARTICIPANTS (OSCAP)

All about Headaches

Assistive Devices

Bathing Tips

Being Assertive

Building Trust & Confidence with Residents

Common Diets

Communication Skills

Cultural Diversity

Customer Service Care

Dealing with Dizziness

Dealing with Family Members

Documentation of Direct Care and Record Keeping

Documenting Physical and Mental Changes

Ergonomics/Body Mechanics

Feeding Your Clients

Flu Season

Getting Off to a Good Start with a Resident

Hand washing

Hearing and Disorders

Heart Attacks and Strokes

Heart Failure

HIPAA

How to Prioritize Your Work

Maintaining a Professional Distance

Maintaining Client's Dignity

Men's Health Issues

Mouth Care

Non-Compliant Clients

Non-Traumatic Emergencies

Normal Aging Process

Nutrition and Hydration

Overview of the Body

Pain and the Elderly

Parkinson's Disease

Performing Safe Transfers

Personal Care Safety Issues

Personal Hygiene

Preventing Pressure Sores

Professionalism and Work Ethics

Safety in the Workplace

Skin Care

Stress Management

Techniques for Giving Bed Baths

Toileting Tips

Understanding Alzheimer's Disease & Other Dementias

Understanding Basic Human Needs

Understanding Depression

Understanding Diabetes

Understanding Hypertension Activity and the Elderly

Women's Health Issues

Working with a Person with a Mental Illness

Working with a Person with an Intellectual or Developmental Disability

Working with Difficult & Combative People

Resident Weekly Care Log

____ / ____ / ____
Week of

	ACTIVITIES	LEVEL	SUN	MON	TUE	WED	THU	FRI	SAT
Transfer	<input type="checkbox"/> Lifted manually/mechanically								
	<input type="checkbox"/> Transfer aid								
	<input type="checkbox"/> Weight bearing								
Locomotion	<input type="checkbox"/> Wheelchair/Cane/Walker								
	<input type="checkbox"/> Other person wheels								
	<input type="checkbox"/> Put on prosthesis or brace								
	<input type="checkbox"/> Wandering								
Bathing	<input type="checkbox"/> Does not bathe appropriately								
	<input type="checkbox"/> In/out of tub/shower								
	<input type="checkbox"/> Lower body/Upper body								
	<input type="checkbox"/> Cueing								
Dressing	<input type="checkbox"/> Buttons/zippers/snaps/tying								
	<input type="checkbox"/> Inappropriate dressing/layers								
	<input type="checkbox"/> Step by step guidance								
	<input type="checkbox"/> Refuses to change/reapplies dirty								
	<input type="checkbox"/> Put on socks/shoes								
Toileting	<input type="checkbox"/> Getting off toilet								
	<input type="checkbox"/> Poor hygiene								
	<input type="checkbox"/> Empty urinal/BSC								
	<input type="checkbox"/> Clothing up/down								
Eating	<input type="checkbox"/> Setup								
	<input type="checkbox"/> Cut into bite-size pieces								
	<input type="checkbox"/> Encouragement to finish meals								
	<input type="checkbox"/> Step by step instruction								
Bladder & Bowel	<input type="checkbox"/> Scheduled toileting plan								
	<input type="checkbox"/> Pads/briefs used								
	<input type="checkbox"/> Bowel program								
Cognitive	<input type="checkbox"/> Memory problem(s)								
	<input type="checkbox"/> Decision making capacity								
	<input type="checkbox"/> Mood problem(s)								
	<input type="checkbox"/> Behavior problem(s)								
Diet	Good (75%) →								
	Fair (50%) →								
	Poor (25%) →								
	Refused →								
	Supplements →								
Weight & Vital Signs	Weight →								
	Blood Pressure →								
	Temperature →								
	Pulse →								
	Respiration →								
	Sugar Monitoring →								
Level of Care Key: L = Limited E= Extensive T=Total									

Resident's Name

Room Number

Medicaid Number

Signatures and Initials of all Resident Assistants providing assistance this week

Initial	Signature
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I certify the information on this form is correct and documented services were provided.

Administrator's Signature

Date

I certify the information on this form is correct and documented services were provided.

Nurse's Signature

Date

Comments:

SOUTH CAROLINA OPTIONAL STATE SUPPLEMENTATION (OSS)

CONSENT FORM

Resident Name: _____

Social Security Number: _____

I understand that as part of my application for services in a participating OSS Facility, my condition must be evaluated by the South Carolina OSS staff.

This evaluation includes information provided by:

- A. my physician and medical records;
- B. professionals, organizations and facility staff members involved with my care; and,
- C. an interview with me and, if necessary, with my family.

I hereby authorize any social service professionals, organizations, doctors, nurses or other medical personnel or medical facilities involved in my care to release to the South Carolina OSS program any medical information regarding my diagnosis, functional abilities and recommended treatment.

I hereby authorize the South Carolina OSS Program to release information on my behalf to the following: physicians, hospitals, health and human service organizations, health and human service agencies, family members, the residential care facility and/or other persons directly involved with my care.

I understand that if my current or future diagnosis includes Alzheimer's disease, senile dementia or a similar disorder, my records may be reviewed by the Statewide Alzheimer's Disease and Related Disorders Registry, and that I or my responsible party may be contacted for additional information. Also, if an extraordinary situation should arise, I understand that photographs may be taken and used to document suspected problems.

Use the space below to indicate the name of any organization, agency or person to whom you do not choose to release information. This consent shall remain in effect for one year from the date the consent is signed or until revoked by me in writing, or until such time as my case is closed by the OSS program.

Date Signature of Client or Responsible Party

If signed by Responsible Party, state relationship and authority to do so

Date Signature of Witness(es)

COMMUNITY RESIDENTIAL CARE FACILITY ACCESSIBILITY CHECKLIST

Facility Name	RC Number
Physical Address	
Inspectors Name	License Number
<input type="checkbox"/> PASS <input type="checkbox"/> FAIL	Date

If NO is checked for an item please use the comment section or attach a plan to describe the measures the facility will take to assure:

1. Making modifications in policies, practices, and procedures to allow equal access to individuals with disabilities
2. Furnishing auxiliary aids when necessary to ensure effective communication
3. Removing architectural and structural barriers in existing facilities where readily achievable.
4. Providing readily achievable alternative measures when removal of barriers is not readily achievable.

1 - APPROACH AND ENTRANCE	Comments:										
<p>Is there at least one route from site arrival points (parking, passenger loading zones, public sidewalks and public transportation stops) that does not require the use of stairs?</p> <p style="text-align: right; margin-right: 20px;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </p>											
<p>A - Parking</p> <p>If parking is provided for the public, are an adequate number of accessible spaces provided?</p> <p style="text-align: right; margin-right: 20px;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </p> <table border="1" style="margin-left: auto; margin-right: auto; border-collapse: collapse; text-align: center;"> <thead> <tr> <th style="padding: 2px 5px;">Total Spaces</th> <th style="padding: 2px 5px;">Accessible Spaces</th> </tr> </thead> <tbody> <tr> <td style="padding: 2px 5px;">1 - 25</td> <td style="padding: 2px 5px;">1</td> </tr> <tr> <td style="padding: 2px 5px;">26 - 50</td> <td style="padding: 2px 5px;">2</td> </tr> <tr> <td style="padding: 2px 5px;">51 - 75</td> <td style="padding: 2px 5px;">3</td> </tr> <tr> <td style="padding: 2px 5px;">76 - 100</td> <td style="padding: 2px 5px;">4</td> </tr> </tbody> </table>		Total Spaces	Accessible Spaces	1 - 25	1	26 - 50	2	51 - 75	3	76 - 100	4
Total Spaces		Accessible Spaces									
1 - 25		1									
26 - 50		2									
51 - 75		3									
76 - 100		4									
<p>Of the accessible spaces, is at least one a van accessible space?</p> <p style="text-align: right; margin-right: 20px;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </p> <p>Note: For every 6 or fraction of 6 parking spaces required by the table above, at least 1 should be a van accessible space. If constructed before 3/15/2012, parking is compliant if at least 1 in every 8 accessible spaces is van accessible.</p>											
<p>Are accessible spaces at least 8 feet wide with an access aisle at least 5 feet wide?</p> <p style="text-align: right; margin-right: 20px;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </p>											
<p>Is the van accessible space at least 11 feet wide with an access aisle of at least 5 feet wide or at least 8 feet wide with an access aisle at least 8 feet wide?</p> <p style="text-align: right; margin-right: 20px;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </p>											
<p>Are the access aisles marked so as to discourage parking in them?</p> <p style="text-align: right; margin-right: 20px;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </p>											
<p>Do the access aisles adjoin an accessible route?</p> <p style="text-align: right; margin-right: 20px;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </p>											
<p>Are accessible routes identified with a sign that includes the International Symbol for Accessibility</p> <p style="text-align: right; margin-right: 20px;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </p>											

