SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Notice of Non-Discrimination

The South Carolina Department of Health and Human Services (SCDHHS) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SCDHHS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

SCDHHS provides free aids and services to people with disabilities, such as qualified sign language interpreters and written information in other formats (large print, braille, audio, accessible electronic formats, other formats). We provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, please contact the Americans with Disabilities Act (ADA)/Civil Rights Official by mail at: PO Box 8206, Columbia, SC 29202-8206, by phone at: 1-888-549-0820 (TTY: 1-888-842-3620), or by email at: civilrights@scdhhs.gov.

If you believe SCDHHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Official using the contact information provided above. You can file a grievance in person, by mail, or via email. If you need help filing a grievance, we are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201 or by phone at: 800-368- 1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

APPLICATION FOR THE MEDICALLY INDIGENT ASSISTANCE PROGRAM

I. APPLICANT – IDENTIFYING INFORMATION

☐ Emergency ☐ Non-emergency Admission Date _____

Hospital _____

Applicant Name _____ Social Security No. _____

Date of Birth _____ Race _____ Sex ____ Marital Status _____

Telephone: Home _____ Work _____ County of Residence _____

Mailing Address _____

Address where you live (if different) _____

How long at this address? _____ If less than 6 months, give previous address, including county

_____

Is applicant a minor who does not live in the home of his parent(s)? ☐ Yes ☐ No

If yes, give parent(s) name, address, and county of residence _____

_____

Is the applicant a citizen or permanent resident alien? ☐ Yes ☐ No

_____

II. THIRD PARTY INFORMATION ON APPLICANT

1. Do you have any other health insurance? ☐ Yes ☐ No
   If yes, give name of company and number for each policy _____
   _____
2. Is illness due to an accident? ☐ Yes ☐ No If yes, what type? _____
   Date of accident _____ Is claim pending? ☐ Yes ☐ No
   If work-related, give name and address of employer at time of accident _____
   _____
3. Are you covered by Medicare? ☐ Yes ☐ No If yes, give Medicare claim number _____
4. Are you pregnant or were you pregnant at admission? ☐ Yes ☐ No
5. Do you receive or have you applied for Medicaid? ☐ Yes ☐ No Date Applied _____
   If receiving, give Medicaid number _____
   Name of Medicaid worker (if known) _____
6. Have you applied for hospital services through another government program? ☐ Yes ☐ No
   If yes, check all blocks that apply. ☐ Veterans Administration ☐ DHEC
   ☐ Commission for the Blind ☐ Other (specify) _____ Date Applied _____

III. MEMBERS OF THE APPLICANT'S FAMILY

Name	Relationship to Applicant	Date of Birth and/or Age	Marital Status

IV. INCOME

1. Do you or other family members have income? ☐ Yes ☐ No (Income includes wages or salary before deductions, net receipts from self-employment, regular public assistance payments such as Family Independence or SSI, Social Security, Veterans benefits, pension or other retirement income, unemployment compensation, workmen's compensation, child support or alimony, interest income, etc.)

Name of Family Member	Gross Income	Frequency	Name and Address of Source

2. If not working now, when was your last day of employment? _____
   Name and address of employer: _____
3. Have you or anyone in your family received a lump sum payment in the past four (4) weeks (income tax refund, insurance settlement, etc.)? ☐ Yes ☐ No
   If yes, amount received _____ From whom? _____

V. RESOURCES

1. Do you or other family members own real property (home, land, buildings, life estates, mobile homes, etc.)? ☐ Yes ☐ No If yes, give the following information:

Type	Owner(s) (If jointly owned, list all owners.)	Location	Amount Owed, if any

2. Do you or other family members own taxable personal property (cars, trucks, boats, vans, mobile homes (other than home), motorcycles, or other kind of vehicle)? ☐ Yes ☐ No If yes, give the following information:

