

South Carolina Department of Health and Human Services

Additional Information for Nursing Home and In-Home Care

		\square Nursing Hor	ne 🗌 In	-Home Care	e (Waiver Ser	vices)	
Inst app	s form is used to gather other infititutional Care, or Waiver Service olication was signed are still in efections about this form, please co	es. All of the right ffect. If there are	s and resp any questi	onsibilities ag ons about tho	greed to when the se rights and re	he origina	I
	Who is the person needing assist	tance (applicant)?			<u>.</u>	¹	
Nam	ne (First, Middle Initial, Last):		So	cial Security N	Date of Birth		
2.	Where is the person right now? If not at Home, tell us where the	Horperson is.	ne 🗆] Hospital	■ Nursing	Home	☐ Other
	Name of Facility or Hospital:						
	Date Entered:						
	Please check if anyone has Cons If yes, please give us a copy of the Conservatorship Name:	• •	ne name and	d phone numbe	r of the person.	•	
		· 					
	☐ Power of Attorney Name:						
	If married and entering a nursing spouse remaining at home?			•			e to
	If there are dependent children or dependent children or dependent	-		• •	• ,	•	to the
	Has the applicant or spouse ever eligible to receive money?					Yes	e may be
7.	Do you or anyone in your home re Before we can make a decision on you	eceive, or have ap ur application, you m	plied for, a ay have to g	i ny other inco i ve us proof of in	me?come for the past 4	Yes 4 weeks.	☐ No
you (es, check all boxes that apply and comp do not have to tell us about it again. Supplemental Security Income (SSI) Veterans Administration (VA) benefits Federal Retirement (Civil Service, FERS Land contract, mortgage or other notes Other:	olete the table below.	If you have a Child Support Military allotm	already told us a ents	bout a type of inco Disability b Money fror	me on your penefits m friends or	relatives
Pe	erson receiving/expecting money	Income source/type	How often received	Amount received	Co	mments	
		30ui ocht je	ICOCITO	TOUTTO			

8. 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.							
 ☐ Bank Checking Account ☐ Trust Fund or Trust Account ☐ Annuity (If Yes, provide a copy) ☐ Motorcycle, Boat, Camper ☐ 401K, IRA or other Retirement Account ☐ Money Set Aside for Burial ☐ Other (Please be specific): 	Bank Savings Account Certificate of Deposit Trust Account Safe Deposit Box (Include a list of the contents) Car, Truck, Van es, provide a copy) Cash on Hand Stocks, Bonds, or Mutual Funds Boat, Camper Farm Machinery or Business Equipment Life Insurance other Retirement Account Pre Need Burial Contract Cemetery Burial Space side for Burial DirectExpress Debit Card for SSA, SSI or other benefits e be specific):						
Owned By	Owned By Include the location, such a		Il us about the asset such as the name of bank or funeral home, or Balance or Other information used to identify the asset				
9. Do you or your spouse own any If you answer YES to any of the following que Home (house, buildings and land whe Other House or Building (not your hor Land (not connected to the home) Vacation Home or Time Share Proper What is the address/location of the proper List Home Property First	estions, please tell us ab ere you live) me)	☐ Yes ☐ N ☐ Yes ☐ N ☐ Yes ☐ N	lo lo lo cation of the prope	rty?			
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		Owner's Name:					
10. 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)?							

• • • • • • • • • • • • • • • • • • • •	☐ No				
If yes, at what bank and in whose name(s)?					
<u>A.</u> <u>B.</u>					
Date Closed: Date Closed:					
12. Has the applicant or spouse sold or given as a gift, any cash, property, vehicle, boat or other reto any person any time in the past five (5) years?	esource No				
Item Sold or Given Away Person to Whom it was Sold or Given Date Given or Sold Amount R	eceived				
13. Where has the applicant lived in the past five (5) years?					
City County State From	То				
14. If ever married, give the following information about the applicant's spouse(s). (List the most rece					
Name:	ent first.)				
	ent first.)				
Living	ent first.)				
☐ In a medical facility ☐ Separated – When or How long?					
☐ In a medical facility ☐ Separated – When or How long? ☐ Married living together ☐ Divorced Date and State/County where filed: ☐					
☐ In a medical facility ☐ Separated – When or How long? ☐ Married living together ☐ Divorced Date and State/County where filed: ☐ Married living apart (Not Separated)					
☐ In a medical facility ☐ Separated – When or How long? ☐ Married living together ☐ Divorced Date and State/County where filed: ☐ Current Address: Phone Number: ☐ Deceased Date of Death: ☐ Deceased					
☐ In a medical facility ☐ Separated – When or How long? ☐ Married living together ☐ Divorced Date and State/County where filed: ☐ Current Address: Phone Number: ☐ Deceased Date of Death: ☐ State and County where estate was probated:					
☐ 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:					
☐ 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: Phone Number: Deceased Date of Death: State and County where estate was probated: Name: Divorced Date and place divorce filed:					
☐ 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 and place divorce filed: Deceased Date of Death: Deceased Da					
☐ 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: Phone Number: Deceased Date of Death: State and County where estate was probated: Name: Divorced Date and place divorce filed:					
In a medical facility					

15. Give the following information about the applicant's mother and father, if known.						
Mother:	Deceased					
Living Address:	Date of Death:					
	County and State where estate was probated:					
Phone Number:						
Father:	Deceased					
Living Address:	Date of Death:					
	County and State where estate was probated:					
Phone Number:						
Signature of person completing this form:	Relationship:					
ESTATE RECOVERY						
	E ESTATE RECOVERY BROCHURE.)					
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 mentally retarded, 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.						
FOR SCDHHS USE ONLY						
Verifications in File: DHHS 1255 ME	Level of Care Verified:					
☐ DHHS 1253 ME	☐ Intermediate ☐ Skilled ☐ SNF (Medicare)					
Checked for Transfers: Yes No	Were any Transfers Discovered: Yes No					
Calculated Sanction Period:						