B - Exterior Accessible Route

Is the route of travel stable, firm and slip resistant?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

Is the route at least 36 inches wide.

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Can all objects protruding into the circulation paths be detected by a person with a visual disability using a cane?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

C - Curb Ramps

If the accessible route crosses a curb, is there a curb ramp?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

Is the curb ramp, excluding flare, no steeper than 1:48, and at least 36 inches wide?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

At the curb ramp is there a level landing

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

D - Ramps

Is there a ramp (other than curb ramps), is it at least 36 inches wide?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

Is the surface stable, firm and slip resistant?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

For each section of the ramp, is the running slope no greater than 1:12, i.e. for every inch of height change there are at least 12 inches of ramp run?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Is there a level landing at the top and bottom of the ramp, and that is at least 60 inches long and at least as wide as the ramp?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

If the ramp has a rise higher than 6 inches, are there handrails on both sides?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Is the top of the handrail gripping surface no less than 34 inches and no greater than 38 inches above the surface?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

E - Entrance

Is the main entrance accessible?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

If the main entrance is not accessible is there an alternative accessible entrance?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Do all accessible entrances have signs indicating the location of the nearest accessible entrance?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

If not all entrances are accessible, is there a sign at the accessible entrance with the International Symbol of Accessibility?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Is the clear opening width of the accessible entrance door at least 32 inches, between the face of the door and the stop when the door is open 90 degrees?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Comments:



	Yes	No	Comments:
Is there a front approach to the pull side of the door, is there at least 18 inches of maneuvering clearance beyond the latch side plus 60 inches of clear depth?	<input type="checkbox"/>	<input type="checkbox"/>	
Are the operable parts of the door hardware no less than 34 inches and no greater than 48 inches above the floor or ground surface?	<input type="checkbox"/>	<input type="checkbox"/>	
If there are two doors in a series, is the distance between the doors at least 48 inches plus the width of the doors when swinging into the space?	<input type="checkbox"/>	<input type="checkbox"/>	
Are edges of carpets or mats securely attached to minimize tripping hazards?	<input type="checkbox"/>	<input type="checkbox"/>	
2. ACCESS TO GOODS AND SERVICES			
Does the accessible entrance provide direct access to the main floor, lobby and elevator (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	
A - Interior Accessible Route	Yes	No	
Are all public spaces on at least one accessible route?	<input type="checkbox"/>	<input type="checkbox"/>	
Is the route stable, firm and slip resistant?	<input type="checkbox"/>	<input type="checkbox"/>	
Is the route at least 36 inches wide?	<input type="checkbox"/>	<input type="checkbox"/>	
Do all objects on circulation paths through public areas protrude no more than 4 inches into the path? (e.g. fire extinguishers, signs, drinking fountains, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	
Are there elevators or platform lifts to all public stories?	<input type="checkbox"/>	<input type="checkbox"/>	
If an elevator is present, are the key pads at a height a person can reach when sitting? (no higher than 42 inches)	<input type="checkbox"/>	<input type="checkbox"/>	
B - Interior Doors	Yes	No	
Is the door opening width at least 32 inches clear, between the face of the door and the stop, when the door is open 90 degrees?	<input type="checkbox"/>	<input type="checkbox"/>	
Is the door threshold edge no more than 1/4 inch high?	<input type="checkbox"/>	<input type="checkbox"/>	
Is the door equipped with hardware that is operable with one hand and does not require tight grasping, pinching and twisting of the wrist?	<input type="checkbox"/>	<input type="checkbox"/>	
Are the operable parts of the hardware no less than 34 inches and no greater than 48 inches above the floor?	<input type="checkbox"/>	<input type="checkbox"/>	
Can the doors be opened easily (5 pounds maximum force)?	<input type="checkbox"/>	<input type="checkbox"/>	

C - Signs

If there are signs designating permanent rooms and spaces do the text characters contrast with their background, are the text letters raised, in Braille and mounted on the latch side of the door?

Yes No

If there are signs providing direction to or information about the interior space do the text characters contrast with their background, are the text letters raised, in Braille and mounted on the latch side of the door?

Yes No

D - Rooms and Spaces

Are hall pathways at least 36 inches wide?

Yes No

Are floor surfaces stable, firm and slip resistant?

If there is carpet is it no higher than 1/2 inch thick and is it attached securely along the edges?

E - Light Switches

Is there clear floor space at least 30 inches wide by at least 48 inches long for a forward or parallel approach?

Yes No

Are the switches no higher than 48 inches above the floor?

Can the switch be controlled with one hand and without tight pinching, grasping, or twisting of the wrist?

F - Seating

Are an adequate number of wheelchair spaces provided?

Yes No

# of Seats	Wheelchair Spaces
4 - 25	1
26 - 50	2
51 - 150	4

see standards 221.2.1

Are wheelchair spaces dispersed to allow location choices and viewing angles equivalent to other seating.

Is there a route at least 36 inches wide to accessible dining seating?

At the dining space is the top of the accessible surface no less than 28 inches and no greater than 34 inches above the floor?

Are the tops of counters or tables between 28 and 34 inches wide?

Are aisles between tables at least 36 inches wide?

Comments:

3 ACCESSIBLE TOILETS AND BATHROOMS			Comments:
Is there at least one wheelchair accessible bathroom (stall, if applicable) in the facility?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Are there signs at accessible toilets that include the International Symbol of Accessibility?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Is the door opening width at least 32 inches clear, between the face of the door, and the stop, when the door is open 90 degrees?	<input type="checkbox"/>	<input type="checkbox"/>	
Does the entry configuration provide adequate maneuvering space for a person using a wheelchair (18 inches beyond the latch side plus 60 inches clear depth)?	<input type="checkbox"/>	<input type="checkbox"/>	
Is the threshold edge no more than 1/4 inch high?	<input type="checkbox"/>	<input type="checkbox"/>	
Is there door equipment that is operable with one hand and does not require tight grasping, pinching, or twisting of the wrist?	<input type="checkbox"/>	<input type="checkbox"/>	
Are the operable parts of the door hardware mounted no less than 34 inches and no greater than 48 inches above the floor.?	<input type="checkbox"/>	<input type="checkbox"/>	
Can the door be opened easily (5 pounds maximum force)?	<input type="checkbox"/>	<input type="checkbox"/>	
Is there a clear path to each type of fixture, e.g. lavatory, hand dryer, etc. that is at least 36 inches wide?	<input type="checkbox"/>	<input type="checkbox"/>	
Is there floor space available for a person to turn around (a circle at least 60 inches in diameter or a t-shaped space within a 60 inch square)?	<input type="checkbox"/>	<input type="checkbox"/>	
Does at least one lavatory have a clear floor space for a forward approach at least 30 inches wide and 48 inches long?	<input type="checkbox"/>	<input type="checkbox"/>	
Do no less than 17 inches and no greater than 25 inches of the clear floor space extend under the lavatory so a person using a wheelchair can get close enough to the faucet?	<input type="checkbox"/>	<input type="checkbox"/>	
Is the front of the lavatory or counter surface, whichever is higher, no more than 34 inches above the floor?	<input type="checkbox"/>	<input type="checkbox"/>	
Are the pipes below the lavatory insulated or otherwise configured to protect against contact?	<input type="checkbox"/>	<input type="checkbox"/>	
Can the faucet be operated without tight grasping, pinching, or twisting of the wrist?	<input type="checkbox"/>	<input type="checkbox"/>	

