SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Additional Information for Select Medicaid Programs

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

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

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

☐ **Optional State Supplementation (OSS)**

☐ **Working Disabled (WD)**

☐ **Inmate Services**

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

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

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

1. Who is applying for assistance?

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

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

☐ **Child Support**

☐ **Money From Friends and Relatives**

☐ **Veterans Assistance**

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

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

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

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

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

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

☐ **Yes** ☐ **No**

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

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

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

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

Address where you lived before incarceration

_____

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

a. Did you work or receive earnings before you were incarcerated? ☐ **Yes** ☐ **No**

b. If living with your spouse before you were incarcerated, was your spouse employed? ☐ **Yes** ☐ **No**

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

a. Type of income	Amount Paid	How often paid
b. Type of income	**Amount Paid**	**How often paid**
c. Type of income	**Amount Paid**	**How often paid**

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

Correctional Facility Staff Person: _____ **Date:** _____

Phone Number: _____

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, contact Janet Bell, ADA and Civil Rights Official, by mail at: PO Box 8206, Columbia, SC 29202-8206; by phone at: 1-888-808-4238 (TTY: 1-888-842-3620); or by email at: civilrights@scdhhs.gov.

If you believe that 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 or by mail or 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

Language Services

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).

خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 888-549-0820 (رقم هاتف الصم والبكم: 888-842-3620). إذا كنت تتحدث اذكا اللغة، فإن

Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-888-549-0820 (TTY: 1-888-842-3620).

Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-549-0820 (телетайп: 1-888-842-3620).

Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-549-0820 (TTY: 1-888-842-3620).

Se você fala português do Brasil, os serviços de assistência em sua lingua estão disponíveis para você de forma gratuita. Chame 1-888-549-0820 (TTY : 1-888-842-3620)

如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-888-549-0820 (TTY: 1-888-842-3620)

Falam tawng thiam tu na si le tawng let nak asi mi 1-888-549-0820 (TTY: 1-888-842-3620) ah tang ka pek tul lo in na ko thei.

धयद आप हद्दी बोलते ह तो आपके लिए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-888-549-0820 (TTY: 1-888-842-3620) पर कॉल कर।

한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-549-0820 (TTY: 1-888-842-3620)번으로 전화해 주십시오.

Haka tawng thiam tu na si le tawng let asi mi 1-888-549-0820 (TTY: 1-888-842-3620) ah tang ka pek tul lo in ko thei.

Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 888-549-0820 (ATS : 888-842-3620).

နမ့်ကတိၤ ကညီ ကျိာ်အယိ, နမၤန့် ကျိာ်အတၢ်မၤစၢၤလၢ တလာ်ဘူဉ်လၢာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး 888-549-0820 (TTY: 888-842-3620)

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-549-0820 (መስማት ለተሳናቸው: 1-888-842-3620).

အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့် င့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 888-549-0820 (TTY: 888-842-3620) သို့ ခေါ်ဆိုပါ။