Type	Registered Owner(s)	Year, Make, and Model	Amount Owed, if any

3. Do you or other family members own liquid assets (cash on hand, checking accounts, savings accounts, U.S. Savings Bonds, stocks, trust funds, certificates of deposit, face value of life insurance, individual retirement accounts, etc.)? ☐ Yes ☐ No If yes, give the following information:

Type	Owner(s) (If jointly owned, list all owners.)	Location	Account Number	Amount/Value

VI. TRANSFER OF RESOURCES

Have you or other family members sold or given as a gift any resources in the past three (3) months?
☐ Yes ☐ No If yes, give the following information:

Type	Owner(s) (If jointly owned, list all owners.)	Location	Account Number	Amount/Value

VII. STATEMENT OF UNDERSTANDING

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 the Medically Indigent Assistance Act.

I understand that if I believe an error has been made by the MIAP county designee in processing my MIAP Application, I may request a reconsideration. This request must be made in writing, within 30 days from the date of the decision notice, to the person designated by the county's chief administrative officer to make reconsideration decisions. I understand that if I believe an error has been made in the reconsideration decision, I have the right to appeal this decision at a hearing with SCDHHS, the agency that administers Medicaid in South Carolina. I may represent myself at the hearing, hire an attorney to help me or have someone speak on my behalf. I must submit a written request for a hearing no later than 30 calendar days from the date on this notice via one of the following methods:

- Online at www.scdhhs.gov/appeals • Faxed to: 888-835-2086 • Emailed to: eligappeals@scdhhs.gov.
- Mailed to: SCDHHS – Central Mail, PO Box 100101, Columbia, SC 29202-3101, Attn:Eligibility Appeals

In the appeal request, I should specifically state which issue(s) I wish to appeal and attach a copy of the notification regarding the specific matter on appeal. (For more information about the appeal process or what to include in your appeal request, go to www.scdhhs.gov/appeals, call 888-835-2039 or send an email to eligappeals@scdhhs.gov.)

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. By my signature, I authorize the release of any information needed to determine my eligibility for the Medically Indigent Assistance Program, and I authorize the MIAP county designee to provide a copy of this application to a Medicaid eligibility worker.

Applicant's Signature:		Date:
Signature of Responsible Person or Authorized Representative:	Title/Relationship:	
Address:		Date:
Witness (signature by a mark "X" requires two witnesses):	Witness:	Date:
County Designee Signature:		Date:

VIII. CASE NOTES WORKSHEET

The eligibility factors identified below must be met before an applicant can be certified for assistance through the MIAP. Please indicate if each factor is met and how it was verified.

1. Is applicant a state resident? ☐ Not questionable ☐ Questionable
   If questionable, how verified? _____

2. Is applicant a citizen or a permanent resident alien? ☐ Not questionable ☐ Questionable
   If questionable, how verified? _____

3. Number of Family Members …… ☐
   Explain who was included/excluded in the family composition and why.

   Family Income – Whose income was included in the calculation?

   How was it verified and calculated?

TOTAL GROSS ANNUAL INCOME ☐

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4. Family Resources
   A. Home Property (Identify the asset, to whom it belongs, and the equity value.)

   Method and date of verification

   MIAP Limit $35,000.00

TOTAL VALUE OF HOME PROPERTY ☐

   B. Non-home real property and taxable personal property (Identify the asset, to whom it belongs, and the equity value.)

   Method and date of verification

   MIAP Limit $6,000.00

TOTAL VALUE OF NON-HOME REAL AND TAXABLE PERSONAL PROPERTY ☐

   C. Liquid Assets (Identify the asset, to whom it belongs, and the value.)

   Method and date of verification

   MIAP Limit $500.00

TOTAL VALUE OF LIQUID ASSETS ☐

   Does the value of the applicant's liquid assets (4C) exceed the MIAP limit? ☐ Yes ☐ No
   If yes, by how much? $_____

   Did the applicant spend the excess on valid debts of the family that were incurred within thirty (30) days of the hospitalization? ☐ Yes ☐ No If yes, how verified? _____
   _____