	Yes	No	Comments:
Are soap and other dispensers and hand dryer (if applicable) within reach ranges and usable without tight grasping, pinching, or twisting of the wrist?	<input type="checkbox"/>	<input type="checkbox"/>	
Is there a grab bar at the toilet at least 42 inches long on the side wall, and located no more than 12 inches from the rear wall?	<input type="checkbox"/>	<input type="checkbox"/>	
If the flush control is hand operated, can it be operated with one hand and without tight grasping, pinching, or twisting of the wrist?	<input type="checkbox"/>	<input type="checkbox"/>	
Is there a roll-in shower, or transfer shower? If not is there a transfer bench in the shower?	<input type="checkbox"/>	<input type="checkbox"/>	
Is there a hand-held shower?	<input type="checkbox"/>	<input type="checkbox"/>	
4 ADDITIONAL ACCESSIBILITY			
	Yes	No	
If there is a public phone is it accessible to those in a wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	
Does the phone have a volume control, have large numbers, braille numbers, and large control buttons (volume, redial, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	
If the facility has hearing impaired residents, does one telephone have TTY?	<input type="checkbox"/>	<input type="checkbox"/>	
Do fire alarm systems, have both flashing lights and audible signals?	<input type="checkbox"/>	<input type="checkbox"/>	

Disclaimer:

The South Carolina Department of Health and Human Services (SCDHHS) is not responsible for enforcement of the Americans with Disabilities Act (ADA). The information, presented here is intended solely as informational guidance and contract compliance in regards to the Optional Supplementation for Assisted Living Program (OSCAP), and is neither a determination of your legal rights or responsibilities under the ADA, nor binding on any agency with enforcement responsibility under ADA.

Pre-enrollment Screening Tool for the Optional Supplemental Care for Assisted Living Participants (OSCAP)

Becoming an OSCAP Service Provider

Prior to the initiation of a contract, potential providers **Must Have A Computer**, internet access and an email address in order to receive correspondence and authorizations from SC DHHS. Additionally, if anyone is interested in becoming an OSCAP service provider it is recommended that you attend a training session. The dates and times will be announced in the OSS Advisory.

The Division of Long Term Care Transformation contracts with qualified providers to provide OSCAP services to Medicaid recipients. These services are prior authorized by OSCAP nurses. The authorization gives consent to provide OSCAP services to eligible participants. Contracting as an OSCAP provider allows the provider to provide services to residents who are blind, age, or disabled and meet the medical necessity and financial eligibility.

Providers must follow the Scopes of Service as well as meet all other contractual obligations in order to be an OSCAP service provider. You should print a copy to review before completing this application.

Each client is required to choose a provider from a Client Choice of Provider Form that lists all OSCAP providers in the area by county. Because of the client choice of provider policy we cannot guarantee the number of participants any provider will be authorized to serve. Therefore, we urge all providers not to rely upon Medicaid as the primary source for reimbursement. Business decisions should not be made based on any agency's or individual's anticipation of receiving any reimbursement from OSCAP.

Check the appropriate boxes and fill in the information that is requested. You must also include the items listed in addition to completing this application.

Applications should be sent to: Division of Long Term Care Transformation , Post Office Box 8206, Columbia, SC 29202-8206, Attention: Alexis Martin . If you have any questions regarding this process or the stated requirements please see the OSS Provider Manual located at:

<https://www.scdhhs.gov>

The following items must be checked and/or enclosed for this application to be considered for processing:

I wish to become a provider of the following services: (Check all for which you are applying)

- OSCAP 1
- OSCAP 2 Note: Facilities has to be enrolled as an OSCAP 1 provider before permitted to apply for OSCAP Tier 2
- I understand that it will be necessary to schedule a South Carolina Department of Health and Human Services (SCDHHS) compliance review visit as part of the contracting process and that I will be contacted prior to this visit.
- I agree to abide by all requirements and policies of the SCDHHS as described in my contract and any other communication received from SCDHHS.
- I have read and have a general understanding of the scope of services for the program for which I am applying to become a provider.
- I certify that neither I, nor any officer, director, administrator, billing agent, managing employee, affiliated person or partner, or shareholder having an ownership interest has been involuntarily terminated or has involuntarily withdrawn from participation in the OSS or IPC Programs within the 1 year.
- By checking this box I am indicating that my agency requires Medicaid participants to sign Admission agreements. I understand that I must include a copy of the agreement form.
- I certify that this agency will submit any subcontracts to SCDHHS for prior approval (i.e. license nurse contract, recreation, VA, home health, and hospice).
- I certify that a governing body or person(s) so functioning shall assume full legal authority for the operation of the provider agency.
- My regularly scheduled holidays are listed on the attached sheet.
- I understand that this agency may be reviewed by SCDHHS or their representatives at any time during normal business hours. This review can be announced or unannounced. I also understand that my agency must produce all requested records related to the administration of the agency, staff records and individual client records.
- Upon implementation of electronic billing I understand that persons providing OSCAP services must use the Care Call system to document their service delivery and adherence to this contract.

- I understand that I must abide by all marketing limitations as indicated in the contract
- I understand that I must not give any type of gifts, samples or other products to SC DHHS staff
- I understand that my staff must report incidents of abuse, neglect or exploitation of adult beneficiaries in accordance with the Omnibus Adult Protection Act (S.C. Code of Laws Section 43-35-5, et seq.) to the SC Department of Health of Health Services.
- I hired a licensed contractor to complete the Community Residential Care Facility Accessibility Checklist
- I would like to have the SCDHHS licensed contractor complete the Community Residential Care Facility Accessibility Checklist

Print the name and address of the person who will sign the contract (ownership):

The name of the person designated to serve as the agency administrator:

The following items must be submitted with your application:

- Certified evidence of operating capital that will show that the provider agency has the capability to operate for a minimum of 60 days in the event Medicaid reimbursement is delayed or withheld for any reason. This must be a written statement from an officer of a financial institution or a certified accountant. Operating capital may be verified prior to final approval for a contract.

The minimum operating capital levels are:

- 4-10 Beds - \$2500
- 11-25 Beds - \$5000
- 26 and above – \$10,000

- Administrator must provide a copy of current community residential care facility license.
- A copy of the provider agency's Workers' Compensation Insurance Policy. If you do not yet have one, please indicate on your application. A copy of the policy must be presented prior to the provision of services.
- A copy or letter of certification of the provider agency's current liability insurance policy showing coverage to include date of application.
- A copy of your articles of incorporation or other document that established you as a legal entity. If you do not already have this, it must be obtained from the Secretary of State. If you are a Sole Proprietor, this is not required. Sole Proprietors must provide a copy of your business license.
- Copy of current license for your CRCF Nurse.
- A completed Pre-contractual Information Form. (See attached form)
- I certify that all information given with this form is true. I understand that any false information will result in this application being denied.

Applicant's Name Printed: _____

Applicant's Signature: _____

Title and Date: _____

Agency Telephone No: _____

Agency Fax No: _____

Alternate Telephone/Cell No. (specify type) : _____

Agency Name: _____

RC Number: R C _____

Agency Address: _____

Agency Hours: _____

Mailing Address (if different from agency address): _____

Email Address: _____

List of Scheduled Holidays

Check each holiday observed by your agency and indicates additional holidays below.

- New Year's Day
- Martin Luther King's Birthday
- Presidents Day
- Good Friday
- Easter
- Monday after Easter
- Memorial Day
- Independence Day (July 4th or day observed)
- Labor Day
- Columbus Day
- Veterans Day
- Thanksgiving
- Day after Thanksgiving
- Christmas Eve
- Christmas
- Day after Christmas
- List additional holidays here _____

Pre-Contractual Information Form

Yes No

Have you ever worked for an agency that has received Medicaid funds?
If yes, what agency and what was your position? _____

Have you have ever been an enrolled or contracted Medicaid provider?
If yes, when (dates) _____
which state? _____
What service did you provide? _____
What was/is your previous/current Medicaid provider number? _____

Are you currently enrolled or contracted with DHHS for any service provision?
If not, when did contract or enrollment end? _____
If terminated, was termination voluntary or involuntary? _____

If this is an agency or corporate entity, has the agency ever been enrolled or contracted with Medicaid?
If yes, when? _____
Dates _____
Which state? _____
What type of service was provided? _____
What was/is the agency's or corporate entity's previous/current Medicaid provider number? _____

Have any officers, agents or employees been terminated, been denied participation in the Medicaid Program or denied a contract with DHHS?
If yes, when? (dates) _____
For what service? _____
Reason _____

Any falsification of information submitted is grounds for denial or termination of a contract.

Signature : _____

Date: _____

OSCAP PROVIDER INFORMATION UPDATE FORM

CRCF Name: _____ RC# _____
Person Completing Form: _____
E-mail: _____ @ _____ Phone _____

- Change of Ownership
This form is not a Change of Ownership Form. Please contact the Provider Service Center at (888) 289-0709, option 4, to complete a Change of Ownership.

Contact Name(s): _____ New RC# _____
Corporation Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
E-mail: _____ @ _____

- ❖ Please attach a copy of the facility's business license or articles of incorporation, Liability Policy, and proof of Working Capital. See OSS Provider Manual for additional information.

- CRCF Contact Information

Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
E-mail: _____ @ _____

- Billing Address:

Contact Name(s): _____
Corporation Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
E-mail: _____ @ _____

- Change of Administrator (attach copy of license)

Name: _____ License # _____
Phone: _____ Fax: _____
E-mail: _____ @ _____

- Change of CRCF Nurse (Attach a copy of license verification)

Name: _____ License # _____
Phone: _____ Fax: _____
E-mail: _____ @ _____

Please send completed form to:

Division of Community and Facility Services
P. O. Box 8206
Columbia, South Carolina
Attention: Alexis Martin – J7

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 or any member of the organization indicated on this form. 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.

Name of Authorized Representative (First name, Middle name, Last name)		<input type="checkbox"/> New <input type="checkbox"/> Change <input type="checkbox"/> Addition <input type="checkbox"/> Remove this person or organization as my authorized representative	
Authorized Representative's address (Leave blank if you don't have one.)		Apartment or suite number	
City	State	ZIP code	
Authorized Representative's phone number		Other phone number	
Authorized Representative's email address			
Organization name (if applicable)	Unit* (if applicable)	ID number (if applicable)	

*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

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**.

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).



Apply faster online

- Apply faster online at [SCDHHS.gov](https://www.scdhhs.gov) or [HealthCare.gov](https://www.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](https://www.scdhhs.gov/internet/pdf/SCDHHSNoticeofPrivacyPractices080107.pdf).



What happens next?

Send your complete, signed application to the address on page 13.
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](https://www.scdhhs.gov) or call 1-888-549-0820. Filling out this application doesn’t mean you have to buy health coverage.



NEED HELP WITH YOUR APPLICATION? Visit [SCDHHS.gov](https://www.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.



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.



Tell us about yourself and 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.



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**.



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STEP 1

Some Medicaid programs that cover specific services require additional information to determine eligibility. By completing this section, we will be able to ask you for information most relevant to your needs. If anyone applying for coverage meets the following criteria, please check all boxes that apply. **Even if you or your household members do not meet any of these criteria, you may still qualify for Medicaid. If none apply, do not check anything; we will evaluate you for all available coverage types.**

- | | |
|---|--|
| <input type="checkbox"/> Need to live in a medical facility or nursing home or need nursing services at home | <input type="checkbox"/> Presumptive Disability This box for pilot use only |
| <input type="checkbox"/> Receiving treatment for one of the following:
-Breast cancer -Cervical cancer -Atypical Breast Hyperplasia
-Precancerous Cervical Lesion (CIN 2/3) | <input type="checkbox"/> Have a physical or intellectual disability |
| <input type="checkbox"/> SSI is ending and need to reapply for Medicaid (example: a letter citing the Pickle Amendment) | <input type="checkbox"/> Age 65 or older |
| <input type="checkbox"/> Foreign refugee who has been granted asylum in the U.S. | <input type="checkbox"/> Receive Medicare |
| | <input type="checkbox"/> Applying for TEFRA or PRTF |

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

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 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.

1. Application start date

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

3. Organization Name (if applicable)

4. ID Number (if applicable)



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: PERSON 1

Complete Step 1 for each person in your family.
Start with information about yourself.

Complete Step 1 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) _____ a. If you don't have a SSN, have you applied for one? Yes No *If no, indicate the reason at question 15.*

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 1-888-842-3620.

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 dependents: _____
c. Will you be claimed as a dependent on someone's tax return? Yes No
If yes, please list 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 5. 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. Have you been diagnosed with and are receiving treatment for any of the following? Yes No
• Breast Cancer • Cervical Cancer • Atypical Breast Hyperplasia • Precancerous Cervical Lesion (CIN 2/3)

12. Do you want to apply for Family Planning benefits? Yes No
Family Planning is a limited benefit program, which provides family planning services, family planning-related services and certain limited preventative screenings. Family Planning is not full Medicaid coverage. If you leave this question blank, we will not assess you for Family Planning.

13. Are you a U.S. citizen or U.S. national? Yes No
14. **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

15. If you have not applied for a Social Security Number, list the reason:
 Issued for non-work reasons only No SSN due to religious reasons Not eligible for SSN
 Newborn, mother currently receiving Medicaid Newborn, mother NOT receiving Medicaid

16. Do you want help paying for medical bills from the last 3 months? Yes No
a. If YES, was your household size the same during these 3 months as it is now? Yes No
b. Was your household income the same during these 3 months as it is now? Yes No
If NO, enter the total monthly income for: Last Month: \$ _____ 2 Months Ago: \$ _____ 3 Months Ago: \$ _____

17. 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
18. Are you a full-time student? Yes No
19. Were you in foster care in South Carolina at age 18 or older? Yes No
20. Are you currently living in a foster home? Yes No
21. Are you currently living in a DJJ group home? Yes No

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



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STEP 1: PERSON 1 (Continue with yourself)

22. If Hispanic/Latino, ethnicity (OPTIONAL)

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

23. Race (OPTIONAL—check all that apply)

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

Current job & income information

Employed
 If you're currently employed, tell us about your income. Start with question 24.

Not Employed
 SKIP to question 36.

Self-Employed
 SKIP to question 35.

CURRENT JOB 1:

24. Employer name and address _____

25. Employer phone number _____

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

\$ _____ 27. Average hours worked each week _____ 28. Start date _____

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

29. Employer name and address _____

30. Employer phone number _____

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

\$ _____ 32. Average hours worked each week _____ 33. Start date _____

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

35. 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?)

\$ _____

36. 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? _____ Net farming/fishing: \$ _____ How often? _____

Pensions \$ _____ How often? _____ Net rental/royalty: \$ _____ How often? _____

Social Security \$ _____ How often? _____ Other income:

Retirement acc'ts \$ _____ How often? _____ Type: _____ \$ _____ How often? _____

Alimony received \$ _____ How often? _____ Type: _____ \$ _____ How often? _____

37. 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 35b).

Alimony paid \$ _____ How often? _____ Other deductions: \$ _____ How often? _____

Student loan interest \$ _____ How often? _____ Type: _____

38. 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 1: PERSON 2

Complete Step 1 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: <input type="checkbox"/> Male <input type="checkbox"/> Female	5. Social Security number (SSN)
6. Does PERSON 2 live at the same address as you? <input type="checkbox"/> Yes <input type="checkbox"/> No		We need this if PERSON 2 wants health coverage and has an SSN.	
If no, list address: _____		a. If you don't have a SSN, have you applied for one? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, indicate the reason at question 16.	
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.) <input type="checkbox"/> YES. If yes, please answer questions a-c. <input type="checkbox"/> NO. If no, SKIP to question c.			
a. Will Person 2 file jointly with a spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of spouse: _____			
b. Will Person 2 claim any dependents on your tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, list dependents: _____			
c. Will Person 2 be claimed as a dependent on someone's tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please list the tax filer: _____ How are you related to the tax filer? _____			
8. Are you pregnant or recently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
9. Does PERSON 2 need health coverage? (Even if you have insurance, there might be a program with better coverage or lower costs) <input type="checkbox"/> YES. If yes, answer the questions below. <input type="checkbox"/> NO. If no, SKIP to the income questions on page 7. Leave the rest of this page blank.			
10. Do you have a disabling physical, mental, or emotional health condition that causes limitations in activities? <input type="checkbox"/> Yes <input type="checkbox"/> No			
11. Do you need to live in a medical facility or nursing home or need nursing services at home? <input type="checkbox"/> Yes <input type="checkbox"/> No			
12. Have you been diagnosed with and are receiving treatment for any of the following? <input type="checkbox"/> Yes <input type="checkbox"/> No			
• Breast Cancer • Cervical Cancer • Atypical Breast Hyperplasia • Precancerous Cervical Lesion (CIN 2/3)			
13. Does PERSON 2 want to apply for Family Planning benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<i>Family Planning is a limited benefit program, which provides family planning services, family planning-related services and certain limited preventative screenings. Family Planning is not full Medicaid coverage. If you leave this question blank, we will not assess you for Family Planning.</i>			
14. Is PERSON 2 a U.S. citizen or U.S. national? <input type="checkbox"/> Yes <input type="checkbox"/> No			
15. If PERSON 2 isn't a U.S. citizen or U.S. national, does PERSON 2 have eligible immigration status? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
d. Is PERSON 2, their spouse or parent a veteran or an active-duty member of the U.S. military? <input type="checkbox"/> Yes <input type="checkbox"/> No			
16. If you have not applied for a Social Security Number, list the reasons			
<input type="checkbox"/> Issued for non-work reasons only <input type="checkbox"/> No SSN due to religious reasons <input type="checkbox"/> Not eligible for SSN			
<input type="checkbox"/> Newborn, mother currently receiving Medicaid <input type="checkbox"/> Newborn, mother NOT receiving Medicaid			
17. Does PERSON 2 want help paying for medical bills from the last 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No			
a. If YES, was this person's household size the same during these 3 months as it is now? <input type="checkbox"/> Yes <input type="checkbox"/> No			
b. Was this person's household income the same during these 3 months as it is now? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If NO, enter the total monthly income for: Last Month: \$ _____ 2 Months Ago: \$ _____ 3 Months Ago: \$ _____			
18. Does PERSON 2 live with at least one child under 19, and is PERSON 2 the main person taking care of this child? <input type="checkbox"/> Yes <input type="checkbox"/> No			
19. Is PERSON 2 a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No			
20. Was PERSON 2 in foster care in South Carolina at age 18 or older? <input type="checkbox"/> Yes <input type="checkbox"/> No			
21. Is PERSON 2 currently living in a foster home? <input type="checkbox"/> Yes <input type="checkbox"/> No			
22. Is PERSON 2 currently living in a DJJ group home? <input type="checkbox"/> Yes <input type="checkbox"/> No			

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



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STEP 1: PERSON 2

23. If Hispanic/Latino, ethnicity (OPTIONAL)

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

24. Race (OPTIONAL—check all that apply)

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

Current job & income information

Employed

If you're currently employed, tell us about your income. Start with question 25.

Not Employed

SKIP to question 37.

Self-Employed

SKIP to question 36.

CURRENT JOB 1:

25. Employer name and address _____

26. Employer phone number _____

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

\$ _____ 28. Average hours worked each week _____ 29. Start date _____

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

30. Employer name and address _____

31. Employer phone number _____

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

\$ _____ 33. Average hours worked each week _____ 34. Start date _____

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

36. 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?)

\$ _____

37. 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? _____ Net farming/fishing: \$ _____ How often? _____

Pensions \$ _____ How often? _____ Net rental/royalty: \$ _____ How often? _____

Social Security \$ _____ How often? _____ Other income:

Retirement acc'ts \$ _____ How often? _____ Type: _____ \$ _____ How often? _____

Alimony received \$ _____ How often? _____ Type: _____ \$ _____ How often? _____

38. 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 36b).

Alimony paid \$ _____ How often? _____ Other deductions: \$ _____ How often? _____

Student loan interest \$ _____ How often? _____ Type: _____

39. 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)

\$ _____

\$ _____



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STEP 1: PERSON 3

Complete Step 1 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) _____

6. Does PERSON 3 live at the same address as you? Yes No **We need this if PERSON 3 wants health coverage and has an SSN.**

a. If you don't have a SSN, have you applied for one? Yes No
If no, indicate the reason at question 16.

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 dependents: _____

c. Will Person 3 be claimed as a dependent on someone's tax return? Yes No
If yes, please list the tax filer: _____ How are you 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 the questions below. NO. If no, SKIP to the income questions on page 7. Leave the rest of this page blank.

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

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

12. Have you been diagnosed with and are receiving treatment for any of the following? Yes No
• Breast Cancer • Cervical Cancer • Atypical Breast Hyperplasia • Precancerous Cervical Lesion (CIN 2/3)

13. Does PERSON 3 want to apply for Family Planning benefits? Yes No
Family Planning is a limited benefit program, which provides family planning services, family planning-related services and certain limited preventative screenings. Family Planning is not full Medicaid coverage. If you leave this question blank, we will not assess you for Family Planning.

14. Is PERSON 3 a U.S. citizen or U.S. national? Yes No

15. **If PERSON 3 isn't a U.S. citizen or U.S. national, does PERSON 3 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

16. If you have not applied for a Social Security Number, list the reasons
 Issued for non-work reasons only No SSN due to religious reasons Not eligible for SSN
 Newborn, mother currently receiving Medicaid Newborn, mother NOT receiving Medicaid

17. Does PERSON 3 want help paying for medical bills from the last 3 months? Yes No
a. If YES, was this person's household size the same during these 3 months as it is now? Yes No
b. Was this person's household income the same during these 3 months as it is now? Yes No
If NO, enter the total monthly income for: Last Month: \$ _____ 2 Months Ago: \$ _____ 3 Months Ago: \$ _____

18. Does PERSON 3 live with at least one child under 19, and is PERSON 2 the main person taking care of this child? Yes No

19. Is PERSON 3 a full-time student? Yes No

20. Was PERSON 3 in foster care in South Carolina at age 18 or older? Yes No

21. Is PERSON 3 currently living in a foster home? Yes No

22. Is PERSON 3 currently living in a DJJ group home? Yes No

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 1-888-842-3620.

STEP 1: PERSON 3

23. If Hispanic/Latino, ethnicity (OPTIONAL)

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

24. Race (OPTIONAL—check all that apply)

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

Current job & income information

Employed
 If you're currently employed, tell us about your income. Start with question 25.

Not Employed
 SKIP to question 37.

Self-Employed
 SKIP to question 36.

CURRENT JOB 1:

25. Employer name and address _____

26. Employer phone number _____

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

\$ _____ 28. Average hours worked each week _____ 29. Start date _____

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

30. Employer name and address _____

31. Employer phone number _____

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

\$ _____ 33. Average hours worked each week _____ 34. Start date _____

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

36. 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?)

\$ _____

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

38. **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 36b).

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

39. **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)

\$ _____

\$ _____



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STEP 1: PERSON 4

Complete Step 1 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) _____

6. Does PERSON 4 live at the same address as you? Yes No **We need this if PERSON 4 wants health coverage and has an SSN.** a. If you don't have a SSN, have you applied for one? Yes No
If no, list address: _____ *If no, indicate the reason at question 16.*

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 dependents: _____

c. Will Person 4 be claimed as a dependent on someone's tax return? Yes No
If yes, please list the tax filer: _____ How are you 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 the questions below. NO. If no, SKIP to the income questions on page 7. Leave the rest of this page blank.

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

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

12. Have you been diagnosed with and are receiving treatment for any of the following? Yes No
• Breast Cancer • Cervical Cancer • Atypical Breast Hyperplasia • Precancerous Cervical Lesion (CIN 2/3)

13. Does PERSON 4 want to apply for Family Planning benefits? Yes No
Family Planning is a limited benefit program, which provides family planning services, family planning-related services and certain limited preventative screenings. Family Planning is not full Medicaid coverage. If you leave this question blank, we will not assess you for Family Planning.

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

15. 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

16. If you have not applied for a Social Security Number, list the reasons
 Issued for non-work reasons only No SSN due to religious reasons Not eligible for SSN
 Newborn, mother currently receiving Medicaid Newborn, mother NOT receiving Medicaid

17. Does PERSON 4 want help paying for medical bills from the last 3 months? Yes No
a. If YES, was this person's household size the same during these 3 months as it is now? Yes No
b. Was this person's household income the same during these 3 months as it is now? Yes No
If NO, enter the total monthly income for: Last Month: \$ _____ 2 Months Ago: \$ _____ 3 Months Ago: \$ _____

18. 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

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

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

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

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

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



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STEP 1: PERSON 4

23. If Hispanic/Latino, ethnicity (OPTIONAL)

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

24. Race (OPTIONAL—check all that apply)

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

Current job & income information

Employed

If you're currently employed, tell us about your income. Start with question 25.

Not Employed

SKIP to question 37.

Self-Employed

SKIP to question 36.

CURRENT JOB 1:

25. Employer name and address _____

26. Employer phone number _____

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

\$ _____ 28. Average hours worked each week _____ 29. Start date _____

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

30. Employer name and address _____

31. Employer phone number _____

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

\$ _____ 33. Average hours worked each week _____ 34. Start date _____

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

36. 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?)

\$ _____

37. 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? _____ Net farming/fishing: \$ _____ How often? _____

Pensions \$ _____ How often? _____ Net rental/royalty: \$ _____ How often? _____

Social Security \$ _____ How often? _____ Other income:

Retirement acc'ts \$ _____ How often? _____ Type: _____ \$ _____ How often? _____

Alimony received \$ _____ How often? _____ Type: _____ \$ _____ How often? _____

38. 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 36b).

Alimony paid \$ _____ How often? _____ Other deductions: \$ _____ How often? _____

Student loan interest \$ _____ How often? _____ Type: _____

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

If you don't expect changes to PERSON 4's monthly income, add another person on the following pages.

PERSON 4's total income this year

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

\$ _____

\$ _____



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STEP 2 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 3.
 YES. If YES, ask for and complete SCDHHS Form 3400-Appendix B (American Indian or Alaska Native Family Member).

STEP 3 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**.
- | | |
|--|---|
| <p><input type="checkbox"/> Medicaid _____</p> <p><input type="checkbox"/> CHIP _____</p> <p><input type="checkbox"/> Medicare _____
Claim number: _____
Date Medicare coverage started: _____</p> <p><input type="checkbox"/> TRICARE (Don't check if you have direct care of Line Of Duty)
_____</p> <p><input type="checkbox"/> VA health care programs: _____</p> <p><input type="checkbox"/> Peace Corps: _____</p> | <p><input type="checkbox"/> Employer insurance _____
Name of health insurance: _____
Policy number: _____ Start Date: _____
Is this COBRA coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Is this a retiree health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Other health insurance _____
Name of health insurance: _____
Policy number: _____ Start Date: _____
Is this a limited-time benefit plan (ex: a school accident policy)? <input type="checkbox"/> Y <input type="checkbox"/> N</p> |
|--|---|

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 4.

STEP 4 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 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.
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.



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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 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.
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 5 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 1-888-842-3620.

APPENDIX A

Health Coverage from Jobs

You DONT need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage.

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

EMPLOYEE information

1. Employee name (First, Middle, Last)

2. Employee Social Security number

EMPLOYER information

3. Employer name

4. Employer Identification Number (EIN)

5. Employer address

6. Employer phone number

7. City

8. State

9. ZIP code

10. Who can we contact about employee health coverage at this job?

11. Phone number (if different from above)

12. Email address

()

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

YES. If YES, continue below.

NO. If NO, stop here and go to Step 3 on the application.

13a. If you're in a waiting or probationary period, when can you enroll in coverage?

(mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name: _____

Name: _____

Name: _____

Tell us about the health plan offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*?

Yes No

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? Weekly Every 2 weeks Twice a month Monthly Yearly

16. What change will the employer make for the new plan year (if known)?

Employer won't offer health coverage

Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? Weekly Every 2 weeks Twice a month Monthly Yearly

Date of change (mm/dd/yyyy): _____

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs [Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986]



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EMPLOYER COVERAGE TOOL

Health Coverage from Jobs

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below match the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage.



EMPLOYEE Information

The **employee** needs to fill out this section.

1. Employee name (First, Middle, Last)

2. Employee Social Security number



EMPLOYER Information

The **employer** needs to fill out this section.

3. Employer name

4. Employer Identification Number (EIN)

5. Employer address

6. Employer phone number
()

7. City

8. State

9. ZIP code

10. Who can we contact about employee health coverage at this job?

11. Phone number (if different from above)

12. Email address

()

13. Is the employee currently eligible for coverage offered by this employer, or will the employee become eligible in the next 3 months?

YES. If YES, continue below.

NO. If NO, stop here and go to Step 3 on the application.

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?

(mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name: _____

Name: _____

Name: _____

Tell us about the **health plan** offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*?

Yes

No

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? Weekly

Every 2 weeks

Twice a month

Monthly

Yearly

16. What change will the employer make for the new plan year (if known)?

Employer won't offer health coverage

Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? Weekly

Every 2 weeks

Twice a month

Monthly

Yearly

Date of change (mm/dd/yyyy): _____

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs [Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986]



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**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 or any member of the organization indicated on this form. 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.

Name of Authorized Representative (First name, Middle name, Last name)		<input type="checkbox"/> New <input type="checkbox"/> Change <input type="checkbox"/> Addition <input type="checkbox"/> Remove this person or organization as my authorized representative	
Authorized Representative's address (Leave blank if you don't have one.)			Apartment or suite number
City	State	ZIP code	
Authorized Representative's phone number		Other phone number	
Authorized Representative's email address			
Organization name (if applicable)		Unit* (if applicable)	ID number (if applicable)

*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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South Carolina Department of Health and Human Services

Application for Nursing Home, Residential or In-Home Care

This application is used to apply for Nursing Home, Waiver Services, or Optional State Supplementation (OSS) at the South Carolina Department of Health and Human Services (SCDHHS). Please answer all questions as completely as possible as they apply to you or the persons for whom you are applying. If you need help filling out this application, you can call 1-888-549-0820.

I am applying for: Nursing Home Waiver Services OSS

Presumptive Disability **This box for pilot use only**
Who?

Federal law requires that anyone who applies for Medicaid for themselves must tell us about their citizenship or immigration status and provide or apply for a Social Security Number (SSN). We can help you apply for a SSN, and benefits will not be denied or delayed while the application is being processed. SSNs provided will be used to help the State agency determine eligibility. Each non-citizen applying for full Medicaid benefits must provide United States Citizenship and Immigration Services (USCIS) documents, such as an I-551 (Green Card) or I-94. Anyone applying as a non-citizen for emergency services only is not required to provide USCIS documents or a SSN.

Some family members of applicants may choose not to apply for Medicaid. In that case, they do not have to provide a SSN or citizenship or immigration status but will be required to provide information about their income and assets. Benefits to applicants will not be delayed or denied just because some family members do not wish to apply for themselves. Even though a person not applying for Medicaid is not required to provide a SSN, it is helpful for us to have this number as we gather the information we need to make a decision. We use SSN to help us check identity, verify eligibility and prevent fraud. We exchange information with other agencies according to Federal rules and to manage our programs.

How do I apply for benefits?

- You must fill out this application using Black or Blue ink or by Typing your answers. You are also able to apply online by going to www.SCDHHS.gov.
- Attach extra sheets if you need more space to answer any of the questions.
- You may mail your application to: SCDHHS PO Box 100101 Columbia, SC 29202-3031.
- To be valid, the application must have your name, contact information and be signed.
- If we do not have everything we need, you will get a list of what you need to send us.
- When we have everything we need, a decision will be made about your Medicaid eligibility. You should receive a letter within 45 days from the date we receive your application to tell you if you are eligible. If you need a disability determination, it may take up to 90 days.
- Immediately report any change in income or other information on your application to your local Medicaid office or by calling the call center at 1-888-549-0820.
- We may share this information with other Federal and state agencies as we gather what we need to make a decision.

1. Tell us who is the person that needs help (Applicant) and how we can get in touch.

Name (First, Middle Initial, Last)		County (Where you live)		Do you want to get information about this application by email? <input type="checkbox"/> Yes <input type="checkbox"/> No E-Mail Address: _____	
Home or Street Address (include apartment or lot number)		City	State		
Mailing Address (If different from where you live)		City	State	Zip Code	What is your preferred language? Spoken <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: Written <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:
Phone Numbers Home: _____		Work: _____	Cell: _____		

2. Tell us about the person(s) who needs nursing home, long term care, or residential care. Please include any dependents the person may have, such as a spouse or children.

This information is Optional for:
 • Anyone not applying for Medicaid coverage;
 • A non-citizen applying for Emergency Services Only

Name	Relationship to the Applicant <small>* (Use Relationship Codes shown below)</small>	Marital Status <small>Single, Married, Divorced, Widowed, Separated</small>	Date of Birth	Sex	Is this person applying for Medicaid?	**See below Is this person applying for Family Planning?	Social Security Number	Race <small>*** (Race codes shown below)</small>	Is this person a US citizen?
1. Applicant	X			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Spouse				<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
3.				<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
4.				<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
5.				<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No

* Relationship Codes: SP Spouse BF/GF Boyfriend/Girlfriend NR Not Related OTH Other CH Child (Natural or Adopted) SC Step-Child GC Grandchild NE Niece/Nephew

*** Race Codes: 01 White/Caucasian 02 Black/African American 03 Multi Race 04 Federally Recognized Native American (Requires Verification) 05 Other Native American
06 Alaska Native 07 Asian 08 Other/Unknown 09 Native Hawaiian/Pacific Islander 10 Hispanic

**Family Planning is a limited benefit program, which provides family planning services, family planning-related services and certain limited preventative screenings. Family Planning is not full Medicaid coverage. If you leave this question blank, we will not assess you for Family Planning.

3. Please tell us if anyone has Conservatorship, Guardianship, or Power of Attorney for the applicant. If yes, please give us a copy of the legal or court papers and the name and phone number of the person.

- Conservatorship Name and Phone Number: _____
- Guardianship Name and Phone Number: _____
- Power of Attorney Name and Phone Number: _____

4. Do you or someone you are applying for want nursing home services, either in a nursing home or at home? Yes No
 If yes, who: _____ Nursing Home Services at Home

5. Do you or someone you are applying for want to go into a Residential Care Facility/Boarding Home? Yes No
 If yes, who: _____

6. Are you or someone you are applying for currently in a Hospital, Nursing Home, or Residential Care Facility? Yes No, at Home
 If yes, who: _____ Date Entered: _____ Where: _____

7. Are you blind, disabled, or applying for someone who is blind or disabled? Yes No

Name of Blind or Disabled Person	Is this Person Receiving or Applying for Social Security or SSI
	<input type="checkbox"/> Receiving Social Security or SSI <input type="checkbox"/> Applying for Social Security or SSI
	<input type="checkbox"/> Receiving Social Security or SSI <input type="checkbox"/> Applying for Social Security or SSI

8. Have you or someone you are applying for received medical services in the past three months? Yes No

Person(s) Receiving Medical Services	Months Services Received

You will have to give us information about income and assets for each month to see if the person may be Medicaid eligible

9. Did you or someone you are applying for retire from the military, have a service related disability, OR are the spouse or dependent of someone who has retired from the military or has a service related disability? Yes No
 If Yes, tell us who? _____

10. Has the applicant or spouse ever worked somewhere that has a retirement benefit for which he or she may be eligible to receive money? Yes No
 If yes, who was working, where and for how long? _____

11. Has anyone in the home stopped working within the past year? Yes No If YES, tell us who was working, where, and when the job ended.

12. Tell us about the income of each family member in the home.

NO ONE IN THE HOME HAS ANY INCOME

Before we can make a decision on your application, you may have to give us proof of income for the past 4 weeks.

If checked, explain how you pay your bills

Income from Employment	Income from Employment			
Name of person working _____	Name of person working _____			
Employer's Name _____	Employer's Name _____			
Employer's Address _____	Employer's Address _____			
_____	_____			
Employer's Phone Number (including area code) _____	Employer's Phone Number (including area code) _____			
Gross amount earned per pay period before taxes? \$ _____	Gross amount earned per pay period before taxes? \$ _____			
How often paid? <input type="checkbox"/> Weekly <input type="checkbox"/> Every two weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly	How often paid? <input type="checkbox"/> Weekly <input type="checkbox"/> Every two weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly			
When is it paid? _____	When is it paid? _____			
Is anyone self-employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please send copies of all the Personal and Business Federal income tax forms most recently filed with the IRS. Include all forms and schedules. Please tell us who is self employed and the name of the business: _____				
Do you or anyone in your home receive, or have applied for, any other income? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, check all boxes that apply and complete the table below				
<input type="checkbox"/> Social Security benefits (RSDI) <input type="checkbox"/> Supplemental Security Income (SSI) <input type="checkbox"/> Child Support <input type="checkbox"/> Disability benefits <input type="checkbox"/> Pension/retirement benefits <input type="checkbox"/> Unemployment benefits <input type="checkbox"/> Rental Income <input type="checkbox"/> Veterans Administration (VA) benefits <input type="checkbox"/> Military allotments <input type="checkbox"/> Money from friends or relatives <input type="checkbox"/> Alimony <input type="checkbox"/> Worker's Compensation <input type="checkbox"/> Federal Retirement (Civil Service, FERS) <input type="checkbox"/> Land contract, mortgage or other notes payable to a household member (Please provide a copy of the contract, mortgage, note or other agreement) <input type="checkbox"/> Other: _____				
Person receiving/expecting money	Income source/type	How often received	Amount received	Comments

13. Look at the list below. Check the box for anything on the list that you, your spouse, or other person in your home may own. For anything that you check, please tell us about it on the lines below.

When we start working on your application, you may be asked to send in proof of the assets you tell us about.

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Bank Checking Account | <input type="checkbox"/> Bank Savings Account | <input type="checkbox"/> Certificate of Deposit | <input type="checkbox"/> Trust Fund or Trust Account |
| <input type="checkbox"/> Safe Deposit Box (Include a list of the contents) | <input type="checkbox"/> Car, Truck, Van | <input type="checkbox"/> Annuity (If Yes, provide a copy) | <input type="checkbox"/> Cash on Hand |
| <input type="checkbox"/> Stocks, Bonds, or Mutual Funds | <input type="checkbox"/> Motorcycle, Boat, Camper | <input type="checkbox"/> Farm Machinery or Business Equipment | <input type="checkbox"/> Life Insurance |
| <input type="checkbox"/> 401K, IRA or other Retirement Account | <input type="checkbox"/> Pre Need Burial Contract | <input type="checkbox"/> Cemetery Burial Space | <input type="checkbox"/> Money Set Aside for Burial |
| <input type="checkbox"/> DirectExpress Debit Card for SSA, SSI or other benefits | <input type="checkbox"/> Other (Please be specific): | | |

Owned By	Tell us about the asset Include the location, such as the name of bank or funeral home, and any account numbers or other information used to identify the asset	Current Value or Balance

14. Do you or your spouse own any property? *If you answer YES to any of the following questions, please tell us about the property on the next page.*

Home (house, buildings and land where you live) Yes No
 Land (not connected to the home) Yes No

Other House or Building (not your home) Yes No
 Vacation Home or Time Share Property Yes No

What is the address/location of the property? *List Home Property First*

Owner's Name: _____

Is this your Home Property or Primary Residence where you currently live or where you want to return to live if you are living somewhere else? Yes No

What is the address/location of the property?

Owner's Name: _____

15. Does anyone have private health insurance, Medicaid from another state (other than SC), or Medicare? Yes No

Policy Holder	List everyone covered by the insurance	Name of Insurance Company	Policy Number or Medicare Number
<i>Please include a copy of the front and back of all health insurance cards</i>			

**If applying for nursing home services, either in a nursing home or at home,
Please answer questions 16 through 24**

16. If married and entering a nursing home, does the applicant want to give (allocate) part or all of income to a spouse remaining at home? Yes No

17. If there are dependent children or dependent adult, does the applicant want to give (allocate) income to the dependent children or dependent adult? Yes No

18. Has the applicant or spouse ever worked somewhere that has a retirement benefit for which he or she may be eligible to receive money? Yes No
If yes, who was working, where and for how long? _____

19. Does anyone have a bank account, or any other asset, for the applicant or spouse? Yes No
If yes, at what bank or location, and in whose name(s)? _____

20. Has the applicant or spouse closed any bank accounts in the past five (5) years? Yes No
If yes, at what bank and in whose name(s)?

A. _____

B. _____

Date Closed: _____

Date Closed: _____

Closing Balance: _____

Closing Balance: _____

21. Has the applicant or spouse sold or given as a gift, any cash, property, vehicle, boat or other resource to any person any time in the past five (5) years? Yes No

Item Sold or Given Away	Person to Whom it was Sold or Given	Date Given or Sold	Amount Received

22. Where has the applicant lived in the past five (5) years?

City	County	State	From	To

23. If ever married, give the following information about the applicant's spouse(s). (List the most recent first.)

Name: _____

Living

In a medical facility Separated – When or How long? _____

Married living together Divorced Date and State/County where filed: _____

Married living apart (Not Separated)

Current Address: _____ Phone Number: _____

Deceased Date of Death: _____ State and County where estate was probated: _____

Name: _____

Divorced Date of Divorce: _____ State and County where divorce was filed: _____

Deceased Date of Death: _____ State and County where estate was probated: _____

Name: _____

Divorced Date of Divorce: _____ State and County where divorce was filed: _____

Deceased Date of Death: _____ State and County where estate was probated: _____

24. Has the applicant received an inheritance in the last five years?

Yes No

If YES, from whom? _____

Date of Death: _____ State/County where estate was probated _____

Additional inheritance?

If YES, from whom? _____

Date of Death: _____ State/County where estate was probated _____

**PLEASE READ THE FOLLOWING RIGHTS AND RESPONSIBILITIES
AND SIGN THE APPLICATION ON PAGE 9**

Rights and Responsibilities

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 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.
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.

Rights and Responsibilities

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 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.
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).

- 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'm not truthful, there may be a penalty under federal law.
- By signing I state that I have read and agree to the rights and responsibilities stated on this page.

Applicant's Signature: _____ **Date:** _____

If the applicant signs with an "X", the signature must have two witnesses

If you are an authorized representative you may sign the application above as long as you have provided the information on FM 1282 (attached).

Witness 1: _____ **Date:** _____

Witness 2: _____ **Date:** _____

Do you want to name someone as your Authorized Representative for your case? Yes No

If you name an Authorized Representative, there is a form for you to sign to give us permission to talk to this person about your case. We will also be able to send all letters and notices to this person. Please check if this person has Power of Attorney Guardianship Conservatorship for you and include a copy if possible.

Please tell us about the person you would like to be your Authorized Representative:

Name: _____ Relationship: _____

Please sign if you have filled out this application for someone:

Signature: _____ **Date:** _____

I helped the applicant complete this application or I am applying for someone who is unable to act on his/her own behalf. I understand that anyone helping an individual to receive benefits dishonestly is subject to criminal penalties. I certify that the answers on this form:

- Were provided by the applicant/beneficiary Are what I personally know about him or her.

**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 or any member of the organization indicated on this form. 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.

Name of Authorized Representative (First name, Middle name, Last name)		<input type="checkbox"/> New <input type="checkbox"/> Change <input type="checkbox"/> Addition <input type="checkbox"/> Remove this person or organization as my authorized representative	
Authorized Representative's address (Leave blank if you don't have one.)			Apartment or suite number
City	State	ZIP code	
Authorized Representative's phone number		Other phone number	
Authorized Representative's email address			
Organization name (if applicable)		Unit* (if applicable)	ID number (if applicable)

*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

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**.